Tough Questions, Even Harder Answers

Have you withheld any beneficial care from your patients lately? Not an easy question to answer. Such a question might put you on the defensive. Or it might cause you to rack your brain, trying to conjure up the kind of examples that the questioner was looking for. As difficult as it is to answer this question, however, it is important for researchers to get good answers to this type of question, because physicians play a crucial role in any efforts to control health care costs. With health care inflation rising almost as quickly as college tuition payments, governments across the industrialized world are struggling to find ways to reign in health care spending. Their job would be so much easier if physicians would be willing to forego marginally beneficial care for their patients,[1] holding off a few more weeks before ordering MRIs on patients with acute shoulder pain; thinking twice before prescribing the latest medication that offers slim if any benefits over generic medications; even being more frugal in referring patients to expensive subspecialists.

It is also important to know what physicians are doing to help control health care costs, because few people are convinced that physicians are up to this difficult task. We physicians were not trained to control costs. Many experts have written, in fact, that physicians should not involve themselves in rationing when caring for their patients, contending that such rationing activities would be carried out in ways that discriminate against the most vulnerable patients.[2–4] The only way to address valid concerns like these is to collect valid data about physicians' rationing activities, to find out what services physicians are withholding from which patients.

Hurst et al.[5] conducted an ambitious and impressive study in which they set out to measure the frequency and content of bedside rationing among primary care physicians in 4 European countries. They faced many challenges in conducting this research. First and foremost, they were inquiring about behaviors that many physicians would deem socially undesirable. Even though they wisely avoided using the loaded word "rationing" in their survey, they nevertheless asked about activities that many physicians must have felt uncomfortable divulging. It is hard to tell whether Hurst and colleagues received honest answers from all of the respondents, and whether their response rate was reduced because of the controversial nature of the topic.

But researchers exploring this topic face an even bigger challenge than the social undesirability of beside rationing—finding a way of asking their questions that will help physicians *accurately* recollect their bedside rationing activities. And here, I am struck by the timeframe of their main question: "During the last 6 months, how often did you personally refrain, because of costs to the health care system, from using the following interventions, when they would have been the best intervention for your patient?" Six months is a long time, and counting up any but the rarest and most memorable activity over such a long period is very difficult. I could tell you how many times, over the past 6 months, I have skydived (zero), traveled to California (once, or was it twice?); I could even give you a good estimate of how many times I have brushed my teeth (180 days times 2 brushings per day, minus a few missed evening brushings—sorry Mom!), because such an activity is so routine and predictable. But refraining from offering patients interventions because of the cost to society? I have no idea what activities to conjure up when asked that question, nor any confidence that I will accurately count up the activities I do conjure up. How many MRIs did I decide not to order these past 6 months? I have no idea.

The 6-month timeframe, for such a complex behavior, clearly creates a challenge for Hurst's respondents. But the timeframe has another important impact, one that many survey researchers overlook—the timeframe shapes people's interpretations of what kind of activities the researchers are inquiring about.[6] For example, when people are asked: "How often do you get angry in a typical year," they usually assume the questioner wants to know about bouts of severe anger, and thus report experiencing such bouts relatively rarely. But in contrast, when asked how often they get angry "in a typical week," they assume the questioner wants to know about more mundane events, and thus report experiencing more frequent bouts of anger, with the bouts tending to be less severe. The timeframe that questioners ask about suggests to respondents what kind of activity the researchers want them to report on.

Had Hurst et al. asked physicians how many interventions they had withheld from patients in their most recent clinic day, respondents might have been prompted to think about minor interventions, like deciding not to look for melanomas between patients' toes, or choosing not to check TSH levels in asymptomatic men, whereas the 6-month timeframe will prompt physicians to recall more extreme decisions, like ICU stays or decisions to forego MRI tests. The influence of time frame holds true even though Hurst and colleagues specified the actions they were interested in. If you ask me how many MRIs I withheld from patients in the past week, I will think about patients where the decision was relatively easy to make. If you ask me about the past 6 months, I'll think about the rare times where I really struggled with the decision.

I would love to see future studies address this issue of timeframe, to see how it changes physicians' descriptions of their bedside rationing. I would also love to see this line of research extended to include physicians in the United States, where the sense of health care as a social good is less strong, and therefore physicians may be less inclined to say they withhold medical interventions "because of costs to the health care system." Given how flawed people's memories are, I'd also like to see more scenario based-research, presenting physicians with hypothetical patients and asking them what they would and would not do for the patients.[7] Well constructed scenarios do a good job of capturing physicians' behaviors.[8] A set of scenarios that identify specific rationing behaviors could be a powerful tool to explore the factors influencing rationing decisions.

But whatever methods researchers use to study this important topic, they should expect challenges! When I worked in Philadelphia, SGIM members Rachel Werner and Caleb Alexander worked together on a project with me during the research month of their residency. As part of their efforts, they

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observed clinical encounters, then interviewed the physicians they had observed, to get an idea of why they withheld specific interventions from patients. They discovered (warning: 1 month research elective, no time to validate research methods!) that even though they, in observing encounters, saw dozens of examples of bedside rationing, the physicians they observed did not interpret the encounters in the same way. Rachel and Caleb have begun thriving research careers since that time, perhaps because neither of them returned to tackle the difficult topic of bedside rationing. Congratulations to Hurst and colleagues for doing this challenging work. Let's hope future researchers, maybe even some motivated medical residents looking for something to do during their next research elective, will follow up on their lead.—**Peter A. Ubel, MD,**[1,2,3,4] *[1]VA Health Services Research & Development Center for Practice Management and Outcomes Research, VA Ann Arbor Healthcare System, Ann Arbor, MI, USA; [2]Center for Behavioral and Decision Sciences in Medicine, Ann Arbor, MI, USA; [3]Division of General Internal Medicine, University of Michigan, Ann Arbor, MI, USA; [4]Department of Psychology, University of Michigan, Ann Arbor, MI, USA.*

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