Chapter 12

Nurse time as a scarce health care resource

Donna Dickenson

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