Physicians, Thou Shalt Ration: The Necessary Role of Bedside Rationing in Controlling Healthcare Costs

LEAD PAPER

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ABSTRACT

Physicians are often asked to be "gatekeepers," determining their patients' access to medical therapies and technologies. At the same time, most physicians have been taught that they should act as patient advocates, pursuing patients' best interests regardless of cost. This paper reviews moral arguments ethicists have made for and against "bedside rationing." It argues that healthcare rationing is appropriate in order to help control healthcare costs, and that rationing decisions made at the bedside by physicians must be part of the rationing system. A system that attempts to control costs by mandating an elaborate set of rules would be burdensome, and many physicians would find ways around the rules anyway.

Physicians are deeply conflicted about their roles in cost-containment. Some of the conflict has to do with discomfort over the concept of "rationing," but they are also in

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conflict about much deeper issues. The author argues that patients can do with less than the "best" treatment and physicians must come to terms with this. Finally, healthcare systems need to signal physicians that it is acceptable for them to offer "less" to their patients in order to serve the greater good.

MS. JOHNSON COMES TO HER PHYSICIAN with symptoms of gastric reflux (GERD). Her doctor gives her a prescription for cimetidine, even though he knows omeprazole would be better at relieving her symptoms. He thinks the cost of this other medication is too high for it to be the initial treatment.

In an old Mel Brooks movie, Moses is seen coming down from the mountains with three stone tablets. He announces to his people in a stentorian thunder: "I come down with a copy of God's Fifteen …" — he fumbles one of the tablets, and it falls to the ground — ". . . er, Ten Commandments for how to live a good life."

This is pure speculation, but I would guess that somewhere on that broken tablet was a commandment that read: "Physician, thou shalt not ration!" I base my speculation on the tone many people take when debating the appropriateness of bedside rationing by physicians. Opponents of bedside rationing argue vehemently that physicians should never ration from their patients. For example, in a *New England Journal of Medicine* editorial, Howard Hiatt (1975) wrote: "A physician must do all that is permitted on behalf of his patient." In a similar vein, Dr. Norm Levinsky, chair of medicine at Boston University, has written that: "Physicians are required to do everything they believe may benefit each patient without regard to cost" (Levinsky 1984). Hiatt and Levinsky's statements are consistent with the traditional moral view that physicians should advocate for their patients without regard to costs. This view is treated almost as a theological truth in the United States. But I am a heretic. I think that it is sometimes appropriate for physicians to ration healthcare from their patients in order to help control healthcare costs. In this article, I briefly describe the "theology" of bedside rationing — why so many people think bedside rationing is immoral. I also discuss why I am a heretic. I think any method of controlling healthcare costs is doomed to fail, unless it is joined by some relaxation of physicians' advocacy duties. Finally, I discuss linguistic confusion about bedside rationing. Many people debate the appropriateness of bedside rationing without ever defining what they mean; this leads to disagreements about the morality of bedside rationing among people whose moral values are actually the same.

Theology 101: the Immorality of Bedside Rationing

Opponents of bedside rationing contend that it violates physicians' moral duties to advocate for patients' interests. In addition, they believe that bedside rationing would erode trust between patients and their physicians. Moreover, they hold that bedside rationing creates savings that do not necessarily go toward improving patient care for other patients. I elaborate on each of these objections below.

It is has been long argued that physicians have a "fiduciary duty" to advocate for patients' interests (Morreim 1989).

A fiduciary is someone who acts on behalf of those who otherwise may not be able to pursue their interests (Hall 1997). Physicians are seen as fiduciaries for patients because they have more knowledge than patients do. Patients may not know what is in their best interests or may not be able to pursue their best interests without a physician's help. Physicians also have fiduciary duties because patients are often dependent on them. Patients are emotionally dependent on physicians because their illnesses make them vulnerable; in addition, patients are legally dependent on physicians, who have been given powers to order medications and perform procedures that other people can not do. Finally, physicians' fiduciary duties arise because healthcare issues are often high stakes. These high stakes distinguish the doctor-patient relationship from otherwise parallel relationships, such as between an auto mechanic and a client. An auto mechanic has more knowledge about cars than a typical person and may have tools to repair a car that the average person could not afford. Although auto mechanics have moral duties, such as to be honest with their clients, their duties are not fiduciary, because the stakes are not high.

People often feel strongly about physicians' advocacy duties towards patients because they recognize that patients need to *trust* their physicians in order to receive good care (Goold 1998). Many aspects of healthcare depend on trusting interactions between patients and their providers. Patients who do not trust their healthcare provider may not tell the provider about the symptoms they are experiencing, or may not tell about high-risk behaviour they are engaging in. If worried that physicians were rationing healthcare from them, patients might lose trust in their physicians. Consequently, the quality of healthcare that physicians can provide to their patients would erode.

Some opposition to bedside rationing arises because of concern about who would really benefit if physicians rationed healthcare from their patients (Asch et al.; in submission). In the case presented in the introduction, a physician prescribed a less expensive medicine to a patient with reflux in order to save money. But whose money was being saved? If the patient would not have incurred most or all of the increase in costs of the more expensive medicine, then who benefits from this rationing decision? Many people think the money will simply go to a greedy insurance company or to the CEO of a managed-care company. These people contend that there is no moral justification for withholding the best care from patients, given that the money saved by bedside rationing will not necessarily benefit patients.

For these and other reasons, the traditional moral view is that physicians need to do what is in patients' best interests regardless of cost. But, as I stated above, I do not hold that view. Below I will describe why I oppose the traditional view of physicians' moral duties. First, however, I need to define what I mean by "bedside rationing."

Defining My Terms

Bedside rationing is a subset of healthcare rationing; in other words, it is one of many ways to ration healthcare. For the purposes of this article, I hold that healthcare rationing occurs whenever the healthcare system, or "society," allows

patients to receive less than the most beneficial healthcare service. If a patient receives treatment A because of resource constraints, when a more expensive treatment, B, would have been better, then treatment B has been rationed from the patient. This rationing could have occurred because of bedside rationing — a clinician might have decided to prescribe A rather than B; or it could have occurred through market forces — the patient could have been asked to pay for either A or B and, thus, chose A; or it could have occurred through any number of other mechanisms.

The definition I have proposed for healthcare rationing is consistent with how most health economists define the term. I have defended this definition elsewhere (Ubel and Goold 1998). Nevertheless, there is no single "best" way to define a complex term like healthcare rationing, nor is it crucial for me to convince you that the definition I propose is the best. Instead, I put forward this definition as a way to clarify the term as I discuss why I believe bedside rationing is morally acceptable.

Before discussing why I believe bedside rationing is an acceptable method of rationing healthcare, I need to note a fact that is perhaps obvious. If healthcare rationing is unacceptable, then bedside rationing is unacceptable. In other words, those who argue that healthcare should not be rationed not only disapprove of bedside rationing but also would disapprove of any other method of rationing healthcare. I will not argue against this view here. Others have argued convincingly, I believe, that there is a need to ration healthcare (Hall 1997; Callahan 1990; Eddy 1994). The proliferation of new technologies being offered to patients with a wide range of illnesses has made it impossible to offer every patient the best possible healthcare services in existence. Each day, new medications become available that, if they were free, would probably be offered to hundreds of thousands of patients. These medications are so expensive, however, we often hesitate to provide them to everyone that would benefit. Cholesterol medications, for example, are slowly diffusing towards a broader group of patients, but if they were as free as water, many people at relatively low risk of coronary heart disease might start taking them. To make this discussion manageable, then, I will ask readers to assume that some amount of healthcare rationing is necessary to help control healthcare costs. The question for this article then is whether any amount of this rationing ought to be done at the bedside by clinicians. In other words, is bedside rationing a legitimate form of healthcare rationing?

Not surprisingly, it is helpful to begin with a definition of bedside rationing. Susan Goold and I have argued that three conditions are necessary for a clinical action to qualify as bedside rationing: (1) the patient must be given less than the best available healthcare, (2) the best healthcare must be withheld in order to save societal resources, and (3) the physician (or clinician) must have control over the healthcare decision (Ubel and Goold 1998). For example, in the reflux case described in the introduction, the physician prescribed the less expensive reflux medicine in order to save society money. Hence, the case was an example of bedside rationing. A subtle change in the case, however, would change this classification. If the patient was responsible for

the difference in cost of these two medicines, the decision would not necessarily qualify as bedside rationing, because the physician could potentially be ordering the less expensive medicine to save money for the patient. (In such a situation, the physician ought to talk with patients about how they want to spend their money.) Another change in the case would also eliminate it as an example of bedside rationing. If the patient's health plan required physicians to prescribe less expensive reflux medicines before prescribing expensive ones, the doctor's prescription would not be at her discretion and the health plan would be rationing the expensive medicine from the patient, not the physician.

To better understand what I mean by bedside rationing, it is helpful to think of alternative ways to ration healthcare. Healthcare can be rationed by ability or willingness to pay. Healthcare can also be rationed by formulary committees who decide that expensive reflux medicines are no longer available to all patients. A health plan may decide not to offer lung reduction surgery to its patients, and a government insurer may decide to limit PET scanners for its citizens. These are examples of administrative level healthcare rationing, but not examples of bedside rationing.

Can the Cost of Reflux Treatments Be Contained without Bedside Rationing?

Imagine a healthcare system that is trying to reduce the use of expensive proton pump inhibitors (PPIs), such as omeprazole, in patients with reflux disease. Imagine at the same time that all the physicians in this healthcare plan have vowed never to ration at the bedside. How would this healthcare system go about reducing the use of PPIs?

To begin with, if this healthcare plan did nothing to control PPI use and physicians were committed to providing the best possible care to their patients without regard to cost, then physicians would almost never prescribe the less expensive reflux medicines. PPIs are simply better reflux medicines than the less expensive H2 blockers. Some people might reject the idea that offering less expensive reflux medicines to patients is an example of rationing (Asch and Ubel 1997). They might argue that many patients do just as well with H2 blockers as with PPIs. For these patients, then, no benefit has been withheld if they receive H2 blockers first; if no benefit has been withheld, then no bedside rationing has occurred. This reasoning is faulty, however, because it utilizes an after-the-fact evaluation to judge a prior-to-the-fact decision. Prior to prescribing a reflux medicine, physicians do not know whether H2 blockers or PPIs will work better for a particular patient. However, patients' chances of successful reflux treatment will be significantly greater with PPIs. Indeed, if money were no object, there would be no reason (in most patients) to prescribe an H2 blocker instead of a PPI.

Because PPIs are superior to H2 blockers but more expensive, the healthcare plan has to find a way to keep physicians from prescribing them if it wants to save money on reflux medications. One way to do so would be to require that all patients undergo a trial of H2 blockers before receiving PPIs. How would such a requirement work? First, the health plan

would need a system for documenting whether patients had already been on H2 blockers, so that they could receive PPIs after the H2 blockers failed. The system would also need to track whether patients had received H2 blockers from other healthcare plans prior to transferring to their new plan. In addition, it would need to develop a system whereby physicians could appeal and prescribe PPIs for patients who had taken H2 blockers on the outside or who had some "contraindication" (some medical reason they could not take H2 blockers). Preparing for such exceptions and appeals costs money. The health plan would need to spend money to develop information systems that could monitor the program. This in itself has resource implications and would have to be weighed against the amount of money that would be saved by reducing PPI prescriptions.

But the system would have to be even more complex than I have indicated, or it would create some clinical problems. For example, PPIs are important medicines for treating patients who have non-reflux related stomach problems caused by the bacterium *H. pylori*. Would physicians be able to prescribe PPIs for such patients? In addition, should the system be prepared to allow exceptions for patients who come in with "severe reflux symptoms"? If so, how should we define severe reflux disease? Once these exceptions are made, how would they be monitored?

I am trying to show, through examples, that rule-based rationing is problematic because the rules can very quickly become unmanageable. Perhaps just as important, rule-based rationing systems are susceptible to physician "gaming" — physicians interpret rules in ways that benefit their patients (Morreim 1991). A notable example of gaming is occurring in the state of Oregon, which, since the mid-1990s, has been trying to reduce its Medicaid expenditures through an explicit rationing plan. Medicaid is a U.S. healthcare program for poor people and is paid for by a combination of federal and state monies. Oregon was having a hard time keeping its Medicaid expenses in line while trying to maintain coverage for all the poor people who needed healthcare. One solution, as formulated by then legislator (and now governor) John Kitzhaber, was for Oregon to specify which healthcare services it would offer to Medicaid patients and which ones it would not. The state hoped to save money by withholding Medicaid services that were deemed less important than other services (Garland 1992). The savings garnered by not paying for such services could then be used to offer Medicaid to more patients.

Despite good intentions, the Oregon Medicaid rationing plan has not saved a dime, because physicians have found ways to get around the rules (Kilborn 1999). For example, if patients have multiple diagnoses below the funding line, physicians will get reimbursed for their treatment. Consequently, when patients come in with "below-the-line diagnoses," physicians almost always find several other "below-the-line" diagnoses in order to get reimbursement for their treatments. Through this and other loopholes, physicians have found ways to make sure patients get the treatments that are best for them. Indeed, physicians are notoriously good at gaming healthcare systems to get benefits for their patients. Thus, to the extent that healthcare plans try to tie physicians' hands to control healthcare costs, physicians wriggle free of the ropes.

What about a Simpler Type of Rule to Control Spending?

So far, I have discussed several rule-based methods of reducing PPI prescriptions. I have argued that these rules need to become more elaborate in order to control healthcare costs, but they can still often be overcome by physician gaming. How about a simpler rule: require gastroenterologist approval of every PPI prescription. Would this simpler rule control costs? Such a rule would have several advantages over more complex rules. It would allow for clinical judgments to be made about which patients really needed PPIs. No committee would need to create an official definition of "severe reflux disease." Instead, clinicians talking to each other on the phone could decide whether a patient really needed a PPI prescription. Such a rule allows for clinical judgments based on the specifics of individual patients. This contrasts with previous rules, which were meant to be applied to all patients.

Despite its advantages, this type of rule has pitfalls too. Most important, it could potentially overwhelm gastroenterologists with pages and phone calls about PPI prescriptions. At one institution where I worked, this plan was rapidly defeated when gastroenterologists told primary-care physicians to write down that they had GI approval any time they wanted to prescribe a PPI. The gastroenterologists were so fed up with receiving phone calls about PPI prescriptions that they found a way to defeat the system.

Let us shift our attention away from reflux disease for a bit and consider a common diagnostic test that has significant expense — CT scans. Who should be able to order a CT? Should all primary-care physicians be able to do so without prior approval? What about primary-care nurse practitioners? At one institution where I worked, nurse practitioners could order CT scans (and MRI scans, for that matter, a significantly more expensive test) without discussing this with a radiologist or primary-care physician. I saw patients who presented with new onset shoulder pain who were referred for MRIs by clinicians without anybody asking a radiologist if that test was indicated. In my clinical judgement, this is a wasteful practice. But how do we keep it from happening?

Healthcare systems could require that all CT scans and MRI scans be approved by radiologists. As with the gastroenterology example described above, however, such a policy would potentially overwhelm radiologists with such requests. Moreover, in many cases, primary-care practitioners have every reason to know that a scan is indicated.

Although it makes some sense to require clinicians to speak with radiologists before ordering extremely expensive radiology tests, I have concerns about a system that requires such conversations. First, such a system ignores many less expensive tests that, nevertheless, are ordered frequently enough that they cost healthcare systems a lot of money. Think of all the plain film x-rays that are ordered for low-back pain and for routine screening of lung fields that have almost no clinical value. Second, such a system imposes burdens on radiologists and other physicians who must now find time in their busy days to speak with each other, even in circumstances where the correct radiology test to order is obvious. This not only takes up these clinicians'

time, but also ultimately costs healthcare systems money, because radiologists and other physicians are highly paid professionals. Third, the systems create a layer of bureaucracy in order to document that conversations have occurred between radiologists and other clinicians. Bureaucracies create hassles. Just as important bureaucracies cost money.

Instead of Bureaucratic Rules or Time-Consuming Approval Requirements, Why Not Give Physicians Feedback about Their Utilization?

There are alternatives to forcing clinicians to call each other on the phone to get approval for every lab test, radiology test, and expensive medication they want to order. One alternative is to give clinicians feedback, every few months or so, about how much they utilize expensive diagnostic tests in comparison to their peers. Research has shown that such feedback reduces physicians' utilization (Berwick and Coltin 1986; Schectman et al. 1991). Physicians hate feeling like they are outliers; they do not want to rely on expensive tests more than other physicians do.

Such feedback systems deserve a role in helping control healthcare costs. They do not require burdensome rules, but they do not avoid bedside rationing. If physicians are only interested in patients' best interests, they will completely ignore how their utilization patterns compare to other physicians. In fact, in a world without bedside rationing, they will continue to order what they think is best for their patients. Those who order fewer CTs and MRIs may have reason to wonder if they are ordering too few tests.

What about Avoiding Bureaucratic Rules by Implementing Capitation or Other Financial Incentives?

Asking physicians to bear some financial risk for the tests and medicine they order for their patients has also been shown to control healthcare costs. Under such "capitated" healthcare systems, physicians are given a certain amount of money to take care of their patients (Hillman 1990). Some percent of the money they spend caring for their patients is then taken from their salary. This encourages physicians to order fewer tests and referrals.

Many people have raised moral objections to capitation-reimbursed systems. I do not plan to discuss these arguments here. Instead, I want to make a simple point: capitation systems only control healthcare costs by encouraging bedside rationing. If patients' best interests were all that mattered, most clinical decisions would be unaffected by capitation: clinicians would still do what is best for their patients, regardless of costs.

What about Rationing with Practice Guidelines?

Some colleagues of mine in Michigan recently published an article on the cost effectiveness of performing routine retinal screening exams for diabetic patients (Vijan et al. 2000). The standard of care, up to now, has been to make sure that all diabetic patients have ophthalmology examinations each year to screen them for diabetic eye disease. My colleagues argued that annual screening is unaffordable for patients with mild diabetes; such a screening rarely prevents blindness, compared to screening every two to three years.

If physicians only worried about patients' best interests, they would ignore my colleagues' work, because annual screening would still prevent more cases of blindness than less frequent screening. However, it is likely that in the near future, leading diabetes organizations will change their recommendations on how to screen patients with mild diabetes and recommend screening every other year in low-risk patients. These guidelines will probably have a significant influence on physicians' referral practices.

If physicians begin to follow diabetes society "guidelines" for how often to screen people for retinal disease, they will be engaging in bedside rationing. However, I expect that many physicians will not realize that they are rationing at the bedside when they follow these guidelines (Asch and Ubel 1997).
I happen to think these guidelines are signals from society about how much money they want physicians spending to prevent rare illnesses. The decision is, however, still ultimately up to individual clinicians. Such guidelines will have no effect on clinical practice unless physicians are willing to ration at the bedside.

How Do I Justify My Heretical Support of Bedside Rationing?

As hinted above, I have a major concern with healthcare systems that ration without any reliance on bedside rationing: these rationing systems will be burdensome. I scratched the surface in discussing how a healthcare system might try to reduce the use of PPIs. I did not even begin discussing the similarly burdensome rationing mechanisms the system would need to control the use of expensive hypertension medicines, reduce subspecialty referrals, decrease the use of marginally beneficial lab tests, reduce the length of outpatient visits, or reduce the frequency with which physicians order follow-up appointments. A system that controls healthcare costs by creating elaborate rules around all these varied types of clinical decisions would be a bureaucratic nightmare and a clinical disaster.

Those who want to control healthcare costs must decide how they will trade off between blunt, obtrusive rules that completely delineate physicians' behaviours and some amount of bedside rationing that encourages physicians to reduce their use of marginally beneficial healthcare services (Welch 1991).

When I say I am in favour of bedside rationing, I mean the following: at times physicians need to relax their advocacy duties and give their patients less than the best possible healthcare services in order to save money for society. The entire rationing burden should not fall on physicians' hands. There is an appropriate role for administrative rationing mechanisms. In fact, many of the "burdensome rationing rules" I discuss above would be made much less burdensome if we could rely on physicians to occasionally ration at the bedside. For example, a healthcare system could ask physicians to prescribe H2 blockers whenever possible before prescribing PPIs. Such a guideline, handed down by a healthcare system or by a respected medical society, would help physicians remember that H2 blockers are still good medicines for many patients and that society needs to control healthcare costs by reducing the use of expensive PPIs. At the same time, this guideline would allow physicians to use their judgment about when to make exceptions

to the guideline.

No system that relies completely on administrative rationing mechanisms will succeed in reducing healthcare costs. In addition, a system that relies heavily on willingness and ability to pay to ration healthcare is morally questionable (for reasons I will not go into here). Thus, the best way to ration healthcare is to have a mixture of administrative rationing mechanisms and clinicians engaging in bedside rationing, with a touch of willingness to pay on the side.

I recognize that there are moral problems with bedside rationing. The problems cannot be eliminated, but they can be reduced. For example, we need to make sure that physicians ration in ways that do not greatly reduce patient trust. I think this is achievable. We also need to do what we can to make sure that money saved by healthcare rationing (bedside or other) goes towards appropriate ends. The goal of healthcare should not be to maximize profits. We need to find ways to help physicians ration at the bedside so that they will not do it haphazardly or in a discriminatory manner. At the same time, we must judge bedside rationing the same way we judge democracy — by comparing it to the alternatives. In this case, the alternatives include burdensome rationing rules, many of which physicians would bend in their patients' favour, and increased use of out-of-pocket expenses to ration healthcare, which favours wealthy patients over others. Bedside rationing has weaknesses, but I think its weaknesses are worth accepting in order to avoid the weaknesses of alternative ways to ration.

What Do Physicians Think of Bedside Rationing?

I have all too briefly discussed the theology behind opposition to bedside rationing and the heresy of relying on bedside rationing to help us control healthcare costs. What do most physicians think about these issues? Do physicians hold to the good old religion and oppose bedside rationing or are they joining heretics like me in accepting its necessity?

Sorting out physicians' attitudes towards bedside rationing is tricky, in part because of linguistic confusion about what it means to ration at the bedside. When physicians disagree about bedside rationing, they could potentially be having one of two kinds of disagreement: (1) they could be disagreeing about the appropriateness of having physicians do less than the best for their patients, or (2) they could be disagreeing about the meaning of the word rationing. That is, physicians might agree with each other that it is appropriate to withhold PPIs from patients, but disagree about whether this is an example of bedside rationing. As an analogy, consider two people who are looking at an insect. In one case, they agree that the insect is a moth, but disagree about whether it is beautiful or ugly. This is similar to agreeing about what it means to ration at the bedside while disagreeing about whether such rationing is justifiable. In another case, imagine they agree that the insect is beautiful while disagreeing about whether it is a moth or butterfly. This is analogous to agreeing that bedside rationing is acceptable — that doing less than the best for patients is acceptable — while disagreeing about

whether this is an example of bedside rationing.

To sort out these two ways of disagreeing about bedside rationing, David Asch and I presented 1,000 general internists in the United States with a vignette in which a hypothetical physician offers a less expensive and less effective colon cancer screening test to a patient in order to save money for society (Ubel 2000). We asked physicians whether the physician who ordered the less expensive colon cancer screening test was acting "appropriately" and whether that physician was performing "healthcare rationing." We found that physicians generally agreed that it was appropriate for the hypothetical physician to offer the less effective test to the patient. In fact, only 20% of physicians felt that ordering the less expensive colon cancer screening test was inappropriate. Physicians were completely divided about whether such a decision was an example of healthcare rationing. Forty percent thought it wasn't, 40% thought it was, and 20% had no idea. This suggests that physicians generally support the idea of making cost-quality trade-offs at the bedside. They are comfortable offering a decent screening test to someone, even though a slightly better and significantly more expensive test is available. They are not sure whether to call such a thing "bedside rationing."

This disagreement among physicians about what qualifies as bedside rationing should not surprise us. As I stated above, there is no single way of defining complex terms such as rationing or bedside rationing. And besides, when we conducted this survey, my elegant definition of bedside rationing had not yet been published! More important, rationing is a loaded term. People may support the concept of rationing without wanting to label it that way. I do not have a problem with that. I personally like to use the term rationing, because I think it forces people to consider the moral implications of their decisions. Other euphemisms might be easier to swallow, but they might make us less likely to notice when we are ingesting rotten food.

Nevertheless, I am happy to define rationing in different ways, if that is what people want to do. Instead, what is more important to me is that physicians recognize that they do not currently pursue patients' best interests without regard to costs. I can find examples for almost any physician I know in which they are forgoing a marginally beneficial test or referral because of its expense. Different physicians have different thresholds, but I would guess even Norm Levinsky does not order a thyroid screening test on every patient he sees every few months. If money were irrelevant, even he would order more thyroid tests. Physicians have not done a good job of recognizing that they are making trade-offs between cost and quality. By failing to recognize these trade-offs, they are probably not doing a very good job of making them. If clinicians recognized the trade-offs they made every day, they could begin to look across their entire practices and see when they were trading off too much quality for not enough cost savings, and when they were not trading off enough.

Conclusion

Heated debates about the morality or immorality of bedside rationing have been missing the point. We are so worried about the loaded term "rationing" or

about old-fashioned moral ideals that were developed in a time when healthcare costs were not nearly as high as they are that we are not facing up to the new reality. We need to control healthcare costs, and physicians must play a crucial role in helping society do so.

Society is still coming to grips with resource constraints in medical care, especially in the United States. Not surprisingly, many people are not sure who they think ought to be making rationing decisions. Clinicians are equally confused; they do not want to bear a disproportionate share of decision-making over rationing. On the other hand, most clinicians do not want to practise healthcare amid a sea of burdensome rules that limit their abilities to take care of patients.

Whether or not clinicians call it "rationing," they need to recognize that they have a crucial role in helping to control healthcare costs. The best way to control costs is for clinicians to relax their advocacy duties in conjunction with other rationing mechanisms. Clinicians need to recognize that patients can do with less than the best. Physicians need to come to grips, individually if not as a group, with what services they can withhold from patients. And finally, healthcare systems need to find ways to signal to physicians that it is okay to do less than the best for their patients in order to serve the greater good of the population.

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