

Allocation of Medical Resources

As Christian physicians and dentists we recognize that increasing treatment capabilities and increasing treatment costs, as well as societal priorities for the allocation of dollars, make it difficult to provide all people with all services which they might need (or perceive they need). Therefore, as individual practitioners, as a profession and as a society, we are often faced with difficult allocation decisions.

The scriptural principle of justice requires us to treat patients without favoritism or discrimination. The scriptural principle of stewardship makes us, individually and corporately, accountable for our decisions about the provision of medical and dental care. The scriptural principles of love and compassion require that we place the interests of our patients and of society before our own selfish interests. Recognition of the finitude of human life, along with the higher calling of eternal life with Jesus, should help Christian healthcare professionals resist the disproportionate expenditure of funds and resources in an effort to postpone inevitable death. Christian healthcare professionals, however, must never intentionally hasten the moment of natural death, which is under the control of a sovereign God. (see Ethics Statement*)

Christian doctors have a responsibility in helping to decide who will receive available health care resources. To refuse that responsibility will not prevent allocation decisions, but will instead leave those choices to institutions and individuals with purely utilitarian or materialistic motives. If this happens, allocations may generally shift toward people who have wealth or other forms of privilege, which is not the biblical way to value human life.

International Concerns:

We must be sensitive to the unmet health care needs of most of the world compared to the position of great privilege we enjoy in the United States. As Christian doctors we must seek to address the suffering of the international community through our personal actions and through our influence in public policy decisions.

Public Policy Concerns:

Society must evaluate its total resources and be certain that adequate dollars are made available for the health care needs of its people.(see Ethics Statement**) This involves the understanding that choices must be made between the value of health care and the competing values of lifestyle, entertainment, defense, education etc. Society must minimize waste caused by unnecessary administrative and malpractice costs. Waste can also occur in expenditures for ineffective or unproved therapies or by funding perceived, rather than true, healthcare needs.

Society must also make decisions regarding the allocation of resources to individual patients but should not place patients in the situation of choosing less effective care because of costs. These decisions must always be made with compassion and recognizing the inestimable value of human life. The choice between similarly beneficial therapies may be made on the basis of cost in order to maximize resources. Limits on therapeutic and diagnostic procedures may need to be based on cost and outcome. Outcome assessments based on "Quality of Life" determinations are problematic. We need to remember God's great love for all individuals and the great value He places on each individual life regardless of the world's valuation of that life. Purely utilitarian

considerations should not determine the allocation of absolutely scarce, lifesaving resources (e.g. transplantable organs). All humans are equal in the eyes of God.

Society must recognize the value of research in continuing to improve the healthcare of its people, and must therefore allocate adequate funding for promising areas of research.

Professional Practice Concerns:

Christian doctors should earnestly examine their lives and practices and prayerfully seek God's guidance about their charges for professional services. They must be careful not to offer unnecessary diagnostic and therapeutic interventions. They should be actively involved in the provision of professional care for the poor and uninsured. Doctors should offer the best care available and inform their patients if that care isn't covered by their insurance plan. Whenever equally beneficial therapies are available the doctor should offer the less expensive therapy in order to benefit others who might use the resources.

The practice of medicine at the level of the individual doctor is primarily an exercise in mercy. Society, because of limited resources, introduces the concept of justice. We as Christian doctors must strive in our practices and in our society to model the person of Christ, and His grace.

* See Statement titled "Physician-Assisted Suicide"

** See Statement titled "Health Care Delivery"

*Approved by the House of Delegates
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Explanation

"Rationing" has always been a dirty word in the practice of medicine. As healthcare professionals and as citizens we have been very reluctant to admit or even consider that some of our neighbors are restricted from healthcare which they may need. However, the increased cost of healthcare, increasing numbers of citizens without health insurance, and increasing disparity between the rich and the poor have forced us to recognize that rationing is part of our current healthcare system.

The issue has been hotly debated for many years in the public policy arena, the literature of medicine and ethics, and in doctors' lounges, but not so much in our pulpits or Sunday School classes. There are many basic questions, most of which have not yet achieved societal consensus. Is healthcare a right or a privilege? What constitutes a decent minimum of healthcare? How does individual choice, e.g. those regarding lifestyle or the purchase of insurance, factor into the issue of whether an individual deserves a particular treatment modality? Are rationing decisions always matters of public policy, or do such decisions also occur in the ICU, the hospital, and in the office practice of medicine and dentistry? Is there, or can there be, a clear distinction between futility (withholding non-beneficial therapy) and rationing (withholding potentially beneficial therapy)?

Secular Perspective

Experts in medical and dental ethics have given considerable thought to these questions and have published voluminously. The principles which clash in these discussions are the professional's duty to beneficence (i.e. doing what is good for the patient), the individual patient's right to autonomy (i.e. self-determination) and society's obligation to justice (i.e. to treat like patient's alike). There is general agreement that minority patients and poor patients, and especially poor minority patients, have too often been treated unjustly in our society.

Most of the reasoning used in discussions aimed at correcting this injustice is clearly utilitarian, i.e. trying to achieve the greatest good for the greatest number. And this has some merit. When there is not enough to go around, how can we determine how to be good stewards of our resources? By trying to do the best we can with our limited resources - and this involves looking at the anticipated consequences of professional and policy decisions.

Others have voiced a virtue ethics perspective which relies on the integrity and fairness of the individual practitioner.

Christian Perspective

For the most part, Christians have been late in entering this modern discussion. This is ironic since it was the example of Jesus which interjected the concept of compassion into Hippocratic medicine, and it was religiously motivated individuals who established the first hospitals and who volunteered to provide medical and dental service on the mission field. However, modern Christian healthcare professionals have been less responsive to the needs around us today, and we have often been unbiblical when we have responded.

Tragically, Christian healthcare professionals have not been immune to the consumerist mentality of modern western society. Too many Christian physicians and dentists have focused on accumulation of personal wealth and have forsaken their biblical mandate to service.

Some Christians have also been quite judgmental in pointing fingers at individual patients or groups of patients whose sinful lifestyle choices have resulted in the need for intensive and/or expensive therapies, or at those who may have contributed to their poverty by poor choices or lack of ambition. And truly, all of us must be prepared to live with the consequences of our sinful choices. However, Jesus in his healing ministry did not discriminate against the down-trodden. In fact he appeared to give preference to the poor and to sinners.

Scripture does teach us about serving and caring for the less fortunate. In addition to the secular principles of medical ethics, Christian professionals and laypersons alike have other principles to guide us in these difficult discussions, e.g. compassion (Luke 7:11-15), service, contentment (Heb 13:5), the Imago Dei (Gen 1:27), and dominion (Gen 1:28). And a Christian understanding of stewardship is broader than is the secular in that it involves an accountability to God. In addition, the biblical concept of justice is broadened to include mercy and grace.

Individual CMDA members, and the association as a professional organization, have tried to teach and model these biblical principles in our practices and in debate on public policy issues. This approach is indeed critical in a discussion of the allocation of medical resources.

In 1997, our association (then the CMDS) cooperated with several other Christian professional organizations in sponsoring a continuing education conference entitled "The Changing Face of Health Care". The proceedings of that conference were published by Eerdmans in 1998 as a book of the same title with a subtitle of "A Christian Appraisal of Managed Care, Resource Allocation, and Patient-Caregiver

Relationship." Some of these tough questions are addressed in depth by Christian clinicians and scholars.

CMDA Position Statement

The Ethics Commission struggled with this issue for a long time before bringing a draft to the House of Delegates. Commission members felt it was important to emphasize biblical principles, to recognize rationing decisions on an international scale, and to differentiate between issues of public policy and those of individual practitioners. The statement became official policy on May 1999.

Abstracts

Introductory Articles

Veatch, Robert M. "Voluntary Risks to Health." JAMA 4 Jan 1980; 243 (1): 50-55.

"The discovery that health status is affected by personal life-styles and apparently voluntary health risks poses new problems. It has potential impact on clinical practice, health insurance, and theories of health and disease. Five major problems need attention. First, are these health-risk behaviors really voluntary? Five responses are explored: several other models (the medical, psychological, social structural, and multicausal models) all challenge the assumption of voluntary behavior. Second, are some sufficiently in the public interest that they ought to be subsidized? Third, does justice require that persons bear the costs of truly voluntary health risks? Fourth, what policies should apply to cost-saving, health-risk behavior? Finally, does the voluntary health-risks theme make life too rational and calculating? These issues must be dealt with in future health planning and clinical decision making."

Leaf, Alexander. "The Doctor's Dilemma- And Society's Too." The New England Journal of Medicine 15 Mar 1984; 310 (11): 718-21.

In this article, the author notices the trend of increasing health costs and envisions the accompanying difficult allocation decisions. He proposes five suggestions "regarding steps that the medical profession, together with the public, might take that should at least reduce the area of conflict. (1) Assess new technologies, procedures, and therapies much more carefully before introducing them into practice, so that their benefits and costs are known. (2) Educate the medical profession and the public to accept medical decisions that are based on probabilities of success or failure and to stop gambling expensive and scarce resources on long shots. (3) Remove fiscal incentives from the medical decisions-making process. (4) Allocate more support national for medical research. (5) Introduce more preventive medicine into clinical practice."

Hadorn, David C. and Robert H. Brook. "The Health Care Resource Allocation Debate." JAMA 18 Dec 1991; 266 (23): 3328-31.

"The problem of health care distribution in the United States demands immediate action. Many different solutions have been proposed to slow rising health care costs and to improve access to care for the poor and uninsured. Debate among proponents of these various proposals might be advanced if a common language were adopted with regard to certain key terms instead of the various meanings currently assigned to these terms. For this reason, we propose and defend the following three definitions: (1) rationing is the societal toleration of inequitable access to health services acknowledged to be necessary by reference to necessary-care guidelines; (2) health care needs are desires for services that have been reasonably well demonstrated to provide significant net benefit for patients with specified clinical

conditions; and (3) basic benefit plans are insurance packages that provide for all and only acknowledged health care needs, again by reference to appropriate clinical guidelines."

Daniels, Norman and James E. Sabin. "Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy." *Hastings Center Report* Mar-Apr 1998; 28 (2): 27-41.

"How can health plans make fair determinations about when 'experimental' (and costly) treatments such as high dose chemotherapy with autologous bone marrow transplantation should be covered despite lack of clear clinical consensus about their benefits? Different models for managing 'last chance' therapies evolving in some health plans offer promising examples of how issues of fairness and legitimacy in decision making can be addressed."

Eck, Alieta. "Funding Health Care Through the Church." *The Changing Face of Health Care*. Grand Rapids, MI: William B. Eerdmans Publishing Company; 1998. pp. 235-44.

In an environment where the insurance maze gets longer, the paperwork thicker and the premiums more expensive, there is an alternative in the form of the Christian Brotherhood Network. Based on Gal. 6:2, the Christian Brotherhood is a network of families who help each other defray the costs of a major medical event. In this article, the author compares government insurance programs with the Christian Brotherhood philosophy. She concludes, "Insurance actually was God's idea. As the apostle Paul writes in 2 Corinthians 8:13-14a: 'Our desire is not that others may be relieved while you are hard pressed, but that there might be equality. At the present time, your plenty will supply what they need, so that in turn their plenty will supply what you need.'"

Henry, William. "Idiopathic Health Systems: A More Powerful Way to Look at Health Resources." *Second Opinion* Sep 1999: 11-23.

In this article, the author states that the narrow way we define the phrase healthcare delivery system "impoverishes our learning and dramatically limits our ability to foster health." Instead, he advocates "a different way of thinking about health care," a way in which we realize that each person has his/her own unique health system, "comprising a unique array of personal and public resources, connected in idiosyncratic patterns, and oriented to goals that are our own." He concludes, "If we are to maximize the return on our societal investments in health, we must be willing to consider investments in a much wider array of resources than we have in the past. We must also be willing to compare the 'health return' on investments in new medical technology, more doctors, and more elaborate hospitals with the health return on investments in information technology, community education resources, better nutrition, enhanced exercise and recreation resources, and better transportation systems. If health derives from many resources in addition to those in the 'healthcare delivery system,' then we must consider those other resources as worthy candidates for our investments in health."

Justification for Rationing

Callahan, Daniel. "Rationing Medical Progress: The Way to Affordable Health Care." *The New England Journal of Medicine* June 21, 1990; 322 (25): 1810-13.

Reforming the American health care system, argues this prominent author, takes more than just cost containment. Pointing out that American health policies have not worked thus far, Callahan urges the re-examination of our values and our fear of rationing in order to achieve an economically sound system. "Whether we like modifying our basic values or not, it seems impossible to achieve equity and efficiency without doing so. Having a minimal level of adequate care available to all means that if such care is to be affordable, it must be combined with limits on choices, progress, and profit. Setting limits means we cannot have everything we want or dream of. The demand for priorities arises when we try to live with both decent minimal care and limits to care. At that point we must decide what it is about health care that advances us most as a society and as individuals. We have bet that we could have it all. That bet is not

paying off. There remains no reason, however that we cannot have a great deal.

We do not necessarily have to limit decent health care in any serious, drastic fashion. What we do need to do is to restrain our demands for unlimited medical progress, maximal choice, perfect health, and profits and income. This is not the same as good health care."

Angell, Marcia. "The Doctor as Double Agent." Kennedy Institute of Ethics Journal Sep 1993; 3 (3): 279-286.

"American doctors in the 1990s are being asked to serve as 'double agents,' weighing competing allegiances to patients' medical needs against the monetary costs to society. This situation is a reaction to rapid cost increases for medical services, themselves the result of the haphazard development since the 1920s of an inherently inflationary, open-ended system for funding and delivering health care. The answer to an inefficient system, however, is not to stint on care, but rather to restructure the system to remove the inflationary pressures. As long as we are spending enormous resources on an inherently inefficient and inflationary system we cannot justify asking doctors to withhold beneficial care to save money for third-party payers. Doing so serves a largely political agenda and endangers the patient-centered ethic that is central to medicine."

Menzel, Paul T. "Double Agency and the Ethics of Rationing Health Care: A Response to Marcia Angell." Kennedy Institute of Ethics Journal Sep 1993; 3 (3): 287-92.

"The arguments against doctors as 'double agents' that are presented by Marcia Angell in the preceding article do not defeat the core justification for rationing some relatively high-expense, low-benefit care, and they do not enable us to conclude that clinicians should be barred from any active, substantive role in decisions to limit that care. They do, however, reveal several important conditions that need to govern cost-conscious medical practice in order to preserve an ethic of fidelity to patients: insurers' profits and providers' incomes must be fair, providers must inform patients of any economic reasons that lead to the forgoing of care, and 'direct incentive' arrangements must not be used to contain costs."

Eddy, David M. "Principles for Making Difficult Decisions in Difficult Times." JAMA June 8, 1994; 271 (22): 1792-98.

In this article, the author proposes 11 principles to guide the debate over cost and allocation. "Ideally, there should be national agreement on a single set of principles...My hope is that health care organizations will debate each of the principles and either will agree with the ones I have proposed or will develop better ones."

The Principles:

1. The financial resources available to provide health care to a population are limited
2. Because financial resources are limited, when deciding about the appropriate use of treatments it is both valid and important to consider the financial costs of the treatments.
3. Because financial resources are limited it is necessary to set priorities
4. A consequence of priority setting is that it will not be possible to cover from shared resources every treatment that might have some benefit.
5. The objective of health care is to maximize the health of the population served, subject to the available resources
6. The priority a treatment should receive should not depend on whether the particular individuals who would receive the treatment are our personal patients.
7. Determining the priority of a treatment will require estimating the magnitudes of its benefits, harms, and costs.
8. To the greatest extent possible, estimates of benefits, harms, and costs should be based on empirical evidence. A corollary is that when empirical evidence contradicts subjective judgments, empirical evidence should take priority.
9. Before it should be promoted for use, a treatment should satisfy three criteria:

There should be convincing evidence that, compared with no treatment, the treatment is effective in improving health outcomes.

Compared with no treatment, its beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

1. Compared with the next best alternative treatment, the treatment should represent a good use of resources in the sense that it satisfies principle No. 5.

10. When making judgments about benefits, harms, and costs, to the greatest extent possible, the judgments should reflect the preferences of the individuals who will actually receive the treatments.

11. When determining whether a treatment satisfies the criteria of principle No. 9, the burden of proof should be on those who want to promote the use of the treatment.

Justice and Equality in Allocation

Buchanan, Allen E. "The Right to a Decent Minimum of Health Care." *Contemporary Issues in Bioethics*, 3rd Ed. Belmont, CA: Wadsworth Publishing Company, 1989. pp. 572-77.

In this article the author deals with two questions that are associated with debate on the right to a decent minimum of health care: (1) "Is there a more extensive right than the right to a decent minimum of health care?" (2) "What is included in the decent minimum to which there is a right?" He examines various arguments attempting to establish the right to a decent minimum of health care.

Boyle, Joseph. "Catholic Social Justice and Health Care Entitlement Packages." *Christian Bioethics* 1996; 2 (3): 280-92.

This paper explores the implications of Roman Catholic teachings on social justice and rights to health care. It argues that contemporary societies, such as those in North American and Western Europe, have an obligation to provide health care to their citizens as a matter of right. Moral considerations provide a basis for evaluating concerns about the role of equality when determining health care entitlements and giving some precision to the widespread belief that the right to health care requires equal entitlement to health care benefits.

Delkeskamp-Hayes, Corinna. "Equal Access to Health Care: A Lutheran Lay Person's Expanded Footnote." *Christian Bioethics* 1996; 2 (3): 326-45.

"Can proposing a policy of equal access to health care be justified on Christian grounds? The notion of a 'Christian justification' with regard to Christians' political activity is explored in relation to the New Testament texts. The less demanding policy of granting a 'right to (basic) health care', the meaning of Jesus' healing activities, early Christian welfare schemes, and Christian grounds for the ascription of 'rights' are each discussed. As a result, with some stretching of the neighbor-love and missionary imperatives it is proposed that a basic health care policy can be legitimized. With regard to equal access to health care, however, all attempts to derive an equalizing imperative from the spiritual 'equality among humans' or by way of the 'love your neighbor as yourself' imperative are shown to fail. Particular attention is given to whether 'attending to the least of my brothers' needs obliges Christians to satisfy those needs optimally, as well as to the personal involvement aspect of the love-commandment in its simultaneously spiritual and temporal orientations."

Engelhardt, H. Tristram Jr. "Equality in Health Care: Christian Engagement with a Secular Obsession." *Christian Bioethics* 1996; 2 (3): 355-60.

"A frenetic search for equality lies at the center of much secular and even 'Christian' bioethics. In a secular world, if one does not believe in God, if this life is one's whole existence, it would seem that one could not settle for less than equal approbation, especially equality before the risks of suffering and death, which medicine promises to ameliorate. Yet, the concern for equality in health care is puzzling. After a modest level of access to health care there is little difference in average life expectancy. Are concerns for

equality in health care even vaguely Christian? The pursuit of Christian perfection has never been correctly equated with state-imposed egalitarianism. Furthermore, an all-encompassing, secular, egalitarian health care system may provide equal access to significantly immoral medical treatments. In contrast to secular thought, the call of Christianity is a call to holiness, not a call to an egalitarianism that superficially resonates with certain elements of Christian thought."

Gronbacher, Gregory M. A. "Understanding Equality in Health Care: A Christian Free-Market Approach." *Christian Bioethics* 1996; 2 (3): 293-308.

"This paper examines the arguments presented by the Roman Catholic Bishops in their 1993 Pastoral Resolution, *Comprehensive Health Care Reform: Protecting Human life, Promoting Human Dignity, Pursuing the Common Good*, concerning health care reform. Focusing on the meaning of equality in health care and traditional Roman Catholic doctrine, it is argued that the Bishops fail to grasp the force of the differences among persons, the value of the market, and traditional scholastic arguments concerning obligatory and extraordinary health care. To attempt to equalize the distribution of health care would be ruinous. A more traditional understanding of Christian thought reveals an acceptance of inequality in health care distribution and a bias against using the secular state to coerce a solution to such concerns for social justice."

Wildes, Kevin Wm. "Health Care, Equality, and Inequality: Christian Perspectives and Moral Disagreements." *Christian Bioethics* 1996; 2 (3): 271-79.

"Equality is a concept that is often used in health care discussions about the allocation of resources and the design of health care system. In secular discussions and debates the concept of equality is highly controverted and can take on many different specifications. One might think that Christians hold a common understanding of equality. A more careful study, though, makes it quite clear that equality is just as controversial among different Christian communities as it is in the secular world."

Ethics and Rationing

Levinsky, Norman G. "Age as a Criterion for Rationing Health Care." *The New England Journal of Medicine*. 21 June, 1990; 322 (25): 1813-15.

As rationing has become increasingly debated, age has been proposed as a criterion for withholding medical care. The author repeats arguments from Daniels, Veatch and Callahan about rationing by age and rebuts them by stating "no more than 1 or 2 percent of the national health care expenditures for the elderly is devoted to high-cost hospital admissions. For substantial savings, we must withhold routine medical care from the elderly." He proposes another rationing hypothesis- that "medical care that extends life devoid of human qualities should not be undertaken, but this principle should apply equally to patients of all ages, not only to the elderly." He concludes by saying "society must not insulate itself from the agony of each decision to forgo beneficial treatment as it is experienced by patients, families and caregivers."

Menzel, Paul T. "Some Ethical Costs of Rationing." *Law Medicine and Health Care* Spring-Summer 1992; 20 (1-2): 57-66.

Rationing is usually thought to demand a high ethical cost, but in this article, the author argues that the cost is not as high as commonly supposed. He explores four costs: "the sacrifice of physician loyalty, the substitution of misleading and discriminatory numerical measurements of medicine's human benefit for more sensitive qualitative judgements, the unfair bite that rationing is likely to take first out of poor people's care before it affects wealthier patients, and the general substitution of public, group standards about life and health for the values and decisions of individuals." He concludes, "Some dimensions of rationing will always remain morally suspect, but rationing's fundamental conflict with respect for the individual patient-subscriber is not as severe or intractable as most people assume."

Brennan, Troyen A. "An Ethical Perspective on Health Care Insurance Reform." American Journal of -Law and Medicine 1993; XIX (1&2): 37-74.

"Much recent analysis of health care insurance reform emphasizes economic and policy issues. In contrast, this article examines health policy issues from the viewpoint of medical ethics. The critical ethical 'problem' in health care today is that ability to pay determines the availability and quality of care. This article discusses three types of proposed solutions: health care insurance reform, health care financing reform, and health care cost reform. It sketches an ethical framework for evaluating health policy and presents seven specific propositions that an ethical analysis of health care reform proposals raises. This article concludes that remedying the unethical treatment of certain classes of patients requires both health care financing reform and health care cost reform; health care insurance reform will not suffice."

Kilner, John F. "The Ethical Allocation of Health Resources: Contributions from the Christian Community." Discernment Spring 1993; 2 (1); 2+.

Allocation of health resources is not just an economic problem, the author states. "Where matters like happiness, justice, freedom and life are concerned, religious communities and traditions are among the best sources of insight available. The Christian community serves the nation as well as God by voicing its views publicly." In this article, Kilner warns against relying too heavily on utilitarian "greatest good for the greatest number" mantra. Instead, he names allocation criteria that "are much closer to embodying biblical understandings of God's love than are more utilitarian criteria."

Kowal K, Hekman K. Managed Care and Physician Ethics: Two Views. Today's Christian Doctor Summer 1996; XXVII (3):30-33.

In this article, Kowal, a practicing family physician, and Hekman, a health care consultant, detail their positions on managed care. Kowal notes some of the problems with managed care contracts, such as the gag rule clause, that have prevented her from signing thus far. Hekman responds lightly to some of Kowal's concerns while writing from a big picture standpoint. He clearly lays out the need for managed care and the opportunity Christian physicians have to "participate in making the U.S. health care system better." Kowal, on the other hand, concludes "Jesus would not have me sign the contracts as they exist today."

Pellegrino, Edmund D. "Ethical Issues in Managed Care: A Catholic Christian Perspective." Christian Bioethics 1997; 3 (1): 55-73.

"A Christian analysis of the moral conflicts that exist among physicians and health care institutions requires a detailed treatment of ethical issues in managed care. To be viable, managed care, as with any system of health care, must be economically sound and morally defensible. While managed care is per se a morally neutral concept, as it is currently practiced in the United States, it is morally dubious at best, and in many instances is antithetical to a Catholic Christian's ethics of health care. The moral status of any system of managed care ought to be judged with respect to its congruence with Gospel teachings about the care of the sick, Papal Encyclicals, and the documents of the Second Vatican Council. In this essay, I look at the important conceptual or definitional issues of managed care, assess these concerns over against the source and content of a Catholic ethic of health care, and outline the necessary moral requirements of any licit system of health care."

Asch, David A. and Peter A. Ubel. "Rationing By Any Other Name." The New England Journal of Medicine 5 June 1997; 336 (23): 1668-71.

American society is afraid of rationing, yet is it something we already do? The authors describe four scenarios based on their own experience or those of others. "In each case, a physician decides in favor of a treatment choice that he or she believes to be both less effective and less expensive...to illustrate that compromises in clinical care are pervasive, varied and often disguised." After a discussion about each

rationale portrayed in the scenarios, the authors conclude that debate should move "beyond the loaded question of whether rationing is acceptable to the more constructive question 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."

Dyck, Arthur J. "Rationing Health Care: A Case of Justice Denied." in *The Changing Face of Health Care*. Grand Rapids, MI: William B Eerdmans Publishing Company, 1998. pp. 74-88.

Rationing, the author argues, is not in keeping with the historic and religious heritage of medicine. Rather, a decline in the moral imperatives of health care practice, that were developed starting with Hippocrates and then integrated into the Judeo-Christian tradition, has made rationing seem like the inevitable choice. However, "there are indeed at least three kinds of policies that should be tried before anyone should even contemplate rationing health care as necessary: (1) Altering practices that drive up the cost of health care; (2) Promoting moral development and spiritual renewal; (3) Preserving and renewing the moral structure guiding health care." The author concludes, "Christians should affirm and live out the moral responsibilities that sustain the moral structure of health care. We should not allow ourselves to be trapped into the utilitarian reasoning that sanctions the rationing of health care for the sake of saving or making money, or for any other reason."

Levinsky, Norman G. "Truth or Consequences." *The New England Journal of Medicine* 26 Mar 1998; 338 (13): 913-915.

The author begins by describing a proposal that a hospital CEO made to his chief of orthopedic surgery regarding lowering the cost of hip-replacement surgery by substituting a less durable prosthesis for patients who they judged would not live 10 years or more. After discussing the various aspects of this case and the state of rationing by doctors, Levinsky concludes, "society has the right to ration care, provided that the limitation of appropriate, effective care is openly revealed...the key to the doctor's role as patient advocate is telling patients the truth. Without the uncompromising commitment of doctors to be honest with their patients about the reasons for offering or withholding specific medical care, patients may be deprived of the opportunity to seek other options."

Letters to the Editor regarding this article can be found in the 6 Aug 1998; 339 (6) issue of NEJM.

Edmund D. Pellegrino. "Ethical Issues in Managed Care". *Today's Christian Doctor* Spring 1999; XXX (1): 28-31.

In this article, a widely respected ethicist tackles the subject of managed care and its moral implications. After stating the dual ideals of "economic feasibility and moral defensibility", Pellegrino goes on to outline the conflicting values of managed care and Christianity. He concludes "Christians and other people of good will concerned about a just ministry and distribution of health care services must turn away from managed care as it exists today."

Bedside Allocation

Pellegrino, Edmund D. "The Allocation of Resources at the Bedside: The Intersections of Economics, Law and Ethics." *Kennedy Institute of Ethics Journal* Dec 1994; 4 (4): 309-17.

"In the preceding article, Mehlman and Massey examine possible legal responses to the issues that confront physicians faced with treating patients who have insufficient financial resources. This commentary explores the same issues from the perspective of ethics, including a comparison of the way law and ethics interpret the physicians-patient relationship, the ethical obligations of physicians that are inherent in that relationship, and the propriety of Mehlman and Massey's legal and ethical proposals to ameliorate physicians' conflicting obligations in providing or withholding care on grounds of conservation of society's resources."

Ubel, Peter A. and Susan Goold. "Recognizing Bedside Rationing: Clear Cases and Tough Calls." *Annals of Internal Medicine* 1 Jan 1997; 126 (1): 74-80.

"Under increasing pressure to contain medical costs, physicians find themselves wondering whether it is ever proper to ration health care at the bedside. Opinion about this is divided, but one thing is clear: Whether physicians should ration at the bedside or not, they ought to be able to recognize when they are doing so. This paper describes three conditions that must be met for a physician's action to qualify as bedside rationing. The physician must 1) withhold, withdraw, or fail to recommend a service that, in the physician's best clinical judgement, is in the patient's best medical interests; 2) act primarily to promote the financial interests of someone other than the patient (including an organization, society at large, and the physician himself or herself); and 3) have control over the use of the beneficial service. This paper presents a series of cases that illustrate and elaborate on the importance of these three conditions. Physicians can use these conditions to identify instances of bedside rationing; leaders of the medical profession, ethicists, and policymakers can use them as a starting point for discussions about when, if ever, physicians should ration at the bedside."

Annotated Bibliography

Wikler, Daniel I. "Persuasion and Coercion for Health: Ethical Issues in Government Efforts to Change Life-styles." *Millbank Memorial Fund Quarterly* 1978; 56 (3): 303-38.

In this article, the author strives to "specify the kind of justification that would have to be provided for any coercive life-style reform measure."

Beauchamp, Dan E. "Injury, Community and the Republic." *Law, Medicine and Health Care*. Spring 1989; 17 (1): 42-9.

In this article, the author discusses public health policy, autonomy and government.

Lee, Robert G. and Frances H. Miller. "The Doctor's Changing Role in Allocating U.S. and British Medical Services." *Law, Medicine and Healthcare* Spring-Summer 1990; 18 (1-2): 69-76.

"This article examines evolution of the British and American physician's role in filtering clinical need from patient 'demand' for health services, and in setting relative priorities among patient needs. It then raises questions about the significance of this change to the physician-patient relationship."

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