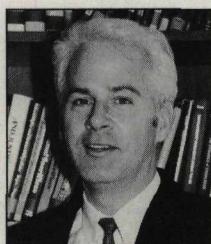# Making Tough Resource Decisions

A Process for Considering Both Values and Costs

BY PHILIP J. BOYLE, PhD, & ELLEN MOSKOWITZ, JD

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Medical record note: "Long-stay patient died in intensive care unit with multiple systems failure. Patient utilized exorbitant resources—staff time and numerous tests, drugs, and interventions. (Staff believed early on that most of the patient's treatments were useless.)"

This case, drawn from the records of an acute care hospital, has become increasingly typical in our nation's hospitals, where providers face difficult decisions about the appropriate utilization of healthcare resources. Because fulfilling the primary mission of patient care depends on using resources wisely and prudently, no healthcare facility can escape explicit consideration of cost.

On the flip side of the coin, however, are the moral concerns surrounding mechanisms to reduce inappropriate utilization. Is it ever defensible to limit, perhaps even deny, healthcare resources? If so, what are fair criteria and processes for decision making? How can facilities ensure they are treating patients consistently? Who should make the resource management decisions?

The challenge is to apply explicit moral analysis to resource allocation efforts. This article examines the need for resource management mechanisms, the values underlying such mechanisms, and the criteria—medical and moral—that ought to inform institutional decisions about resource utilization.

FOUNDATIONS FOR RESOURCE MANAGEMENT

What Is "Resource Management"? Effective resource management involves prospective decision making, including setting priorities. This enables healthcare facilities to provide services that are consistent with institutional commitments and, under some circumstances, to limit or deny services that are inconsistent with those commitments.

Summary Effective resource management involves prospective decision making, including setting priorities. This enables healthcare facilities to provide services that are consistent with institutional commitments and, under some circumstances, to limit or deny services that are inconsistent with those commitments. The challenge is to apply explicit moral analysis to resource allocation efforts to ensure that facilities are treating patients consistently and fairly.

Not only are allocation decisions unavoidable, they also can promote holistic, socially responsible medical practice. But current mechanisms, which are largely hidden from view and informal, can negatively affect important relationships with constituents.

The just allocation of our precious healthcare resources rests on values that can either conflict with or complement one another. The core values in resource management include respect for persons, professional integrity, due process, informed consent, stewardship, and the common good.

An interdisciplinary team of providers should oversee an ongoing review of resource management mechanisms. The group should meet regularly to look at how the mechanism works, what its goals are, what unit of care it evaluates, and what measurements are used to reach the goals. The measures might include severity of illness, effectiveness, cost, and social factors. Examining questions related to each of these areas can help the group determine whether an existing or proposed resource management mechanism is morally defensible.

Resources are managed in many different ways, sometimes formally, more often informally. Formal methods range from the obvious, such as admission and retention policies, to the less obvious, such as hiring freezes or nursing reductions in some units. Informal mechanisms are more difficult to observe because each staff member uses his or her own criteria and the process rarely comes to light.[1]

What Is a Healthcare Resource? The most precious healthcare resource is the provider's time, but formal structures rarely address time allocation. More commonly, a healthcare resource is thought of as a machine, a bed, a drug, a physical diagnosis, a diagnostic test, or some therapeutic intervention. The moral analysis varies considerably, depending on whether one is looking at a simple intervention (such as a physical diagnosis) or a long-term episode involving many services (such as a long stay in the intensive care unit).

Which Health Resources Should Be Managed? Some providers advocate concentrating on only the most expensive services, but it is a mistake to gore only certain oxen. The aggregate costs of relatively inexpensive services may be as significant as those of a higher-cost service. If providers are going to limit or deny services, they must scrutinize the resources involved to avoid depriving only those patients in need of very expensive treatments.

Who Should Make the Allocation Decisions? Should the patient and physician negotiate resource management decisions, or should they be made at the institutional level? Institutional policy-making limits both the patient's choices and the physician's ability to make prudential judgments. However, policy-based resource management reduces the impact of individual clinicians' biases.

CORE VALUES IN RESOURCE MANAGEMENT

Respect for Persons

Respect mandates that providers act for the good of the patient, which at times means simply "Do no harm." The central question, then, is what counts as harm. At a minimum, this value requires that providers respect all persons, not just some. For example, any mechanism that denies or limits treatment on an unjustifiable or arbitrary basis would be morally indefensible.

Professional Integrity

Any mechanism for resource management should respect the norms of the relevant health professions. These norms would be violated if, for example, a professional were required to practice in an area for which he or she was not adequately trained.

Due Process

Due process requires powerful bodies to act according to established rules and to provide notice about decisions that affect all interested parties, an opportunity to be heard, and access to a reasonable appeals process. Like cases must be treated alike, which means that rules must be applied consistently to all patients and in all areas of the facility.

Informed Consent

Providers must ensure that patients are informed about relevant mechanisms that significantly affect their care. Any well-ordered society, including a healthcare facility, must be animated by a notion of "fair terms of cooperation and mutual advantage."[*] Fair cooperation is possible only if all the parties know where they stand.[†]

Yet not all clinicians or theorists would support such openness. G. Calabresi and P. Bobbitt, for example, maintain that some choices are so tragic they need to be made quietly, away from public scrutiny, to avoid damaging the good order of society.[‡] Also, though healthcare professionals generally do not consciously hide resource management mechanisms or individual decisions related to such mechanisms, they may be uncomfortable discussing limitations of services and hence keep patients and families in the dark. But excluding from decision making those who have the most at stake dissolves the glue that binds us as a community,[§] without any clear gains being made.

Stewardship

In promoting access to care and the good health of all in the community, a resource management mechanism must ensure that no resources are wasted. Good stewardship requires each person to conserve resources, just as he or she expects others to.

The Common Good

A respect for the common good requires balancing the needs of the community and the individual. Single-minded pursuit of community goals could blind the organization to the needs of individuals, particularly those at the margins of society. Resource management mechanisms should facilitate service provision and advocacy for those most likely to be neglected.

NOTES

* John Rawls, *A Theory of Justice*, Harvard University Press, Cambridge, MA, 1972.
† Leonard Fleck, "Justice, HMOs, and the Invisible Rationing of Health Care Resources," *Bioethics*, vol. 4, 1990, pp. 97-120.
‡ G. Calabresi and P. Bobbitt, *Tragic Choices*, W. W. Norton, New York City, 1978, p. 69.
§ James L. Nelson, "Tragedy, Prejudice, and Publicity in Setting Priorities," unpublished manuscript prepared for the Hastings Center Project on Priorities in Mental Health, 1993.

And, because offering one patient a service might mean denying services to other patients, fair allocation depends on at least some public discussion about what to limit and why. The challenge is to strike the appropriate balance between clinical and policy-level decision making.

WHY IS RESOURCE MANAGEMENT NECESSARY?

Publicly elected officials have discovered (as with Oregon's explicit rationing scheme) that it will never be politically acceptable for them to make resource allocation decisions. Instead, healthcare facilities and managed care organizations will make these tough decisions in the context of resource limitations imposed by competitive forces.

Not only are allocation decisions unavoidable, they also can promote holistic, socially responsible medical practice. Comprehensive decision-making processes involving the entire healthcare team can help clinicians craft care plans that better serve the patient, in addition to ensuring judicious resource use.

Perhaps more important, current mechanisms for allocating resources—which are largely hidden from view and informal—negatively affect important relationships with constituents. Patients and families think that allocation rules are applied inconsistently; staff think formal processes are subverted by informal mechanisms; and the community sees little accountability for the decisions being made.

In this era of cost constraints, healthcare facilities and other stewards of healthcare resources will likely be held to a new, higher level of social accountability. Properly managing healthcare resources can produce a more equitable and socially responsible healthcare system.

CORE VALUES IN RESOURCE MANAGEMENT

The just allocation of our precious healthcare resources rests on values that can either conflict with or complement one another. When values do clash, in our pluralistic society, it can be hard to identify an overarching moral rule that will satisfy all parties involved. The most important values underlying resource management decisions include those listed in the **Box** on p. 49.

EVALUATING RESOURCE MANAGEMENT MECHANISMS

An interdisciplinary team of providers should oversee an ongoing review of resource management mechanisms. Like an ethics committee, the group can benefit from multiple perspectives. If the group meets regularly, it will develop the skills needed to examine the value assumptions underlying mechanisms. The designated team can also assist in the appeals process—a prudent arrange-

ment for organizations that restrict services.[2]

The primary issue for the group will be how to evaluate resource management. The following questions, though they cannot account for every circumstance, could prove helpful in determining whether an existing or proposed resource management mechanism is morally defensible.

How the Mechanism Works

• Was an informal mechanism in place before the formal mechanism was implemented?

• How did the informal mechanism work?

• Who devised it, and when was it used?

• Is the use or purpose of the formal mechanism different from that of the informal one? If so, how has it changed, and why?

• Is the formal mechanism followed? If not, why not? (Were there, for example, concerns about legal liability, financial interests, family demands?)

• Are informal practices still applied in managing the resource? Why?

• Do all healthcare providers apply the mechanism uniformly? If not, why not?

The evaluation group's first task is to understand how a mechanism was established, why it was formalized, how it is currently working, and whether anything stands in the way of its proper functioning. The mechanism may look acceptable on paper but carry some moral distortions in its actual application. Some mechanisms may be impossible to enforce.

Goals Pursued

• What are the goals of this healthcare resource and this mechanism to manage resources?

• Whose goals are they?

• Does the healthcare resource meet its intended goals?

• Are the resource management mechanism's goals morally defensible?

Medical and institutional goals can overlap or conflict. The medical goals of a healthcare service could include stabilizing the patient, restoring health, or providing comfort. The institutional goals, on the other hand, could include reducing the length of stay or ensuring high-quality care institution-wide. Similarly, various healthcare decision makers (e.g., patients, families, physicians, nurses, administrators) often have conflicting goals. Conflicts between goals are likely to increase as cost constraints pressure facilities to further limit services.

Solving such conflicts begins with making the goals explicit so they can be openly discussed. Otherwise, nonexplicit goals might prevail without the benefit of due process or informed consent. Or providers might pursue goals that are morally questionable or unattainable given available resources.

The Unit of Care Measured

• What unit of care (e.g., single intervention with a drug or complex episode of care in the ICU) does the mechanism evaluate? How does this affect other resource use?

• What are the consequences for using this resource measurement? (Would it require the inclusion of certain services, for example?)

The goals of healthcare resource management change according to the unit of care. A unit of care can be a single intervention (e.g., dialysis), an event of treatment (e.g., an entire period of ICU care), or an episode (the course of an illness). Focus on a subunit must be justified, since

CASE STUDY

The intensive care unit (ICU) at Saint Joseph's Hospital of Atlanta serves as an instructive case in the evaluation of resource management mechanisms. The ICU has explicit admission, discharge, and transfer criteria to ensure services are provided only to those in need of such intensive care. The hospital's written policy is as follows:

Purpose: To define assessment criteria (that constitute safe parameters) for transfer or discharge of patients from a critical care unit.

1. Vital signs are assessed as stable for the individual patient as agreed upon by the attending physician and nurse caring for the patient four (4) hours prior to transfer.

2. Neurological status is assessed to be either the patient's normal preadmission level or at a level of stability that does not require further critical care nursing interventions for four (4) hours prior to transfer.

3. Respiratory status is assessed to be such that the patient is able to maintain adequate ventilation and oxygenation without mechanical assistance four (4) hours prior to transfer.

4. Cardiovascular status is assessed to be such that the patient's tissue perfusion is adequate.

5. Cardiovascular status is assessed to be such that all life-threatening dysrhythmias have resolved to the point where certain IV cardiac medications which

are given only in critical care units are no longer necessary to control the dysrhythmia or regulate vascular tone four (4) hours prior to transfer.

6. Fluid and electrolyte status is assessed to be within reasonable limits for the individual patient four (4) hours prior to transfer.

7. Any patient may be discharged from the critical care unit who is determined to be moribund in the assessment of the attending physician and for whom no extraordinary medical measures will be used to prolong life or prevent death.

ASSESSING THE POLICY

A team analyzing the morality of such a policy would need to look at the following issues.

How the Mechanism Works The team's first task is to understand how the policy actually works. Is it used consistently? Are patients who are moribund, for example, actually discharged from the ICU? If the policy is not being followed, the team needs to find out why. For example, do providers think it is unjust?

Goals Pursued The next step is to define the ICU's goals and measurements and to ensure that they are explicit and well understood by providers, patients, and families. For example, the ICU's mission, to provide extraordinary care, makes it clear that patients who do not require such care should be discharged, even though families may not understand that.

Unit of Care Measured Since the unit of care measured is the entire episode of ICU care, it should be evalutated in light

of its long-term consequences. The evaluation team might view the focus on the entire episode of care as a moral advantage, since it encompasses all interventions and thus forestalls charges of discrimination.

Measurements Employed The policy contains a mix of medical measurements, including severity of illness and effectiveness. The term "moribund" in criterion 7 might cause some concern. How do physicians determine who is moribund? Do they use an agreed-on scale or their clinical judgment? Without an agreed-on scale as a safeguard against clinicians' biases, the term "moribund" is too vague; the team might consider eliminating it or making it more specific.

Criterion 7 also presents the other condition for transfer or discharge: "for whom no extraordinary measures will be used." The policy does not say, however, who makes this determination. A choice to forgo life-sustaining treatment should be made by the patients themselves—not physicians—so the policy should be clarified to protect patient self-determination.

The policy does not refer to social factors or cost, but given their implicit effect on decisions, the evaluating team should consider whether to address these issues directly. For example, if two drugs have the same effect but one is more expensive, the mechanism could direct clinicians to choose the cheaper drug while informing the patient of the more expensive alternative.

The policy also does not spell out due process concerns, such as pretransfer notice and opportunities to appeal decisions. The evaluation team should ensure the policy addresses these issues.

the impact could be broad. For example, if an admission mechanism allows access to a special unit (and its array of services) only for persons who can be rehabilitated, failure to meet that one measure could mean limitation or denial of all other services. Thus moral evaluations must examine the unintended but real consequences of limiting services.

The Measurements Employed

• What measurements are being used to reach the mechanism's goal?

• Are they medical or social?

• Does the mechanism place greater weight on medical measurements? Is this justifiable?

In most cases, resource management mechanisms use traditional physiological, medical categories (e.g., the severity of the patient's condition, the prevalence of the condition). Only rarely do resource mechanisms employ social measures (such as allocation of solid organs for transplantation based, in part, on the patient's social history). They almost never take into account the need to protect cherished social values (e.g., informed consent).

The physiological orientation alone will often prove ethically inadequate, giving priority to some values at the expense of others. If patients are given a resource only because it is effective in prolonging life, for example, this would give priority to longevity over comfort. The moral issue is not whether social measures should be used, but rather which social measures are relevant to meet a publicly agreed-on goal. Therefore, again, those evaluating a mechanism's moral adequacy must first identify and articulate the goals it promotes.

Severity of Illness Measure

• How much weight should a resource management mechanism give to severity of illness?

• What elements determine severity of illness? Are they measured consistently? By whom?

Severity of illness can be used as a criterion to either include or exclude patients from receiving services. The practice of giving the sickest patients any or all healthcare resources, no matter how costly or ineffective, has recently been called into question, and futility policies have been developed to limit or deny resources that provide extremely low benefit. In the allocation of solid

Resource mechanisms almost never take into account the need to protect social values.

organs for transplantation, for example, the sickest patients may not be the best candidates. On the other hand, a resource allocation mechanism that excludes the sickest from access to services may constitute unjustifiable discrimination.

Whenever severity of illness is used as a criterion, it is essential to agree on an explicit definition of "sickest." For example, some might think those in a persistent vegetative state are the sickest, whereas others might perceive patients who are conscious and suffering as being sickest. Scoring systems or scales for measuring severity of illness (e.g., APACHE [Acute Physiology and Chronic Health Evaluation] scores) can predict mortality and indicate an agreed-on level of sickness. These may prove helpful in providing for consistent evaluations, but are by no means value free.

Providers' judgments will still come into play, and providers may be tempted to consider additional measures along with the formal mechanism. For example, the measure may call for patients to be discharged from the critical care unit if they are "moribund," but a nurse might suggest patients be discharged because of failure to thrive. When the formal mechanism conflicts with the provider's judgment, a forum for discussion and a process for appeal must be available.

Effectiveness as a Measure

• What does effectiveness refer to (e.g., a cure, palliation, a return to baseline function)?

• How long must the change last?

• Who will judge the effectiveness, and based on what level of evidence?

A physician might believe the only legitimate use of a healthcare service is to effect a cure, whereas the patient might believe that comfort or prolonged life is sufficient reason to receive a healthcare service. Again, the mechanism must be explicit about the kind of effectiveness sought. Most would agree providers have no obligation to provide treatments that are physiologically futile, but when a treatment would offer a marginal benefit, more discussion among affected parties is required.

Another issue is the duration of the effectiveness. Respect for the whole patient requires that the use of any resource be analyzed in relationship to the service's overall goal. Thus, if an indi-

vidual intervention might benefit a single body system (e.g., the heart), but offers no hope of reaching an agreed-on goal (e.g., improving the quality of life), then provision of the resource should be vigorously questioned. Resource management mechanisms requiring a broader analysis of effectiveness are preferable to narrower measures because they are more likely to take into account the good of the patient.

Experts in the health measurements movement prefer evidence of effectiveness based on random clinical trials, followed by (in order) consensus statements, meta-analysis of the data, and practice guidelines. The evaluation of a mechanism must take into account the origin and credibility of the evidence. For example, if a hospital formulary committee chose to make one drug available and not another on the basis of their effectiveness, providers would need to determine who established the drugs' effectiveness and whether they had any conflicts of interest.

Cost as a Measure

- If costs are a relevant criterion for resource distribution, which costs should count?
- Over what period of time should costs be calculated?

In the moral evaluation of a mechanism, it is important to examine the costs of alternative treatments and nontreatment (e.g., the cost of a kidney transplantation versus the cost of keeping a person on dialysis for his or her lifetime). If more expensive alternatives are not given, providers must inform patients and give the reasons (e.g., the more expensive service has only a marginal effect).

Given the finite nature of healthcare resources, it is imperative to evaluate whether an expenditure diverts money from other socially desirable goals of the institution.

Social Factors as Measurements

- Which factors should be considered?
- Who decides about the formation of the formal mechanism?
- Who makes the decisions in the day-to-day application of the mechanism?
- Has the mechanism been reviewed by all parties who have an interest in the resource?
- Does the mechanism have a means of appeal?
- Does the mechanism provide for alternative means of treatment and for reasonable accommodation?
- Does the mechanism provide a means to address providers' biases?

Resource management mechanisms may be morally questionable if they do not sufficiently respect values that society cherishes, such as those discussed earlier. A major question is: Who makes the decision about resource management?

Consensus exists that (1) the mechanism and how it works must be made public to all interested parties, (2) the values of patients and families, not just those of health professionals, must be considered, and (3) an appeals mechanism must be available.

If a mechanism restricts patient and provider choice, the mechanism should offer alternative treatments, when feasible; adequate flexibility for professional clinical judgment; and information on whether the service is available elsewhere. In addition, exceptions must be allowed to accommodate, within reason, religious requests for resources (e.g., the provision of care for brain-dead Orthodox Jews whose families do not acknowledge whole-brain-death criteria).

Mechanisms should also include ways to minimize the effect of clinicians' biases in resource allocation. Such a mechanism might, for example, prompt clinicians to ask themselves whether the individual resource decision could be applied to all patients.

Finally, for a resource management mechanism to work, it must be used. Sociological evidence suggests that clinicians are less likely to use health measurements if the rationale for their use is not clear.[3] Does the mechanism appear to use valid and reliable health measurements? Does it address real problems in resource allocation? And does using the mechanism contribute to good clinical outcomes?

MINIMAL REQUIREMENTS

Debates on the ethics of hospital resource management are in their infancy. Because of the heterogeneity of the mechanisms used to manage resources, most early attempts at moral analysis will use a variety of measures and a process of trial and error to judge mechanisms.

Still, healthcare organizations can identify certain necessary features of ethical analysis, including certain core values and explicit discussion of such things as medical and social measurements employed and the appeals process. Unless these minimal requirements are met, our present mechanisms for resource management cannot be morally defensible. □

NOTES

1. Robert Zussman, *Intensive Care: Medical Ethics and the Medical Profession*, University of Chicago, Chicago, 1992.
2. Paul Applebaum, "Legal Liability and Managed Care," *American Psychologist*, vol. 48, 1993, pp. 251-257.
3. Office of Technology Assessment, U.S. Congress, *Identifying Health Technologies That Work: Searching for Evidence*, U.S. Government Printing Office, Washington, DC, 1994.