Physician Rationing: Here's Why Your Doctor Won't OK That MRI

By Krystal Alexander — July 29, 2016

Withholding a medical intervention because the cost versus benefit or risk versus benefit doesn’t match up is understandable. For the experienced physician, it is especially acceptable in cases where the test or intervention is unlikely to aid in a diagnosis or treatment. In these cases, physicians are exercising profound judgment, and likely saving the patient considerable out of pocket costs and easing the weight on an already burdened health care system. However, when it comes to rationing and allocating medical services, is the physician’s perception of his/her role accurate?

This month the Journal of General Internal Medicine published the results of a national survey conducted to evaluate physicians’ attitudes and behavior toward rationing of medical services. The study [1], conducted by lead investigator Dr. Robert D. Sheeler and his colleagues at Mayo Clinic, found that over half of the physicians reported withholding beneficial clinical services over the past six months due to cost considerations. Topping the list of frequently denied services included prescription drugs (48.3%) and magnetic resonance imaging (44.5%).

The survey [2] assessed the self-reported attitudes and behaviors of a random sample of US physicians (n=2,541). Along with demographic data, the questions were designed to elicit each physician’s awareness of the frequency with which they decline to offer certain interventions to their patients, due to the anticipated burden of cost to the health care system.

These are the highlights of the researchers findings as outlined in the study:

- 53.1 % of the physicians surveyed reported they had personally refrained from using at least one of the listed clinical services during the preceding six months, because of the cost to the health care system.
- About one-third of physicians reported rationing prescription drugs and one-fourth rationing MRIs at least monthly.
- Age, sex, region of practice, and practice compensation type were not associated with
Specialty, practice setting, and political affiliations showed significant association with rationing. When compared to primary care doctors, surgeons and procedural specialists were less likely to report rationing, as were physicians in medical school settings. Conversely, those in small practice settings were more likely to report rationing. Those politically inclined to identify themselves as liberals or progressives were also less likely to report rationing of clinical services.

What’s interesting about the survey is that researchers managed to capture the attitudes behind rationing of medical resources, without actually using the word ration. Instead, they devised three versions of a question attempting to explore the physicians’ stance on how clinical services should be allocated, without openly asking the question. Physicians were randomly assigned surveys bearing one of the three questions. Measured on a scale from strongly agree to strongly disagree, the three questions were as follows:

- “I should sometimes deny beneficial but costly services to certain patients because resources should go to other patients that need them more” – 48 percent strongly disagreed.
- “Cost to society is important in my decisions to use or not use an intervention.” – 39.4 percent strongly disagreed.
- “Physicians should adhere to clinical guidelines that discourage the use of interventions that have a small proven advantage over standard interventions but cost much more” – 39.6 percent strongly disagreed.

In analyzing what each sentence is appealing to, the first places emphasis on consideration of the individual patient, whereas the latter two frame rationing as a response to healthcare costs at the expense of society on a whole. Simply put, one is just as important as the whole. Or more important, if we account for the percentages. The first sentence also looks at the equitable distribution of limited resources, an issue that speaks to justice, one of the highly subjective core pillars of medical ethics.

Furthermore, the variation in the results above suggests what doctors have long known and argued over, that the definition of “rationing” is imperfect and subjective; and the English language can be quite tricky. While avoiding the term "rationing" may help physicians feel more comfortable with addressing the controversial topic, it runs the risk of poorly defining the issue and opening it up to varying interpretations. Before we attempt to understand the behaviors associated with rationing and ask physicians to own them, we need the medical community to agree on a collective definition of the term.

NOTES:
(1) The list of interventions included laboratory tests, routine radiography, magnetic resonance imaging (MRI), screening tests, referral to a specialist, referral to an intensive care unit, prescription drugs, referral for surgery, referral for dialysis, and hospital admission.

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