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Developing the Capacity of Ethics Consultants to Promote Just Resource Allocation

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One of the most striking findings of the study by Foglia and colleagues (2009) was that clinicians and managers were most concerned with limited resources while ethics committee chairpersons focused largely on other concerns. Similarly, in our experience in surveying clinicians, we find that they often face limited resources and the need to ration ‘at the bedside’ yet rarely seek advice from ethics consultants to address the attendant ethical concerns. We agree with the authors that addressing these issues “will require added skills” (28); it may also require a broader theoretical framework that draws more explicitly from political philosophy than clinical ethics usually does, yet is nevertheless applicable in a clinical setting. Here we will complement the authors’ discussion with such a normative perspective based on integrative social contract theory, and offer some practical suggestions for addressing the organizational challenge of resource allocation efficiently and fairly.

In our own studies, we too have found that clinicians commonly face limited resources and the need to ration “at the bedside,” yet they rarely seek advice from ethics consultants to address the attendant ethical concerns (DuVal et al. 2004; Hurst et al. 2007; 2008). In our study of physicians’ perception of scarcity in four European countries, most respondents (87.7%) perceived some resources as scarce, and most (78.7%) reported some patient groups as more likely than others to be denied beneficial care on the basis of cost. Almost all respondents (97.3%) found at least one cost-containment policy acceptable. The types of policies preferred suggest that respondents are willing to participate in cost-containment, and do not want to be guided by administrative rules (70.5%) or restrictions on hospital beds (71%).

In these various surveys, the fact that clinicians and managers were concerned with resource allocation points to the reality that resource allocation is a challenge at all levels of health care—from the bedside on up. The findings suggest that organizations do well to include clinicians in discussions of resource allocation decisions for several reasons: clinicians themselves have an important role in allocating resources; they can provide valuable feedback on consequences of allocation decisions made at the institutional level; they are willing to exercise allocation decisions, and their active inclusion in the process makes them valuable partners rather than disenfranchised and disillusioned players.

How can clinical ethicists contribute to addressing concerns about resource allocation more effectively than they appear to do in these surveys? We agree with the authors that ethicists “will require added skills”, to address these issues. To that end, there is indeed a need for

theoretical and practical development. From the theoretical perspective, Foglia and colleagues (2009) frame a part of their analysis using stakeholder theory. This theory, developed largely by Ed Freeman (Freeman 1991), recognizes that organizations and their managers have responsibilities to many parties. In so doing, the theory defines the purpose and responsibilities of organizations. Spencer and colleagues (2000, 57), in their valuable book on the ethics of health care organizations, acknowledge that Freeman (1991) has conceptualized the purpose of business organizations as one of serving as a vehicle for coordinating and bettering stakeholder interests through voluntary exchange. The moral force of the organization's responsibility comes, first, from the fact that stakeholder relationships are relationships between human beings with rights and duties, and obligations to one another.

As noted by Kurlander and Danis (2007), stakeholder theory has been criticized on several grounds (Donaldson and Dunfee 1995, 88). Donaldson and Dunfee argue that it does not account for the important role of community standards. In their view, the most important shortcoming is that it "lacks a normative foundation both for assessing the ethical validity of the interests asserted by particular groups of stakeholders, as well as for identifying and prioritizing the rights and duties of affected stakeholders" (88). Donaldson and Dunfee offer Integrative Social Contract Theory (ISCT) as an alternative approach to address these concerns. Drawing more explicitly from political philosophy than clinical ethics usually does, this theoretical approach is nevertheless applicable in clinical settings. It builds on the classic social contract approaches of the philosophers Hobbes, Locke, Rousseau, and Rawls: the view that humans choose to form societies, which impose restrictions on their individual behavior, on the basis of tacit agreement which allows cooperation among parties and the freedom to pursue their individual goals. Entering into this "macro-social contract" serves to "preserve for individual economic communities significant moral free space in which to generate their own norms of economic conduct, through actual 'micro-social contracts'" (Donaldson et al. 1995, 89).

Donaldson and Dunfee (1995) argue that the larger social contract generates "hypernorms," which provides agreed upon minimum standards of decent behavior, which might include such principles as not causing gratuitous harm, honoring contracts, and treating others fairly. While these standards govern relationships everywhere, they leave a moral free space for particular communities and organizations to create their own rules and agreements, so long as they are compatible with the previously established hypernorms. Rules then exist for prioritizing conflicting norms depending on their consistency with hypernorms, prevention of adverse effects, the extent of the community in which the norms hold, and how precise the norms are (Donaldson and Dunfee 1995, 106).

Spencer et al. (2000) argue that ISCT is conceptually useful in organizational ethics. First, it is able to explain why society, segments of the population, and individuals have certain expectations of healthcare organizations (HCOs), for example, that they will provide adequate medical care. Society has allowed HCOs to come into existence under a tacit social contract in which the HCO commits to meeting such expectations. HCOs are not entirely free to write their own mission: they must respect hypernorms without being able to resort to excuses such as that these minimums are only relative or that they apply only in limited contexts.

While stakeholder and ISCT theories both offer theoretical foundations for setting organizational priorities, ISCT may more readily enable allocation decisions based on principled conclusions than stakeholder theory does, with less exclusive reliance on procedural justice. Its application could thus help to develop ethical analysis of resource allocation in health care beyond strictly procedural norms, a move that has recently been

called for as part of the responsibility of bioethics in contributing to public policy (Ashcroft 2008).

Turning to a more practical focus, how might ethicists provide help in facing allocation issues? We would suggest that clinical ethicists can make a valuable contribution to the troubling allocations decisions faced by individual clinicians at the bedside (Hurst et al. 2008) and to the system-wide decisions faced by organizations and their leaders and managers (Kurlander and Danis 2006).

For clinicians at the bedside, ethics consultants could help make the process less difficult, more transparent, and balanced, and contribute to decisions being more ethically justifiable. Importantly, an ethics consultant could also help assert, when necessary, that the limits perceived by a clinician on resources within an organization are indeed unjust rather than ‘simply’ frustrating (Hurst et al. 2008).

We believe that clinical ethicists can help address organizational allocation decisions as well, but the ground is not well trod for applying a comprehensive framework to meso-level resource allocation. We believe, however, that a number of ingredients do exist which could form part of such a process.

It seems to us that the first ingredient necessary to promote sound resource allocation for a HCO is clarification of its mission (Jennings et al. 2002). Under ISCT, this mission should comply with hypernorms, and respect societal expectations that a HCO provide adequate medical care without, for example, prioritizing diseases with more prestigious treatments at the expense of other equally valid health care needs. A second ingredient is a process—be it a survey, focus groups, or discussions in routinely held meetings in various component units of the organization—that allows, through a give and take process, for gathering of information about the resource limitations that providers encounter in their day to day work.

A third necessary ingredient is the availability of an ongoing, iterative process that allows for realignment of resources in keeping with the organizational mission and thus reduces mismatches between assigned resources and needs. The Integrated Ethics Initiative might be such a vehicle although it is not designed specifically for this task. Daniels and Sabin have recommended a strategy of accountability for reasonableness. (Daniels and Sabin 2008), and highlight instances where their framework has been applied. (Daniels and Sabin 2008, 67–83). However, these examples do not cut across an entire organization. Hence their framework would do well to be merged with the visionary comprehensive approach to health services management provided by Shortell and colleagues (2000). Shortell envisions HCOs as entities offering fully integrated services across a continuum of healthcare needs. So, for example, a perceived shortage of resources in the dialysis unit might be addressed by examining whether the care of patients at risk for kidney failure is sufficient to prevent end stage renal disease at the same time that an increase in dialysis beds is contemplated. Such an approach yields coordinated resource allocation and would fit well with integrated ethics approach.

Taken together these ingredients offer the promise of promoting fair and efficient resource allocation at the institutional level but are rarely pieced together to yield comprehensive approaches. Clinical ethicists could participate in building the capacity in their HCOs to allocate resources fairly by contributing their understanding of organizational ethics and distributive justice along with their mediation skills developed in ethics consultation.

References

- Ashcroft R. Fair process and the redundancy of bioethics: A polemic. *Public Health Ethics*. 2008; 1(1): 3–9.
- Daniels, N.; Sabin, JE. *Setting Limits Fairly: Learning to Share Resources for Health*. 2. New York, NY: Oxford University Press; 2008.
- Donaldson T, Dunfee TW. Integrative social contract theory. *Economics and Philosophy*. 1995; 11:85–112.
- DuVal G, Clarridge B, Gensler G, Danis M. A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *Journal of General Internal Medicine*. 2004; 19(3):251–258. [PubMed: 15009780]
- Foglia MB, Pearlman R, Bottrell M, Altemose J, Fox E. Ethical challenges within Veteran's Administration healthcare facilities: Perspectives of managers, clinicians, patients, and ethics committee chairpersons. *American Journal of Bioethics*. 2009; 9(4):28–36. [PubMed: 19326309]
- Freeman, RE. *Business Ethics: State of the Art*. New York, NY: Oxford University Press; 1991.
- Freeman, RE. Stakeholder theory and the modern corporation. In: Donaldson, T.; Weaned, PH., editors. *Ethical Issues in Business*. Upper Saddle River, NJ; Prentice Hall: 1999.
- Hurst SA, Forde R, Reiter-Theil S, et al. Physicians' views on resource availability and equity in four European health care systems. *BMC Health Services Research*. 2007; 7(1):137. [PubMed: 17764556]
- Hurst SA, Slowther A, Reiter-Theil S, Danis M. Should ethics consultants help clinicians face scarcity in their practice? *Journal of Medical Ethics*. 2008; 34(4):241–246. [PubMed: 18375673]
- Jennings B, Gray BH, et al. Ethics and trusteeship for health care. Hospital board service in turbulent times. *Hastings Center Report*. 2002; 32(4 Suppl):S1–24. [PubMed: 12362531]
- Kurlander, JE.; Danis, M. Organizational ethics in health care. In: Ashcroft, RE.; Dawson, A.; Draper, H.; McMillan, J., editors. *Principles of Health Care Ethics*. 2. West Sussex, UK: Wiley; 2007.
- Shortell, SM.; Gillies, RR.; Anderson, DA.; Erickson, KM.; Mitchell, JB. *Remaking Health Care in America*. 2. San Francisco, CA: Jossey-Bass; 2000.
- Spencer, EM.; Mills, AE., et al. *Organization Ethics in Health Care*. New York, NY: Oxford University Press; 2000.