RATIONING AT THE BEDSIDE: IMMORAL OR UNAVOIDABLE?

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Abstract

Although most theorists of healthcare rationing argue that rationing, including rationing that takes place in the physician-patient relationship ("bedside rationing") is unavoidable, some health professionals strongly disagree. In a recent essay, Vegard Bruun Wyller argues that bedside rationing is immoral and thoroughly at odds with a sound view of the physician-patient relationship. We take Wyller to be an articulate exponent of the reluctance to participate in rationing found among some clinicians. Our essay attempts to refute the five crucial premises of his argument yet build on his genuine insights. In our analysis, Wyller's critique of bedside rationing is instructive both for harbouring some very common misconceptions that must be exposed and refuted, but also for offering important words of caution. In particular, bedside rationing must be performed in ways that do not harm the physician-patient relationship. Read irenically, Wyller's critique is a reminder of *what must not be lost* in our painful endeavour to update the ethics of medicine to encompass the unavoidability of rationing.

Introduction

Among theorists of healthcare rationing it has become a truism that rationing is to some extent unavoidable. However, many clinicians nevertheless continue to disagree vehemently. In particular, the practice of rationing healthcare at the bedside – that is, for the individual, identifiable patient under the clinician's care – is argued by many to be unacceptable. In this paper one prominent recent articulation of such a view is taken as the point of departure in order to shed light on the controversy surrounding bedside rationing. In the process we argue for some normative views, such as openness in bedside rationing.

In a recently published anthology, "Fair Resource Allocation and Rationing at the Bedside",[1] all but one author – professor of pediatrics Vegard Bruun Wyller – appear to accept bedside rationing in some instances and on principle. In his essay, entitled "Give to the Doctor What Is Due to the Doctor! Why 'Fair Rationing at the Bedside' Is Impossible", Wyller claims that bedside rationing is immoral.[2] Instead, Wyller promotes a relational ethics and the ideal of the Good Samaritan as an appropriate ethos for medicine. Wyller makes five main claims that we will proceed to evaluate: that the need for rationing can be all but obviated; that rationing masks an ethical choice as a scientific calculation; that rationing involves a problematic transfer of power; that rationing harms the physician-patient relationship; and that bedside rationing is incompatible with a sound ethos for medicine.

In our analysis, Wyller's critique of bedside rationing is instructive both for harbouring some very common misconceptions that must be exposed and refuted, but also for offering important words of caution. Read irenically, Wyller's critique is a reminder of *what must not be lost* in our painful endeavour to update the ethics of medicine to encompass the unavoidability of rationing.

As Daniels & Sabin put it, the starting point for rationing is that "Society simply cannot meet all medical needs, and certainly not all medical preferences, so it must decide which needs should be given priority and when resources are better spent elsewhere".[3] Rationing means portioning out healthcare resources, whether medication, money, equipment time, procedures, or the time and attention of health professionals. Although they have different connotations we take the terms rationing and priority setting to point to the same phenomena, and will use the terms interchangeably throughout. Wyller quotes with approval Ubel's definition that "rationing occurs whenever [patients receive] less than the most beneficial healthcare service";[4] he then adds his own definition of *bedside* rationing as the physician deciding "to give a patient suboptimal treatment because he finds it morally more acceptable to prioritize someone (or something) else".[2] The first of these two definitions is wider, in that it also includes the rationing that occurs as an unacknowledged consequence of a medical decision.

Although Wyller appears to be critical of healthcare rationing as such, his main target is what we will term "the paradigm of bedside rationing". This paradigm involves the contention that rationing is ubiquitous and unavoidable, and must also be performed by individual health professionals in the encounter with individual patients; moreover, that such rationing ought to be performed explicitly and in line with justified moral principles, perhaps operationalized within the framework of health economics. Wyller's position is that bedside rationing is avoidable and *should* be avoided, because it necessarily involves modes of deliberation alien and harmful to a sound ethics of the physician-patient relationship.

The Values at the Bedside study surveyed physician practices and attitudes in four European countries (the UK, Switzerland, Norway, and Italy). More than half

(56.3%) of the respondents reported practicing rationing in the last six months.[1] Most respondents (82.3%) showed some degree of agreement with rationing practices.[5] Half (51.2%) agreed that costs mattered in their decision whether or not to offer an intervention. More than half agreed that rationing may interfere with the physician-patient relationship.[1] In sum, the study confirms that physicians are divided and ambivalent when it comes to rationing at the bedside. Most agree that rationing is challenging, whereas a substantial minority rejects bedside rationing altogether. We take Wyller to be an articulate representative of the latter group, and his essay as expounding viewpoints and judgements that are widespread among physicians deeply critical of healthcare rationing.

Wyller's critique of bedside rationing

In our analysis, Wyller's critique consists of five objections to the paradigm of bedside rationing, objections that will now be addressed in turn.

1. The need for rationing can be all but obviated

According to Wyller, the paradigm of bedside rationing accepts scarcity in healthcare as a given, when it is really the result of a political decision. Many wealthy nations – such as Wyller's native Norway – have the opportunity to increase the sum total spent on healthcare, thus, according to Wyller, coming close to obviating the need to ration beneficial services. Wyller concedes that increased spending cannot do away with every kind of rationing, but throughout his essay he maintains that bedside rationing can and ought to be avoided.

Our response would be that, while the first part of Wyller's claim holds true, that is, that wealthy nations are able to increase their health care expenditures, he is

wrong to imply that this would come close to resolving the problems of priority setting. It is crucially important to realize that increased budgets – even with the adjunct of increasing the efficiency of resource utilization – could never dissolve the need for every kind of rationing. Rationing is a much more pervasive phenomenon in healthcare than Wyller lets on. Rationing and priority setting has to take place at macro, meso and micro levels whatever the sum total and the proportion of gross national product spent on health care. This contention – the ubiquity of healthcare rationing – is fundamental to our critique of Wyller's position, and will therefore be defended at length.

According to Wyller (and we concur), any instance of giving the patient suboptimal healthcare because it is found morally more acceptable to give priority to something or someone else is a case of healthcare rationing/priority setting. Now, if *optimal* healthcare is the standard every instance of healthcare provision should be measured by, then it is clear that very many actual instances fall short of the mark and are cases of rationing. Moreover, it is easy to construct thought-experiments in which it is literally impossible to provide optimal healthcare to all. Two such simple examples to illustrate this: First, should every patient suffering from depression get to see the country's very best psychotherapist with no waiting time? Second, should an anti-cancer drug which provides a minimal net health benefit for the patient be covered by public budgets *regardless of the costs* – even if such costs were astronomical? The answer is a clear "no" in both scenarios. These examples show that, if "ought" implies "can", everyone must accept rationing of healthcare *in principle*, for there are situations where rationing becomes a virtue of necessity; rationing *as such* cannot then be immoral or unacceptable. Any rationing decision may be morally or medically unjustified or well-justified, and more or less

consequential for the patient. However, once rationing is seen to be sometimes a virtue of necessity and therefore *in principle morally and medically acceptable*, a controversial proposal to ration in a particular case cannot be rejected *simply because it is rationing*.

Furthermore, since not everyone can receive *optimal healthcare, all the time*, then arguably patients should be content to receive – and providers content to provide – healthcare that is *good enough*. The decisive question then becomes not whether an instance of healthcare provision involves rationing, but whether what is provided is good enough. What constitutes "good enough" healthcare is, of course, not settled by any of this, but must be an open question where the relevant moral and medical arguments and their bearing on the particular case must be considered.

We have shown that *in principle* rationing is ineradicable from healthcare systems; it now remains to show that *actual* healthcare systems is permeated by rationing at the macro, meso, and micro levels, and that extra allocation of resources can only go so far in reducing the need for rationing. We commence by pointing to a number of examples.

At the macro (i.e., governmental) level, politicians decide the size of the total healthcare budget and may allocate funds for specific purposes and groups. For instance, in Norway, a group of breast cancer patients who had undergone mastectomy bared their scars at a rally outside of parliament, in order to protest the long waiting lists for reconstructive surgery. The rally received ample media coverage and the patient group was ultimately rewarded with specific government grants so that the requested operations could be prioritized. However, it was later acknowledged that this allocation of healthcare resources at the macro level had the very unfortunate side-effect of *increasing* waiting lists for surgery for children with cleft lip and

palate.[6] The latter group, then, received *suboptimal* care – healthcare was rationed – as an unintentional side-effect of governmental priority setting. Such side-effects are very common, perhaps unavoidable, effects of giving certain groups a higher priority within the healthcare system: there will be less funds, personnel and equipment available for other groups. Thus, promoting one group's interests and needs will often lead to rationing of healthcare for another.

At the meso (i.e., bureaucratic and hospital) level, clinical practice guidelines will typically involve some implicit rationing. For instance, as Norheim shows, a guideline recommending primary prevention of cardiovascular disease only if total 10-year risk exceeds 5% *rations treatment* for patients with lower risk estimates.[7] The cut-off chosen, then, relies on medical premises (such as premises about the nature of complications and risk factors) but also on moral premises such as judgements of appropriate levels of cost-effectiveness. Norheim shows how the term "[medical] indication" often masks an underlying rationing decision: for certain patient groups a health service is deemed "not indicated" *not* because the service is pointless, but for the implicit reason that potential health benefits are deemed too meagre compared to the resources spent.[7]

At the micro (i.e., clinical/bedside) level, many decisions involve rationing.[5, 8] Absolutely scarce resources (e.g., intensive care unit beds) must be allocated in a just manner. Patients will often have to be triaged in emergency departments or when referrals for, for instance, specialist clinics or radiological examinations are evaluated; in the latter cases, patients may be placed on waiting lists according to the perceived urgency of their medical needs. When hospitals attempt to bring down the average duration of stays, the timing of discharge is often a compromise implying a risk for the patient thought to be acceptably low.[9] When a general practitioner prioritizes a

patient with an acute need, this may lead to shorter consultations or rescheduling for her other patients. Indeed, the very decision to schedule brief appointments as the standard involves a compromise and means that at least some patient needs will not be catered to. Patients may request diagnostic imaging or comprehensive blood screening tests that the physician declines – not because they are wholly without benefit, but because the potential benefits are deemed too unlikely and/or meagre to justify the resources spent. The choice of antibiotic therapy may be made not only with a view to maximum efficacy, but also to prevent microbial resistance in the area. Guidelines that involve implicit rationing, as in the example above with prevention of cardiovascular disease, must be implemented bedside, as when the clinician makes a conscious decision whether to follow the applicable guideline. This, then, is an example of a rationing mechanism formulated at the meso level which is then implemented at the micro level. These common examples involve patients receiving suboptimal healthcare for the benefit of other patients – thus, they are examples of rationing.

If healthcare budgets and the number of healthcare professionals were greatly increased, then in many of the scenarios sketched rationing would no longer be a virtue of necessity. Increases in budgets and the capacity of healthcare education, then, are real options for politicians, as Wyller is right to remind us. However, there remain cases in which rationing still arguably *should* take place (e.g., antibiotic therapy), or *must* take place (e.g., the quality of treatment is provider-dependent, as in the depression example, so that most providers are merely able to provide good enough, not optimal services); moreover, increasing healthcare budgets and the capacity of services may in itself lead to increased expectations, utilization, and demand.[10] Increasing healthcare spending so that every healthcare need, however

marginal, may be met would be prohibitively expensive, and would require increased training of specialists that would take years. It therefore seems justified to say that all-but-eradicating every need to ration in healthcare by increased funding and improved efficiency, is a wholly unrealistic project, whatever the size of the GNP of a nation. Moreover, from a global justice point of view it is has been argued that for affluent nations to spend much more on their own health care would be immoral.[11-13]

To all this one could imagine a clinician conceding that cases like the many examples given are indeed the staple of healthcare and are, by definition, instances of rationing. However, it may be said, such cases are relatively uncontroversial, in that all stakeholders typically see them as acceptable, realizing that these are compromises dictated by practical necessity. Is there then not a clear and ethically significant distinction between cases such as these, where patients are subjected to minor or moderate inconveniences, such as time on waiting lists or slightly less efficient treatment, and (what our imaginary interlocutor may want to term) *true rationing,* in which truly beneficial healthcare (e.g., chemotherapy that prolongs life by, on average, six months) is intentionally withheld from the patient because costs are deemed excessive?

Although there is a conceptual difference, we do not think there is an ethically decisive difference. In fact, all the examples given involve clear *withholding* of healthcare (or substituting for a less efficacious form) that either definitely or possibly could have lead to a large, moderate or small health benefit if provided. The patient with a mere 4% risk may yet die of myocardial infarction which could have been prevented; another patient's disease may progress while on the waiting list, significantly worsening prognosis; yet another patient may suffer pain and discomfort while on a waiting list. In several of these situations, the potential detrimental

consequences of withholding care may be explicitly acknowledged by the clinician. Like in the chemotherapy case, this rationing may be partly or fully justified by low cost-effectiveness. The examples given therefore do not differ in any principled way from the chemotherapy case. They are all instances of rationing. There is, then, no ethically relevant difference between "true" rationing and other kinds. (The suggestion that bedside rationing where an identified individual patient is bereft of beneficial services constitutes a special case is treated in subsection 5). Of course, a rationing decision may be well or poorly justified, medically and morally, and be more or less detrimental to the patient's health. Again, however, our point is that a particular proposal to ration cannot be rejected *on the grounds of it being a case of rationing*.

Peter Ubel explains how "rationing" has accumulated heavy historical and emotional baggage and has become something many US clinicians feel a need to reject.[14] However, when a proposal to ration is couched in different terms (e.g., "clinical parsimony" instead of "rationing of marginally beneficial healthcare");[15] "value" or "comparative effectiveness research" instead of "cost-effectiveness"; "balanc[ing] the best interests of individual patients with our duty to protect public health"), it may appear prudent and fair, and no longer cruel and immoral. Skirbekk & Nortvedt found that clinicians were apt to drape deliberations on priority setting in purely medical language; terms like "rationing" and "priority setting" were avoided.[16] Instead, physicians deliberated on the basis of the informal norm of "making a difference for the patient through medically sound decisions".

To sum up, we take our argument that healthcare rationing cannot be immoral or unacceptable *in principle,* to be decisive. Furthermore, although increased funding can decrease the need to ration, Wyller is wrong to imply that any budgetary increase

could ever make *all* cases of rationing of beneficial healthcare unnecessary, far from it. This is the most significant mistake in Wyller's essay; priority setting is much more pervasive in healthcare than Wyller lets on, and will remain so even in the event of greatly increased resource allocations for healthcare. The examples given – which could be multiplied – show the near-ubiquity of healthcare rationing.

Paradoxically, the need to ration, carefully and in line with morally justified criteria and procedures, should appear most acute to physicians such as Wyller who decry what they perceive as the underfunding of healthcare.[1] For, if resources truly are critically scarce, the need to prioritize the needs of the weak would be particularly strong.[17] Indeed, the individual physician should in some sense regard the total healthcare budgets as fixed. In this perspective, Wyller should have been eager to support efforts to instigate transparent priority setting based on morally justified criteria and procedures, in order to make the best possible use of healthcare resources and reduce the negative impact of scarcity – *until* he succeeds in convincing the electorate and the politicians that healthcare funding must be increased dramatically.

We would suggest that a *status quo bias* partly explains why the rationing of beneficial healthcare may be silently accepted (e.g., in Norway: treatment of depression in the elderly; treatment of certain rheumatological diseases; examples could be multiplied [6](p. 191-3)), whereas a *new is better than old* bias makes rationing of new and very costly services of questionable benefit regularly decried as unacceptable. It is part of human nature to grow accustomed to "the way we have always done things" and exempt old practices from the scrutiny applied to novel proposals.[18]

[1] See Wyller's op-ed "Prioriteringsutvalget – udemokratisk og umoralsk", Vårt Land 17 Nov 2014, available at http://www.verdidebatt.no/debatt/cat1/subcat8/thread11538785/.

2. Rationing masks an ethical choice as a scientific calculation.

The cost-benefit analyses of health economists displace, in Wyller's view, what ought to be the province of ethics and politics. Decisions about resource allocation are not scientific, but political and moral in nature. Concepts such as QALY create "the illusion that 'fair' decisions depend solely upon advanced arithmetic and therefore could be left to health economists".[2]

In our view, Wyller is right that the calculations and jargon of health economics may mask the "tragic" and interpersonal character of healthcare rationing. One problem here is inherited from the theoretical optimism underlying health economics: the consequentialist urges us to choose the solution promising the highest net total of good, and portrays this alternative as the *uniquely* correct one. Consequently, she may turn a blind eye to the loss of the very real goods that were promised by the competing alternatives that were rejected. In health economics one may get the impression that there is no moral problem or "moral residue" as long as the disadvantages are *distributed fairly*. The rationing procedures mask the fact that these choices are often hampered by the residual problem of *remainder* and *regret*, that is, the distress experience emerging from the fact that the rejection of the competing 'oughts' does not follow clearly – or cannot be fully explained – by reference to the logic of the rationing procedure applied.[19] [20] Rationing procedures may thus mask the residual dimension of such choices.

However, this danger should not be exaggerated. It is certainly possible to prioritize something yet remain quite aware that something else is at the same time rationed; that this might be unfortunate; and that real goods are lost. Indeed, such awareness is embedded in economics' strong emphasis on *alternative costs*. A

systematic approach to priority setting is thus compatible with the presence of moral uneasiness and the awareness that at least some priority decisions are "tragic choices" in which important goods are lost, whatever the priority choice made. Such an awareness may also be instrumental, in that it fuels a moral consciousness and creativity that spur us to find ever better solutions to priority dilemmas.

In addition, a systematic approach to priority setting would begin by pointing to the healthcare services that produce only minute health benefits, at the lowest cost-effectiveness. Careful systematic rationing would urge the discontinuation of such forms of services, *not* of effective treatments that make a serious difference to patients. The elimination of the former kinds of health services is hardly tragic.

Because health services are often promoted by unconscious "drivers", such as the awe of technological novelties,[18] rather than by transparent and rational processes, the calculations of health economics may be helpful in indicating the true costs and benefits of different services. Norheim urges us to take the bird's-eye perspective where all fields of medicine are seen in comparison, and from where a "cross cutting impartiality" can be instigated.[21] The upshot would not be, as Wyller fears, the masking of an ethical choice, but on the contrary, the realization that *there are in fact ethical choices to be made* as to whether certain services should be promoted or discontinued.

3. Rationing implies a problematic transfer of power.

Related to the previous objection is the point that the endorsement of general principles of healthcare rationing leads to the empowerment of experts at the expense of politicians. As the former are not politically accountable, this is both un-democratic and leads to a decrease in transparency: "the concern for distributive justice has

become an administrative and bureaucratic challenge instead of a political one. Bringing this concern all the way to the bedside … seems to me to be an extreme variant of power transfer".[2]

In response, we would argue that if basic criteria for priority setting are in fact morally justifiable, then it is right to set priorities by these criteria explicitly. Defining, tweaking, and deciding on the basic criteria is the domain of politicians; however, the practical implementation of the criteria must necessarily take place at lower levels – by bureaucrats and health professionals in particular. This is a necessary and legitimate delegation of power – an empowerment *by*, and not *at the expense of*, politicians. According to Daniels & Sabin's popular approach "Accountability for Reasonableness", priority setting should be public, transparent, underpinned by reasons, open to relevant stakeholder concerns and open to revision and appeal.[3] In this way priority setting arguably retains democratic legitimacy even though it is not performed by elected officials.[2] Because priority setting also takes place at the clinical level, criteria for priority setting – in formats appropriate to the clinical level – must be carried forth all the way to the bedside setting, and applied by health professionals with moral and clinical discernment. In other words, priority setting has to be performed at the meso and micro levels and thus cannot be solely the province of politicians.

[2] Some of Wyller's opposition to bedside rationing appears to stem from a caricatured conception of what bedside rationing must involve: "It would demand that each and every physician weigh the effect of a certain health 'commodity' against all other possible applications of the same amount of resources. Even a more restricted application of the principle will confront the physician with an immense – and indeed impossible – task, and may turn out to be quite arbitrary and inefficient" (Wyller, op. cit., p. 258). For a more palatable view of what bedside rationing should consist in and how it may be carried out in practice we recommend the many real-life examples given in the very anthology Wyller's essay contributes to, and in Daniels & Sabin's book.

Indeed, once appropriate and justified rationing criteria have been decided upon it may be wise of politicians to require specific rationing decisions to be taken at lower levels, thereby, as it is sometimes expressed, tying themselves to the mast (Ulysses-style). In this way, politicians would make themselves less vulnerable to the forces of media-facilitated campaigns and sentimentality spurred by heart-wrenching stories of individual patients or groups (as per the reconstructive breast surgery discussed above): the general principles have already been decided upon, through a fair and transparent process; appeals are welcomed, but are not handled at the political level.

4. Rationing harms the physician-patient relationship.

Bedside rationing introduces an interfering third party into the physician-patient relationship. With the knowledge that her physician accepts the principles of bedside rationing, the patient may never be sure whether the physician's decision is for her own good, or rather is a compromise for the benefit of a third party. This erodes the trust which is crucial for the physician-patient relationship. Wyller quotes with approval Levinsky, who argues that physicians must act for the beneficence of their patients without taking extraneous factors such as costs into consideration.[22]

We begin our reply by conceding that Wyller is onto something important here. Freidson distinguishes between bureaucratic, consumer-oriented, and profession-based organization of professionals' work, a differentiation that can be applied to medicine.[23] There is a tension between these three different forms of organization; if a viable balance is not negotiated, the former two may threaten to standardize and instrumentalize medicine and decrease the room for the exercise of professional virtues and judgement.[24] The demand on physicians to steward societal

resources and to ration may be perceived as imposed on them from the outside as a requirement stemming from a bureaucratic vision of healthcare. The demand to ration may then be thought to be yet another burden that threatens to destroy the delicate balance and narrow the space for true professionalism. As such it must be opposed.

However, Wyller seems to overlook that there are already many other "third parties" to the physician-patient interaction. Modern physicians are already handling "multiple accountabilities".[25] A Norwegian general practitioner (GP), for instance, must live with the many exceptions to patient-doctor confidentiality given in health law, and with a dual role in completing sick-leave certificates. Yet, despite not being *solely* the patient's advocate, GPs enjoy very high levels of public trust.[26] Evidently, then, the physician-patient relationship *can* to some extent accommodate "third parties" without eroding trust. Such a sturdy relationship may be able, therefore, to handle explicit rationing as well.

Indeed, the physician-patient relationship *is* already handling this, as bedside rationing is, as has been argued, an unavoidable feature of clinical medicine. If rationing already takes place today, then bringing this fact out into the open ought to *increase*, not decrease trust. When asked, patients prefer rationing to take place in the open.[27] Once we are aware that rationing takes place, the alternative to openness would be deception – hardly a promising ethical basis for a sound physician-patient relationship. As Strech et al. argue, openness would also reduce the emotional distress of undisclosed rationing experienced by the physician and the burden constituted for the physician-patient relationship.[8] Pearson argues that the physician's traditional sole emphasis on the present patient's interests may turn into a "Darwinian advocacy" in which physician-patient dyads compete with others for available resources. He proposes an alternative model of patient advocacy, "proportional advocacy", in which

physicians take responsibility not only for the individual patient's interests, but for the fair allocation of healthcare to the population, balancing competing interests.[28]

In sum, Wyller's warning that explicit rationing at the bedside will erode trust must be heeded, but is to some extent premised on the misconception that such rationing is avoidable. As argued, there are reasons to believe that the physician-patient relationship can handle the practice of rationing.

5. The paradigm of bedside rationing is incompatible with a sound ethos for medicine. According to Wyller, the medical ethos must build on a relational ethics (ethics of proximity, ethics of care), such as the ethics promoted by Emmanuel Levinas. The Bible's Good Samaritan is brought forth as an ideal for the caregiver professions. Wyller is critical of impartial systems of ethics to the extent that these rely on abstract and universal principles and neglect the context-dependent reasons that constitute the mainstay of ethics of proximity approaches. In particular, the modern principle of distributive justice inherent in the paradigm of rationing appears "totally infeasible when it comes to medical practice 'at the bedside' … [this] application of the principle will confront the physician with an immense – and indeed impossible – task, and may turn out to be quite arbitrary and inefficient".[2] The term "fair rationing" springs from modern conceptions of universalistic justice, whereas "at the bedside" connotes an ethics of proximity and care perspective, that is, an ethics that emphasises the normative value of interpersonal relationships. These are, it is maintained, fundamentally and irresolvably in conflict: "a fusion seems insuperable – 'fair rationing at the bedside' is simply impossible. So why even try?"[2] Towards the end of the essay Wyller admits that health professionals may sometimes be required to take "moral actions in situations characterized by acute discrepancy between means and

needs".[2] He suggests, however, that resources for morally sound resolution of such situations would be found in a relationally and partialist oriented care ethics and the Aristotelian tradition, not in the universalistic ethics of modernity underpinning the paradigm of bedside rationing. The precise nature of his preferred moral guidance, however, remains undeveloped in the essay.

We answer that if some rationing is unavoidable, then a sound ethics of the physician-patient relationship must be able to accommodate this fact. Concerns have been raised that proximity and care ethics approaches are simply unsuited to provide such an ethical framework for medicine because they lack resources for analysing justice and rationing.[29] A well-developed modern professional ethics ought to be able to incorporate and justify notions of justice and rationing and a healthy ethos for medicine *as well as* important intuitions about the moral primacy of the particular patient. It is also important to note that an ethics of proximity taking its inspiration from Levinas never holds that the patient at the bedside must receive priority in each particular situation, that is, that one should never consider and balance the various interests, state of affairs, and vulnerabilities. Levinas' prime concern was metaethical, with elucidating the primordial sources of moral responsibility or what Levinas calls *le sense de l'éthique*, the meaning of ethics, and its origin. There is an important insight in Levinasian ethics that concern for the particular individual is the essence of ethics and that justice must always be tempered by what Levinas would call, *inter alia*, love for one's neighbour, proximity, vulnerability, and "suffering for the suffering of the Other". Wyller could build on these insights, but he could not take them as an argument against giving *some* attention to justice at the bedside.

As for the Aristotelian tradition, it may (*pace* Wyller) be compatible with priority setting. In a recent essay, Crisp shows how an Aristotelian ethics of the

physician-patient relationship can incorporate attention to other needs than the ones of the present patient [30]. In short, Crisp argues that benevolence and giving priority to one's own patient both can and must have boundaries constituted by considerations such as justice and professional responsibility: "The Aristotelian doctor can care passionately for her patient; but she will also care passionately about certain other considerations and virtues, and will not allow her patient-centred concern to override her commitment to these other virtues".[30] Similarly, in Bærøe's account of reasonable clinical judgments, an account that aspires to justify bedside rationing in principle, Aristotle's formal principle of justice figures prominently as a starting-point.[31]

The first set of Wyller's preferred theoretical approaches, then, an ethics of proximity and care, *either* may not be a suitable ethical framework for the physician-patient relationship, since it struggles to accommodate concerns about justice and duties to other patients; *or*, as with Levinas, concedes that such concerns are appropriate; whereas the second, Aristotelian ethics, may turn out to be able to justify the very rationing paradigms Wyller rejects. If Wyller wants to uphold his thesis he must detail an Aristotelian account of the physician-patient relationship that is plausible yet incompatible with rationing; this has not been done.

If the clinician refuses to partake in explicit rationing, then significant rationing and priority setting will nevertheless take place, through a wide range of mechanisms. To mention but a few, the interests of the professions and specialties,[32] the allure of novel technologies,[18, 33] the presence of strong patient advocates and organizations which have the media on their side and who often also are supported by industry, and the structure of the healthcare services and financial incentives. All these mechanisms shape priority decisions in unacknowledged and often, arguably, unfair ways. Awareness of unprincipled differential treatment across diverse medical

fields will enable us to relocate resources in ways that might promote fairness and justice and reduce waste.

Wyller's anti-position with regard to rationing, both his *implicit neglect* of some actual rationing, and his *explicit refusal* to partake in it, have unfortunate consequences. As a virtue of necessity, the modern doctor has more than one patient and works in teams and institutions caring for many patients, and hence must relate to other interests and patients in addition to the patient in front of her. If rationing takes place unreflectingly, the result will be poorer and less fair than if decision-making is faced consciously, reflectingly and head-on.[8] Human decision-making is prone to the influence of a host of biases;[34] making decisions explicit and transparent will reduce the influence of such biases.[35] On the basis of empirical findings it has been argued that implicit rationing will typically turn out unfair;[36] for instance, clinicians admit that they do not necessarily perform rationing decisions by the same standards in all cases.[8]

Menzel points to a helpful distinction between *statistical* and *identified lives* influenced by priority setting.[37] Primary prevention of cardiovascular disease, for instance, benefits statistical, non-identifiable patients. Treatment, on the other hand, typically benefits the identifiable patient receiving it. Menzel's second distinction is between *beneficiaries* of treatment and mere *recipients* of treatment; a patient who receives treatment may not necessarily benefit from it, as in the case of clinical prevention. Menzel points out that we are much more likely to accept rationing when the persons denied a beneficial service remain statistical than when they can be identified. Menzel suggests that also bedside rationing is perceived as more acceptable in cases where the physician is not outright denying a service that with all likelihood would have benefitted the patient; bedside rationing is less controversial

when "the identity of beneficiaries is hidden by risk and probability, especially at the time of treatment".[37]

It is here that Wyller's critique is at its most incisive. Wyller does the debate a service by introducing a moral framework, the relational ethics of Levinas and others, which is eminently capable of explaining the intuitions pointed to by Menzel: The physician's reluctance towards bedside rationing stems from the perceived responsibility to act in the best interest of the patient presently facing them. When you ration services you no longer act solely in the best interest of the patient, and the moral conflict becomes most acute when the patient would clearly have been a beneficiary (in Menzel's terms) of the service; and the strength of the perceived conflict would increase, one would think, in line with the assumed *probability* of the patient benefitting from the service and the *size* of the benefit.

Relatedly, at the bedside it is natural for the physician to strive to realize the present patient's potential for health, without asking whether one's care would have produced more QALYs in another patient.[38] Explicit rationing at the bedside (although it does not require the invocation of terms from health economics) therefore in some sense goes against the grain of medical practice, and must be shown to be morally, medically and practically justified before physicians will engage in it.

Wyller, then, is arguably able to articulate the clinician's deepest misgivings about bedside rationing, by identifying the moral intuitions involved and placing them in the context of a relational ethics of the physician-patient relationship. However, he has yet to give any argument to the effect that these intuitions should be *ethically decisive in all situations.* Until he does so, we have no non-intuition based reason to think that bedside rationing in which an identifiable patient is denied a beneficial treatment is morally unacceptable on principle. On the contrary, such cases are on a

par with the rationing that has been argued to be pervasive throughout all levels of the healthcare services.

What then to make of clinicians' intuitions against bedside rationing? One cannot expect that clinicians will act in defiance of their anti-rationing intuitions without first being convinced of the moral acceptability of bedside rationing. This challenge however, appears to be more one of didactics than of normative ethics; that is, of phrasing the arguments in such a way that they provide cohesion and intelligibility, meaning and order instead of alienation in clinicians' minds and hearts.

Concluding remarks

Arguably, the traditional ethics of the health professions and services resonates best with deontological, virtue and care ethics, whereas consequentialism and in particular its operationalization and quantification within the framework of health economics may be perceived as somewhat alien to medicine and clinicians. Wyller is not opposed to all instances and processes of rationing; his critique is, in particular, directed towards what we have called the paradigm of rationing – involving QALYs, calculations and the replacement of some individual clinical-moral discernment with agent-neutral applications of formulas, informed by empirical data from evidence-based medicine and health economics. Furthermore, Wyller's opposition is in particular to the application of this paradigm at the bedside level. His essay is a warning that considering healthcare rationing mainly within the framework of health economics may blind us to the morally relevant realities of the wider picture: on the macro level, to the size of the total healthcare budget in relation to other societal commitments, and the waste and inefficiency of health bureaucracies; on the micro level, to the challenges generated by the physician-patient relationship and clinician

intuitions. Wyller, however, goes too far in disqualifying impartial considerations of care and priorities at the bedside.

Finally, rationing at the bedside is not simply a rational process of cognitive discernment. It also a matter of the heart, involving strong emotions such as pity and fear, compassion and the myriads of moral demands experienced by the individual doctor faced with the patient's vulnerability. An ethics of priority setting only rationally endorsed and impartially applied will fail to capture the central moral intuitions that the notion of "care at the bedside" contains. This worry is, we believe, at the core of Wyller's misgivings. If bedside rationing is to be accepted and its principles lived out, proponents must forge an alliance and a mutual understanding with practitioners. Practitioners must come to perceive rationing as unavoidable, yet morally feasible. Their priority setting decisions must be receive backing from general principles, regulations, guidelines, leaders, and colleagues. Theorists must attempt to justify a realistic practice of rationing even though it may perhaps fall short of the ideals dictated by their impartialist frameworks.[39]

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