Allocation

This Latinism (*ad* = k; *locare* = to place, to locate) has not yet caught on among doctors, but it is common among economists. Allocation is *dealing with scarce resources* , loosely translated: *allocation* . The allocation decision is the answer to the questions: How to place? Where to allocate? How much to whom? Who first? The most difficult one is: *To whom yes and to whom no?*

Allocation decision making

Allocation decision-making is conditional or forced by the very fact of the *lack of* certain resources (means, capacities). In the socialist system, more attention was paid to the *distribution of goods than to their creation* . It also had psychological consequences in the form of some widespread ideas, attitudes (expectations) and ways of behaving. By repeating *the myth of the cornucopia* was the belief that society (the state) is obliged to provide everyone with the care they need, regardless of its cost. Consistent application of this unrealistic attitude would lead to economic disruption. It was different in the days when the only investigative methods were auscultation and palpation, but in the era of modern medicine, healthcare as a whole is a highly costly and deeply unprofitable function, forcing us to be economical. Care can therefore only be provided to the extent that corresponds to the possibilities (not the need).

Insufficient funds

Apart from breathing air, everything else in healthcare requires costs and can become *scarce* . Premises, workforce, expertise, possibilities for diagnostic and therapeutic procedures, etc. and, last but not least, time. Even the mental condition of the staff including doctors is *to some extent* dependent on the costs incurred (on the organization of the operation, the degree of load and recovery, on the financial evaluation, etc., as anywhere else). It cannot be said that there are no shortages in rich countries, and therefore no need for allocation decisions. In a poor developing country, during an epidemic, there is a shortage of doctors and antibiotics, common elsewhere. In a developed country, there is a dearth of very expensive high-end innovations, which - once put into operation - become the object of interest of those in need, who initially always outnumber those to whom this initially exclusive assistance can be provided. – **Just like diagnostic and therapeutic considerations, allocation decision-making is therefore an irreplaceable part of the workload of every doctor**. Perhaps only in the form of an inconspicuous question, which nevertheless arises several times a day: how much time to devote to which patient?

Deficiency and its consequences

An unwelcome consequence of the lack of resources and resources is the fact that we cannot provide the necessary help to everyone. The *crucial question of allocation decision-making arises* : **To whom yes and to whom not?** It represents a moral dilemma, because the *principle of beneficence* collides with *the principle of justice* , and there is no other rational solution than limiting the former to the latter. The ethical relevance of allocation decision-making lies in the imperative: *the decision should be fair* (see Chapter 8). In this case, too, it is about searching and finding a higher good (compared to a lower one). The principles of this behavior create what classical ethics (*philosophia moralis*) called **distributive justice** (*justitia distributiva*).

Responsibility of the decision maker

The decision-maker is then sometimes exposed to the psychological pressure of his own insecurity or the dissatisfaction of the party whose needs were not met. There are also accusations like "you killed him". They are unfair: allocation decisions are not the denial of the principle of nonmaleficence, but the failure to apply the principle of beneficence to someone and its application to someone else – in the name of the principle of justice. After making a decision according to the best knowledge and conscience, feelings of guilt are out of place.

Similarly, it cannot be argued that an allocation decision favoring the needs of one and neglecting the needs of the other is contrary to the principle of "nothing at the expense of none" justice. The neglected second is not harmed *ipso facto* , i.e., by the mere fact of the aid given to the first, but by the disorder of health which establishes the need for assistance independently of the first; a need that unfortunately cannot be met.

Levels of decision making

Allocation decision-making can take place on *two levels* .

- At the **microallocation level** , we make decisions *between individuals* . Examples: two patients are recommended to the anesthesiology-resuscitation department at the same time, but there is only one free bed; it is necessary to admit a patient to a fully staffed intensive care unit and all that remains is to transfer one of those hospitalized so far to an internal ward; a similar problem arises when prescribing an expensive or otherwise insufficient medicine, when drawing up waiting lists (for an examination with a computer tomography, for an operation using a gamma knife, for intensive psychotherapy, etc.). As we will see later, a strictly medical point of view does not always decide.

- At the **macro-allocation level** , decisions are made *between groups* . Should a hospital, whose financial possibilities are limited, purchase a respirator or a dialysis machine? Is it advisable, e.g. in the case of AIDS , to finance medical care for an ever-increasing number of patients, or research? Should we give priority to the anti-drug program or the oncology program if we only have funds for one of them? Should we raise the salaries of doctors or judges, if both are not possible at the same time?
  - Macro-allocation decision-making takes place at directorate, municipal, ministerial or government level. On the other hand, every doctor who has patients is constantly forced to make microallocation decisions. Therefore, we will pay more attention to it.

Microallocation decision criteria

In a thought experiment, let's imagine a very simplified, but rather burdensome situation of a military doctor at a front dressing station during the war, when he has a difficult opportunity to transfer patients to a higher medical stage and when it only matters to him. The insufficient value that needs to be fairly allocated is the capacity of the doctor, i.e. the treatment itself. The wounded in the endless line of stretchers can be helped on a "come-first-served" basis; the doctor thus leaves the decision to "fate" or on the *natural lottery* (natural lottery). This rudimentary form of justice will hold up under less demanding circumstances (in the waiting room of an ambulatory workplace), but in field conditions it defies medical rationality. The doctor will prefer a more serious injury (open peritoneal injury cavities) before a lighter one (smooth extremity muscle shot), as it rightly respects the **diagnostic point of view** .

Example

He can decide between two badly wounded with significant blood loss, one still conscious and the other in an agony state. The doctor reasonably foresees that the patient in agony will probably not survive the lengthy treatment (involving blood transfusion); if he attends to it, it is likely that the other will also find himself in a terminal state. Therefore, if he gives preference to the second one, who is still conscious, he did the right thing, because he reasonably respected the **prognostic point** of view . - According to the author of this text, the doctor from the novel "Johny took the rifle" would have done better if he had devoted his skill not to Johny, but to someone else, even a seriously wounded one, whose prognostic prospects were more favorable; surely there were plenty of them. – Deciding *according to age* can also be considered a prognostic point of view . Other things being equal (*ceteris paribus*) it is advisable to prefer a twenty-year-old to a fifty-year-old.

Factors in decision making

Assume that a plainclothes doctor has gained experience in cardiac surgery. If he is deciding between the treatment of a serious head injury and a serious chest injury, he cannot be blamed if he respects **his own professional competence** and gives priority to a patient with a chest injury, who will be helped more with the same, even less, effort.

Medical factors

We would like to be satisfied with these **purely medical criteria** for deciding on the priority of treatment, but it is not always reasonable, so it is also necessary to know about non- **medical criteria** for microallocation decision-making. If a doctor is deciding between a twenty-five-year-old lieutenant and a fifty-year-old colonel who is a computer expert of a nearby anti-aircraft battery protecting a dressing room, he will prefer the other (probably *ceteris paribus*), because the lives of many depend on this man's performance. It respects **the aspect of the importance of the social role** (function) or social usefulness. For the same reason, he will prefer the father of minor children to the unmarried and childless.

It is debatable how far this point of view should be applied, because sometimes the subjectivity of the doctor's perception of it cannot be excluded. Should *ceteris paribus* (other things being equal) preference be given to a person with integrity over a person with a rich criminal history? If a doctor in a hurry, in the stressful conditions described, makes such a decision (assuming that according to his educated conscience), he cannot be blamed.

Merit point of view

How justified is the point of **view of merit** ? Its opponents argue that the beneficence aspect considers benefits that may occur and from which others may benefit, while the deservingness aspect considers past benefits that are already a done deal regardless of the future destinies of their originator. In competition with others, this point of view really has less moral weight, and therefore the battalion doctor will rightly give priority to the one who is just bringing up his minor children, to the one who has long successfully brought up his adult children. However, merit is not a fiction and *ceteris paribus* is entitled to respect. That is why prisoners from concentration camps, for example, are rightly preferred in our healthcare system.

Personal affection

For easy abuse, the **aspect of personal affection** is questionable . However, a military doctor cannot be blamed if, *ceteris paribus* , he prefers the treatment of his close relative or closest friend (however, woe betide him if the same does not apply *in other circumstances*).

Where none of the mentioned criteria, medical or non-medical, establish a reason for preference, the doctor does not perfectionistically chase after subtle differences, because it would be a waste of time. In such a case, it is governed by the principle of elementary justice, i.e. a **natural lottery** ("first come, first served"). This metaphor, sometimes symbolized by the "circle of Fortune", expresses the sum of coincidences or otherwise uncontrollable events that interfere with human lives and history and change their direction. As part of our situation in the world, we have no choice but to accept it, if there is no other way.

In civilian life, the situation of allocation decision-making is usually more complicated than in the rear of the front, usually it is not so urgent (more people make decisions, more capacities and alternative solutions are available), but the criteria are the same, except for one, often controversial: the **market point** of view (" who cares"). It also respects the natural lottery and is contrary to elementary justice, since the recipient of an expensive service can only be the one who is willing and able to bear the costs - *unless the allocation is adjusted otherwise*, for example insurance. However, the insurance company's budget cannot be in deficit (loss) because it would collapse. Therefore, there will always be high-cost over-the-counter procedures that most people cannot afford. There is no reasonable reason why such services should be denied to those willing to pay for them out of their own resources. Making them available to others is not a matter of a mere redistributive decision (unless there is to be an explosion of corruption, the bankruptcy of an insurance company, or even the disruption of the economy), because this does not make the lack enough. Their availability is *primarily due to the creation of wealth* . The winged saying "money comes first" applies not in an axiological sense *(* axiology = philosophy of values), but in an operational sense, or *economic*; so let's distinguish *first* from the *highest* . – The market environment prevents the emergence of corruption, i.e. parasitic pseudo-market relations, because the deficiency is simply reflected in the price, which makes the bribe unnecessary.

It should be noted that many a doctor finds himself in a "double fire": he is forced to defend the legitimacy of his allocation decisions to his patients, to whom he sometimes has to deny scarce resources, while to superior authorities (including the insurance company) he feels shortchanged and against their equally justified sometimes he fights back with the same energy as against problematic decisions. Solving even these conflicts is part *of the creation of the health policy of the state* .

The future of allocation decision making

The ethics of allocation decision-making will become an increasingly urgent topic. It is likely that the pace of economic growth in developed countries will slow down (a number of critics of contemporary civilization speak of the need to actively limit it), which will also be reflected in the total volume of resources allocated to the health sector. One must reckon with the possibility of a growing inverse relationship between the sophistication of high-cost medical science and technology on the one hand and their general availability on the other. Necessary economy will require from many patients *the ability to renounce theoretically possible but practically unavailable expensive treatment, or available only to a limited extent and, from a prognostic point of view, prescribed not to him, but to someone else* . Allocation problems therefore pose **increased demands on the patient and on the ethical foundation of his attitudes** .

Patient awareness of the situation

The knowledge that there is a treatment procedure, perhaps effective, but unavailable, can severely depress the patient and their loved ones. The effect of such information is comparable to the communication of a diagnosis of an infaust disease, with the difference that mere unavailability lacks the fatal inevitability of a fatal disease and causes deeper feelings of wrong not only in the patient, but also in his loved ones. – **Should we tell the patient that he cannot afford adequate treatment? Or that he will not be indulged because someone else is more needed?** Certainly, because this fact cannot be hidden from him. People often avoid information about the inauspicious prognosis of their disease, but they diligently search for information about treatment options. After all, people should know about the problems of allocation decision-making in a situation of scarcity and the fair preference of some over others long before they get sick.

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