Educational support materials for ABIM's *Care for the Underserved Module*

**Question 15**

It is expected that physicians will act in the best interest of their patients, advocating for patient care within the constraints set by society, reasonable insurance coverage, and sound clinical practice. However, physicians, patients and their surrogates may differ in perceived goals of care and estimation of patients’ quality of life. Further, critically ill patients are often unable to participate in their own decision-making process. Research suggests physicians are often uncomfortable with interventions perceived to be too intensive. (1) One study observed that provider discomfort with intense care plans stemmed from provider’s perceptions that: 1. the patient or surrogates were overestimating the chance for survival and future quality of life; 2. intensive care was inappropriately prolonging the process of dying; and 3. resources were being inappropriately utilized. (2)

Other nonclinical factors, such as race, have been associated with decreased resource utilization for seriously ill patients. For example, African Americans are less likely to receive procedures such as dialysis, surgery, pulmonary artery catheterization, endoscopy, and bronchoscopy. (1) Physician decision-making about the provision of limited and/or expensive care is often called “bed-side rationing” and has engendered extensive debate. Some argue that physicians' rationing in medical decision-making can at times be are morally justified. (3-5) Others suggest that any consideration of rationing and economics harms the physician–patient relationship. (2,5)

European data suggests a majority of providers agree with rationing to some degree, and also report prior personal experience with rationing interventions. (6) Criteria for rationing frequently mentioned included small expected benefit (82.3%), low chances of success (79.8%), low quality of life (70.6%), and patient age over 85 (70%). However, it may be just as important to consider the equitable distribution of resources, especially when the care being provided is limited and/or expensive. (7)

While physicians generally should not recommend treatments they deem medically inappropriate just because of patient or family insistence, dialysis may be offered as a default because it is a feasible therapy with objective short-term effectiveness. (8) Ultimately, continued communication and appraisal of clinical status among patients, families, and care providers may enhance understanding and decision-making, minimize discomfort among providers and families, and result in fewer cases of extended intensive care for patients with poor prognoses.

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*This educational support material was created by the Society of General Internal Medicine’s Disparities Task Force. For more information, visit [www.sgim.org/go/disparities](http://www.sgim.org/go/disparities)*
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For further information, see the following: