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Rationing by Any Other Name [Sounding Board]

Asch, David A.; Ubel, Peter A.

University of Pennsylvania School of Medicine; Philadelphia, PA 19104-2676

Although many clinicians and health policy makers are comfortable with the notion that some beneficial health care services are simply too expensive to provide, fewer are comfortable using the word "rationing" to describe these compromises. The word is so loaded that some cannot use or hear it without thinking of policies that discriminate against vulnerable population groups. Some policy makers carefully avoid the word, substituting euphemistic phrases such as "emphasizing truly beneficial services." When the word is used in medical contexts, it is usually to discredit an insurance program or a suggested health policy that cuts too close to a favored program.

Besides having negative connotations, the word "rationing" also suffers from inconsistent definitions. [1] To most economists, rationing is simply the process of allocating goods in the face of scarcity. In health care settings, however, the word is frequently invoked to describe distributions based on cost and, in particular, decisions to limit some clinical services because they are thought to be too expensive for society. On the other hand, some argue that rationing includes only explicit decisions taken at a systemwide level to limit services to some categories of people. [2] This definition would exclude less explicit mechanisms, such as market pressures based on price. Others believe that rationing properly refers only to cost-based limitations on "necessary services" rather than limitations on beneficial services that, although effective and desired, are beyond what would be considered basic needs. [3]

Whatever words one uses and whatever definitions one gives to those words, the reality is that clinical services believed to be beneficial are limited because those services are seen as too costly to provide. All around us are examples of practices and policies that promote such compromises. At the same time, since clinicians, managers, and policy makers rarely say that they are engaged in rationing, what is it that they say they are doing?

In this paper, we describe several alternative characterizations of rationing. Each alternative is introduced with a case. These cases are based on our own experience or on

situations we have been told about. In each case, a physician decides in favor of a treatment choice that he or she believes to be both less effective (from the perspective of the patient) and less expensive (from the perspective of society, the health care plan, or the clinical practice, but not the patient). Our purpose in presenting these scenarios is to illustrate that compromises in clinical care are pervasive, varied, and often disguised. If there is to be a resolution to the debate about compromise in clinical care, it must come from discussion of what actually happens rather than of the language used to describe it.

Thinking Beyond the Individual Patient 🇺🇸

Dr. Smith is about to perform coronary arteriography on Mr. Stevens and is deciding whether to use ionic or nonionic radiocontrast dye during the procedure. He decides on the less expensive ionic contrast dye, even though he believes the nonionic dye is less likely to cause complications. Dr. Smith reasons, "If everybody used nonionic contrast dye, some patients would be better off, but not enough to justify the large increase in cost to society."

Here the clinician opts for a less costly clinical strategy by considering the effects of a more expensive strategy on overall social welfare. In this case, the tension between the cost of the alternative and its benefit is overt but is displaced from the patient at hand to a wider field. Dr. Smith could have assumed an individual perspective and considered only the welfare of this particular patient. Had he assumed an individual perspective, he might have been uncomfortable choosing the less effective agent. Instead, he considers the effect among many other patients and clinicians. Although this switch from an individual to a group perspective may seem transparent, there is evidence that physicians make different decisions for individual patients and for groups of similar patients. [\[4,5\]](#)

Appealing to the "Standard of Care" 🇺🇸

Mr. Green complains to his physician, Dr. Brown, of a new, persistent headache. Dr. Brown orders a computed tomographic (CT) scan to evaluate the possibility of a brain tumor, even though she believes magnetic resonance imaging (MRI) would be more sensitive. In discussing the issue with Mr. Green, Dr. Brown mentions that, in general, ordering a CT scan in this situation is the "standard of care."

In this instance, the physician opts against the more effective and more expensive MRI, arguing to the patient or to herself that the less expensive CT scan is the standard of care. Nevertheless, the standard of care is itself often influenced by considerations of the cost to society. One reason it is not the standard of care to obtain MRIs for patients such as Mr. Green is that the resulting costs would be too high. If MRIs were less costly, the standard of care for patients with headaches might be different.

It is possible to view Dr. Brown's actions in many ways. Is Dr. Brown playing with words in order to reduce social costs? Is she making peace with herself in resolving a potentially difficult conflict? Is she following a long-standing professional norm that just happens to have incorporated the consideration of costs to society? Whatever the view, in many

situations physicians appeal implicitly or explicitly to the "standard of care." In many cases the standard of care reflects some consideration of cost, yet most physicians in these situations probably do not feel that they are trading off their patients' welfare against social cost.

Displacing Responsibility

Ms. Johnson sees her general internist, Dr. Edwards, about her gastroesophageal reflux disease. She is surprised when Dr. Edwards prescribes cimetidine rather than omeprazole, which she has heard is the best treatment. Dr. Edwards explains that although he believes omeprazole would probably be somewhat better for relieving Ms. Johnson's symptoms, the health care company's formulary policy restricts the prescription of omeprazole to patients whose need for the drug has been determined by a gastroenterologist.

In this situation, Dr. Edwards justifies or explains his less costly choice by appealing to an external rule. Dr. Edwards apparently believes that one drug would be better than another but shifts the responsibility for choosing the less effective, less expensive agent onto the health care company. The way one views this situation depends not only on clinical factors (for example, how much difference one perceives there really is between the two drugs), but also on professional and institutional factors (how much independence Dr. Edwards really has in making a choice). Some of these decisions may actually be out of the individual physician's control, but others may not. For example, perhaps the responsibility in fact rests with the formulary committee. On the other hand, if Dr. Edwards truly believes that omeprazole is better, he could refer the patient to a gastroenterologist.

Responsibility can be displaced, appropriately or not, in many different directions. The justification that "in general, we don't consider omeprazole to be first-line therapy for gastroesophageal reflux disease" in effect shifts the decision from an individual physician to a professional norm. In doing so, it resembles the "standard of care" argument presented earlier. Justifications such as, "Your policy doesn't cover a glucometer unless you require insulin," may reveal a firmer rule, although sometimes even these can be bent. Physicians might blame the medical marketplace: "If I were to order an MRI for every patient with a headache, I would be identified as a high-cost clinician and managed-care organizations would drop me from their panels." Or clinicians might shift responsibility to the patient: "Doxycycline is as effective as azithromycin; you just have to take it for a week." These justifications are all intended to transfer responsibility for perceived cost-quality trade-offs away from the physician. And in general, external rules are both limiting and liberating: a formulary that restricts access to expensive drugs can simultaneously tie physicians' hands and allow them to avoid decisions they do not want to make.

Suppose Ms. Johnson did not mention omeprazole to Dr. Edwards, but instead asked for cimetidine. In this case, Dr. Edwards would be spared the need to explain his choice. It would certainly be convenient for him that Ms. Johnson asked for the less expensive

medicine, which he would have prescribed, rather than the more expensive medicine, which he thought was clinically superior.

One way to view this situation is to recognize that patients' preferences should always be considered when making medical choices. Preferences for medical rather than surgical approaches to certain conditions, for example, may reflect deeper attitudes about risk or aggressive therapy that ought to be considered in making decisions. But incorporating the expressed preferences of patients into medical decision making may not be enough if patients do not adequately understand the available alternatives. Ms. Johnson may not have heard of omeprazole. Although Dr. Edwards would have done exactly what Ms. Johnson requested in the second instance, he would have taken a passive stance in serving as her advocate.

Making Do with Less Than the Best

Mrs. Glenn sees her family practitioner, Dr. Shepard, for a referral to an orthopedist for a total knee replacement. There are two orthopedists in the community. Dr. Aldrin is considered a national expert in the procedure, but the plan under which Dr. Shepard sees Mrs. Glenn has an arrangement with Dr. Grissom, a general orthopedist. Dr. Shepard anticipates Mrs. Glenn's concern: "I know that you would like a referral to Dr. Aldrin, because she is considered the expert in knee replacements, but Dr. Grissom is an able orthopedist."

One can imagine many different financial or organizational reasons why Dr. Shepard would refer Mrs. Glenn to Dr. Grissom, and these differences might affect how one views the situation. Common to any of these unstated arrangements is the question of whether Dr. Shepard's responsibility is to arrange the best possible care for Mrs. Glenn or simply to arrange good care. Even if Dr. Aldrin really is the better orthopedist, perhaps she is not able to operate on all the patients in the community who need her help. Immutable constraints such as these increase our tolerance for making do and might make Dr. Shepard more comfortable with his actions, even if he would have referred his own mother to Dr. Aldrin.

Using the "Best Treatment" Only after Others Fail

Ms. Cooper sees her general internist, Dr. Kelley, about her seasonal allergies. Dr. Kelley explains that although he believes a nonsedating antihistamine is likely to be better tolerated, he thinks it is reasonable to try a less expensive conventional antihistamine first and to use the more expensive kind only if Ms. Cooper is troubled by sedation.

It takes a broad definition of "compromise" to argue that Dr. Kelley is compromising Ms. Cooper's care in order to save money. After all, Dr. Kelley intends to prescribe the more expensive agent that he believes is more effective, but only if the less expensive agent fails. There are many situations in which physicians start with an inexpensive approach and move to a more costly and generally more effective one only if it is necessary.

We might think differently if Dr. Kelley used to prescribe the more expensive agent as first-line therapy in similar cases but developed this new strategy only after his health care company introduced financial incentives favoring the less expensive approach. Still, some might argue that Dr. Kelley should have been following a strategy like this all along. Nevertheless, if Dr. Kelley really believes that one drug is more likely to succeed than the other, he has made a compromise, albeit a small one, in the care of Ms. Cooper.

Discussion

We suspect that many physicians will recognize elements of their own practices in these cases. Does this mean that they are rationing care? Perhaps not, if rationing refers only to practices that are in some way unethical or unprofessional. Perhaps so, if rationing refers to any decrease in the quality of care intended to save money. Or perhaps it does not matter at all what we call these cases, because whatever words we use, all the cases still involve decisions that favor a less expensive option even though it is perceived to be less effective. Each case reflects a compromise. As physicians, patients, insurers, and others face trade-offs between cost and quality, the debate should not be about some global notion of rationing or compromise, but about which justifications are valid and which compromises are appropriate.

For example, in many situations the practice of thinking beyond the individual patient may be an effective way to link individual decisions to broader issues. Clinicians practicing in public or nonprofit settings, in which savings in one area can support costs in another, are justified in making compromises within this wider perspective. The same reasoning is less persuasive when savings in one area leave the system in the form of profits for owners.

Compromises embedded in the standard of care make sense as long as the standard of care itself makes sense, but not otherwise. In some cases, an appeal to the standard of care is just a shorthand way of describing good medical practice -- when good medical practice reflects a wider social perspective. But an appeal to the standard of care should not justify or legitimize a choice unless that choice makes sense for other reasons.

Efforts to displace responsibility are hard to evaluate in the abstract. One should look at the effects of the compromise, at the underlying motivations of those imposing the constraints, and at the extent to which the physician's traditional fiduciary posture is weakened. Although physicians have strong and historic obligations to individual patients, clearly they cannot fight every battle relentlessly. Nor should they abdicate their professionalism in favor of some wider institutional or social mission. Although these extremes are well defined, drawing the correct line between them is likely to remain a matter of specific circumstances and personal judgment.

Cost containment that occurs passively, because the patient is not aware of the alternatives, is not justified by this fact alone. Although physicians interested in cost containment may find it convenient when patients request a less expensive but less effective treatment or test, physicians should not rely on these expressed preferences.

There may be legitimate reasons for making such a choice, but the expressed preference of an uninformed patient is not one of them. Taking advantage of one patient's less expensive preferences makes no more sense than giving in to a request for an inappropriately expensive test or treatment from another.

Finally, using the "best" but most expensive treatment only after others fail will be seen by many physicians as a timeless and essential part of practicing medicine. The compromise embodied in this approach is that sometimes symptoms are not relieved as fast as they might be or conditions are prolonged or exacerbated while one waits to see whether the first treatment will succeed. In practice, however, any ill effects of compromises such as these are usually small.

Indeed, the best measure of all compromises is their magnitude. Using the "best" treatment first makes more sense when the second-best one is much less likely to work, or when the clinical stakes are higher. Thinking beyond the individual patient is easier and more tolerable when the individual patient is not likely to lose much. Because there is no uniform way of dealing with these trade-offs, they always require personal judgment and they will always involve gray areas when those judgments vary. Our goal is not to eliminate the gray areas when choices are hard and when judgments vary, because we believe gray areas are unavoidable. Rather, in making these different rationales explicit and demonstrating that many of the practices in our scenarios are pervasive, we hope to help move discussion beyond the loaded question of whether rationing is acceptable to the more constructive question of what kinds of compromise are justified. The goal, in the end, is to help physicians learn to practice medicine more effectively when compromise is inevitable.

David A. Asch, M.D.

Peter A. Ubel, M.D.

University of Pennsylvania School of Medicine; Philadelphia, PA 19104-2676

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