

Priority Setting and the Ethics of Resource Allocation within VA Healthcare Facilities: Results of a Survey

Mary Beth Foglia, Robert A. Pearlman, Melissa M. Bottrell, Jane K. Altemose, and Ellen Fox

ABSTRACT

Background

Setting priorities and the subsequent allocation of resources is a major ethical issue facing healthcare facilities, including the Veterans Health Administration (VHA), the largest integrated healthcare delivery network in the United States. Yet despite the importance of priority setting and its impact on those who receive and those who provide care, we know relatively little about how clinicians and managers view allocation processes within their facilities.

Purpose

The purpose of this secondary analysis of survey data was to characterize staff members' perceptions regarding

the fairness of healthcare ethics practices related to resource allocation in Veterans Administration (VA) facilities. The specific aim of the study was to compare the responses of clinicians, clinician managers, and non-clinician managers with respect to these survey items.

Methods

We utilized a paper and web-based survey and a cross-sectional design of VHA clinicians and managers. Our sample consisted of a purposive stratified sample of 109 managers and a stratified random sample of 269 clinicians employed 20 or more hours per week in one of four VA medical centers. The four medical centers were participating as field sites selected to test the logistics of administering and reporting results of the IntegratedEthics Staff Survey, an assessment tool aimed at character-

Mary Beth Foglia, PhD, MA, RN, is an Ethicist and Member of the Ethics Evaluation Group at the National Center for Ethics in Health Care (VHA), Department of Veterans Affairs, and Affiliate Faculty in the Department of Medical History and Ethics at the University of Washington, Seattle, marybeth.foglia@va.gov.

Robert A. Pearlman, MD, MPH, is Chief of Ethics Evaluation at the National Center for Ethics in Health Care (VHA).

Melissa M. Bottrell, PhD, MPH, is Acting Chief of IntegratedEthics at the National Center for Ethics in Health Care (VHA).

Jane K. Altemose, MPH, is a Program Director at the Health Services Research and Development (VHA), Department of Veteran Affairs.

Ellen Fox, MD, is the Director of the National Center for Ethics in Health Care (VHA).

izing a broad range of ethical practices within a health-care organization.

Results

In general, clinicians were more critical than clinician managers or non-clinician managers of the institutions' allocation processes and of the impact of resource decisions on patient care. Clinicians commonly reported that they did not (a) understand their facility's decision-making processes, (b) receive explanations from management regarding the reasons behind important allocation decisions, or (b) perceive that they were influential in allocation decisions. In addition, clinicians and managers both perceived that education related to the ethics of resource allocation was insufficient and that their facilities could increase their effectiveness in identifying and resolving ethical problems related to resource allocation.

Conclusion

How well a healthcare facility ensures fairness in the way it allocates its resources across programs and services depends on multiple factors, including awareness by decision makers that setting priorities and allocating resources is a moral enterprise (moral awareness), the availability of a consistent process that includes important stakeholder groups (procedural justice), and concurrence by stakeholders that decisions represent outcomes that fairly balance competing interests and have a positive net effect on the quality of care (distributive justice). In this study, clinicians and managers alike identified the need for improvement in healthcare ethics practices related to resource allocation.

INTRODUCTION

Priority setting and the subsequent allocation of resources is a major ethical issue facing healthcare institutions, including the Veterans Health Administration, the largest integrated healthcare network in the United States. The VHA faces particular challenges in this domain, given its broad mandate to provide for the healthcare needs of veterans, especially low-income veterans and those with service-related disabilities, within a fixed healthcare budget set by Congress. Yet despite the importance of priority setting and its impact on those who receive and those who pro-

vide care, we know relatively little about how clinicians and managers view allocation processes within their institutions. In this article, we discuss results from our field test of the Integrated Ethics Staff Survey, an instrument developed to elicit healthcare professionals' perceptions about ethical practices in healthcare, including those related to allocation processes and decisions.

Priority setting in healthcare is a complicated endeavor, made more so by the diverse values and perspectives of different stakeholders. For example, the continuing move toward managed healthcare has, at times, created seemingly insoluble ethical challenges for managers and clinicians alike. The values underlying managed care are not always easily reconciled with the values and traditions of physicians, nurses, and social workers. While managed care emphasizes cost-effective allocation of resources across a population of patients, clinical decision making is guided by principles of autonomy, beneficence, non-maleficence, and justice within a system that values the decisional autonomy of the individual patient and the professional judgment of the provider.¹ There is clearly common ground between clinical and managerial perspectives (for example, evidence-based care), but bridging these differences in an ethically cohesive manner remains an incomplete and ongoing enterprise.

Priority setting always involves balancing competing values and interests while at the same time recognizing that decisions that provide benefit to one population of patients may result in harm to another significant constituency.² Hence, priority setting is a matter of justice and involves trade-offs that can pose genuine and seemingly intractable ethical dilemmas for decision makers, whether at the level of government (macro-allocation), healthcare organization (meso-allocation), or individual patient (micro-allocation).³ While both clinicians and managers find priority setting ethically challenging, there is some evidence that moral distress arising from the coexistence of managerial and clinical values

is exacerbated for clinicians who are also vested with management responsibilities. For example, a study by Meslin and colleagues found that clinician managers, whether they were physicians or nurses, perceived that their duty to patients was sometimes in conflict with their obligation to control costs or to be a steward of institutional resources.⁴ A study by Sibbald and colleagues found similar conflicts among clinician managers in critical care settings.⁵ Unfortunately, clinician managers may not receive the assistance they require to bridge these distinctive value systems. For example, Lemieux-Charles and colleagues found that clinician managers wanted, but did not have access to, needed ethics expertise.⁶

Our study was designed to address gaps in our knowledge about the degree to which clinicians, clinician managers, and non-clinician managers perceive that the processes needed to fairly allocate resources are available, utilized, and communicated. In addressing these gaps we hope to contribute to improved processes for setting priorities and allocating limited resources at the meso allocation or individual facility level.

METHODS

Study Purpose

The overall purpose of this secondary analysis of survey field test data was to characterize staff members' perceptions regarding the fairness of healthcare ethics practices related to resource allocation within VA medical centers. The specific aim of the study was to describe and compare the responses of clinicians, clinician managers, and non-clinician managers to these survey items. We also explored the influence of available demographic and work-related characteristics on staff's perceptions related to resource allocation.

Study Design and Sample

We utilized a paper and web-based survey and a cross-sectional design of VHA clinicians and managers. Data were collected between August 2003 and July 2004. Our

sample consisted of a purposive stratified sample of 109 managers and a stratified random sample of 269 clinicians employed 20 or more hours per week in one of four participating VA medical centers. Managers were stratified to include representation of both executive and middle management. Clinicians were stratified to ensure representation of nurses, physicians, social workers, and other allied health personnel, as well as to represent major care lines, such as medicine, surgery, mental health, and geriatric extended care. The sample was derived from staff lists provided to us by participating facilities. Before accessing the staff list, the field test plan was reviewed and approved by each facility's leadership and relevant labor unions. In addition, human subjects approval was obtained at two of the field test sites. The institutional review boards at the remaining two sites determined that the staff survey was quality improvement and did not require committee approval to proceed.

The participating medical centers represented a convenience sample that volunteered to field test the survey instrument. All four medical centers were university affiliated teaching facilities, but were geographically dispersed and represented different VHA regional service networks. The facilities were located on the east and west coasts, and south and mid-west regions. Human subjects approval for secondary analysis of field test data was obtained through the Human Subjects Division of the University of Washington and the VHA Research and Development Committee in Seattle.

Study Instrument

The staff survey is an instrument being developed by the National Center for Ethics and Health Care as one component of Integrated-Ethics, a national educational and organizational change initiative designed to establish a standardized, comprehensive, systems-focused model for improving ethics quality in healthcare based on established criteria for performance excellence in healthcare organi-

zations, methods of continuous quality improvement, and proven strategies for organizational change.⁷ The primary objective of the Integrated Ethics Staff Survey is to provide a snapshot of healthcare ethics practices from the perspective of facility staff members across multiple content domains. Prior to field testing, content validity was established and cognitive testing was conducted to ensure concordance between the respondents' interpretation of a survey question and the questions' intended meaning.

The field test version of the survey contained 105 items covering six domains:

- Healthcare ethics environment,
- Shared decision making,
- End-of-life care,
- Privacy and confidentiality,
- Professionalism, and
- Resource allocation.

This version of the survey took about 30 minutes to complete.

The resource allocation domain, on which we focus here, was intended to measure staff members' perceptions of how well their facility demonstrates fairness in allocating resources across programs, services, and patients. At the time of field testing, the resource allocation domain consisted of 15 items (see table 1).

Two items explored staff's perceptions about how well their facility identifies and resolves ethical issues related to

Table 1. Resource Allocation Domain Survey Items

Survey Item	Response Anchors	Points on Scale
Moral awareness		
How often are resource allocation decisions considered <i>business decisions</i> that have little to do with ethics?	Almost never-Almost always	5
How effectively does your facility <i>identify and resolve problems</i> related to resource allocation?	Not at all effective-Very effective	4
Procedural justice		
How often does management <i>communicate the reasoning</i> behind local resource allocation decisions?	Almost never-Almost always	5
How well do you <i>understand</i> your facility's <i>decision-making</i> process for allocating resources?	Not at all well-Very well	4
How <i>influential</i> are <i>clinicians</i> in resource allocation decisions at your facility?	Not at all influential-Very influential	4
How well does your facility <i>educate staff</i> on the ethics of resource allocation?	Not at all well-Very well	4
How well does your facility make allocation decisions that are <i>consistent with its mission</i> and values?	Not at all well-Very well	4
How would you rate your facility on the <i>quality of its process</i> for allocating resources?	Poor-Excellent	5
Distributive justice		
How often do <i>formulary restrictions</i> prevent patients from obtaining the most effective medication?	Almost never-Almost always	5
How often does <i>excessive clinician work load</i> result in substandard care?	Almost never-Almost always	5
How often does <i>replacing more trained staff</i> with less trained staff compromise the quality of patient care?	Almost never-Almost always	5
How often does the focus on <i>conserving resources</i> come at the expense of providing quality patient care?	Almost never-Almost always	5
How often do local resource allocation decisions interfere with your ability to do what is <i>medically best for patients</i> ?	Almost never-Almost always	5
How <i>fairly</i> does your facility <i>allocate resources</i> among programs and services?	Almost never-Almost always	5
Global		
Overall, how well does your facility allocate its resources across programs, services, and patients?	Poor-Excellent	5

resource allocation (moral awareness). Six items explored perceptions about the processes that a facility has in place to promote the fair allocation of resources (procedural justice), and six items explored staff's perceptions about how skillfully their facility balances competing values, obligations, and interests when setting priorities and allocating resources (distributive justice). One item was a global rating question related to how well, all things considered, a facility allocates its resources (for example, fiscal, material, human) across programs, services, and patients. The items included four- and five-point rating questions and five-point frequency questions.

When reporting results to field test facilities, we were careful to emphasize that an "undesirable score" should be treated as a "red flag"—requiring further investigation on a facility's part to determine whether an ethics quality gap actually exists. An *ethics quality gap* is the difference between actual practice and best practice⁸ and is similar to other quality improvement concepts.⁹ For example, managers should communicate the reasoning behind important allocation decisions to stakeholders (best practice), yet we know that actual practice departs from this standard. Hence, the ethics quality gap is the difference between the standard or specification and the actual practice. Essentially, the survey provides facilities with an evidence-based foundation for ethics quality improvement based on the perceptions of a representative sample of facility staff.

Data Collection Methods

Recruitment of participants and distribution of the survey consisted of the following steps. Participants received a packet of materials through interoffice mail from our project staff in an individually addressed envelope. Each survey envelope included a cover letter from a facility's executive director that described the goals and intended outcomes of the project and invited voluntary participation, but emphasized the right of staff to de-

cline participation. The same information was also sent to staff members selected to participate via the VA e-mail system. In addition to these materials, staff members from facilities that pilot tested the web-based version of the survey were given information about how to access the survey online. A second packet of materials was sent approximately two weeks after the initial materials were distributed. In addition to the materials included in the prior mailing, this packet included a copy of the paper survey as well as a pre-addressed return envelope. A second e-mail reminder was sent to staff via the VA e-mail system.

Data Analysis

We received a total of 480 surveys including 378 from clinicians and managers and 102 from clerical and clinical support staff. The analysis reported here is based on the survey responses of clinicians and managers.

Data were entered and analyzed using the Statistical Package for the Social Sciences 12.0.1 for Windows with the statistical significance set at .05 for all comparisons. Our first aim was to characterize staff's perceptions of ethics practices related to resource allocation. Descriptive statistics were calculated for each item in the resource allocation domain in order to establish overall response distributions. A second aim was to explore the relationship between the respondents' primary job function (that is, clinician, clinician manager, non-clinician manager) and their responses to survey items. One-way analysis of variance (ANOVA) and *post hoc* tests were used to establish which group(s) differed significantly from one another on a particular response. We applied the Scheffe *post hoc* test to significant findings unless the assumption of equal variances was violated (that is, Scheffe is recommended when group sizes vary). In cases of unequal variance, we applied the Dunnett C *post hoc* test. Both of these tests are conservative and reduce the prospect of Type 1 errors.

A final aim was to examine the relationship between available respondents' demo-

graphic and work-related characteristics and their responses to survey items. One-way analysis of variance and *post hoc* tests were used to explore differences in responses that were based on the type of clinician (that is, physician, registered nurse/advance practice registered nurse, and allied health), practice setting (that is, inpatient, outpatient, and extended care), and primary service line (for example, medicine, surgery, mental health, geriatrics). An independent *t*-test was used to explore whether significant differences existed between genders or across length of time employed at present facility (that is, less than 10 years, 10 years or more).

RESULTS

Response Rate

The survey response rate across the four participating sites was 45 percent. The response rate at individual facilities ranged from a low of 28 percent to a high of 61 percent. Response data were only available across categories of respondents and not for specific groups (for example, clinicians, clerical).

Sample Characteristics

Sample characteristics for this study are summarized in table 2. Nearly 65 percent of the respondents were employed at their present VA facility for six or more years. Of these, more than half were employed at their present facility for more than 10 years. The vast majority of the respondents worked day shift during the week and all of the study respondents worked half-time or more. Nearly two-thirds of study respondents were female.

Managers represented nearly one-quarter of the sample. Of the 109 responding managers, more than three-quarters of these were clinician managers. Of those respondents with a clinical background (including clinician managers), almost one-half were registered nurses or advance practice nurses, one-quarter were physicians, and 15 percent were social workers. Of those respondents with direct patient care responsibilities, about half

Table 2. Descriptive Statistics of Sample Characteristics

Characteristic	<i>n</i>	%
Years employed at present facility (<i>N</i> = 369)		
Less than 1 year	40	10.8
1-3 years	59	16.0
4-5 years	31	8.4
6-10 years	49	13.3
More than 10 years	190	51.5
Shift worked (<i>N</i> = 368)		
Day shift during the week	333	90.5
Evening shift during the week	11	3.0
Night shift during the week	12	3.3
Other	12	3.3
Gender (<i>N</i> = 358)		
Female	229	64.0
Male	129	36.0
Primary job function (<i>N</i> = 370)		
Clinical	255	68.9
Manager	83	22.4
Researcher	22	5.9
Other	10	2.7
Management type (<i>N</i> = 109)		
Clinical manager	86	78.9
Non-clinician manager	23	21.1
Clinician type (<i>N</i> = 354)		
ARNP	31	8.8
Physician	90	25.4
RN	126	35.6
Social worker	53	15.0
Therapist (e.g., OT, PT)	23	6.5
Other	30	8.8
Practice setting (<i>N</i> = 353)		
Extended care	26	7.4
Inpatient	136	38.5
Outpatient	174	49.3
Other	17	4.8
Primary service line (<i>N</i> = 356)		
Administration	4	1.1
Geriatrics	72	20.2
Medicine	129	36.2
Mental health	79	22.2
Surgical	29	8.1
Other	43	12.1

Note: *N* equals the number of subjects who answered the particular demographic item.

worked in outpatient settings including the emergency department, 39 percent worked in inpatient settings including critical care, and 7 percent of the respondents practiced in extended care settings such as in a nursing home or in home care. Medicine was the primary service line for 36 percent of the sample respondents, followed by mental health (22 percent), geriatrics (20 percent), and surgical services (8 percent).

Overall Response Distribution

The overall response distribution of the sample is summarized in table 3.

Moral Awareness

Two items elicited staff's perceptions regarding how well their facility identifies and resolves ethical issues surrounding the allocation of resources. More than 40 percent of the respondents reported that allocation decisions are "Usually" or "Almost always" (that is, 1 or 2 on a 5-point scale in which 1 equals "Almost never") made as if they are solely business decisions that have little to do with ethics. More than half of the respondents reported that their facility is "Not at all effective" or "Not very effective" in identifying and resolving ethical problems related to resource allocation.

Resource Allocation Processes:

Procedural Justice

Six survey items elicited staff's perceptions regarding the processes that their facility has in place to promote the fair allocation of resources. Only a small minority of the respondents reported that they understood their facility's decision-making process for allocating resources "Very well," and nearly three-quarters reported that their facility educates staff about the ethics of resource allocation "Not very well" or "Not at all well." In addition, more than half of the respondents reported that clinicians were "Not at all influential" or "Not very influential" in resource allocation decisions. Further, only one-quarter of the respondents reported that management "Usually" or "Almost always" commu-

nicates the reasoning behind allocation decisions. A majority of the respondents reported that the quality of their facility's process for allocating resources was only "Fair" or "Poor." However, almost three-quarters of the respondents reported that their facility did "Moderately well" or "Very well" in making allocation decisions that are consistent with its mission and values.

Resource Allocation Outcomes:

Distributive Justice

Six survey items elicited staff's perceptions regarding how skillfully their facility balances competing values, obligations, and interests to achieve a fair allocation of resources. Less than one-third of the respondents reported that the focus on conserving resources "Usually" or "Almost always" came at the expense of providing quality patient care, and only 14 percent of the respondents reported that allocation decisions "Usually" or "Almost always" interfered with their ability to do what is medically best for patients. Yet, more than one-third of the respondents reported that "Half of the time" or more, replacing more trained staff with less trained staff compromised the quality of patient care. Finally, a significant majority of the respondents reported that their facility is "Moderately fair" or "Very fair" in its allocation of resources across programs and services.

Global Item

Less than 20 percent of the respondents reported that their facility does a "Very good" or "Excellent" job in allocating its resources across programs, services, or patients.

Comparison among Clinicians, Clinician Managers, and Non-Clinician Managers

Further data analysis was conducted to explore the impact of job function on perceptions of ethics practices related to resource allocation. The respondents were classified by primary job function into three groups: clinician, clinician manager, and non-clinician manager. ANOVA results for group comparisons are summarized in table 4.

Table 3. Overall Response Distribution

Survey Item	Response Categories	Distribution	
		<i>n</i>	%
Moral awareness			
Business decision	Almost never	53	18.6
	Sometimes	90	32.3
	About half the time	23	8.2
	Usually	69	24.7
	Almost always	45	16.1
Identify and resolve problems	Not at all well	32	15.1
	Not very well	82	38.7
	Moderately well	77	36.3
	Very well	21	9.0
Procedural justice			
Communicate reasoning	Almost never	107	31.7
	Sometimes	118	34.9
	About half the time	26	7.7
	Usually	68	20.1
	Almost always	19	5.6
Understand decision-making process	Not at all well	87	24.6
	Not very well	119	33.7
	Moderately well	115	32.6
	Very well	32	9.1
Influential clinicians	Not at all influential	55	19.5
	Not very influential	105	37.2
	Moderately influential	95	33.7
	Very influential	27	9.6
Educate staff	Not at all well	85	28.2
	Not very well	129	42.9
	Moderately well	69	22.9
	Very well	18	6.0
Decisions consistent with its mission	Not at all well	14	5.2
	Not very well	69	25.7
	Moderately well	148	55.2
	Very well	37	13.8
Quality of process	Poor	69	25.7
	Fair	86	32.0
	Good	71	26.4
	Very good	32	11.9
	Excellent	11	4.1

(Continued next page)

Table 3. Continued

Survey Item	Response Categories	Distribution	
		<i>n</i>	%
Distributive Justice			
Formulary restrictions	Almost never	78	26.3
	Sometimes	172	57.9
	About half the time	20	6.7
	Usually	17	5.7
	Almost always	10	3.4
Excessive clinician work load	Almost never	84	24.1
	Sometimes	194	55.6
	About half the time	18	5.2
	Usually	30	8.6
	Almost always	23	6.6
Replacing more trained staff	Almost never	84	24.1
	Sometimes	138	41.3
	About half the time	12	3.6
	Usually	51	15.3
	Almost always	66	19.8
Conserving resources expense quality	Almost never	68	19.3
	Sometimes	168	47.7
	About half the time	27	7.7
	Usually	48	13.6
	Almost always	41	11.6
Interfere medically best for patients	Almost never	79	23.1
	Sometimes	189	55.3
	About half the time	26	7.3
	Usually	23	6.7
	Almost always	25	7.3
Fairly allocate resources	Not at all fairly	24	9.7
	Not very fairly	71	28.6
	Moderately fairly	122	49.2
	Very fairly	31	12.5
	Global		
Allocate across services, patients	Poor	53	18.9
	Fair	95	33.8
	Good	82	29.2
	Very good	39	13.9
	Excellent	12	4.3

Note: the total number of responses per item varies depending on number of respondents who either answered “don’t know” or left the question blank.

Moral Awareness

There were significant differences among groups for one of the two moral awareness items. Clinicians were more likely than clinician managers to report that allocation decisions were made solely as if they were business decisions with little to do with ethics. There were no group differences related to how effectively a facility identifies and resolves ethical problems related to resource allocation.

**Resource Allocation Process:
Procedural Justice**

There were significant group differences for five out of six items related to a facility's processes for allocating resources. Clinicians were less likely than clinician managers to report that management communicated the reasoning behind allocation decisions. Clinicians were also less likely than other respondents to understand their facility's resource allocation process, to report that they were in-

Table 4. ANOVA Comparisons: Clinicians, Clinician Managers, and Non-Clinician Managers

Survey Item	df	F	p-value	Group Differences	
				Groups*	p-value
Moral awareness					
Business decisions	2,251	4.62	.01	C-CM	.01
Identify and resolve problems	2,187	2.84	.06	--	--
Resource allocation process					
Communicate reasoning	2,298	4.74	.009	C-CM	.02
Understand decision-making process	2,312	8.68	.001	C-CM	.004
				C-NCM	.012
Influential clinicians	2,249	11.97	.001	C-CM	.002
				C-NCM	.001
Educate staff	2,269	2.06	.130	--	--
Decisions consistent with its mission	2,235	6.77	.001	C-CM	.05
				C-NCM	.05
Quality of process	2,238	4.85	.009	C-CM	.05
Resource allocation outcomes					
Formulary restrictions	2,261	6.73	.001	C-CM	.02
				C-NCM	.02
Excessive clinician work load	2,309	8.20	.001	C-CM	.05
				C-NCM	.05
Replacing more trained staff	2,293	12.35	.001	C-CM	.05
				C-NCM	.05
Conserving resources expense quality	2,310	8.25	.001	C-CM	.05
				C-NCM	.05
Interfere medically best for patients	2,305	8.33	.001	C-CM	.05
				C-NCM	.05
Fairly allocate resources	2,216	9.66	.001	C-CM	.05
				C-NCM	.05
Global					
Allocate across services, patients	2,247	5.92	.003	C-CM	.05
				C-NCM	.02

*Note. C represents clinicians; CM represents clinician managers; and NCM represents non-clinician managers.

fluent in resource allocation decisions, and to report that allocation decisions were consistent with the institution's mission and values. Finally, clinicians had a less favorable perception than clinician managers of the overall quality of the allocation process. There were no significant group differences with respect to how well a facility educates staff relative to the ethics of resource allocation. Overall, clinicians' responses suggest that they viewed facility allocation processes less favorably than either clinician managers or non-clinician managers did.

Outcome of Allocation Decisions: Distributive Justice

There were group differences for all six questions related to how well an institution balances competing obligations as reflected by the perceived outcome or impact of allocation decisions on care delivery. Clinicians were more likely than either clinician managers or non-clinician managers to report that formulary restrictions prevent patients from obtaining the most effective medications and that replacing highly trained staff with less trained staff (skill mix) compromises quality and that excessive clinician work load results in substandard care. Notably clinician managers, similar to clinicians, were more likely than non-clinician managers to report that excess work load compromises the quality of care.

Clinicians were more likely than other respondents to report that allocation decisions interfere with their ability to do what is medically best for their patients, and that their facility's emphasis on conserving resources comes at the expense of quality patient care. Clinicians also reported that their facility's resources are less fairly allocated than did clinician managers and non-clinician managers. Overall, clinicians seemed more likely than other respondents to perceive that allocation decisions negatively affect clinical practice.

Global Item

Overall, clinicians reported that their facility does less well, in total, in allocating its

resources across programs, services, and patients than non-clinician managers did.

Demographic and Work-Related Characteristics

Differences were also explored for available demographic and work-related characteristics, but no significant group differences were found based on gender, clinician type (physician, registered nurse or advance practice registered nurse, and allied health), number of years employed at present facility, practice setting (inpatient, outpatient, extended and community care), or primary service line (medicine, surgery, geriatrics, mental health).

DISCUSSION

This study examined healthcare ethics practices related to resource allocation in VA medical centers from the perspective of clinicians, clinician managers, and non-clinician managers. Five findings are noteworthy.

First, the responses of clinician managers were, with few exceptions, statistically indistinguishable from non-clinician managers, but varied significantly from clinicians' responses. Although clinician managers may be in an ideal position by virtue of their experience as clinicians *and* managers to assist clinicians and non-clinician managers in balancing the interests of individual patients with the duty to maximize benefits across patients,¹⁰ our data suggests that when clinicians become managers, they largely adopt the perspectives and attitudes of managers when it comes to the allocation of resources. This suggests that clinician managers need to ensure that they remain sensitive to the concerns expressed by clinicians and especially sensitive to concerns about the effect of allocation decisions on the care of patients.

Second, clinicians were more critical than clinician managers or non-clinician managers of an institutions' allocation processes and of the impact of resource decisions on the care of patients. There are at least three explanations for this gap. One explanation is that this

finding reflects the general understanding in the business ethics literature that staff's perceptions of organizations' ethical practices are often "rosier at the top."¹¹ As a result, leaders who wish to foster an ethical environment should seek out staff's perspectives on ethics practices within their organizations in order to identify and address problematic practice.¹² Another explanation for why clinicians' responses varied from managers is that the values and processes that inform priority setting in a facility may be largely invisible to clinicians. This is supported by our finding that clinicians did not perceive themselves to be influential in allocation decisions and were less likely than either clinician managers or non-clinician managers to understand their facility's decision-making processes or to report that the reasoning behind important allocation decisions was explained to them. Another potential explanation for this finding is that clinicians are more likely to be attuned to patient needs and the effects of problematic allocation decisions than managers are.

The third finding of interest is that clinicians were less likely than managers to report that resources were allocated *fairly* among programs and services. This has implications for facility leadership, because the organizational justice literature suggests that procedural (processes), distributive (outcomes), and interactional (communication) elements each contribute uniquely to the creation of a "fairness perception" among employees, and that there are important economic consequences associated with these perceptions.¹³ When employees have a favorable perception of organizational fairness, they are more satisfied,¹⁴ less likely to be absent or leave an organization,¹⁵ have an increased commitment to an organization's goals,¹⁶ have more trust in decision makers,¹⁷ give more positive ratings of supervisors and managers,¹⁸ show more organizational citizenship behavior,¹⁹ and engage in less theft and other forms of retaliatory behavior towards the organization.²⁰ Overall, our findings underscore the importance of ethical leadership practices in the institution.

They suggest that the greatest opportunity for leaders to influence "fairness perception" by their staff is by developing more inclusive allocation processes (procedural justice) and communicating the reasoning behind important institutional decisions (interactional justice). By actively seeking clinicians' input and meaningfully integrating it into decision making, and by explaining the rationale behind their decisions, leaders can help ensure that clinicians understand the decision-making process and are therefore less likely to perceive decision-making practices as ethically problematic.

Fourth, a negative finding is that there were no differences found among physicians, nurses, and other allied health personnel with respect to perceptions about allocation practices. Despite differences in their roles in patient care, their institutional responsibilities, and influence within the care delivery system, doctors, nurses, and other direct caregivers, such as social workers, may have more in common with each other than with clinician managers with whom they share a common clinical background. One implication of this finding is that when leaders seek stakeholders' input, they should probably not depend solely on clinician managers to represent clinicians' perspectives on priority setting, but rather should include frontline clinicians as a distinct group of stakeholders. This may be one tactic to help ensure that clinicians perceive themselves to have greater influence in decisions that affect the delivery of care to patients.

Finally, in this study, a plurality of clinicians and managers perceived that their institution was ineffective in identifying and then resolving ethical problems related to resource allocation, and fully two-thirds of the respondents perceived that education related to allocation is inadequate. Awareness of a problem precedes systematic improvement, and this survey offers one way for organizations to obtain this crucial awareness.

This study has several important limitations. First, the data were collected as part of field testing of the Integrated Ethics Staff Sur-

vey. Therefore, psychometric properties such as reliability had not been established and no item reduction had occurred. As a result of field testing, six of the original 15 resource allocation items were revised or dropped from the final version of the survey. However, the majority of dropped items were highly inter-correlated with the questions included in the final survey. Second, the study was conducted in VA settings and may not be generalizable beyond the VA. In addition, the field test sites were not randomly selected and therefore may not be generalizable across VA facilities. However, sites were geographically diverse and varied in size and complexity. Third, data collection methods varied at the different field test sites. Two sites collected data through paper surveys only, while two facilities collected data through a web-based survey as well as a paper survey. The use of different data collection methods could have introduced bias into the sample, but was essential to testing the effect of the survey distribution method on response rates prior to rolling out the survey nationally within VHA. Multiple data collection methods are commonly used in other research studies due to the emergence of web access and early evidence suggesting that response rates are positively affected by offering the respondents paper and web-based options. Finally, the small numbers in some categories, such as non-clinician managers or weekend and night-shift employees, may have weakened the representativeness of the sample. However, the purpose of this field test was to assess the feasibility of the implementation methods and to examine instrument psychometrics. While a more representative sample would be ideal, the sample reported here was sufficient in size and geographic distribution to allow initial instrument development.

In conclusion, how well a healthcare facility ensures fairness in the way it allocates its resources across programs and services depends on multiple factors, including awareness by decision makers that setting priorities and allocating resources is a moral enterprise (moral awareness), the availability of a

consistent process that includes important stakeholder groups (procedural justice), and concurrence by stakeholders that decisions represent outcomes that fairly balance competing interests and have a positive net effect on the quality of care (distributive justice). In this study, clinicians and managers identified the need for improvement in ethical practices related to resource allocation in healthcare.

DISCLAIMERS

The opinions expressed in this article are those of the authors and do not reflect the views of the National Center for Ethics in Health Care, the Veterans Health Administration, or the Department of Veterans Affairs.

NOTES

1. Emanuel, E. J. (2002). Patient v. population: resolving the ethical dilemmas posed by treating patients as members of populations. In *Ethical Dimensions of Health Policy*, Edited by Marion Danis, Carolyn Clancy, and Larry Churchill. Oxford: Oxford University Press. Morreim, E.H. (1991). *Balancing act: The new medical ethics of medicine's new economics*. Boston: Kluwer Academic Publishers.
2. Kilner, J. F. (2004). Health Care Resource Allocation: Macroallocation and Micro-allocation. In *The Encyclopedia of Bioethics*, Third Edition. (Vol. 2, pp. 1098-1115). New York: Macmillan-Reference.
3. Gilmartin, M. J., Freeman, R. E. (2002). Business Ethics and health care: A stakeholder perspective. *Health Care Management Review*, 27, (2), 52-65.
4. Meslin, E. M., Lemieux-Charles, L., Wortely, J. T. (1997). An ethics framework for assisting clinician-managers in resource allocation decision making. *Hospital and Health Services Administration*, 42, (1), 33-48.
5. Sibbald, R. W., Lazar, N. M. (2005). Bench-to-bedside review: ethical challenges for those in directing roles in critical care units. *Critical Care*, 9, (1) 76-80.
6. Lemieux-Charles, L., Hall, M. (1997).

When resources are scarce: The impact of three organizational practices on clinician-managers. *Health Care Management Review*, 22, (1), 58-69. Lemieux-Charles, L., Meslin, E. M., Aird, C., Baker, R., Leatt, P. (1983). Ethical issues faced by clinician/managers in resource allocation decisions. *Hospital and Health Services Administration*, 38, 2, (Summer), 267-285.

7. Fox, E. (2007). IntegratedEthics: Improving Ethics Quality in Health Care. www.ethics.va.gov/IntegratedEthics.

8. Fox, E., Bottrell, M., Foglia, MB., Chanko, B. L., Stoeckle, R. (2007). Preventive ethics: Addressing Health Care Ethics Quality Gaps on a Systems Level. www.ethics.va.gov/IntegratedEthics.

9. Deming, W.E. (1986). *Out of the crisis*. Cambridge, Mass.: MIT Press; Donabedian, A. (2003). *An introduction to quality assurance in health care*. Oxford: Oxford University Press.

10. Meslin, E. M., Lemieux-Charles, L., Wortely, J. T. (1997). An ethics framework for assisting clinician-managers in resource allocation decision making. *Hospital and Health Services Administration*, 42, (1), 33-48; Lemieux-Charles, L., Hall, M. (1997). When resources are scarce: The impact of three organizational practices on clinician-managers. *Health Care Management Review*, 22, (1), 58-69.

11. Sauser, W. I., Sims, R. R. (2006) Fostering an Ethical Culture. In R. Sims (Ed.) *Human Resource Management: Contemporary Issues, Challenges and Opportunities*. (p. 266). Information Age Publishing.

12. Fox, E., Crigger, B., Bottrell, M., Bauck, P. (2007). Ethical Leadership: Fostering an Ethical Environment and Culture. www.ethics.va.gov/IntegratedEthics.

13. Colquitt, J. A., Conlon, D. E., Wesson, M. J., Porter, C., Yee, Ng K. (2001). Justice at the millennium: A meta-analytic review of 25 years of organizational justice research. *Journal of Applied Psychology*, 8, (3), 425-445.

14. Mossholder, K. W., Bennett, N., Martin, C. L. (1998). A multilevel analysis of pro-

cedural justice context. *Journal of Organizational Behavior*, 19, 131-141.

15. Dailey, R. C., Kirk, D. J. (1992). "Distributive and procedural justice as antecedents of job dissatisfaction and intent to turnover." *Human Relations* 45:305-317; Bischoff, S. J., DeTienne, K. B., Quick, B. (2000). Effects of ethics stress on employee burnout and fatigue: An empirical investigation. *J Clin Ethics*, 21, (4), 512-532.

16. Ball, G. A., Trevino, L. K., Sims, H. P. (1994). Just and unjust punishment: influences on subordinate performance and citizenship. *Academy of Management Journal*, 37, 299-322.

17. Konovsky, M. A., Pugh, S. D. (1994). Citizenship behavior and social exchange. *Academy of Management Journal*, 37, 656-669.

18. Ball, G. A., Treviño, L. K., Sims, H. P. (1993). Justice and organizational punishment: attitudinal outcomes of disciplinary events. *Social Justice Research*, 6, 39-67.

19. Skarlicki, D. P., Latham, G. P. (1996). Increasing citizenship behavior within a labor union: a test of organizational justice theory. *Journal of Applied Psychology*, 81, 161-169.

20. Skarlicki, D. P., Folger, R. (1997). Retaliation in the workplace: the role of distributive, procedural, and interactional justice. *Journal of Applied Psychology*, 82, 434-443.