Now that we've seen four different ethical theories and how they would affect the allocation of scarce resources in health care, we have a final question we need to take up. And that's what the role of the bedside clinician should be in making these allocation decisions.

We've seen that the Hippocratic Oath tells the bedside physician, or nurse, or pharmacist, or dentist, do what you think will benefit the patient. Maximize patient best interest. That clearly can't work in a world of scarce resources. It can't work as a basis for making the allocation.

So when it comes to the role of the clinician, we have two options. One would be to ask the physician to abandon the Hippocratic patient benefit perspective and take on the role as society's agent to make decisions to limit their patient's treatments when they are marginal and other patients could get more benefit from those resources.

Turns out there are two problems with doing that. The first is the bedside clinician is in a uniquely poor position to make the allocation decision. They surely know what's in the interests of their own patients, but they have no idea what the benefit would be from alternative uses of the resources.

So a cardiologist may know of an extra day of stay in a hospital may help a heart attack patient. But that cardiologist would have no idea whether the same money used in a well baby clinic, or an immunization program, or in a program for the elderly, or in a surgery department might do more good.

In fact, clinicians may be uniquely poorly qualified because they will tend to overemphasize the benefit for their own patients at the expense of other patients. That's one problem. The second problem is more basic. It's not clear whether clinicians should take on this role where it means deserting their loyalty to their individual patients.

It would be, if you like, metaphorically like asking the doctor to take down the Hippocratic Oath from the waiting room wall and replace it with a sign that reads something like the following. Warning, all ye who enter here. I will generally work for your welfare. But society has asked me to abandon you at the margin and be its agent in rationing health care.

I'm not sure that physicians want to take on that new role. I'm not sure that their patients want them to take it on either. But if we don't go that route, someone else is going to have to make the allocation

decisions when resources are inevitably scarce.

We're going to have to have someone who has the perspective of the societal needs for those resources. It might be a hospital administrator. It might be an insurance company executive. It might be a government agent.

We will have to have someone making the choices. If we go that route, it will mean that there will be a built-in division of moral labor, if you like, where the clinician will take as her moral mandate working for what is best for the patient as long as it preserves patients' rights.

And various administrators will be gatekeepers to decide where scarce resources are best used. This built-in role conflict is going to inevitably produce feuds between clinicians on the one hand and administrators on the other hand. But I see no alternative if we're not going to rely on the clinician as society's rationing agent.