Ethics Education resource pack

Ethics & Resource Allocation

Introduction to the Resource Allocation pack

The objectives of this pack are:

- To introduce members of the clinical ethics committee /group (CEC) to basic ethical frameworks and ways of thinking about ethics
- To provide knowledge of key ethical theories and frameworks specifically in relation to resource allocation in healthcare
- To provide guidance on how to approach ethical dilemmas arising in a clinical case

Clinical ethics committees may be asked for advice on resource allocation issues at the level of individual patient care or in relation to setting priorities within an acute trust. As a generalisation, committees in acute trusts are more likely to consider issues involving individual patient treatment.

This resource pack aims to help the CEC to apply relevant knowledge to the consideration of clinical cases.

The pages on **Ethical Frameworks** will provide general information on ethical thinking and the pages entitled **Specific ethical considerations for resource allocation** focus on particular ethical theories relevant to resource allocation such as benefit, need and distributive justice.

This information can then be used in the discussion of a clinical case scenario. The page entitled **A structured approach to case consultation** sets out one way of identifying key issues to consider in discussing a case. The case study **'Who should have the intensive care bed?'** can be discussed with the assistance of the **Issues to Consider** page.

The **powerpoint** provides a summary of the issues and can be used in the meeting as a focus for this part of the discussion.

This resource pack also deals with the ethical issues arising in macro allocation of resources – that is distribution of resources at a population level.

In the UK decisions about distributing resources for larger communities and populations lie within the remit of Primary Care Trusts or health authorities. Many PCTs either have, or are considering developing a committee or forum to advise on commissioning

priorities for the PCT. Clinical ethics committees / groups in PCTs will consider issues around strategic priority setting.

The CEC may wish to look through these documents at the pilot meeting if it has time or at a later date.

Ethical Frameworks

Introduction

If a clinical ethics committee (CEC) is to provide support on ethical issues relating to clinical practice, and to facilitate discussion of the ethical dimension of clinical problems, members of a CEC will require an understanding of the moral theories and ethical frameworks that have informed the development of medical ethics.

In this section we provide a brief introduction to some of the key moral theories and ethical frameworks that have had an important influence on health care practice, particularly in Western medicine.

Ethical Theory

We may feel instinctively that a certain conclusion to a problem is 'fair' or 'unfair', but what criteria do we use to make such judgments? There are different ethical theories that can be applied to a problem to elucidate our thinking, but even so the results may not fit with our moral intuition.

There are several types of normative ethical theory including consequentialism, deontology - such as Kantianism - and virtue ethics. They can be applied in several **procedures** of ethical analysis, such as in analysis of cases (casuistry) and in different **settings** such as in a range of 'communitarian ethics': for example, a feminist approach or a social class based approach.

Moral or ethical theory may consider the application of rules or the consequences of actions.

Deontological theory - what one MUST do, based on duties and obligations
Teleological theory - the purpose or consequences of the moral acts

Consequentialist Theory

This is one sub class of teleological moral theory. According to consequentialist accounts of morality the moral value of an act, rule or policy is to be found in its consequences, not in intentions or motives. Utilitarianism is the most influential consequentialist theory. Jeremy Bentham in the late 18th century and John Stuart Mill in the 19th century formulated this way of thinking. Such 'hedonistic' utilitarians argue that the principle to judge our moral thinking is utility, that is, the maximisation of happiness, in the sense of pleasure and the minimisation of suffering, in the sense of pain. In any situation the morally right thing to do is the action that promotes the greatest happiness for the greatest number of people.

However pain and pleasure are not the only criteria that later utilitarians have used to evaluate the consequences of actions, rules or policies. Welfare-utilitarians consider the contribution to, or lessening of, human welfare. Preference-utilitarians seek to establish and satisfy human preferences.

Some key issues:

- Calculate net benefit

The net benefit or dis-benefit is found by balancing the happiness and unhappiness resulting from an act or policy. If one then seeks the greatest happiness of the greatest number that may be taken to justify overriding individual unhappiness in the interests of the happiness of the greatest number.

- Difficulty in calculating consequences

This theory requires that the consequences of acts or policies must be calculated. However in many situations one cannot predict consequences with any certainty and therefore consequentialism is probabilistic, one forecasts the consequences to the best of one's ability. Ethics committees using consequentialist criteria necessarily operate in an area of uncertainty.

- Act and rule utilitarianism

Bentham tended to deal with the consequences of **acts**. However, '**rule** utilitariansim' justifies certain rules on utilitarian grounds. For example, one might justify the general rule 'do not lie' on the utilitarian ground that lying produces more bad consequences than good consequences overall.

Deontological Theory

A criticism of consequentialist theory is that it is so concerned with **ends** that it may overlook the moral importance of **means** - the ways in which the ends or goals are achieved. Deontological theory uses rules rather than consequences to justify an action or policy. The best-known deontological theory is that of Immanuel Kant in the 18th century. 'Kantianism' is a modern term, referring to a Kant-like emphasis on duties and rules. Kant defended rules such as 'do not lie', 'keep promises', 'do not kill' on what he claimed were rational grounds. Rules should comply with the *categorical imperative.* The categorical imperative holds that:

- Moral rules should be universalisable i.e. applied to all rational, moral members of the community rather than to just some
- All persons should be treated never simply as means but also always as ends in themselves
- Members of the moral community should take a hand in making the laws as well as living by them

Many modern *Kantians,* as opposed to Kant himself, are not absolutist in their application of moral rules or laws, whilst nevertheless stressing the importance of generally living by moral rules or laws.

Virtue ethics

Virtue ethics is the name given to a modern revival and revision of Aristotle's ethical thinking. Aristotle's ethics, while not generally thought of as consequentialist, is certainly teleological. For him, the telos, or purpose, of a human life is to live according to reason. This leads to 'happiness' in the sense of human flourishing. This flourishing is achieved by the habitual practice of moral and intellectual excellences, or 'virtues'. For Aristotle, the excellences are of two types. A moral virtue is an excellence of character, a 'mean' between two vices. One of Aristotle's virtues is courage, a mean between recklessness and cowardice, which are vices. Modern virtue ethics sets itself the task of discerning the virtues for our time. In a healthcare setting what virtues would we like doctors, nurses, etc. to possess - self-control, truthfulness, generosity, compassion, discernment, integrity?

Aristotle also identified a second type of excellences, intellectual virtues, which constitute a preference for truth over falsehood and for clarity over muddle, both in pure reason and in practical affairs. Both the moral and intellectual virtues are, for Aristotle, the expression of reason.

Casuistry

Casuistry, or case based reasoning, does not focus on rules and theories but rather on practical decision-making in particular cases based on precedent. So first the particular features of a case would be identified, and then a comparison would be made with other similar cases and prior experiences, attempting to determine not only the similarities but also the differences.

So if a clinical ethics committee were asked to consider whether it was ethical for a clinician to breach his / her duty of confidence, the committee would identify key factors, like the health risks to others if information was not disclosed. It would then make a comparison with other similar cases, identifying the relative risks of non-disclosure. Casuistry should not be divorced from consequentialism, deontology, or virtue ethics but complement them.

The Four Principles

Beauchamp and Childress' Four Principles approach is one of the most widely used frameworks and offers a broad consideration of medical ethics issues generally, not just for use in a clinical setting.

The Four Principles provide a general guide and leave considerable room for judgement in specific cases.

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.

Beneficence: balancing benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

Non maleficence: avoiding causing harm; the healthcare professional should not harm the patient. Most treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of the treatment.

Justice: respect for justice takes several forms:

- Distribution of a fair share of benefits
- Legal justice - doing what the law says
- Rights based justice, which deals in the language, and perhaps the rhetoric, of claimed human rights, and hence goes beyond, though it includes, legal rights.

These principles are prima facie – that is, each to be followed unless it conflicts with one or more of the others - and non-hierarchical i.e. one is not ranked higher than another. In recent years however, respect for patient autonomy has assumed great significance in the context of patient choice, underpinned by the requirement to provide the patient with sufficient information to put him / her in a position to choose.

The 'Four Principles' are intended as an aid to balance judgement, not a substitute for it.

Taken from: Slowther A, Johnston C, Goodall J, Hope T (2004) A practical guide for clinical ethics support. The Ethox Centre. Section C: Ethical Frameworks.

Specific ethical considerations relevant to resource allocation in healthcare

Maximising Welfare / Benefit
In considering how to make the best use of limited health care resources the focus of the decision shifts from the individual patient to a group of patients or potential patients, which may be the national population, a local community, or users of a specific service in an a hospital.

One ethical theory that lends itself to community or population level decisions is utilitarianism. For a utilitarian, the ethically correct action will be that which results in the maximum overall benefit.

Thus, in making decisions about health care this theory requires consideration of the benefit to be gained from the various competing options in terms of the improvement in health for an individual and also the number of individuals who could benefit.

In the context of the allocation of limited healthcare resources a key issue is the cost of the benefit achieved by the healthcare intervention. This approach would tend to favour resources being allocated to less expensive treatments or services that provide the greatest benefit. This may be a treatment that produces a large benefit for a small number of people or a small benefit for a large group of patients.

A criticism of this theory is that it fails to take into account the 'need' for healthcare intervention and relies rather on cost effectiveness.

The practical application of utilitarian theory in allocation of health care resources can be seen in the use of Quality Adjusted Life Years (QALYs) as a means of quantifying the net benefit from health care interventions to allow comparison of different interventions.

QALYS
QALY stands for **Q**uality **A**djusted **L**ife **Y**ear.

Alan Williams has described the thinking behind the development of QALYs thus:

"The essence of a QALY is that it takes a year of healthy life expectancy to be worth 1, but regards a year of unhealthy life expectancy as worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about)."
A. Williams, 'The Value of QALYs', Health and Social Service Journal July (1985), 3.

Health care interventions are measured both by the number of extra years of life, and by the increased quality of life, that they can achieve. Thus an intervention that provides 10 years of extra life at full health would have a QALY value of 10, and an intervention that improves quality of life from 0.5 to 0.8 for a person with a predicted further life expectancy of 30 years, would have a QALY value of 9. [0.3 (0.8-0.5) multiplied by 30]. Once the QALY value of a health care intervention is calculated and its cost is known it is then possible to calculate the **cost** per QALY of each intervention and provide a direct

comparison between interventions. The general idea is that a high priority health care activity is one where the cost per QALY is as low as it can be.

Objections have been made against QALYs including the criticism that QALYs are ageist. Also many healthcare interventions are not the subject of a QALY assessment and direct comparisons between the cost-effectiveness of different treatments is not possible.

Equity and Distributive Justice

A possible criticism of the utilitarian or QALY based approach to resource allocation is that it does not provide an equitable or fair way of distributing resources.

Aristotle, explaining his view of distributive justice, says, in effect, that equals should be treated equally, and unequals treated unequally in proportion to the relevant inequalities.

The utilitarian or QALY based approach could be said to treat unequals equally, in that it does not take account of differences in **need** for health care but focuses entirely on the **benefit** gained from an intervention.

Some individuals or groups of patients will have poorer health than others, or more serious diseases, and will have a greater need of health care. If degree of need is a main criterion, a just distribution of health care resources may require that these individuals or groups are allocated greater resources, even if the benefit gained by treatment is small compared to that achieved by a different treatment in patients who are less sick.

In the context of health care it could be argued that resources should be allocated to ensure that those in poorest health, or greatest need, are as well off, in terms of health, as they can be.

Patient Autonomy

To what extent should a patient's wishes regarding the choice of the course of treatment be respected? In considering how to allocate scarce health care resources for the whole community, or for all patients with a particular condition, respect for the autonomy of a specific individual may conflict with other values such as equity or the need to benefit the whole community or group, or with the autonomous choices of other individuals. Does respecting a person's autonomy to make decisions about their treatment mean that they should be able to choose an expensive treatment over a cheaper treatment? If the consequence of complying with such a choice is that treatment will be unavailable to other patients because of the limited available resources this may not be fair.

A balance needs to be struck between respect for individual autonomy, benefiting the whole population and fair distribution of limited resources.

This is taken from a more detailed discussion of ethical issues of resource allocation to be found on the UK Clinical Ethics Network website: Ethical Issues-Resource Allocation in Health Care

http://www.ethics-network.org.uk.

A structured approach to case consultation

1. What are the relevant clinical and other facts (e.g. family dynamics, GP support availability)?

2. What would constitute an appropriate decision-making process?
   - Who is to be held responsible?
   - When does the decision have to be made?
   - Who should be involved?
   - What are the procedural rules e.g. confidentiality?

3. List the available options

4. What are the morally significant features of each option e.g.
   - What does the patient want to happen?
   - Is the patient competent?
   - If the patient is not competent, what is in his or her 'best interests'?
   - What are the foreseeable consequences of each option?

5. What does the law / guidance say about each of these options?

6. For each realistic option, identify the moral arguments in favour and against.

7. Choose an option based on your judgment of the relative merits of these arguments using the following tools.
   - Are there any key terms the meaning of which need to be agreed e.g. 'best interest', 'person'?
   - Are the arguments valid?
   - Consider the foreseeable consequences (local and more broad)
   - Do the options 'respect persons'?
   - What would be the implications of this decision applied as a general rule?
   - How does this case compare with other cases?

8. Identify the strongest counter-argument to the option you have chosen.

9. Can you rebut this argument? What are your reasons?

10. Make a decision

11. Review this decision in the light of what actually happens, and learn from it.

Taken from: A practical guide for clinical ethics support
Section C: Ethical Frameworks, a practical clinical ethics framework that may be useful for a clinical ethics committee to work through in discussion of a case.

Case study

'Who should have the intensive care bed?'

Barry is a 32 year old man with meningitis and is brought into the A&E department of hospital A. He is unconscious with an extremely low blood pressure and evidence of renal failure. His condition is grave and without intensive care support he is almost certain to die. With intensive care support he may make a full recovery. Until this illness he has been fit and well. The Intensive Care Unit (ICU) in hospital A is full, with some patients critically ill and some in a relatively stable condition but for who optimum care would still require the facilities of an ICU. There is evidence that moving a patient from an ICU early increases their chances of complications and may increase mortality. There is an available bed in an ICU in hospital B, which is fifty miles away. The intensive care consultant on call must decide if Barry should be moved to hospital B or if a patient already in ICU should be transferred to allow Barry to be admitted. The clinical ethics committee is asked to review the case retrospectively and advise on how such cases should be approached in the future.

Case discussion - Issues to Consider

Questions for the committee to consider in the case of 'Who should have the intensive care bed?'

1. Does the clinical team, or the institution, which the CEC is advising owe an equal duty of care to both patients?
2. If each patient is owed the same duty of care, should the aim be to maximise the chance that both patients live, or minimise the chance that both patients die.
3. In contrast to 2, should the sickest patient be given any greater priority in receiving best possible care?
4. If the patient in ICU is owed a greater duty of care, is this **sufficient** to justify the decision not to admit the other patient, given the foreseeable probable outcome?
5. Is patient autonomy relevant in this situation?

Keep in mind that it is not possible to provide the best care to both patients

Discussion of the issues

Firstly establish the clinical facts and clarify the concepts used.
This may involve seeking expert opinion from sources outside the clinical team treating the patient and / or outside the Trust.

Maximising benefit
Consider the relative benefits of different courses of action

- The benefit to Barry of being admitted to ICU
  - he will die if he is not given intensive care
  - actual benefit will depend on the likelihood of his surviving even with intensive care

- The disadvantages of transferring Barry to another hospital and the effect on his likely survival

- The effect of transferring a patient already in ICU in hospital A to another hospital

Responding to need

- Consider the relative need for intensive care treatment.
- Barry is in urgent need because without intensive care treatment he will die.

Respecting autonomy

- What weight should be given to the refusal of a patient, or their relatives, to agree to a transfer to another hospital to allow a very sick patient to have their bed?

Duty of care

- Health professionals in an ICU have a duty of care to their patients and must act in their patients' best interests.
- Consider the difficulty in making a decision that is not entirely in this patient's best interest.
- Does the intensive care team also have a duty of care to a patient who is currently physically elsewhere in the hospital but who is in need of intensive care treatment?
- Does the hospital management have an equal duty of care to both patients, and if so how does this fit with the clinician's duty of care?

This case and a more detailed discussion of the issues is available on the UK Clinical Ethics Network website:
http://www.ethics-network.org.uk/Ethics/eresource.htm

Professional Guidance

General Medical Council

Management in Health Care - The Role of Doctors
May 1999

"7. Conflicts may arise when doctors are called upon to make decisions about the use of resources and about patients' care, when the needs of an individual patient and the needs of a population of patients cannot both be fully met. Dilemmas of this kind have no simple solution. When taking such decisions, doctors should take into account the priorities set by Government and the NHS and/or their employing or funding body. But they must also be clear about their own role. As clinicians, doctors must make the care of their patients their first concern, bearing in mind the effects of their decisions on the resources and choices available for other patients. As managers, doctors must allocate resources in the way that best serves the interests of a community or population of patients. In both roles, doctors should use evidence from research and audit to make the optimum use of the resources available".

GMC/Ethical Guidance/Guidance/
http://www.gmc-uk.org/standards/manage.htm

Priorities and Choices
July 2000

"The Duties of Care

2. The three main duties of care of a doctor are to protect life and health, to respect autonomy and to treat justly. These duties can conflict. For example, the duty to respect autonomy means that a competent adult has the right to refuse treatment, even if to do so will result in death. The duty to protect life and health is not absolute; the availability of modern technology to maintain life does not mean that it should always be applied if, for example the overall consequence might be to cause distress in a patient who was dying.

3. To treat justly or to ensure equity in the provision of treatment and care is at the centre of the NHS. It means that no-one should be discriminated against because of their ability to pay, their social position, their health status, their race, religion, sex, lifestyle or their age. Indeed, those whose needs are greatest, for whatever reason, even if their illnesses are to some extent self inflicted, have the same rights as anyone else and if equity is to be respected they may well require a greater share of the available resources to maintain life or restore health. But treating justly in a way which meets everyone's needs is impossible where resources are limited. This duty of care, therefore, may be in conflict with both the need to protect life and health and to respect autonomy.

4. Resources are usually thought of in financial terms, but there are other resources which are limited, such as the availability of doctors, nurses, other health professionals

and carers or the availability of equipment or other resources such as organs for transplantation. Under the NHS, the approach has been to attempt to ensure equal access to all citizens and then to prioritise access according to clinical need whilst determining the scope of public provision by discussion, whether at health authority or at the national level.

The Provision of Services

5. It is for government to decide on the broad resource questions which relate to the National Health Service both in terms of the overall financing of the service, the provision of equipment and the employment of personnel. Recently attempts have been made to eliminate postcode rationing, by establishing a national body (the National Institute for Clinical Excellence (NICE)) to advise on appropriate healthcare provision with regard to new and current technology. Within this national framework health authorities and boards, and in the future, primary care groups, will have important roles in commissioning services, thus deciding on priorities if not choices".

GMC/Ethical Guidance/Priorities and Choices
http://www.gmc-uk.org/standards/default.htm

Legal Issues

For a comprehensive account of the legal considerations surrounding resource allocation in healthcare see the relevant pages of the UK Clinical Ethics website:
http://www.ethics-network.org.uk/Ethics/eresource.htm

Here is a summary of some key points:

Is there a right to medical treatment?

Article 2 of the European Convention on Human Rights states that there is a 'right to life'. There is a positive obligation upon the State to ensure that this right is respected. Does this mean that there is a right to medical treatment? The positive obligation under Article 2 must be interpreted in a way that does not impose an impossible or disproportionate burden on the authorities. Therefore, although the State cannot be expected to fund every treatment, it must act reasonably in allocating resources.

Article 8 provides a right to respect for private and family life. This does not impose an obligation upon the State to provide medical treatment. Article 8(2) allows the state to restrict the right to respect for private and family life in the interests of the protection of health or morals, or the protection of the rights and freedoms of others. This requires a balance to be struck between the interests of the community and those of the individual.

A refusal to fund medical treatment because of the advanced age of the patient could be a breach of **Article 2** and **Article 14** (prohibition on discrimination). **Article 14** would also be relevant where resources are not allocated for treatment on the grounds of gender.

The attitude of the Courts to resource allocation

A patient who has been refused treatment may appeal to the court by way of judicial review. The court would decide whether the PCT has acted lawfully in refusing to fund treatment.
The NHS does have a statutory duty to provide medical treatment, but because resources are finite this cannot be a duty to provide all conceivable treatments in all circumstances.
If a decision about funding is made on irrational grounds (for instance taking into account irrelevant factors or not taking into account obviously relevant factors), then the court is likely to interfere.

If a decision not to fund treatment is based on factors that are relevant e.g. clinical effectiveness of treatment and is made as a result of an explicit and transparent process, then the refusal would probably be justifiable.

Courts are likely to regard PCTs as acting reasonably if they refuse to fund treatment where the cost is high and the prospects of success or benefit are limited.
See also the relevant pages of the BMA website:

The impact of the Human Rights Act 1998 on medical decision making
October 2000

Which human rights are relevant?
Article 2 - Right to life

"Treatment that could prolong life may sometimes be withheld on the grounds of scarce resources. Whilst it is open to a patient to argue that economic factors should not be taken into consideration in making treatment decisions, any claim under Article 2 would need to show that failing to provide treatment would lead to a real, perhaps inevitable, and immediate risk of death and that providing treatment was likely to avert that risk. Even if this case could be made, for example with some new expensive drugs for cancer patients, public authorities are only required to take those steps to avoid death that are "appropriate" and it appears that a shortage of resources may be a valid constraint to providing life-prolonging treatment. In reaching policy decisions about the allocation of resources, Health Authorities, or other decision-making bodies, must be able to show that they have considered their patients' Article 2 right, and must be able to justify interfering with that right. Such decisions must be transparent, logical and able to withstand scrutiny. The decision must also be non-discriminatory; a blanket age restriction on treatment such as cardiopulmonary resuscitation, for example, is likely to contravene Article 14 .The court is unlikely to interfere in a particular case with a Health Authority's decisions on allocation of resources provided the appropriate procedures have been followed".

http://www.bma.org.uk/ap.nsf/650f3eec0dfb990fca25692100069854/b8427fd0e0995cd780256b53004c757a?OpenDocument

BMA/Ethics/Human Rights/Impact of the Human Rights Act/which human rights are relevant/Article 2 – right to life:

Reading

Pre reading

Hope T, Savulescu J and Hendrick J**.** *Medical Ethics and Law. The Core Curriculum*. Churchill Livingstone. 2003: Chapter 13 Resource Allocation

Ethical Frameworks (taken from Slowther A, Johnston C, Goodall J, Hope T (2004) A practical guide for clinical ethics support. The Ethox Centre)

Rice T. Individual autonomy and state involvement in health care. *J Med Ethics* 2001; 27:240-244
(Available electronically: http://jme.bmjjournals.com/current.shtml, search Author: 'Rice')

Key texts

Butler J**.** *The Ethics of Health Care Rationing: Principles and Practices*. Cassell. 1999.

Newdick C**.** *Who Should We Treat? Law, Patients and Resources in the NHS.* Oxford University Press. 1995

Further reading

Campbell A., Gillett G., Jones G. *Medical Ethics* 3rd edition, Oxford University Press 2001, Justice and Health Care, Chapter 15

Healthcare Allocation: an ethical framework for public policy (edited by Anthony Fisher and Luke Gormally), The Linacre Centre, London, 2001

Oliver A, Healey A and Le Grand J. Addressing health inequalities, *The Lancet* 2002; 360:565-567.

Rivlin M. Should rationing of health care be explicit? *Bulletin of Medical Ethics* 2002; 20

Weinstein MC. Should physicians be gatekeepers of medical resources? *J Med Ethics* 2001; 27:268-274

Websites and contact groups

NHS Alliance
http://www.nhsalliance.org

National Institute of Clinical Excellence (NICE)
http://www.nice.org.uk

British Medical Association
http://www.bma.org.uk

General Medical Council (GMC)
http://www.gmc-uk.org/standards/default.htm

Department of Health - Health Inequalities
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en

Department of Health - Human Rights Issues
http://www.dh.gov.uk

The King's Fund
http://www.kingsfund.org.uk

Public Health Resource Unit
http://www.phru.nhs.uk

The Berkshire Priorities Committee
www.berkshire.nhs.uk/priorities

BBC News – Health
http://news.bbc.co.uk