Chapter 12

Nurse time as a scarce health care resource

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For a very long time discussion about scarce health care resource allocation was limited to allocation of *medical* resources, and the paradigmatic case was kidney transplants. Two sorts of criteria emerged from this debate: clinical – who is the most 'savable'? – and social – who is the most 'worth saving'? Although writers on the subject pointed out that medical criteria were often thinly veiled social ones, by and large they opted for one or the other.

In this chapter I shall suggest that their narrow focus on medical resources prevented these authors from seeing that there are many cases – perhaps even the majority – in which neither clinical nor social criteria work. The allocation of nursing time as a scarce health care resource may have to be made on quite different grounds, and everyday decisions about that dilemma far outnumber the more attention-getting cases about organ transplants. In discussing nurse time as a scarce resource, I shall go on to argue that the two principles to be respected are nurse autonomy and randomisation.

MEDICAL AND SOCIAL

In the case of organ transplants and dialysis allocation, there have been many vociferous claims that clinical criteria are to be preferred because they are objective. For example, the United States National Organ Transplant Task Force recommended medical standards as the fairest and most rational in its 1986 report. The aim is to 'maximize graft and patient survival and quality of life'.[1] But what constitutes the most medically 'correct' choice is ambivalent. The most 'savable' in terms of prognosis is unlikely to be either the neediest or 'illest' in terms of diagnosis – a point to which I shall return later in discussing a fictional case study about the allocation of nurse time.

Nor are medical criteria as objective as is sometimes claimed. A purely medical set of standards for organ allocation turns out to benefit whites disproportionately, for example.[2] Because histocompatibility makes a successful graft more likely, the Task Force suggested the medical benefit rule of a six-HLA antigen match and no mismatches. But it turns out to be harder to obtain six antigen matches in Afro-Caribbeans because their donor pool is smaller in the USA (or in Britain) than the white one. As Robert Veatch puts it, 'This means that a policy that gives priority to the best tissue matches will be a policy that gives priority to whites.'[3]

No one is claiming that a medical standard for allocation of scarce resources deliberately tries to penalise already disadvantaged groups. But that is frequently its effect. In the same year in which the US Task Force brought out its recommendations, an infant heart transplant candidate, 'Baby Jesse', was refused the procedure on 'medical' grounds.[4] Although he met the preliminary clinical criteria, his parents were unmarried teenagers with a criminal history and drug abuse problems. They were judged incapable of providing the necessary follow-up procedures, such as punctual administration of immuno-suppressive medications.

About the same time, in a case at the Churchill Hospital in Oxford, a vagrant patient's dialysis was terminated because he was judged unable to follow the diet and other requirements for successful treatment. Although these were presented as purely medical criteria, the case caused an outcry, particularly among the hospital's nursing staff. Well-educated and affluent patients or parents have the best chances of looking after themselves or their children properly, of course. To maximise the chances of a successful graft, and avoid 'wasting' a heart or kidney, the medical model would suggest concentrating the resource among the well educated and affluent.

Medical criteria shade over into social ones, and social criteria have had a very bad press since the Seattle 'God' committee closed down operations. This body was set up in the early 1960s with apparently laudable aims: to reassure the community that doctors were not playing God, ironically enough. It, too, claimed to be able to make choices objectively: its director, Dr Belding Scribner, hoped 'to represent the community and assure that choices are made objectively and without outside pressure'.[5] Although the committee did set some medical guidelines, it was primarily concerned with social variables in drawing up its recommendations for allocation of kidney transplants: net worth, marital status, church membership, Scout leadership, psychological stability and present or potential future income. Decisions were made in secret, and no criteria for individual decisions were published. Most criticism at the time – attacks which, combined with members' feelings of guilt, were virulent enough to close the committee down – focused on the class bias of these criteria: 'the bourgeoisie saving the bourgeoisie'.[6]

Rules favouring high earners will also discriminate against women, however. The committee was willing to give preference to a non-earning housewife with small children, but once these hostages to fortune were grown, older women would have had to take their chances – rigged chances.

THE CASE OF MRS ROBERTSON

In contrast to the thirty-year-old debate about medical versus social criteria in the allocation of organ transplants, discussion of nurse time as a scarce health care resource is still relatively new. I want to show that looking at the allocation of scarce resources from the particular viewpoint of nursing time makes both the usual sorts of criteria look strangely irrelevant.

Robert Veatch and Sara Fry have developed a fictional example of a nurse who is confronted with the entirely typical case in which her duty is not to the patient, but to patients in the plural.[7] On a medical-surgical nursing care unit, night nurse Clora Bingham has four needy patients. Mrs Robertson is an 83-year-old woman who is dying and semi-comatose, in need of a suctioning procedure every fifteen to twenty minutes to prevent a mucous plug from blocking her bronchi and causing respiratory failure. Mr Jablowski, 47, was admitted for observation and has had several bloody bowel movements. Mr Hanson, 52, is a newly diagnosed diabetic with unstable blood sugar levels who needs frequent vital sign checks and is getting intravenous insulin. The fourth patient, 35-year-old Mr Manfra, has no immediate medical needs but has been suicidal in the past. Fears that he might now repeat his suicidal behaviour have been heightened: he learned today that he has inoperable cancer of the spine.

It seems unlikely that Clora Bingham can actually give all four patients equal amounts of her time, or that, if she could, this would be the right thing to do. If she has to suction Mrs Robertson every fifteen to twenty minutes, she will be unable to give Mr Manfra the length of time for a talk which he might need. She will effectively do him no good at all if she rushes off in the middle of one of his sentences, and perhaps even some harm: he may become all the more depressed and angry. It looks very much as if her time is effectively indivisible, just like a kidney – although a first reaction to the issue of nurse time as a scarce resource is to say that it is divisible, unlike the kidney.

On either clinical or social utility criteria, Mrs Robertson seems the least 'important', although her condition is the most critical. She cannot be saved, and she has less 'useful' potential life span to contribute to society than any of the three younger patients. Assuming for the moment that no negligence suit or disciplinary action would result, should Clora Bingham forget about Mrs Robertson?

That this appears quite unacceptable says something uncomplimentary about clinical and social utility criteria. It shows the extent to which discussion of scarce resources has been too strictly medical, in terms of organ transplants and dialysis. Thinking in terms of the nurse's decision is a useful counterweight. How could she continue to view herself as a responsible person if she left Mrs Robertson to die unattended?

Nurses have been found to be able to cope with a patient's death most easily when they can tell themselves, with justice, that nothing more could have been done. Their peace of mind seems to depend on it. In interviewing nurses on a coronary care unit, David Field found that there was surprisingly little sense of 'failure' when a patient died, so long as the nurses were sure that they had done everything possible to stave off the death. Although the purpose of the unit was to prevent death, and nurses might have been expected to feel remorse when they failed to save a patient, good staffing, ward organisation and technology did indeed give backing to the nurses' view that those who could be saved were being saved. The nurses, all qualified, were legally covered to give drugs and instigate life-saving treatment even if no doctor was present. Deaths were infrequent (about 7.5 per cent of admissions), and nurses better able to cope with them than junior doctors, interestingly. One nurse's comments are indicative:

> We're dealing with people on a fairly narrow range of medical problems, and usually we know whether we can do anything constructive in a situation or whether it's hopeless, and so we're not left with that guilt feeling that I experienced sometimes as a student of not knowing whether there might have been anything more that I could have done, because usually you say, 'Well, we did everything that could possible have been done in the situation and there was nothing I could have done to avert what happened.'[8]

It would be wrong, and probably psychologically intolerable, for the nurse to omit a procedure which she knows to be necessary for keeping a patient alive, even if by some miraculous chance Mrs Robertson survived despite Clora Bingham missing one or more of her suctioning times. (This assumes that Mrs Robertson has not signed a living will or given some other indication before entering the semi-comatose state that she wanted nothing further done for her; and that she is not suffering so greatly that moral questions about prolonging her agony would arise even in the absence of a living will.)

How will Clora Bingham feel if she devotes the maximum time to Mrs Robertson and Mr Manfra manages to commit suicide? In a sense suicide is Mr Manfra's own project, not hers, and an extreme view of patients' rights might stress that it was his free choice. But an initial suicidal reaction to diagnosis of inoperable cancer is sometimes followed by determination to live the remaining life to the full. Could Clora Bingham be sure that Mr Manfra might not have changed his mind, given a bit of her time? Clearly not, but she can be much more sure about what will happen to Mrs Robertson if she misses her suctioning procedure. Mrs Robertson is almost certain to die without the treatment, and to die during Clora Bingham's shift. There is no equivalent level of certainty with Mr Manfra.

Whatever the odds, if Mr Manfra commits suicide Clora Bingham will doubtless feel deep regret. But there is no reason for her to experience remorse and guilt, which would have to do with some moral failure of hers. Mr Manfra's suicide is nothing to do with such a failure: it is ultimately his decision. And she is much more likely to feel guilty about Mrs Robertson's death if she knows there was something she could have done about it. I would argue that Mrs Robertson has the first claim on Clora Bingham's time, not as a result of qualities inherent in the patient – either the possibility of clinical benefit or greater 'social utility' – but because of the nurse's own moral sensibilities, which are infringed by letting Mrs Robertson die just to follow medical utility criteria.

RANDOMISATION

Assuming that any time remains after Mrs Robertson's suctioning procedures have been carried out, how should Clora Bingham divide it? I want to suggest that she should give serious thought to a third principle which has sometimes been suggested to decide who gets the kidney or the expensive operation, but which has generally had less influence than medical or social criteria: randomisation.[9] Again, using the example of nurse time as the scarce resource gives a different result.

In relation to allocation of kidneys, a minority of writers have argued for randomisation, or equalisation of chances. No patient is to get the kidney on grounds of better clinical prognosis or greater 'social utility'; everyone is given equal chances through the device of a 'lottery', or, in practice, through a first-come-first-served system. This model sounds impractical, but it is described as being the basis of the Italian system of kidney allocation.[10] Italian doctors refuse to use lack of clinical merit as a criterion, because patients do not choose to suffer from serious conditions: 'Why, after all, should their shorter lives be measured against lives that would have been longer from no merit of their own?'[11]

In contexts other than kidney allocation, lotteries have sometimes been held to be the only fair and 'objective' way of deciding between claims to scarce resources. Freund has said,

> The more nearly total is the estimate to be made of an individual, and the more nearly the consequence determines life and death, the more unfit the judgement becomes for human reckoning. . . . Randomness as a moral principle deserves serious study.[12]

The most gripping example of this policy is the case of *U.S.* v. *Holmes* (1841), in which the presiding judge ruled that a surviving crew member, Holmes, should not have collaborated with his mates in devising and implementing social criteria for deciding who among a shipwreck's survivors must be thrown off a lifeboat in order to lighten its load. Despite his counsel's contention that the crew's method of selection – 'not to part man and wife, and not to throw over any woman' – was more humane than drawing straws, Holmes was convicted of unlawful homicide. (In fact the crew members failed to prevent female deaths: two sisters jumped overboard to drown with their brother, who was among the fourteen men jettisoned.) In the judge's opinion, only casting lots would have been a remedy which the law could sanction: 'In no other way than this or some like way are those having equal rights put on an equal footing, and in no other way is it possible to guard against partiality and oppression, violence and conflict.'[13] In the Clora Bingham example, we are also concerned with 'those having equal rights' being 'put on an equal footing'. But we can modify the general principle of randomisation to this case, which is really more about equalisation of chances for those having equal rights. In the Holmes case, there was no way to divide up the precious good, the place in the lifeboat: it was all or nothing. I argued earlier that the nurse's time was actually more indivisible than it looked at first. But now that we have taken care of the prime constraint on her time, Mrs Robertson, Clora's remaining time could be divided up equally, to give 'those having equal rights' – the remaining three patients – equal chances. The principle behind this is egalitarianism, the same principle that lies behind randomisation, but the application of the principle in this case calls for equalisation.

For Clora Bingham to divide her time equally among the remaining three patients, in accordance with the principle of egalitarianism, should be feasible, I think, though there are still more problems in giving Mr Manfra what he needs than there are for the other two men. Let us assume that Mr Hanson's vital sign checks need to be carried out less frequently than the suctioning procedure did for Mrs Robertson. Say that as an adult-onset diabetic, he is perhaps less likely to lapse into coma than a young patient might be.[14] If the checks and observations for Mr Jablowski and Mr Hanson allow substantial intervals, Clora Bingham may well be able to give Mr Manfra some uninterrupted time for a talk. There is no reason why she has to equalise her time mechanically: the principle does not require precisely five minutes for each of the three patients every fifteen minutes.

Clearly if any of the three men die, Clora Bingham will feel grief and regret, but she would not necessarily feel remorse or decide that her action in apportioning her residual time equally among them was wrong. Dividing her remaining time equally overall will be Clora Bingham's way of 'getting it right' whatever the outcome for the three remaining patients, I think. It will also spare her a lengthy weighing-up of the three individual patients' precise claims to portions of her time – making the scarce resource of her time still scarcer.

Equalising the nurse's time, once the urgent claims of the dying patient are met, corresponds to the principle of casting lots among the remaining patients.

AGE AND AGEISM

Robert Veatch proposes a modified form of randomised allocation for organ transplants: 'People in equal need of an organ ought to have an equal shot at it even if one potential recipient would be more likely to make a socially worthwhile contribution.'[15] But Veatch also wants to weight in age, the obvious objection to randomising nursing time. A 90-year-old might be seen to 'deserve' less of the nurse's precious time than a younger person, if benefit is measured in terms of years of life which the nurse can add.

But we have already seen that ignoring the urgent claims of the oldest person in the fictionalised example, Mrs Robertson, was deeply counter-intuitive. Clora Bingham's moral autonomy and peace of mind depended on her doing all she could for the dying Mrs Robertson. For less acute cases, however, should a nurse divide her time according to the age of patients? After all, if there is only one dialysis machine or kidney available, and a choice must be made between giving it to an 80-year-old and a 20-year-old, most people find the answer obvious enough.

However, the nurse owes a duty of care to both the 80-year-old and the 20-year-old, if both are patients on her ward. Does she somehow owe a little more duty to the 20-year-old? The criterion of age is a very slippery slope. John Harris is suspicious of automatic preference for younger patients, which he calls a form of ageism; but even he sets a 'fair innings' standard of 70 years, the statistically average life-span.[16] No one over that age is to be allowed the scarce medical resource in preference to someone younger. (Harris, in common with most authors until recently, does not discuss nurse time.)

As with all criteria open to the 'slippery slope' objection, the age limit of 70 raises some obvious absurdities. A patient who presents herself for treatment at a dialysis centre on her seventy-first birthday would be turned away, whereas she would have been treated if she had arrived a day earlier. It is not at all clear what is so magical about 70. If years of life which the health care professional could add are the criterion, any arbitrary age limit will be less effective than a complete analysis of the patient's life-style and clinical prognosis. But that will shade into social criteria again: a 71-year-old who can afford the proper diet and is well educated about healthy living will be a better bet than a 70-year-old with none of these advantages. And the first patient is more likely to be middle class.

Is 70 the magic age because it is somehow the 'norm'? But women live on average six or seven years longer than men: a cut-off point of 70 will disadvantage women and advantage men. In both cases, the supposedly impartial age limit turns out to reinforce existing social inequality. And because people in modern Western societies do normally live to a statistical average of 70 says nothing at all about whether they should live till 70. To argue otherwise is a form of the naturalistic fallacy, the common assumption being that a form of behaviour which is natural is also morally right.

It might be argued that the 71-year-old has already enjoyed 'a good life'. In Veatch's view, justice as fairness demands that,

> persons be given an opportunity to have well-being over a lifetime equal to that of others. This means that infants, who have had no opportunity for well-being, would get a higher priority than older persons who have had many good years of life.[17]

But what if the years have not been good, or are just becoming so? If life is good, it does not necessarily become any less sweet with age, assuming that the patient is not in pain or distress which cannot be palliated. If it has not been good – and Veatch tends to assume that it has – a last chance at happiness is being denied. On this argument, we would always give preference to the youngest person, and Mr Manfra would get the bulk of Clora Bingham's time, leaving Mrs Robertson to die unattended. That this goes against the grain shows how little nurse time – and nurse autonomy – have counted until recently in discussion about allocation of scarce resources.

CONCLUSION

The ethical dilemmas faced by nurses in dividing the valuable resource of their available time have been largely invisible in the literature on scarce resources, which has been medically orientated. I hope that this chapter will have gone a little way towards rectifying that omission, even for those who disagree with its conclusions. These are that the guiding principle should be randomisation (equalisation) – which respects patients as persons by putting them all on an equal level – and nurse autonomy to decide otherwise in difficult cases such as dying patients – which respects nurses as moral agents.

NOTES

1 United States Department of Health and Human Services, Task Force on Organ Transplantation, *Organ Transplantation: Issues and Recommendations*, Washington, D.C.: Department of Health and Human Services, 1986, p. 87.

2 Veatch, R. M., *Death, Dying and the Biological Revolution: Our Last Quest for Responsibility*, New Haven: Yale University Press, 1989, revised edn, p. 207.

3 ibid.

4 The US Task Force did not want to exclude medically suitable applicants because they lacked social support. It therefore suggested that social service agencies should make up any deficiencies. How realistic this recommendation is must be open to doubt.

5 Calabresi, G. and Bobbitt, P., *Tragic Choices*, New York: W. W. Norton & Company, 1978, footnote 110, p. 232.

6 Sanders, D. and Dukeminier, J., 'Medical Advance and Legal Lag', *U.C.L.A. Law Review*, 1968, vol. 15, pp. 377–8. For further critical discussion of the Seattle 'God' Committee, see Calabresi and Bobbitt, op. cit., pp. 187–8, and footnotes 111–12, p. 233.

7 Veatch, R. M. and Fry, S. T., *Case Studies in Nursing Ethics*, Philadelphia: J.B. Lippincott Co., 1987, case 23, 'Allocating Nursing Time According to Benefit', pp. 84 ff.

8 Field, D., *Nursing the Dying*, London: Tavistock/Routledge, 1989, p. 78. That nurses were best able to cope with a patient's death when they could justifiably feel that they had done everything possible was also reported in Glaser, B. G. and Strauss, A. L., *Awareness of Dying*, Chicago: Aldine, 1965.

9 Randomisation is widely used as a principle for dividing up groups of subjects in clinical trials, of course, but very rarely in allocating scarce health care resources.

10 In Calabresi and Bobbitt, op. cit., pp. 182 ff.

11 ibid, p. 182.

12 Freund, P. A., 'Introduction: Ethical Aspects of Experimentation with Human Subjects', *Daedalus*, Spring 1969, p. xiii. A similar argument is made in Katz, A., 'Process Design for Selection of Haemodialysis and Organ Transplant Recipients', *Buffalo Law Review*, 1973, vol. 22, and in Ramsey, P., *The Patient as Person: Explorations in Medical Ethics*, New Haven, Conn. Yale University Press, 1970, pp. 259–66. However, Katz ultimately proposes that the lottery be limited to a pool of clinically suitable applicants, tempering randomisation with medical criteria. This approach is also taken by Childress, J. F., 'Who Shall Live When Not All Can Live?', in S. Gorovitz *et al.*, *Moral Problems in Medicine*, Englewood Cliffs, N. J. Prentice-Hall, 1983, 2nd edition; Outka, G., 'Social Justice and Equal Access to Health Care,' *Journal of Religious Ethics*, 1974, vol. 2, pp. 11–32; and Green, R. M., 'Health Care and Justice in Contract Theory Perspective,' in Veatch, R. M. and Branson, R. (eds), *Ethics and Health Policy*, Cambridge, Mass.: Ballinger Publishing, 1976, pp. 111–26.

13 *U.S.* v. *Holmes*, 26 Fed. Case 360.

14 Armstrong, M. E., *et al.* (eds), *McGraw-Hill Handbook of Clinical Nursing*, Tokyo: McGraw-Hill Kogashuka, 1979, pp. 684–5.

15 Veatch, op. cit., 1989, p. 206.

16 Harris, J., *The Value of Life: An Introduction to Medical Ethics*, London: Routledge & Kegan Paul, 1985, pp. 88 ff.

17 Veatch, op. cit., 1989, pp. 204–5.