The Rationing of Health Care: A Doctor's Dilemma

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ABSTRACT: Physicians are currently presented with very difficult ethical issues regarding who receives what level of medical care and for how long. A meaningful response to these perplexing issues necessitates a collaboration of doctors with others steeped in religious and ethical traditions. This paper addresses the complicated issue of the rationing of health care, and this issue is then addressed by responses from representatives of the religious community. This symposium took place at the New York Hospital—Cornell Medical Center in March 1991.

Doctors and chaplains meet at the patient’s bedside to address common concerns. Together we care for patients who require both medical and spiritual support. This collaboration can extend beyond the bedside and into the realm of health care policy and reform. The task of balancing opposing goods has long been the clinician’s dilemma. However, we are often ill-equipped to consider the broader implications of our practice for society at large. As the potential for unlimited medical progress grows, so too does our awareness that our resources are limited. The challenge of doing the greatest good for the greatest number, without compromising the care of the individual, has become the daunting task ahead of us as a profession. In the face of this promise and scarcity, we would do well to hear the counsel of the religious community. Because theologians have long struggled with ways to meet the needs of the individual and the broader concerns of the community, their voice is an especially important one.

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As physicians we have been consumed by the painful and often contradictory process of health care reform. At the bedside we have been forced to grapple with both governmental bureaucracy and the exigencies of patient care. Because a coherent strategy of reform has yet to be articulated, we find ourselves in the untenable position of being both provider and rationer of patient care.

This untenable expectation may result from conflicting attitudes toward health care reform in our society. Blendon and Altman's review of the public's attitude toward health care reform underscores the environment in which physicians practice.¹ They report that while the majority of the American public believe that our health care system requires "fundamental change," most remain pleased with the care they receive and disinterested in the issue of cost containment. The public supports regulation and competition just as long as its own personal entitlement remains unthreatened. Such ambivalence has led to conflicted cost containment initiatives which strain the doctor-patient relationship.

Cost containment as rationing

The enactment of the Prospective Payment System by Congress in 1983 is one such effort to limit expenditures. Theoretically centered on Diagnosis Related Groups, it sought savings through the elimination of waste. This was politically expedient as quality of care, at least theoretically, remained unthreatened.

The incentive to undertreat which is implicit in DRGs would, however, fundamentally undermine patient care. "Quicker and sicker" became a code phrase among many of us to signify our anecdotal belief that patients were being discharged prematurely as the acuteness of illness of in-patients increased. Soon our impressions were supported by data.

Fitzgerald, Moor, and Dittus, reviewing the records of 608 elderly patients with hip fracture from 1981 to 1986, demonstrated that the length of stay decreased when prospective payment was instituted.² With less time available for inpatient rehabilitation, more patients were discharged to a nursing home and remained there a year later. The authors conclude that "since the implementation of the PPS, hospitals have reduced the amount of care given to patients and . . . shifted much of the rehabilitation burden to nursing homes." They speculate that the "number of patients remaining in nursing homes one year after the fracture suggests that the overall quality of care may have deteriorated."

A recent retrospective study of 16,000 patients hospitalized before and after prospective payment, however, determined that medical care has not deteriorated under the PPS. While the authors report that prospective payment improved inpatient "process of care" and did not adversely affect mortality rates, these conclusions are reached only after correcting for the increased