

WORKING WITH LIMITED RESOURCES: NURSES' MORAL CONSTRAINTS

THREE STORIES

Anna, a home care nurse, finds that she is unable to give the needed level of care to her clients. She knows that some clients need to see a registered nurse every day, but her agency's criteria, aimed at cutting costs and using their limited number of nurses as widely as possible, prohibits this. Although a nursing attendant is available to see clients daily, Anna feels that some clients need the assessment skills of a registered nurse on a more frequent basis. Anna visits these clients, at the end of her "official" day, on her own time. She feels uneasy about this "voluntary overtime," and also recognizes that not all nurses are willing to do this. As a result of the extra, unpaid time, Anna is exhausted and is afraid of "burn-out."

Paul is a nurse on a busy medical floor in a mid-sized hospital. Lately, because of a shortage of beds in his hospital's intensive care unit, his unit has been forced to admit clients who meet the criteria for intensive care. Although an extra nurse is provided to help care for these clients, Paul fears that it is adding to the stress and workload on his unit, and that the expertise and equipment will not be available if a client goes into crisis. Nurses who complain about taking ICU clients are labeled as "whiners."

Michelle works in an emergency room (ER) in the downtown area. The ER is usually very busy, and the staff just manage to cope. This week, however, there has been an outbreak of severe influenza, and the staff have lost their ability to cope. The halls are lined with stretchers occupied by very ill people awaiting hospital beds, the ER examination beds are full, and the waiting room is crowded with many more waiting to be seen. The ER manager is on the telephone attempting to call in extra nurses and physicians, and to obtain hospital beds for those who are waiting.

*Use of nurse refers to registered nurse.



ETHICAL PROBLEMS WHEN RESOURCES ARE LIMITED

Each year our health care system cares for more people. Nurses* care for larger numbers of sick people with the same number of staff. Individual health care professionals, under great pressure to contain costs, are being asked to consider not only the clinical implications of their decisions but also whether particular services are worth the cost of providing them. There is a tension between serving as advocates for clients and looking out for the economic interests of the health system.

When resources are limited, the dilemma for nurses is how to fulfill their ethical duty to "assist persons to achieve their optimum level of health in situations of normal health, illness, injury, or in the process of dying" (CNA, 1997, p.8). This paper will examine some concepts necessary to understand the environment in which nurses provide care, ideas for nurses as agents who are working towards change, and strategies for dealing with limited resources in the present.

UNDERSTANDING THE PROBLEM

Definition and explanation

Resource allocation is the distribution of goods and services to programs and people. In health care, when there appears to be a problem with scarce resources, we can identify three kinds of scarcity: Supply scarcity is a shortage of a finite resource because of natural limits to the availability of that resource, for example, insufficient organs for transplant. Fiscal scarcity results from a shortage of funds, for example, a shortage of adequate staff hired to work in a hospital. Crisis scarcity occurs when not enough resources are available in a crisis situation, for example, when immediate medical care is required for many people because of a plane crash. The three stories at the beginning are examples of these three kinds of scarcity.

The complexity of the health care system contributes to problems in allocating resources. One way of sorting this out is to divide the decision-making into three levels:

1. **Societal level:** Funding provided to health care by governments, competing with education, social services and other human needs and wants.
2. **Institutional level:** Decisions are made by hospitals, agencies, and health authorities about which programs to offer and whether, for example, to spend more on preventive or primary health care.
3. **Individual level:** Individual clinicians make decisions about treating individual clients. For example, a physician may decide to prescribe a less expensive (but marginally less effective) medication.

These levels can not be isolated in actual practice. Decisions made at the individual level affect the institutional level, and those made at the institutional level affect individuals. The same is true for societal level decisions. This interaction between the levels is important to keep in mind: daily decisions made by nurses and others will affect other levels. As well, it is important to remember that the individual client/provider level is where health care actually occurs, and decision-makers at other levels need to hear about problems to remain responsive to citizens' needs.

Some authors suggest that individual resource allocation decisions made by providers amount to the rationing of health care resources at the bedside (Ubel & Goold, 1997). Rationing is the provision of guidelines for the use of resources when there are not enough to meet all demands. Rationing may be justified in conditions of supply scarcity, such as lack of available organs for transplantation, but unjust rationing can occur when resources are either allocated or denied based on such discriminating factors as race, religion, sex, or age, or when rationing is hidden.

Heath (1997) identifies less explicit forms of rationing that ultimately limit the use of resources. For example, the reduction in the number of available hospital beds is a form of rationing by dilution: the remaining beds are spread thinner and thinner among those who need them, lengths of stay become shorter and it becomes harder to gain admission. Drastically reduced lengths of hospital stay and staffing levels, which has in particular affected nurses, have produced the sort of rationing by dilution that contributes to a lack of dignity and choice for ill individuals because of a lack of resources for proper care.

The context in which nurses provide care

Decisions about how much and where to spend health care dollars are inherently based on values. Which values should be used? Because our health care system is "a major force in determining what can be referred to as the ethical and legal tone of a society" (Sommerville, 1999, p.xi), the underlying values should be those that Canadians prefer. The principles of the *Canada Health Act* represent the values of Canadians (see next page).

Some authors suggest, though, that corporate values are becoming more important in resource decisions (Varcoe and Rodney, in press; Saul, 1995) and that such values are not the best choice for health care. Varcoe and Rodney claim that these values cause ideological and structural constraints that limit the moral agency of nurses. Understanding these constraints helps nurses analyze the context in which they work; how they participate in such constraints; and realize the possibility for change. The following is based on their analysis (in press).

An ideology is a set of ideas and images, a shared set of fundamental beliefs. Varcoe and Rodney claim that two ideologies contribute to the current reality in health care: a corporate ideology and an ideology of scarcity.

Saul (1995) claims that we have lost sight of the commitment to the common good that characterized the development of Canada as a nation. A corporate ideology, based on technology and self-interest is the result of a society organized around economics, rather than around those things that contribute to a good life for its citizens. Varcoe and Rodney suggest that corporate ideology forces nurses to adjust their work to maximize the kind of efficiency that is valued.

An ideology of scarcity is an effective way to promote the ideas and images of corporate values (Varcoe, 1997). Messages about scarcity come from many sources, including the media, managers, and agency publications. The idea that resources are scarce and unattainable is common and accepted in nursing practice, resulting in an emphasis on efficiency within scarcity, or doing "the best you can with what you have" (Varcoe and Rodney, in press, p.7).

Varcoe and Rodney's research reveals that nurses express this ideology in discussing time, showing an acceptance of the scarcity of time as a driving force organizing nursing practice. This requires nurses to be efficient in a system that measures efficiency primarily through the number of physical tasks performed; a process that ignores the emotional and intellectual work that nurses do. Nurses thus organize their work based on a belief in and acceptance of scarcity.

Nurses also convey an awareness of the difference between the care they value and have been taught to provide, and the care that they are able to give. This discrepancy is also described in terms of time. When time is inadequate the result is moral distress for nurses, and a negative impact on clients who receive limited forms of care. Nurses such as Anna may try to alleviate their moral distress by volunteering unpaid time. Thus time, nurses' most valuable resource, is viewed as a scarce commodity, and is spent in the service of corporate, rather than nursing or client, priorities. In this way, the idea of scarcity supports cost-constraint measures, which, along with corporate values, emphasize efficiency regardless of quality and effectiveness.

Varcoe and Rodney have found evidence that corporate "efficiencies" are supported in part through workplace sanctions. Nurses let one another know what is expected, approve of those who are efficient in terms of providing physical care and "getting the tasks done," and frown upon those who are "slow," are "bleeding hearts," or "spend too much time talking" (p. 14).

Administrative sanctions work together with sanctions applied by individual nurses to enforce practice that is compatible with corporate goals. Failure to meet corporate goals may mean real sanctions, including staff layoffs, and/or replacement of registered nurses with less prepared staff.

Nurses are also expected to accommodate the efficiencies of other health care providers and departments. For example, nurses may dispense drugs when the pharmacy cuts its hours; ER nurses care for medical clients in the hallways, sometimes for days, when there are not enough in-client beds available. Further, nurses may hesitate to seek more equitable solutions for fear of being labeled whiners, even though they have helped decrease other departments workloads by adding to their own.

CHALLENGING THE ASSUMPTIONS: WORKING AT THE SOCIETAL LEVEL

Nurses have learned to work within workplace constraints. For example, they sometimes bend the rules, as Anna did, or they might negotiate with others, such as physicians or community agencies, for a better outcome for their clients. In the face of cutbacks, health care professionals, especially nurses, are holding the health care system together, often at great personal cost. Because nurses are "coping," the underlying problems continue uncorrected.

Most coping tactics are at the individual level, and not necessarily based on a critical awareness of the dominance of corporate values and practices. Varcoe and Rodney suggest the following strategies for change at the societal level:

1. A greater critical awareness of the ways in which ideologies are used to structure nurses' work.
2. An awareness by nurses of the ways in which they participate in undermining their own values.
3. Challenging the often taken for granted idea that "there is no more money," which hides the fact that money is simply being spent "elsewhere."
4. Decide that corporate values, and the workplace sanctions used to preserve them are unacceptable.
5. "Efficiency" should take into account effectiveness, client well-being, and long-term as well as short-term gains.
6. The criteria of efficiency must be linked more to outcomes, not to the maximization of tasks.

As well, at the societal level, nurses as a professional group must lobby for accessible and equitable health care. Nurses' expertise can assist governments, organizations and the public to make better decisions.

PRINCIPLES OF THE CANADA HEALTH ACT OF 1984:

1. **Public administration:** Provincial health care insurance plans must be administered and operated on a non-profit basis by a public authority, responsible to the provincial government and subject to an audit of its accounts and financial transactions.
2. **Comprehensiveness:** All medically necessary procedures must be insured.
3. **Universality:** One hundred percent of all citizens are entitled to the insured services.
4. **Portability:** Eligible persons can take entitlement to health care across the country. Out-of-country services are to be paid on the basis of the amount that would have been paid by the home province.
5. **Accessibility:** Provinces must provide health care that is uniform and with reasonable access throughout the province.

LIVING WITH THE STRESS OF LIMITED RESOURCES: NURSES AS INDIVIDUALS

At the individual level, nurses need to remember that they make resource allocation decisions daily. Anna, for example, decides to visit her clients at the end of her shift. Michelle must decide which clients to see first and who can wait. Paul, worried about the morale of his unit, can choose to begin a conversation among his colleagues about initiating changes that might work better.

The following are some strategies and resources for individual nurses:

1. The *Code of Ethics for Registered Nurses*, which outlines the fundamental moral values of the nursing profession, is a good place to begin. The code lists seven values, three of which play a dominant role in all discussions of resource allocation. These are:
 - Fairness (statements 3, 4, 5, 6)
 - Accountability (statements 7 and 8)
 - Practice environments conducive to safe, competent and ethical care (statements 4 and 5)
 - Also relevant are the values of Choice, and Health and Well-being.
2. An individual can build coalitions with others. Nurses often do not recognize that they are dealing with a resource issue, but describe their action as "advocating for my client." Anna, the home care nurse, might find other resources available in the community, partnering with others to ensure the best outcome for her clients.
3. Realize how you as an individual may unwittingly participate in the ideology of scarcity (Varcoe, 1997). For example, understand the role that sanctions play in the workplace. Paul might look at how other nurses on his unit are treated when they disagree with taking ICU clients. If they are sanctioned for their efforts he can act to support them.
4. Acknowledge that nurses have expertise in working in situations where there are limited resources. Nurses have always tried to help as many people as possible, making assessments as to how to use their skills and have traditionally not viewed their expertise as an important resource. Realize that resource decisions, made daily by individual health care workers, are influenced by constraints that may need to be critiqued. Michelle may recognize that during the influenza outbreak, staff will have to work harder and neglect clients who are less ill. If the pace continues after the outbreak is over, Michelle's experience can help resolve ongoing staffing problems.
5. Nurses should not be forced to ration their time. Recognize when methods used to determine efficiency do not reflect nursing values. Also learn to identify situations in which nurses are forced to distribute their time in unethical ways.
6. Nurses must identify resource allocation problems and document and report them consistently. For example, there are professional responsibility clauses in contracts, incident report forms and so on that Anna, Paul and Michelle might use to report problems. It is important that other nurses not apply sanctions when their colleagues use these routes.

NURSES AS A COMMUNITY

Nurses can only do so much at the individual level. Because they have first-hand knowledge about how allocation decisions at other levels influence client care and nursing practice, nurses must address "institutional, social, and political factors influencing health and health care" (CNA, 1997, p. 8).

Storch suggests that nurses should consider Kidder's notion of "ethical fitness" (1995). Ethical fitness is the human activity of ethical reflection and justification, requiring a certain degree of knowledge and skill in ethical problem-solving. Storch (1999) suggests three approaches:

1. To be a person of moral character;
2. To engage in appropriate moral behaviour and role-modeling such behaviour,
3. To work to establish a moral community.

A moral community is one where all nurses, including managers, share information and their own interpretation of that information with each other, and translate their ideas into conduct. Together they can reflect on the kind of nursing practice life they want to be involved in. Although such reflection may seem remote from everyday nursing work, a moral community can only be realized through the daily use of moral action and decision-making.

Support for building a moral community can be provided both through formal structures (such as ethics committees and ethics rounds) and by informal means (such as ethical discussion on units). What is necessary is a climate of openness to ethics and ethical discussion, which must be considered an integral part of the provision of care. A culture in which nurses are encouraged to see ethical problems in the workplace, are free to challenge standards or practices they consider unethical, and are encouraged to keep themselves ethically fit, must be created.

Other strategies and resources for nurses at the institutional level include:

1. Again, the *Code of Ethics for Registered Nurses* is an important resource. The code says that "for each of the values, the scope of responsibilities identified extends beyond individuals to include families, communities and society" (CNA, 1997, p.5). Historically nurses have recognized issues and been active in promoting social welfare and health for communities and society. The code gives nurses a framework around which to build a moral community.
2. At the institutional level, nurses must participate in committees, task forces, etc., and assist in the development of policies that affect nursing practice.
3. Nurses must facilitate and participate in public debate, so that Canadians' values and preferences are included in decision-making. Any changes to health care should result from an open and public process. Nurses' close relationships with clients and families can facilitate such openness.
4. Nurses must lobby provincial/territorial and federal governments for nursing research funding to determine the best nursing practices, and demonstrate how these are both cost-efficient and yet contribute to equitable care for those who need it.
5. One of the scarce resources is nursing. Nurses should work collectively to secure the best use of nursing resources available and to improve working conditions to retain and recruit more nurses.

SUMMARY

Florence Nightingale wrote, "Bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse. But the art of nursing ought to include such arrangements as alone make what I understand by nursing, possible" (Nightingale, 1969, p.8).

Nurses such as Anna, Paul and Michelle struggle to nurse well under difficult conditions. To make nursing possible we need to

explicitly acknowledge the problems, understand the beliefs behind the resource allocation drive, and begin to develop and use strategies that will improve the health care system.

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For those wishing to examine these issues further, an annotated bibliography is available.

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For more information mail, fax or e-mail:

Canadian Nurses Association
50 Driveway
Ottawa ON Canada K2P 1E2
Telephone: 1-800-361-8404
or (613) 237-2133
Fax: (613) 237-3520
E-mail: prr@cna-nurses.ca
Web site: www.cna-nurses.ca

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