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The Role of Ethics Committees and Ethics Consultation in Allocation Decisions: A 4-Stage Process

Daniel Strech, MD, PhD†, Samia Hurst, MD†, and Marion Danis, MD‡

†Institute for History, Ethics, and Philosophy of Medicine, Centre of Public Health and Healthcare, Hannover Medical School, Hannover, Germany †Institute for Biomedical Ethics, University of Geneva Medical School, Geneva, Switzerland ‡Department of Bioethics, National Institutes of Health, Bethesda, MD

Abstract

Background—Decisions about the allocation and rationing of medical interventions likely occur in all health care systems worldwide. So far very little attention has been given to the question of what role ethics consultation and ethics committees could or should play in questions of allocation at the hospital level.

Objectives and Methods—This article argues for the need for ethics consultation in rationing decisions using empirical data about the status quo and the inherent nature of bedside rationing. Subsequently, it introduces a 4-stage process for establishing and conducting ethics consultation in rationing questions with systematic reference to core elements of procedural justice.

Results—Qualitative and quantitative findings show a significant demand for ethics consultation expressed directly by doctors, as well as additional indirect evidence of such a need as indicated by ethically challenging circumstances of inconsistent and structurally disadvantaging rationing decisions. To address this need, we suggest 4 stages for establishing and conducting ethics consultation in rationing questions we recommend: (1) training, (2) identifying actual scarcity-related problems at clinics, (3) supporting decision-making, and (4) evaluation.

Conclusion—This process of ethics consultation regarding rationing decisions would facilitate the achievement of several practical goals: (i) encouragement of an awareness and understanding of ethical problems in bedside rationing, (ii) encouragement of achieving efficiency along with rationing, (iii) reinforcement of consistency in inter- and intraindividual decision-making, (iv) encouragement of explicit reflection and justification of the prioritization criteria taken into consideration, (v) improvement in internal (in-house) and external transparency, and (vi) prevention of the misuse of the corresponding consulting structures.

Keywords

rationing; prioritization; ethics committees; ethics consultation; hospital management
Various normative frameworks have been developed in the last 10 to 15 years to encourage or ensure an ethically appropriate implementation of unavoidable rationing, particularly in the context of Anglo-American medicine.\textsuperscript{1,2} Only recently there has been any examination of the concrete ethical conflicts that arise when doctors make decisions under the implicit limits currently pertaining to medical services\textsuperscript{3–5} and of how doctors and patients can deal with these conflicts in an ethically defensible way.\textsuperscript{6,7} So far very little work has been done on the question of what role ethics consultation and ethics committees could or should play in questions of allocation at the hospital level.\textsuperscript{8}

Decisions about the allocation and rationing of medical interventions likely occur in all health care systems worldwide.\textsuperscript{9} Rationing is defined here and most widely understood internationally as the withholding of a medical technique that has net additional benefit for the patient for reasons of cost.\textsuperscript{10} Net additional benefit means that the balance of the potential benefits and harms of a measure compared with alternative measures results in an additional benefit generally. It does not matter how minor the additional benefit is. Rationing should be distinguished from rationalizing, which aims to reduce excessive or faulty treatment and inefficiency without reducing net additional benefit. Rationalizing as defined here does not include (value) judgments about the clinical relevance of the magnitude of the net benefit. If a net-benefit is withheld because it is tiny and expensive this represents rationing and not rationalizing. See, for example, the recent characterization of the recommendations from the US Preventive Services Task Force on screening for breast cancer as rationing since they advise against mammograms at age 40 at a cost of $680,000 per quality-adjusted life year saved.\textsuperscript{11,12}

When rationing is unavoidable, it should be done in a fair and efficient manner. This holds for rationing carried out by policy makers just as much as it does for individual rationing by hospital managers or doctors at the patient’s bedside. The following discussion of ethics consultation regarding questions of rationing presupposes that rationing is in fact unavoidable in clinics. Often rationing is implicitly and thus nontransparently carried out by individual doctors whose latitude for decision and action are limited by budgets and prospective compensation (diagnosis-related groups). Although controlling costs with such instruments is effective, it affects not just the quality but also the fairness of medical care.

This article aims to examine from both empirical and conceptual perspectives the possible value of ethics consultation to promote fair rationing. The article will also consider how ethics consultation supported by hospital management might address the danger of rationing pursued for the sake of a third party economic interest. There is a pressing need to develop practical strategies, since ethics committees as well as individual ethics consultants face questions of rationing today, or at least will very likely be faced with them in the near future.

This article begins by arguing for the need for ethics consultation in rationing decisions using empirical data about the status quo and the internal structure of bedside rationing. Subsequently, we introduce and discuss a 4-stage process for establishing and conducting ethics consultation in rationing questions. Finally, we provide a brief overview of additional open questions that could not be dealt with in their entirety here.

THE NEED FOR ETHICS CONSULTATION IN RATIONING QUESTIONS

Questionnaires among doctors worldwide have shown that doctors are currently making rationing decisions in outpatient and inpatient medicine.\textsuperscript{13,14} A survey of doctors in Italy, Great Britain, Norway, and Switzerland conducted by Samia Hurst et al revealed\textsuperscript{13} that 56% of doctors reported having to ration clinical interventions, though only 15% stated that they did so on a daily or weekly basis. This suggests that rationing is currently widely practiced although any given physician is aware of doing so infrequently. A survey of German
clinicians report similar findings.\textsuperscript{15} To our knowledge, no published systematic surveys have explicitly surveyed the extent of bedside-rationing decisions in the US system. However, several articles have argued that logically no health care system, including the US system, can provide all patients with all treatments that may have the potential for benefit.\textsuperscript{16,17} Indirect evidence about the practical relevance of bedside rationing has been gathered even for the US system in several surveys about physicians’ willingness to ration health care.\textsuperscript{9,18–20}

It is pertinent to the potential role of ethics consultation in rationing decisions that doctors’ rationing decisions are a function of the particularities of individual cases, such as patient characteristics, and the clinical context.\textsuperscript{5} The inevitability that such a case-based approach entails a great deal of variability poses the danger that scarce medical resources are being distributed according to criteria that are inconsistent and often poorly ethically justified. For example, nonpatient factors can also play a large role in allocation decisions, such as the clinic’s general financial situation, the pressure of competition, or difficult collaborative relationships between clinics. In their interviews, several doctors have remarked on a preference to economize with patients who were poorly or not at all informed about the measures withheld or with patients who presented less of a threat of a claim for damages or third-party claims. One participant in a study by Berney et al expressed this problem rather concisely: “those that shout the loudest get the most” p. 624.\textsuperscript{21} Moreover, in-depth interviews with German physicians made it clear that more ethically justifiable allocation criteria such as medical benefit or cost-effectiveness were interpreted quite variably by the doctors interviewed, which could lead to equally inconsistent allocation decisions in practice.\textsuperscript{22}

Another study by Hurst et al directly examined how potentially helpful ethics consultation was thought to be in dealing with scarce resources.\textsuperscript{8,23} The types of support most often seen as useful were professional reassurance that the decision was correct (48%), someone capable of providing specific advice (41%), help in weighing outcomes (36%), and clarification of the issues (36%). Nearly a third saw the following functions of ethics consultation as helpful: help in talking things through with the patient and mediation of conflict.

A 4-STAGE APPROACH FOR ESTABLISHING AND CONDUCTING ETHICS CONSULTATION IN RATIONING QUESTIONS

We suggest 4 steps for establishing and conducting ethics consultation in rationing questions: (1) training, (2) identifying actual scarcity-related problems at clinics, (3) supporting decision-making, and (4) evaluation. These steps are intended to achieve didactic and practical goals. The didactic goals are to foster understanding of the theories of justice and their continued application-based development. The practical goals are (i) to encourage an awareness and understanding of ethical problems in bedside rationing, (ii) to encourage rationalization before rationing, (iii) to reinforce consistency in interindividual and intraindividual decision-making, (iv) to facilitate explicit reflection and justification of the prioritization criteria taken into consideration, (v) to improve internal (in-house) transparency (as well as external transparency as much as possible) in decision-making processes and results, and last but not least, (vi) prevent the misuse of the corresponding consulting structures. For a more in-depth philosophical discussion of the goals see.\textsuperscript{1,6,24,25} Not all functions of the 4-step approach can be equally helpful in reaching every goal. Table 1 shows how these various steps can achieve these goals more or less directly (Table 1). Reaching these goals depends on the context-specific implementation of the consultative functions we outline and thus need the strong support by hospital management.
TRAINING

Consultants must be able to convey practically relevant knowledge regarding the problem of scarce resources and medical action as a basic precondition of just resource allocation. The goals of this training include encouraging an awareness of the ethical problems of clinical practice associated with scarce resources and enabling a critical and constructive involvement with these problems. The relevant training content can only be very briefly summarized here:

Reasons for Scarcity of Means
What are the essential reasons for the scarce resources in the health care system?

Physician’s Responsibility and Patient Trust
The withholding of potentially beneficial measures for reasons of cost or the general limitation of doctors’ therapeutic freedom generates a particularly strong sense of wrongdoing (intuitively at first) on the part of doctors and patients. Emotions and rational arguments justifying this intuitive sense of wrongdoing in practice need to be clarified and explored. Do these sentiments and thoughts reflect worries about unfairness or worries about violating the allegiance to the patient? Discussion should focus on the possibility that rationing, when carried out fairly under scarcity conditions, can be in the best interest of patients (regarded from an interpersonal, public health standpoint).

Rationing Versus Rationalizing
Distinguishing between rationing and efforts to promote efficiency is crucial for sound discussion of resource limitations. In practice, however, doctors are confronted with various gray areas between these 2 phenomena. Empirical problems (such as a complete lack or shortage of valid evidence on effectiveness and cost-effectiveness) concerning the clarification of whether certain actions are to be considered rationing or rationalization should be discussed.

Justice
The content and practical relevance of ethical principles such as respect for patient autonomy and nonmaleficence are increasingly familiar to doctors. Ethics consultation in rationing questions will additionally clarify the principle of justice in its content and relevance for the doctor’s work. Doctors need practice-oriented knowledge of concepts of justice and economic analysis. This knowledge serves to clarify the fact that the application of alternative theories of justice or methods of economic analysis could lead to different results in rationing decisions. The depth of this training has to be tied to the related goals. The maximal goal would be to enable clinic employees to independently interpret economic analyses just as they should be able to interpret and use the literature on evidence-based medicine.

Prioritization Criteria
Besides helping clinicians to learn the possibilities and pitfalls of rationing decisions, the training offered should also focus on the criteria that are justified in playing a role in resource allocation in the clinical setting. There is relatively broad consensus that the extent of the benefit and of the cost-effectiveness of an available intervention, the severity of the illness, and the availability of an alternative intervention should play a central role in the ethical consideration of rationing decisions. There is a similarly broad consensus that some criteria, such as patients’ socio-economic status or religion, should not play any part in rationing decisions. Patient age, the so-called “rule of rescue” and the exclusive
consideration of cost-effectiveness are much more controversial as prioritization criteria.\textsuperscript{32–34}

The brief description of these 5 topics is of course only meant as an initial outline for the content of training in rationing questions. In principle, good training tailored to the participants seeks not just to encourage an awareness of the problem but also to contribute positively (if only in a minor way) to the consistency and the thoughtfulness of the decisions, even without any further support from ethics consultation (Table 1). An increasing awareness of problem areas concerning the allocation of scarce resources could also (though again to a rather minor extent) lead to greater efforts to improve efficiency before rationing in clinical practice.

**IDENTIFICATION OF RESOURCE CONSTRAINTS IN THE CLINICAL SETTING**

While initial training might primarily encourage a general awareness and understanding of the problems of scarce resources, the second step might focus on awareness and understanding of the constraints of the clinical environment in which clinicians work. One possible approach could begin with a survey among the clinic personnel, ideally not limited to staff doctors, or even not limited to health care providers, to determine qualitatively what conflicts currently arise in dealing with scarcity among professional groups and departments to assess the practical consequences perceived by survey participants. The objective is to identify the spectrum of actual problems with scarcity and the clinic employees’ expectations toward ethics consultation, and to provide an initial orientation concerning the distribution of problems associated with resource scarcity among the individual departments.

The problems thus identified could serve as the point of departure for a further analysis of hospital-specific problems. This includes, among other things, examining the relevant contextual variables (routine processes, informal agreements, guidelines for rationing decisions, etc) that have to be taken into consideration in developing solutions and consultation structures. Besides creating an awareness of the problems, this step also serves to systematize the internal discourse on dealing with scarcity (urgency, range, magnitude, initial clarification of misunderstandings). Finally, such a survey would create the first impetus for critical reflection on the allocation of the clinic’s and of one’s own resources. This could also provide a renewed impetus to greater rationalization, though at this point the consistency, justification, and transparency of concrete decision-making will hardly be significantly facilitated (Table 1).

**SUPPORT IN DECISION-MAKING PROCESSES**

The training and further education as well as sensitization regarding ethical questions described in the first 2 steps can achieve the initial valuable effects sought in applied ethics. Yet these potentially positive effects should be appropriately evaluated and also directly encouraged in concrete situations. Prior to an overarching, systematic analysis, the distinctive features that emerge for ethical case discussions in questions of rationing are sketched here as the third central step.

Ethics consultation in individual rationing decisions has parallels to the classic steps and functions of ethics consultation and case discussion in general. This often includes facilitation of discussion in ethically difficult situations involving different affected persons.\textsuperscript{35,36} However, additional competences are warranted for the ethics consultation on rationing decisions that have not been well discussed. Even the basic work of compiling information relevant to the decision as objectively as possible raises the question of the
extent to which ethics consultants should explicitly refer to data on the cost-effectiveness of the measures in question. On the one hand, the sound appraisal of the validity and generalizability of evidence on cost-effectiveness is a necessary factor in questions of rationing. On the other hand, ethics consultation for clinicians in real hospital life will be constrained by lack of time that makes an extensive analysis of cost-effectiveness data impractical. Besides the more urgent decisions on bedside rationing faced by clinicians, more predictable rationing decisions by hospital management, for example, can be supported by ethics committees that provide more time and personal resources for a sound appraisal of the validity and generalizability of evidence on cost-effectiveness.

The discussion of ethical questions concerning allocation will also need to encourage transparency of decision-making and communication within the team. This aspect of ethics consultation could itself alleviate some of the psychic burdens of rationing although there is no solid evidence of this to date. To confront the serious worry that clinical ethics consultation on bedside rationing could become a rubber stamp for excessive cost-cutting, there has to be some assurance that besides psychic relief the individual discussion of cases will include consideration of substantial ethical arguments and the possibility of questioning the parameters of the decision. Thus, ethics consultation has to bear the responsibility of explicitly introducing well-justified criteria for rationing into the case-discussion and the decision-making process (eg, the severity of the illness, marginal net additional benefit) and draw attention to circumstances when ethically problematic rationing criteria are being used (eg, patient age without regard to prognosis, socio-economic status).

Another important function of ethics case discussion in rationing questions is to jointly work out the available alternatives as a starting point of the discussion. The question of whether rationing is in fact the only possible solution or the best solution for the individual case or whether other strategies for efficiency could be effective should be raised continually, even as early as the compilation and interpretation of case-specific information and at the very latest during the discussion of the case.

How much should or can ethics consultants intervene in decision-making and inject their own views of the better justified criteria for prioritization or even of the decisions themselves? Concerning this point we can expect a controversial discussion of the methods and application of ethics consultation. To date, there has been a rather restrained definition of the responsibility of ethics consultation. In general, taking decision is the doctor’s responsibility. As in other types of ethics consultation, one of the decisive questions in the consultation of rationing cases is how clearly the ethics consultation can or should distance itself from the final decisions. Although ethics consultation is broadly accepted to be consultative only, and not binding on decision-makers, this description is somewhat simplistic as clinicians may nevertheless feel bound to follow ethics consultants’ advice. Is the consultant, then, to take an explicit position in rationing questions (eg, pointing to insufficient consistency in decision-making or ethically problematic prioritization criteria)? To the extent that the ethics consultant is unfamiliar with the details of medical illness and the advantages and disadvantages of various therapeutic options, the ethics consultant can function to facilitate discourse, clarifying relevant information and ethical principles, mediating between actors and internal transparency. The material and procedural conditions of a just allocation listed in Table 1 are primarily facilitated here through “decision-making support.” Whether this also has any traction in practice is unclear at the moment. A further, more specific, issue is the difficulty in defining whom exactly ethics consultation regarding rationing issues is directed to. In other sorts of ethical difficulties, there is often consensus regarding who ought to have the final word, be it the patient, surrogate, or a health care provider. Ethical issues involving resource allocation are fraught with controversy regarding this question also, making the exercise of ethics consultation more complex in such cases. It
is important to explicitly consider these difficulties in reflecting on and evaluating the first practical experiences.

**EVALUATION**

As mentioned, the extent to which consultation was appropriate to the specific situation should be evaluated in follow-up. The evaluation (accompanied by systematic study when possible), as the fourth step, can provide important justification in both directions. The subjective assessment of satisfaction with the consultation by those who request consultative advice is not sufficient but nonetheless indicated. An objective evaluation (results and process evaluation) could take the form of comprehensive documentation of the consultation processes and the associated decisions, for example. Appropriate documentation would have to include various elements: (i) the basic question(s) as well as the processes that determined the question, (ii) the information taken into consideration and its assessment/interpretation (interpretation of information includes among other things the question whether the information used to answer the basic question at issue was sufficiently valid, comparable, and relevant), (iii) the principles and normative criteria taken into account, particularly their context-relevant specification and justification, and (iv) the decision finally made with a description of the compromises it entailed (e.g., through documentation of the points of critique of the decision). Appropriate documentation allows for an evaluation of the processes that can examine, for example, how conflicting information, positions, and arguments were dealt with. The assessment of the results includes among other things the comparison with similar cases and thus a review of decision-making consistency.

**CONCLUSION**

We tried to make clear that to be legitimate, ethics consultation in individual rationing decisions at the clinical level needs to be embedded into a broader framework addressing material and procedural conditions of just allocation. Admittedly, it is hard to anticipate to what extent the 4-stage framework we have outlined here can be put into practice and further translational research is needed. Contextual variables such as the different objectives and tasks of specific ethics committees as well as the specific characteristics and underlying laws of the different health care systems (e.g., universal vs. nonuniversal health care) will contribute to different implementation strategies. Despite the ambitiousness of the undertaking we have tried to present a process that can be translated into clinic-level rationing processes in all health care systems. Although the degree to which rationing occurs in the United States is less systematically studied than in Europe, bedside rationing certainly does occur. Furthermore, to the extent that there is significant need to reduce health care costs in the United States, the need to ration, along with other cost cutting strategies, is quite pressing. In light of that need, finding strategies to ration fairly in the United States is quite critical. Recent qualitative research on Veterans Administration managers, clinicians, ethics committee chairpersons, and patients shows the readiness of clinical managers to use ethics frameworks and to involve stakeholders when making allocation and rationing decisions. Both managers and clinicians state, however, that they still lack a consistent process and criteria for allocating resources in an ethically acceptable way, thus documenting the need for the type of service we are advocating.

We note that we have not addressed some important conceptual and practical challenges and questions related to ethics consultation in rationing questions. Future contributions will have to examine how to approach the problem that individual ethical consultants are unable to assess to what extent scarcity, and thus rationing is unavoidable in the system, the clinic, or the individual case. Differences of opinion regarding these questions are likely to be difficult to resolve due to a lack of sufficient data from clinical trials. While only a small
amount of research has examined cost-saving innovations, more research of this sort needs to be done to facilitate analyses that help clinicians to systematically and fairly manage conflicts about how much potential benefit can justifiably be denied through rationing. However, it has been argued that clinicians in settings with fewer resources may justifiably exert more limits to guarantee the sustainability of health care as they assess whether a measure has a clinically relevant additional benefit or not.

Another significant problem stems from legal constraints. In Germany, for example, every form of transparency concerning clinical-level rationing decisions currently faces very difficult challenges of criminal and civil liability. German legal code, as currently interpreted, precludes any rationing of any potentially beneficial treatment options. This holds especially for doctors or clinic managers, who do not have sufficient democratically authorized legitimacy for such responsibility. This highlights the need for societal recognition of the necessity of rationing, along with societal sanction and legalization as essential underpinnings of rationing by clinicians.

Last but not least, because resource allocation is something that happens at multiple levels (community, institution, and provider levels) it is important to further assess the role of ethicists as advisors not only with the individual provider but with the organization they work in as well. We recommend that the logical place for this to happen should be in organizational ethics committees.

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**TABLE 1**

Functions of Ethics Consultation in Questions of Rationing and Their Significance for Material and Procedural Conditions of a Just Allocation

<table>
<thead>
<tr>
<th>Functions</th>
<th>Awareness of the Problems</th>
<th>Rationalizing Before Rationing</th>
<th>Consistency</th>
<th>Well-Considered (Justified) Prioritization Criteria</th>
<th>Explicitness and Transparency</th>
<th>Prevention of Instrumentalization</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Internal</td>
<td>External</td>
</tr>
<tr>
<td>1. Training</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>ø</td>
<td>ø</td>
</tr>
<tr>
<td>2. Internal core problems</td>
<td>+</td>
<td>+</td>
<td>ø</td>
<td>ø</td>
<td>+</td>
<td>ø</td>
</tr>
<tr>
<td>3. Decision-making support</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>ø</td>
</tr>
<tr>
<td>4. Evaluation</td>
<td>+</td>
<td>(+)</td>
<td>(+)</td>
<td>(+)</td>
<td>+</td>
<td>(+)</td>
</tr>
</tbody>
</table>

“+” indicates promotes, “+,” unclear, but tends to promote, “ø,” no direct influence, “(+/-),” unclear, promotion and inhibition are both possible.