

Paper IV

**Priority setting in health care:
A framework for reasonable clinical judgments**

Accepted for publication in Journal of Medical Ethics

PRIORITY SETTING IN HEALTH CARE: A FRAMEWORK FOR REASONABLE CLINICAL JUDGMENTS

Abstract:

What are the criteria for reasonable clinical judgments? The reasonableness of macro-level decision making has been much discussed but little attention has been paid to the reasonableness of applying macro-level generated guidelines to individual cases. In this paper, I consider a framework for reasonable clinical decision making that will capture cases where relevant guidelines cannot reasonably be followed. This paper is organised into three main sections: 1) I analyse individual claims on health care from the point of view of concerns about equity. 2) I discuss the demands of responsibility and equity on professional, clinical performance and explore how the combination of these demands emerges into seven requirements which constitute the framework. Since this framework is developed to assist in reasonable clinical decision making I also suggest practical implications of all these requirements. 3) I discuss challenges concerning the framework. First, I consider a crucial presumption the framework relies upon, namely clinicians' willingness to justify their decisions as requested. Second, I discuss how public deliberation may influence clinical decision-making. Third, I consider how clinicians' need for having confidence in their own judgments in order to perform in a manner worthy of trust, would be compatible with adherence to the framework supported by public deliberation. I conclude that fair distribution in the interplay between macro- and micro-level considerations can be secured by legitimising procedures on each level, well organised and continuing public debate and individual clinical judgments based upon well justified and principled normative bases.

INTRODUCTION

It is well acknowledged that health care resources are limited while aggregated health care needs seem limitless. This imbalance necessitates difficult health care priority setting at every level of decision making within the organised health care service. Because of technological progress and new treatment possibilities, there is no reason to believe this imbalance will be any easier to deal with in the future. Various approaches have been taken to face this

challenge justly. Søren Holm has shown how the development in the Scandinavian welfare-state countries can serve to clarify different strategies for how to approach priority setting justly throughout publicly managed health care systems.[1-5] The development so far has been described as divided into two phases. When priority setting first entered the political agenda the focus was the outcome of the priority setting decisions. Just distribution was sought by regulating health care decisions by applying the correct priority setting-system of principles to secure rational assessments. This strategy turned out to be flawed. The principles were too general to be implemented consistently throughout the system. In Norway, for instance, it was thought that the degree of “severity of the condition” would be enough to settle the priority decision.[1, 6] But the concept of severity is multifaceted and it did not allow for a clear distinction between acceptable and not acceptable priorities. Instead it left room for ‘discretionary considerations’ to be manoeuvred strategically within the financial system.[5] The second phase, according to Holm, is characterised by a focus on the process leading towards just solutions, rather than the presumed rational outcome of the decisions. The procedural approach clarified how the decision making processes ought to progress, stressing the importance of transparency and accountability. This shift in thinking about priority setting is supported by the work of Daniels and Sabin.[7, 8] Fair priority setting is attempted in accordance with the framework of “Accountability for Reasonableness”. This framework emphasises four requirements considered necessary for the legitimate outcome of priority assessments: “*transparency about the grounds for decisions; appeals to rationales that all can accept as relevant in meeting health care needs fairly; and procedures for revising decisions in the light of challenges to them.*”[7] In addition there must be either voluntary or public regulation of the process to ensure that the conditions above are met.[8] When priority setting is regulated this way, it might legitimise the outcome of macro- and meso- level decisions of how to distribute resources between patients groups. A procedural approach to distribution has also indirectly found its way into the micro-level where clinical decisions about individual claims on health care resources are made. The development of evidence based clinical guidelines can be seen to rely on normative considerations which should not be presented as a “technical fix”.[9-12] That is, such assessments should not be hidden behind terms of scientific evidence if health care is to be distributed justly. Rather, the rationale behind these practical tools can, and should, be subject to accountability. A framework has been provided for considering the acceptability of the process of developing evidence based guidelines as well as the guideline itself as a tool for priority setting.[13-14]

At the micro-level, new challenges arise. Assuming that fair clinical guidelines are developed, these guidelines cannot be formulated specifically enough to cover every possible reason for justifying an individual claim to health care. Individual needs expose complexity and uncertainty with regard to clinical findings, progression of illness and responsiveness to treatment.[15] Also, if we accept that a concept of health might include subjective experiences of well-being, then individual health care needs might also be affected by how a patient functions in work, social settings and everyday life and their socioeconomic conditions when these are seen to affect the patient's health. A patient's anxiety might constitute a need to see a specialist even though the referral is not supported by physiological findings. A patient's social working environment might influence her functioning and well-being and thereby be a reason for sick leave. It will not be possible to capture all these personal variations in one rule. This goes for evidence based guidelines as well. In cases of preventive treatment for cardiovascular diseases, for instance, there might be reasons against providing publically funded treatment to individuals who are not prepared to take responsibility for their own health when a change of lifestyle is required. However, there might be reasons why it is difficult for an individual to change his lifestyle, i.e., because of income and living conditions. Various reasons might justify different interpretations of what health care is needed in individual cases. We cannot expect all reasons or constellations of reasons to coincide with the reasons considered during the development of the guideline. Moreover, we can argue that decision making at macro- and micro-level is carried out in different contexts of legitimacy because of the different sets of reasons to be considered. [Bærøe, submitted paper] If we accept this, it follows that adherence to a legitimate guideline does not necessarily lead to a legitimate clinical decision on what kind of service to provide. To secure just distribution of health care we need both to develop legitimate guidelines and to rely upon clinical discretion in judging the appropriateness of guidelines in each case. The question then arises: What criteria of legitimacy does the clinician's discretion need to satisfy?

Clinical guidelines are generally specific about what the physician should do in certain situations, but the clinician still has to judge whether each case actually falls within the scope of the guideline or whether a different course of action is justified. Although this is the level where the actual distribution of health care normally takes place, surprisingly little attention has been paid to exactly what comprises just or unjust adherence to guidelines. In this paper, I will try to provide a framework for reasonable clinical decisions. If we are aiming at just

health care, a framework of this type may be considered a necessary supplement to macro-level procedures for fair priority setting.

This paper is organised into three main sections: 1) I analyse individual needs and claims on health care from the point of view of concerns about equity. 2) I discuss the demands of responsibility and equity on professional, clinical performance and explore how the combination of these demands emerges into seven requirements which constitute a framework. Since this framework is developed to assist in reasonable clinical decision making I also suggest practical implications of all the requirements. 3) I discuss challenges concerning the framework. First, I consider a crucial presumption the framework relies upon, namely clinicians' willingness to justify their decisions as requested. Second, I discuss how public deliberation could influence clinical decision-making. Third, I argue that the clinicians' need for having confidence in their own judgments in order to perform in a trustworthy manner towards their patients, would be compatible with adherence to the framework supported by public deliberation.

INDIVIDUAL CLAIM ON HEALTH CARE

Health care need can be seen as the pairing of a given condition and an intervention that reduces or eliminates this condition.[16] This description of 'health care need' should not be confused with what a given system or individual finds appropriate to provide or receive as a claim on health care. Specifically, Hasman et. al state, it should not be seen to include any considerations of costs. According to their view, the gap between 'health care need' and 'claim on health care' is filled by specific normative considerations which justify the claim put forward. This distinction between a health care need and a health care claim probably works best when needs are clearly identified in terms of some specific condition and the claim is satisfied by a well-documented intervention. Such cases are suitable for explicitly deliberated priority setting, considered alone or in comparison with other needs. The definition also presupposes that both the condition and the appropriate intervention have to be determined for there to be a need at all. At the clinical level, because of the uncertainty about what is actually needed, the health care provided is about diagnosing actual conditions and testing for appropriate interventions. This process of trying, failing and succeeding, that is the process of uncovering the actual need, does also represent a need for health care. However, this need for health care cannot be considered exclusively in terms of condition-intervention pairing since the whole process hinges upon which conditions the clinician chooses to rule out

or confirm and which order he approaches them in. This kind of health care need diffuses into what clinicians consider appropriate to provide, i.e. claim, at a given time. So the distinction between 'health care need' and 'claim on health care' suggested by Hasman et. al. is not sufficient to cover the whole domain of clinical decision-making. It also follows that when conditions are undetermined cost considerations might well be involved in trying to identify the condition-intervention pair and should thereby be seen as more directly connected to what there is a *need* for than Hasman et. al. allow for. In the following, I circumvent the distinction between 'need' and 'claim' as I presuppose that the claims the clinicians are willing to put forward in a publicly (or partly publicly) funded health care system, should serve as a point of departure for an analysis of equitable health care distribution at the micro-level.

Every time a claim on health care is made, the claim suggests an answer to the question: Who should get what, when? The process of identifying claims can be seen to hide issues of priority setting as the identification process in itself cannot be neutral as regards value-dependent considerations. We need to consider how clinicians can interpret individual claims on health care, also in indeterminate conditions, while remaining accountable for just distribution of resources. I see this as a two-step process of identification and assessment, although these steps may coincide in real-time. [Bærøe, submitted paper] As the first step, different kinds of reasons that might constitute a claim should be identified. The list is not necessarily exhaustive, but the reasons might be listed as emerging out of:

- i) Medical considerations of the patient's actual state of health drawn from examination of the patient
- ii) Considerations about what kind of health services it is actually possible to provide and the availability and cost of those services
- iii) Considerations of what kind of service is recommended as appropriate for this type of patient
- iv) Contingent, context- and patient-related considerations (including patient's preference) which would strengthen or weaken the claim for a particular service

The reasons for justification offered in (1)-(3) would be modified by the knowledge that every professionally educated clinician should, in theory, have, while the reasons in (4) depend on the clinician's discretionary interpretation of relevant aspects of the patient's situation. Contingent, context- and patient-related considerations might result in relevant reasons that

can be roughly divided into four different groups. First, because of the complexity of a patient's medical condition, there might be scientifically justified reasons in a particular case for a certain course of action which goes against the recommendations in apparently relevant guidelines. Second, there may be aspects of a patient's situation which do not concern the actual health state, but which may constitute reasons for what to offer as regard the prospects of recovery. For instance, will the patient get enough rest if he is sent home just after surgery? Third, the patient might be in a particular situation of disadvantage, for example, socioeconomic conditions which affect his or her health condition or prospects of recovery. In considering such facts, the clinician may find reasons to make advantageous exceptions for the patient. Fourth, the patient's preference for a particular intervention might constitute a reason to claim a particular course of action.

In the second step of identifying a health care claim, different reasons emerging out of (1)-(4) are weighed relatively to each other. Out of this process comes what the clinician considers appropriate reasons for dealing with the patient's health condition. Even though there are standards such as best evidence and collegial consensus which might support reasons for providing a certain treatment, these reasons only represent different perspectives on a given case and might be outweighed by other concerns in the all-things-considered perspective of the interpreter. When resources are limited, the balancing, all-things-considered perspective on what service to provide should be seen as an issue of equity, making all the reasons that are included in justifying the course of action, reasons of equity. If we accept that a health care claim may involve all the kinds of considerations presented in (1)-(4), how will we know what reasons underlie the equitable decision from case to case? To provide an answer to this question we need to say a bit more about the second step of determining a health care claim.

Normative basis

Ideally, the process of weighting different concerns in the second step of identifying a health care claim is supported by the deliberator's concepts of what appropriate health care is. More precisely, I take such concepts to represent a normative basis that might justify the reasons supporting the claims. Furthermore, I consider this ideal basis to consist of two components. First there should be a concept of the goal of health care. This concept must be modified for clinical decision-making and should be seen as a sub-goal of the more complex and multifaceted goal for health care in general.[5, 17] For instance, the idea that health care concerns human well-being supports a wider range of reasons than the narrower view that

only the treatment of well-defined diseases is the goal of health care. Second, there should be principles of distributive justice indicating the relevant, general characteristics (if any) of those receiving the health care. For example, one could follow an egalitarian view that distribution should advantage those worst-off.[18-20] A justification based on such a view could offer reasons that discriminate between what to offer two patients with the same diagnosis but a different capacity to make the required lifestyle changes. Or, such reasons might be ignored by an interpreter, for instance if holding the view that distribution should be based upon equal distribution of resources and not welfare.[21] A normative basis consisting of a general goal of health care and principles for distributive justice imposes structure on the weighting process and will explain the adequacy of the all-things-considered judgment from the clinician's own perspective. It will also explain why some reasons in a given context appear important to one interpreter, while another, who bases his or her judgment on a different normative basis, will consider other reasons to be most important. However, internal conflicts between different important reasons might occur even from the point of view of a single interpreter. These conflicts must be sought solved by reference to principles or theories outside this limited normative basis. In short, if we adopt the idea that each interpreter strives for a coherent system of justification, we can imagine the interpreter moving back- and forth between context- and patient-related reasons, the normative basis of health care aim and distributive principles and more general justifying principles outside the basis.[22-23] Conflicting reasons in particular cases might then lead to revision of the original normative basis for decision-making in light of 'external' theories and principles, and apparently relevant reasons might be rejected or confirmed.

In practice, health care authorities might try to manoeuvre the weighting process of adequacy in certain directions by incentives which reward the desired outcome. I take it as read that the ideal just health care provision should be established without any ad hoc incentives replacing what should be the decision-maker's direct concern for equity. So, in the following I will explore equitable claims on health care against the background of what has been presented here in terms of an ideal interpreter.

THE FRAMEWORK

Before I present the framework, we must first consider the formal conditions that create the structure for equitable claims on health care.

The double responsibility of the clinician

Considering the idea of a social contract between society and the professions may shed some light on how clinicians work.[24] The medical profession is given the possibility to perform specialised body of knowledge and skills in society, while the public at large expects physicians in return to act in a manner worthy of trust.[25, 26] This means that the profession in general should not only secure treatment of high quality according to individual needs, but also to see that resources are distributed justly which includes spending resources effectively. In general terms, we can say that physicians should be accountable not only to their individual patients, but to society at large. Clinicians, therefore, have two distinct functions of responsibility to fulfil in their professional performance. On the one hand, clinicians should be considered responsible for their actions towards their individual patients. On the other hand, the clinicians share the responsibility for the collective performance of the profession towards the whole society of actual and potential patients. The collective responsibility of the clinicians can also be specified more according to the speciality they represent, the organisation they work in and so forth. For our purpose, however, the distinction between responsibility towards the individual and towards the collective in general will suffice. We will now consider how formal demands of equality impose structure on individual equity considerations when professionals have to choose whether or not to adhere to clinical guidelines.

Horizontal and vertical equity demands

The formal principle of proportional equality presented by Aristotle can be seen as the core concept in any theory of justice.[27] In short, this principle tells us that equal cases are to be treated equally and unequal cases unequally proportional to the differences between them in relevant concerns.[28] When this principle is applied to concrete contexts, the demands for equal and unequal treatment correspond to demands of horizontal and vertical equity, respectively. In a health care context these demands tell us that patients who are alike in relevant respects should be treated in a like fashion and that patients who are unlike in relevant respects be treated *in an appropriately* unlike fashion".[19] According to my view of health care claim outlined above, the interpretation of 'relevance' and 'appropriateness' when deciding who should get what and when, can be seen to hinge on substantive principles of just distribution and substantive beliefs about the goal of health care.

When we combine these equity demands with the two dimensions of the clinicians' responsibility outlined in the previous paragraph, we can conclude that the clinician is responsible for:

- a) Horizontal equity regarding equal treatment of cases considered equal within his or her own patient population
- b) Vertical equity regarding discrimination between the needs of his or her own patients
- c) Contributing to vertical equity by unequal treatment of unequal cases within the whole patient population of a health care system
- d) Contributing to horizontal equity by equal treatment of equal cases within the whole patient population of a health care system

It follows from the double responsibility attached to professional medical performance that all conditions (a)-(d) should be satisfied at the same time. These demands can be analysed into more specific requirements to what should come out as equitable claims on health care resources. Below, I will discuss the requirements following from these conditions.

These requirements compose a framework for equitable clinical decision making and are presented, together with some suggested practical implications, in Box 1. This framework can be used, for instance by clinicians, to evaluate whether it is appropriate to refrain from following the recommendation of a guideline in a particular context.

Box 1

Requirements	Practical implications
<p>I. Self-reflection: Does the clinician acknowledge the normative basis that underlies his/her interpretation of health care claims and does he/she reflect over the substantive content of this basis?</p>	<ul style="list-style-type: none"> ▪ Normative and political theory should be broadly integrated in the education of medical practitioners
<p>II. Search for all relevant reasons for equitable health care: Does the clinician try to discover all reasons he or she might find relevant?</p>	<ul style="list-style-type: none"> ▪ Reasons for <i>not</i> following a guideline should be noted in the patient's journal
<p>III. Recognition of the demand of impartiality: Does the clinician acknowledge the demands of impartiality?</p>	<ul style="list-style-type: none"> ▪ When <i>not</i> following a guideline, the reasons for this should be generic in the sense that they would apply to every patient in the same situation
<p>IV. Recognition of political consequences: Does the clinician recognise the political consequences of the health care claim he/she puts forward?</p>	<ul style="list-style-type: none"> ▪ When <i>not</i> following a guideline, justification of the treatment according to substantive principles of distributive justice should be noted in the journal
<p>V. Recognition of prioritised services: Can the clinician justify what kind of services the health care service should prioritise?</p>	<ul style="list-style-type: none"> ▪ When <i>not</i> following a guideline, justification of the adequacy of the treatment provided according a substantive goal of health care should be noted in the journal
<p>VI. Recognition of the aim of justification: Does the clinician try to justify the claim so that it would be acceptable to colleagues sharing this aim of justification?</p>	<ul style="list-style-type: none"> ▪ Deliberation of normative health care issues among health care workers on a regular basis ▪ The clinician should allow justifications noted in the patient's journal to be monitored for use in collegial deliberation of the issue ▪ Further education courses in normative and political theory
<p>VII. Professional self-regulation: Are the requirements above institutionalised?</p>	<ul style="list-style-type: none"> ▪ The authority responsible for development of guidelines must request special justification in cases where guidelines are <i>not</i> followed ▪ The national and local health care authorities and the associations of medicine must make the necessary arrangements so that the practical implications above can be carried out

Before we move on to explore different requirements for equitable clinical decisions that follow from the conditions listed above, we must remember the background these requirements must be considered against. First, because of the different sets of reasons at macro- and micro-level and the internal, context-related weighting of reasons that takes place, guidelines developed at macro-level are based on a context of legitimacy that differ from the context within which individual health care needs are considered. It follows that uncritical adherence to a guideline would not always be the equitable thing to do. Second, the normative structure of a judgment about appropriate care for a specific patient should be understood according to the account of health care claims provided above.

First requirement: Reflection with regard to the normative basis for health care claims

Condition (a) implies that the clinician needs to reflect explicitly over what he or she acknowledges as the goal of health care provision as well as the principle(s) for distribution of health care he or she accept. Without reflection upon the normative basis and how this basis affects the adequacy of the claims on health care he or she puts forward for the patients, justification for discrimination between unequal needs might be applied inconsistently from case to case. Obviously, this would not be considered just, since it undermines the requirement that cases that actually are sharing all the same relevant characteristics are treated equally. Consequently, the first requirement for equitable, clinical claims on health care is that the clinician acknowledges how the normative basis affects the interpretation of health care claims and reflects upon the substantive content of the basis he or she endorses.

A practical implication of this first requirement will be that in order to encourage self-reflection, normative and political theory should be broadly integrated into the education of medical practitioners.

Second requirement: Search for all relevant reasons of equitable health care

Condition (b) tells us that the clinician is to provide unequal treatment of cases that are unlike in relevant respects in an appropriately unlike fashion. Whether vertical equity in health care is realised or not might hinge on the amount of information about the patient the clinician uses to come to his or her conclusions. Are *all* relevant aspects considered? In cases of urgency where the medical components constituting the need are obvious, additional information will

in general not be necessary to settle the claim as equitable. In less urgent cases, we must assume that there might be context- and patient-related reasons that will make a difference to what the clinician considers acceptable treatment if these reasons are recognised. In order to promote vertical equity between his or her patients, the clinician will have to search intentionally for relevant information about each individual patient, looking for context and patient-related reasons that might justify a different course of action from the one recommended in the relevant guideline. Such awareness seems crucial for clinicians taking responsibility for their patients. The second requirement for equitable health care should then be to search for *all* reasons the clinician recognises as relevant in the individual patient story and which would make a difference to the decision of what service to provide.

A practical implication of this second requirement will be to ask the clinicians to note the justifying reasons in the patient's journal when not acting in accordance with a guideline. As long as the guideline provided is developed according to fair procedures, a justification will be needed for why another course of action is taken to be more legitimate in the particular situation. Additionally, if the clinicians are expected to a search for all reasons of equity they might see, they should also be encouraged to reflect upon whether the choice of adhering to the guideline is well justified. This could also safeguard against relevant reasons of equity being missed by the search ending as soon as the reason(s) matching the guideline are confirmed. To expect the clinicians to note these reasons in the journal, however, would be too much to ask for.

Third requirement: Recognition of the demand of impartiality

Conditions (a) and (b) also imply that the treatment the clinician provides his or her patient must be compatible with what any other patient with the same characteristics within the clinician's patient population should get. This means that the clinicians must be expected to perform according a demand of impartiality, telling us that no omissions or 'special', unjustified treatment should be offered to selected patients. The clinician's recognition of the demand of impartiality is the third requirement for equitable health care decisions.

A practical consideration of this requirement could be that when *not* following a guideline, the justifying reasons for this should be generic in the sense that they would apply to every patient in the same situation.

Fourth requirement: Recognition of political consequences

Condition (c) stresses the clinicians' responsibility for vertical equity when the patient population is considered at large. This implies that the clinician must also take responsibility for the effect their clinical decisions have on an aggregated level of health care claims as regards equitable distribution. This means that clinical decisions should be based upon reasons which coincide with a principle of fair social distribution of health that the clinician accepts. So one should ask whether the reasons for this claim, both medical and non-medical, really justify the priority given to it compared to all the needs there are to be met at a societal level. Are all of the reasons used to justify this claim, reasons that every clinician should stress on behalf of their patients? If yes, would this still be an equitable claim in situations of resource scarcity? Testing the claims and reasons in this way can lead to a reflected awareness of which vertical equity reasons to include and which to exclude when justifying individual health care claims. The fourth requirement of equitable health care decisions tells us that the political consequences of a claim should be recognised by the clinician and justified according to principles of just distribution.

The practical implication that follows is that when a clinician is choosing *not* following a relevant guideline, the justification of the treatment according to substantive principles of distributive justice should be noted in the journal.

Fifth requirement: Recognition of prioritised services

Condition (c) focuses on vertical equity at a society level. It implies that the clinician should reflect upon whether the treatment he or she is about to provide is a service in line with the general goal of health care. The question is whether the specific case is paired with some intervention that should be considered part of an adequate health care service. This means that the clinician must consider what kind of treatments ought to be prioritised from society's point of view. More precisely, he or she must be expected to recognise what kind of treatments should be included or excluded in the general health care service. These considerations will have to be justified according to a substantive goal for health care. The fifth requirement for equitable health care decisions is thus that the clinician is able to justify what kind of treatments the health care services should prioritise.

A practical implication of the fifth requirement could be that when *not* following a guideline, the clinician's justification of the adequacy of the treatment according a substantive goal of health care should be noted in the journal.

Sixth requirement: Recognition of the aim of justification

Condition (d) illuminates another important point. The clinician's normative basis for interpretation of equitable claims should not be considered a private matter. This is not only because the clinician's normative basis influences the actual distribution of a population's health care resources, which makes it a political and public issue and calls upon democratic participation. It is also because, according to the demands of horizontal equity, there is an implicit demand that the clinician's normative basis should coincide with the normative basis of the other clinicians. The reason for this is that an equal normative basis will increase the possibility of non-arbitrary and consistent equal treatment of equal cases within the whole patient population. Thus, the normative basis for clinical judgment must be presented in such a way that it can be accepted by other clinicians as a common ground for interpretation and decision making. To consider whether the beliefs and principles also ought to be acceptable to colleagues, deliberative scrutiny is required. Ideally, condition (d) implies that the normative basis should be common for all clinicians if reasons in similar contexts are to be recognised with equal relevance independently of who is making the judgement.

However, there are strong arguments that the idea of a common normative basis of shared concepts of health care goals and principles of just distribution should not be expected, as well as a body of empirical knowledge, indicating that such a basis is a utopian idea.[8, 29] This could be due to what Rawls has called 'the burden of judgment'. 'Burdens of judgment' are the sources of the human reason that might cause individuals deliberating over the same issue to disagree even when all of them aim to reach a result that is acceptable for all. Just to mention some, these sources might be: unlike weighting of relevant considerations, vagueness of concepts and influences from individual experience in the assessment of evidence and weighting.[29] However, even though we cannot expect the normative basis of all clinicians to coincide, we might bring the collective performance a step closer to the ideal of equal treatment of equal cases. This can be done by encouraging clinicians to *strive to justify* the concepts that constitute the normative basis for claims so that these could also be accepted by other clinicians. As a minimum condition then, the justification will have to be consistent. This will decrease the range of arbitrary decisions based on some unconsidered, inconsistent

normative basis. To press the justification further towards a common acceptance of a normative basis among those considering equal cases, clinicians should face and deliberate challenges and criticism from other points of view. This should be done in order to widen practitioners' horizons of recognised reasons and principles beyond what one could come up with alone, and in order to inform deliberation aiming at establishing a normative basis acceptable for all. I take the sixth requirement for equitable, clinical health care decisions to be recognition of the aim of justifying the health care claim so that it could be acceptable for colleagues sharing this aim of justification.

This requirement implies that there is a need for deliberation of normative health care issues among health care workers on a regular basis. Another practical implication would be that justifying considerations noted in the patient's journal should be open to monitoring and used as a basis for collegial discussion. Further, as normative and political theory develop continuously, this sixth requirement also calls for further education in normative and political theory.

Seventh requirement: Professional self-regulation

All the requirements above are derived from the formal conditions of responsibility and equity, and must be considered all at once in order to frame equitable, clinical decisions. The responsibility for ensuring just distribution of health care lies mainly with the profession itself, but also with the national and local health care authorities which regulate the area for discretionary professional power through laws, directives, guidelines and education. Further, the health care authorities should be seen as responsible for demanding accountability for equitable decision-making while the medical profession is responsible for bringing the requirements for equitable claims about. The seventh requirement is that the practical implications of requirements I-VI above should be institutionalised to ensure professional self-regulation throughout the distribution of health care.

A practical implication of this requirement is that the authority responsible for developing guidelines must request special justification in cases where guidelines are not followed. Another implication is that the national and local health care authorities and the associations of medicine must make the necessary arrangements so that all the practical implications above can be carried out.

DISCUSSION

The seven requirements above add up to a framework for judging equitable claims on health care, and especially when guidelines are not followed. The framework follows from the formal conditions of professional responsibility and equity, and all the requirements presented should be compatible. However, there are challenges to this framework we must address.

First, the framework relies upon the crucial presumption that clinicians are willing and able to deliberate in accordance with the requirements. Should clinicians be expected to be motivated so as to act as requested?

Second, how can the points of view of the citizens in a democratic society influence the normative basis affecting the equity of claims on health care? In the previous section, I put the political demand for democratic participation in parentheses in order to discuss the issue in theoretical terms. But at this point the demand should be considered again.

Third, we must consider what can be recognised as an inherent tension in the approach to fair distribution described as the second phase of priority setting. According to Holm's description of this phase, it relies upon the assumption that there is no principled way of making priority decisions.[5] However, the idea of a principled and commonly acceptable normative basis is exactly what the clinicians need to rely upon in order to distribute health care by clinical decisions in a way they can justify as fair. Furthermore, professional physicians are expected to act and judge what is right to offer without undue hesitation in clinical settings. This means they have to trust their own judgments as being correct in order to appear worthy trust in the eyes of their patients. But as a profession, they will not be trusted by the public at large if this means that each clinician offers what they judge appropriate no matter the substantive content of their justification. Theoretically, I take:

- i) the acknowledged lack of a principled normative basis for just health care distribution,
and
- ii) the need of individual clinicians to judge and act as if such a commonly accepted normative basis actually exists,

to represent an inherent tension in the second phase of priority setting that has to be dealt with in order to allow just priority setting to move a step further. How can this be brought out without infringing the insights from the first phase?

I start considering the first challenge and from this discussion the solutions to the second and third challenges follow as well.

First challenge: Willingness to deliberate according to the framework

The normative basis that underlies the interpretation of health care claims must be internalised in order to work consistently from case to case. Clinicians cannot adopt the normative basis as a set of principles ready-made for implementation. They have to work through the necessary deliberation using the principles and ending up with a basis they are able to endorse and which should be acceptable to others as well. Moreover, they must continuously be willing to revise their views in the light of better arguments. To achieve this requires an adequately motivated person with the necessary skills and knowledge. However, this procedure can be seen as running side by side with another process of justifying what health care to offer. This justification is directed towards the individual patient and others involved in the particular context. While the aim of the first procedure is to obtain a common normative basis to ensure equal treatment of similar cases across the patient population on a society level, the aim of the second is to ensure that individual claims on health care are equitable. The first kind of justification is about acting in a trustworthy way as a profession on an aggregate, society level, while the second concerns trustworthiness in the face of individual patients. These two processes of justification can be explored according to the approaches to ‘reasonableness’ provided by Rawls and Scanlon.[29, 30]

Both Scanlon and Rawls identify the core structure of reasonable judgment in the willingness of the deliberator to provide justification that is acceptable to others sharing the same aim of justification. However, they apply the concept with different agendas. The idea of ‘reasonable persons’ is crucial in the construction of Rawls’ theory of political liberalism.[29] His idea of political liberalism emerges out of what he sees as the unavoidable occurrence of ‘reasonable disagreement’ as regards substantial moral beliefs due to the burdens of judgment. This idea structures his theory of how to approach a political concept of justice. In his account, ‘reasonable persons’ are partly characterised by a “*willingness to propose fair terms of cooperation and to abide them provided others do*”. [29] This can be seen to capture what is

required of the clinicians to ensure equal treatment of similar cases under the demand of horizontal equity in the whole patient population. This demand implies that reasonable clinicians must strive to justify the normative basis for their clinical decisions so it can be endorsed by colleagues.

Scanlon, on the other hand, applies the term 'reasonableness' to clarify the normative and motivational force of judgments about right and wrong. He holds the view that: "...*thinking about right and wrong is, at the most basic level, thinking about what could be justified to others on grounds that they, if appropriately motivated, could not reasonably reject*".[30]

While Rawls' agenda is political and focuses on justice, Scanlon's theory concerns the part of morality "...*having to do with our duties to other people, including such things as requirements to aid them, and prohibitions against harming, killing, coercion, and deception*".[30] Scanlon has adopted the phrase "what we owe to each other" to label the part of morality he has in mind. He explains the special authority of requirements of justifiability to others by showing that this idea is involved in our relations with each other in aspects of life that matter to us. So 'reasonableness' in Scanlon's account relates to both the appropriate way of justifying a course of action and the accompanying motivating reasons that emerge out of 'what we owe to each other'. The professional encounters between physicians and patients can be categorised as situations falling into the domain of morality that Scanlon describes as "what we owe to each other". The clinicians' responsibility for the individual patients will not be brought out unless the clinicians fulfil their duties of helping and not harming their patients. The direct concern for the well-being of the patients and the reading of the situation and possible intervention in terms of right and wrong can be seen as closely connected to the willingness emerging out of what 'we owe to each other' as interacting human beings.

When considering the double responsibility of the clinician and the demands of equity, being a professional clinician means standing with one foot in the realm of morality regarding responsibility for the individual patient and the other foot in the realm of politics regarding responsibility for the collective performance of clinicians. This means that the interpretation of 'reasonableness', with regard to professional clinical judgments, should be extended to include both the account of a 'reasonable person' and the account of 'reasonableness' distinctly captured in the theories of Rawls and Scanlon. The clinicians aim at reasonable and trustworthy professional performance by justifying the claim in general, political terms of justice to other health care workers and in context-related, moral terms of right and wrong to

all those influenced by the decision. Against this background we will now consider whether the willingness the framework requires can be expected.

Double responsibility - different approaches to reasonable judgments

The clinician's professional responsibility towards individual patients on the one hand and towards society on behalf of the profession, on the other, implies two different approaches to reasonable judgments. It is not clear how these two different approaches relate to each other. From the discussion so far, I have shown the need for:

- 1) context-independent deliberation among health care workers about the goal of health care and the principles for distribution to find a common basis for judgments about what health care to provide in individual cases.
- 2) context-dependent justification in terms of right and wrong, based on considerations which include the views of those directly influenced by the decision.

While the process in 1) allows for abstraction from those individuals the claims concern, it is in 2) directed directly towards these individuals. The requirements contained in the framework can be seen to promote the reasonableness of the judgments in 2) by demanding the reasons in the particular contexts to be explicitly linked to the normative basis in 1). However, for any individual claim, there is no guarantee that these processes of justification considered distinctly, will be compatible. When confronting a particular case one might see it as right to offer a service which has not previously been included in the general health care service or distributed to patients with these characteristics. In one aspect this does not cause any problem to the framework, since the normative basis should allow for experience-based revision. In another aspect, however, and particularly in cases of scarce resources, the reasons relating to 'what we owe to each other' might very well conflict with the reasons one derives directly from the normative basis. In such cases we must expect there to be a conflict between the clinicians' motivation to justify and act in accordance with 'what we owe to each other' on the one hand, and in accordance with the requirements of the framework on the other.

There is no simple solution to this problem. The clinicians need to act in a way which is seen as trustworthy both in the eyes of individual patients and from society's perspective, so this problem can never be reduced to an issue of choosing sides. The question is how to stimulate

the two processes of justification to be as compatible with each other as possible so that clinicians can act responsibly towards both individual patients and society at the same time. How can this be carried out?

Second challenge: Public deliberation

As I see it, the theoretical solution to this challenge, will be by opening for more information input than each of these justification processes allow for on their own. In practical terms, this means a need for a well organised and continuous public debate to create a well-informed normative basis for health care claims put forward by clinicians. Such a debate should ideally include everyone for whom the justification of health care claims is relevant and not only the clinicians. This means the national and local health authorities, practitioners, patients, potential patients and proxies. A public debate could be seen to lift the potential conflict between the political and the moral approach to reasonableness out of the clinic and into the public arena. The debate would be enlightened and driven forward by individual, specific reasons which challenge principle-dependent bases for justification and vice versa. Such a collective deliberative process if coordinated and organised well, held on track, sufficiently monitored, reviewed and published, could provide valuable, substantive insights into reasonable health care claims. Back in the clinic, such a debate should be seen as a source for informing the normative basis of individual discretion in judging equitable health care claims. This will apply to both the professionals and the patients. A dynamic, public debate would create a pool of reflection, comparison of needs, experience and criticism that could contribute to a steeper learning curve for reasonable clinicians to form their opinion about the normative basis. A public arena of this type might also benefit the patients. Open deliberation would allow patients, by participating in collective deliberation and voicing their own experience and opinions, to influence how health care claims are interpreted by the clinicians.

If we move away from the potential internal conflict of reasonableness in professional judgment and revisit the conflict between clinical judgment and clinical guidelines set out in the introduction, there is yet more to gain from a public discussion. Publicity about macro-decisions that generate guidelines also needs to inform public reflections about health care claims. This would allow macro- and micro-level decision-makers to inform and challenge each other reciprocally about the reasons behind their decisions.

The foremost aim of this public arena should not be to taken to reach consensus among the participants. Rather, the major aim is to remove unjustifiable claims on health care, by establishing a source which promotes well-justified clinical judgments. Practical implications of this aim are that coordinated collective discussion should be organised with public conferences and seminars, by journal publications and media debate. In addition, theoretical and empirical research on relevant normative issues ought to be encouraged and relevant education made available to support both professionals and lay people.

I see the kind of public deliberation described here as necessary for the framework I suggest to work optimally by promoting the required willingness of the clinicians to deliberate adequately. Moreover, public deliberation should be recognised as a crucial support for an equitable distribution of health care at the clinical level.

Third challenge: Inherent tension in the second phase of priority setting

The framework has been established and the discussion has been carried out without making any claims on the substantive content in the normative basis for clinical judgment. Rather, the framework provides us with a check list pointing out what is needed for substantive individual health care claims to be considered reasonable when supported by public deliberation. If clinicians carry out the required procedure for justifying their substantive normative basis using an organised collective deliberation which informs and challenges the individual justification, they can be expected to make equitable claims. The second phase of priority setting was characterised by the recognition that principles alone could not legitimise priority setting. At the same time, I claim, the clinicians cannot act in a trustworthy way if they do not act as if a basis of such principles exists. The framework supported by public deliberation can be seen to reconcile both these claims by offering a procedure which legitimises the underlying principles for judging equitable health care. By following the procedure suggested here, clinicians can establish the solid ground needed for trusting their own judgments and acting without undue hesitation. Hence, the theoretical tension I argued was inherent in the second phase of priority setting can be solved by the framework and public deliberation.

CONCLUSION

Working from an account of claims on health care and conditions for professional performance, I have developed a framework for reasonable clinical priority setting. This framework is provided as a supplement from “below” to the fair macro-level priority setting

that generates guidelines from “above” for implementation at micro-level. This should be considered as a way of securing fair outcomes from the interplay between these two levels of decision making. In what has been described as the second phase of how to deal with priority setting in health care, I have pointed out an internal conflict. This conflict concerns on the one hand, the lack of a common stable unit of a recognised goal of health care and principles for distribution as a normative basis for health care distribution which tells clinicians how to weight their different reasons. On the other hand, it concerns the clinician’s need for just such a basis in order to act in a trustworthy fashion as a competent professional in each particular case. The framework provided here presupposes the existence of organised public debate to support optimally justified individual claims on health care. By using this framework, clinicians can solve this conflict. Considered in this way, the framework for reasonable clinical decision making might be taken as a step towards a new phase of priority setting. This phase should be based upon the acknowledged need for securing fair distribution in the interplay between macro- and micro-level considerations by legitimising procedures on each level, well organised and continuing public debate and individual clinical judgments based upon well justified and principled normative bases.

Acknowledgments:

I am grateful for comments on earlier drafts of this manuscript from Ole Frithjof Norheim, Sigurd Lauridsen, Kamilla Kjølberg and Silje A. Langvatn.

Funding:

The project is funded by The Research Council of Norway.

Competing interests:

None

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