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

Module #19

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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For further information, see the following:

1. R.S. Phillips, M.E. Hamel, J.M. Teno et al., Race, resource use and survival in seriously ill hospitalized adults. J Gen Intern Med 11 (1996), pp. 387–396.
2. Ubel PA, Goold S. Recognizing bedside rationing: clear cases and tough calls. 1997; 126 (1): 74-80.
3. Ubel PA, Arnold RM. The unbearable rightness of bedside rationing. Physician duties in a climate of cost containment. Arch Intern Med. 1995; 155:1837-42.
4. Hall M. Rationing health care at the bedside. New York University Law Review. 1994; 69:693-780.
5. Welch HG. Should the health care forest be selectively thinned by physicians or clear cut by payers? Ann Intern Med. 1991; 115:223-6.
6. Hurst SA, Slowther AM, Forde R, et al: Prevalence and determinants of physician bedside rationing: Data from Europe. J Gen Intern Med 2006;21:1138-1143.
7. Ubel PA, Goold S: Recognizing bedside rationing: Clear cases and tough calls. Ann Intern Med 1997;126:74-80.
8. Patel SS, Holley JL. Withholding and withdrawing dialysis in the intensive care unit: benefits derived from consulting the renal physicians association: American Society of Nephrology clinical practice guideline, shared decision-making in the appropriate initiation of and withdrawal from dialysis. 2008; Clin. J. Am. Soc. Nephrol., 3(2): 587 - 593.