
Ethics Committees and Resource Allocation

by John D. Lantos

Nobody, including most bioethicists, seeks or wants the job of allocating scarce resources. Instead, bioethicists have focused on the rights of patients to health care resources, and the obligation of providers and of society to maintain an adequate supply of resources to meet patients' demands. The current health care system diffuses responsibility and hides accountability for resource allocation decisions. Ethical theory and moral deliberation could only guide allocation decisions in a health care system in which resource allocation decisions could be made in an open and explicit way.

The job of allocating scarce medical resources is an undesirable one. Nobody, including members of ethics committees, wants to decide who will benefit from medical treatment, who will be forced to suffer when their pain might be ameliorated, and who will be forced to die when their life could be saved. In their classic work, *Principles of Biomedical Ethics*, Beauchamp and Childress discuss the different ethical theories which might be brought to bear on allocation decisions (1989), the libertarian approach, the utilitarian approach and the egalitarian approach. But the authors are reluctant to advocate the merits of one over another, reflecting in their reticence the limitations of bioethics to make such decisions.

Bioethics is not uniquely unambitious in regard to this issue. Both individuals and societies will do everything they can to disguise the need for such choices, or, if they cannot disguise the need, to diffuse or try to hide the responsibility for them (Calabresi and Bobbitt 1978). Thus, decisions may be made by lotteries, by juries, by queues, by markets, or by meritocratic standards, but each approach is recognized to be imperfect in fairly predictable ways. Any particular solution to these difficult choices will embody one idea or form of justice rather than another. Since there are many different aspects of justice and many different facets of equality, all cannot be simultaneously satisfied. Public policies balance competing approaches by alternating among them, as each approach inevitably comes to be criticized by proponents of other approaches.

Equality is not a simple or one dimensional entity. Sen has shown that, in most cases, increases in one type or form of equality lead to decreases in other forms (Sen 1992). Thus, if we increase taxes in order to provide universal health care, we increase access to health care, but decrease freedom to decide how we spend our money. If we achieve cost savings through managed care in order to provide equal access to more health care resources, we decrease our freedom to choose where and from whom we get our medical care. If we increase patients' rights to choose how much health care they get, we may spend more money on minimally beneficial but expensive crisis intervention, rather than more beneficial and cheaper preventive measures. The constellation and formation of political power structures in society at any particular moment will determine which particular procedural and substantive approaches to resource allocation will be implemented.

In much of the discourse of medical ethics, resource allocation problems have been viewed as problems of determining the scope of an individual's right to receive health care. Physicians are generally seen as having a duty or obligation to provide care, and society to pay for it. The assumption has generally been that re-

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sources are, or should be, plentiful, and that when they are not, it is due to inefficiency, corruption or greed, rather than true scarcity. Given this assumption, the focus of analysis has been on the principles of fairness and non-discrimination for patients, rather than an analysis of how health care systems take the shape that they do. Health law often takes a similar approach, empowering patients to demand care even if providers think it is futile.

There are other approaches to resource allocation. For economists the problem has involved the creation of efficient markets for the exchange of goods (Reinhardt 1993). For government officials and public policy analysts, the issue has been the appropriateness of tradeoffs between health care and other goods, such as military preparedness, education, and public safety. In each of these cases, the structure of the health care system and of the mechanisms of paying for health care, as well as the mechanisms for distributing health care, are essential parts of the problem.

Bioethicists who view the resource allocation problem as primarily one of individual rights ignore what Calabresi and Bobbitt call the first order determinations

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of scarcity. That is, they don't ask how we should decide how many societal resources should be available for health care.

Instead, health care is viewed as an absolute, individual right, which allows individuals to make potentially unlimited claims on societal resources. In this context, discussions of the allocation of scarce resources have an ethereal quality to them, often using triage metaphors that are inapplicable and irrelevant. In war

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time, there is usually an absolute scarcity of personnel and equipment, and, in battle, decisions must be made how to allocate those scarce resources to achieve the best overall outcome. Furthermore, in wartime "best outcomes" are defined functionally in terms of winning the war. Soldiers who cannot be restored to a level of health sufficient to continue fighting should not be saved if other, more healthy soldiers also need care. These conditions and constraints generally do not apply in hospitals or intensive care units.

A theory of resource allocation must look beyond the boundaries of bioethics, and must include considerations derived from political philosophy, economics, and a theory of the proper relationship between individuals, institutions and the state. There is no way to discuss issues of resource allocation for medical care without looking at the process by which resources are made available, the constraints on decision makers who must allocate those resources, and the comparative values of medical care and other goods in society.

Bioethics committees usually function within particular health care institutions. Generally they are within a hospital, although they may serve a medical school or a consortium of health delivery systems. Nevertheless, they are bounded by the same constraints as the providers are bounded. They take the present system of resource availability and reimbursement as a given. In such a role, they rarely look at the larger issues of whether the current arrangement of health care provision is doing a better job at improving health than other arrangements might.

Given these constraints, one must ask what the goals of such ethics committees ought to be. Ethics commit-

tees must be distinguished from legislative, judicial and executive bodies. They neither make laws, interpret them, nor enforce them. Instead, their goal is usually to clarify the moral implications of different decisions or institutional structures, and to devise policies for living within the constraints of the existing political structures.

Ethics committees generally do not take political positions. Instead, they strive to be a morally neutral space in which competing ethical views can be aired and analyzed. Of course, as Kolakowski has pointed out, even non-judgmental moral neutrality is itself a strong moral value (1990). It makes us intolerant of intolerance, and leads to a strong commitment to diversity and individual liberty.

Rationing decisions, however, require that some community values take precedence over some individual values, and, consequently, that we limit the degree to which we will respect individual preferences. Decisions about resource allocation will necessarily involve some mechanism for overriding the demands of individuals in the name of the common good. Ethics committees have usually avoided developing mechanisms for evaluating such decisions, and have sought, instead, to uphold the rights of the individual to make autonomous and unrestrained decisions. This tradition of modern bioethics mirrors traditional medical moral values. Both put the individual patient first; neither prepares us to make or evaluate resource allocation decisions.

In order to find a way out of this dilemma, it is necessary to first imagine a reconstructed health care system in which decisions about how to collect money and how to allocate money could be evaluated together. The current split between payers, providers, and patients creates systems in which accountability is diffused and responsibility is disguised. Payers seldom refuse to pay; they simply make reimbursement difficult. If they do refuse to pay, the patient can still make claims upon hospitals and doctors. Physicians often profess a willingness to honor such claims but blame hospital administrators for policies limiting the care of indigent

patients. Finding who is truly responsible becomes a moral shell game.

In such a system, an ethics committee must choose whom to serve and whose decisions are subject to its analyses and moral deliberation. That choice limits the relevance of ethics committee deliberations in many cases to foregone conclusions or idealistic recommendations. In a reformed health care system, ethics committees may have new power, new options, and new challenges. Without health care reform, neither ethics committees nor any other deliberative body is in a position to make meaningful decisions about resource allocation.

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