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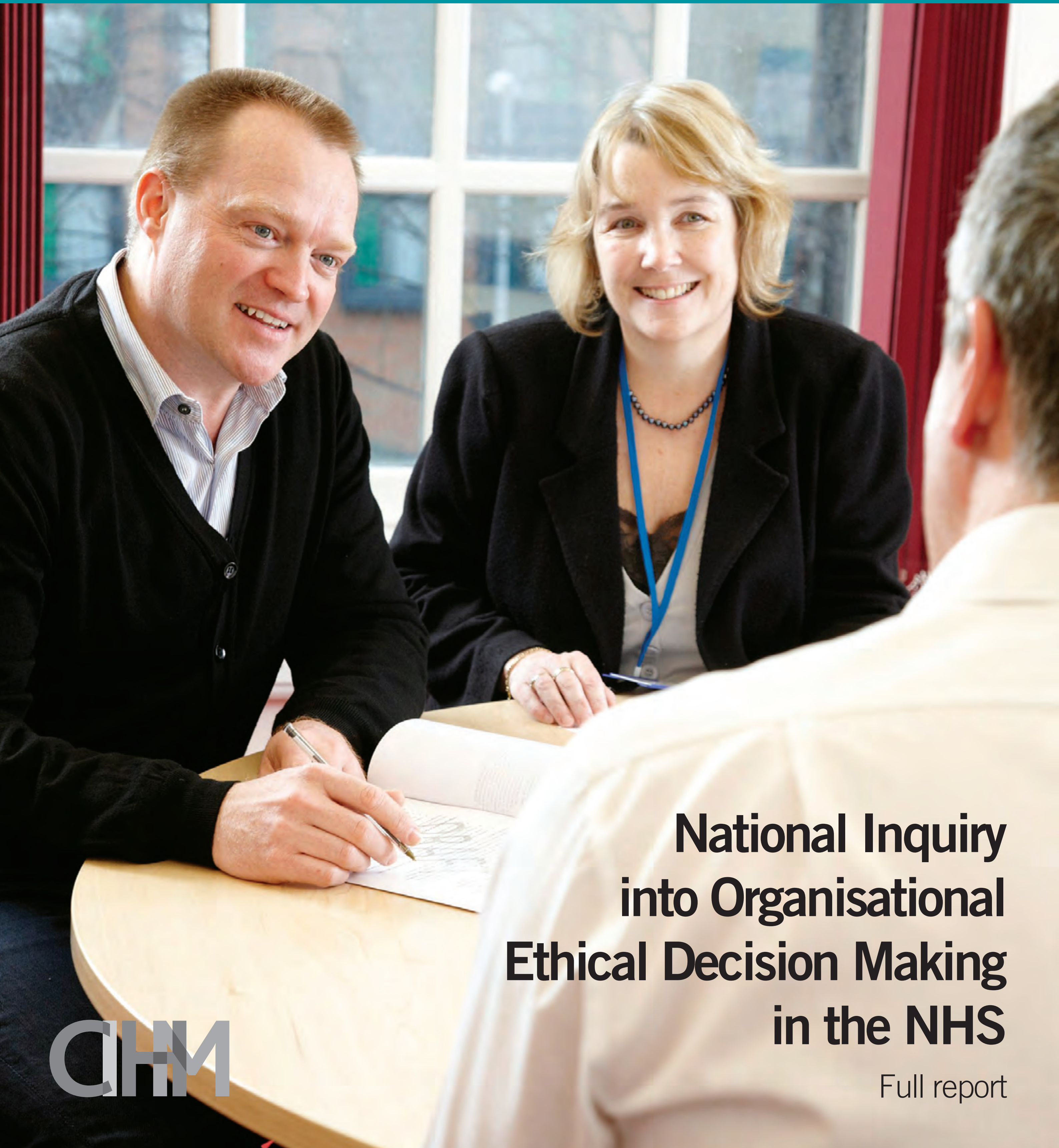

National Inquiry into Organisational Ethical Decision Making in the NHS

Full report

Intended Audience

This report is particularly relevant for NHS senior managers and board members although all those within the NHS who are making strategic and organisational decisions may find it of value. The checklist in the report can be used to influence decision making at all levels of the organisation. Wherever there is an element of ethical complexity to the decision in question, we think these considerations are important, and the checklist is intended to be flexible enough to be used in a number of different contexts.

Both this report and an executive summary can be found at **www.cihm.leeds.ac.uk**

If you would like a printed copy please contact us at **j.l.paglia@leeds.ac.uk**

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Authors:

Jim Baxter,
Professional Ethics Development Officer,
Inter-Disciplinary Ethics Applied,
A Centre for Excellence in Teaching
and Learning, University of Leeds

Martin Fischer,
Associate, Centre for Innovation in Health
Management, Leeds University Business School

Rebecca Malby,
Director, Centre for Innovation in Health
Management, Leeds University Business School

In addition on the inquiry panel:

Juliet Brown,
Programme Manager, Centre for Innovation
in Health Management, Leeds University
Business School

Gail Cartmail,
Assistant General Secretary, Unite the Union

Lance Gardner MBE,
Chief Executive, Care Plus Group

Dr Ian Greenwood,
Lecturer, Division of Work and Employment
Relations, Leeds University Business School

Angela Monaghan,
Chair, NHS Calderdale

Professor Chris Welsh,
Medical Director, NHS East of England

Diane Whittingham,
Chief Executive, Calderdale and
Huddersfield NHS Foundation Trust

Who are CIHM?

The Centre for Innovation in Health Management (CIHM) is a centre within the Business School at the University of Leeds. The School's strength in health and public service leadership, organisational development and change is driven by the CIHM as an impact arm of the School.

At CIHM we are passionate about improving public services and also about leadership and systems. Our activities include applied research, medical leadership development, board development, culture change programmes, leadership development of top leaders in the public sector and in particular the NHS.

CIHM is a not for profit organisation, with a membership of 700 health leaders (community leaders, doctors, third sector, mainstream NHS) in the UK and 100 International health leaders. Our fees support our work in and for the NHS and wider public services.

This report has been led by CIHM working with colleagues in the University's Inter-Disciplinary Ethics Applied Centre for Excellence in Teaching and Learning (IDEA CETL). The IDEA CETL carries out teaching and research in applied ethics, and offers training and consultancy to professionals, businesses and public bodies. The Centre exists to help students, professionals and employees to identify, analyse and respond to the ethical issues they encounter in their disciplines and their working lives.

Executive summary

This report identifies, and seeks to begin to address, a need for greater attention to be paid to ethical decision-making in NHS trusts. The NHS is a huge organisation, whose complex structure, coupled with the profound impact of its activities on the lives of its patients, means that decisions made by managers and others are unusually demanding and ethically loaded.

Attempts have been made at various levels to identify sets of values and principles which can guide decisions. However, an emphasis on the practical process by which decisions are made, both in terms of their content and the organisational factors that impinge on them, is a relatively new idea which has the potential to drive effectiveness in ethical decision-making. This report focuses on decisions made by senior managers particularly.

One aim of this report is to recommend a move from *identifying* a value set towards *implementing* those values in practice. In reality, the only way to come to a better understanding of our values – professional, organisational or individual – is to allow those values to emerge through their influence on decision-making, and the only practical purpose of coming to such an understanding is to enable us to make better decisions. In addition, we suggest that NHS managers need to become more aware of the role of values in decision-making. This awareness has three key aspects:

- Understanding that, while accurate data is extremely important, decisions can rarely, if ever, be taken effectively on the basis of data alone.
- Paying attention to the interplay between data and values in a decision, and the way each informs the other.
- Striving to understand, interpret and apply values through discussion with other decision-makers.

Improving ethical decision-making

The researchers carried out a series of semi-structured, one-to-one interviews with managers in a set of NHS trusts. Interviews focused on four specific decision-types:

- Addressing health inequalities by PCTs.
- Discontinuing or decommissioning a particular service.
- Deciding what information to include in (and what to leave out of) Quality Accounts.
- Covering staff shortages in hospitals.

Analysis of these interviews revealed a number of aspects of the decision-making process which, if given proper attention, have the potential to improve effectiveness in ethical decision-making. These are gathered together in a “checklist for ethical decision-making”, reflecting what we see as current best practice for senior management decision-making in the NHS. This checklist is intended as a reference tool to provide structure to meetings at which decisions with ethical dimensions are taken, to channel discussion in productive directions, and to ensure that solutions are arrived at in a manner which is as informed and as fully justified as possible.

The table below shows the ten items in our checklist for ethical decision-making. These are discussed in detail in Chapter 2, and demonstrated through case studies in Chapter 3.

Decision-making content

1. Have you agreed on the aims of the decision?
2. Do you understand the separate roles of values and data in your decision?
3. Have you considered and defined the key value terms involved in the decision?
4. Do you have access to the relevant data, and are you interpreting it correctly?
5. Have you fully considered your roles and responsibilities?

Organisational context

6. Are you spending enough time on this decision, proportionate to its impact and difficulty?
7. Are you involving enough people, and the right people, in the decision?
8. Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?
9. Is the process set up in a way that is genuinely conducive to challenge and debate?
10. Have you fully considered the relevant guidance, regulations and legislation?

Delivery

11. Have you set up systems/measures to show that you have delivered and not simply implemented?

Evidence from the interviews

We examined interviewees' use of two sets of value terms primarily:

- Equity, equality, justice.
- Openness, honesty, transparency.

We found some variation in the degree to which trusts have thought through how to interpret equity, equality and justice. In general, when asked to define the terms, interviewees were able to make an attempt, at least understanding that equity differs from equality, and sometimes that equity takes account of relevant facts about the people concerned, or is concerned with outcomes. However, there was also considerable confusion about the meaning of terms and differences of interpretation within and between trusts.

We found that the most common model underlying interviewees' discussion of equity was the 'use-per-need view', according to which distribution of resources should reflect the need for care. We found a number of attempts to apply this in practice, particularly by understanding the needs of particular social and ethnic groups and targeting resources accordingly.

We also looked at distinctions among openness, honesty and transparency. Openness and transparency go further than honesty: as well as not deceiving, the duty to be open and transparent requires a thoroughgoing willingness to reveal facts about oneself if they would have implications for others, even when those others may be unaware of the implications. Interviewees were generally aware of these distinctions, however we found evidence that decisions are not always taken in a way which optimally serves openness and honesty.

We also examined interviewees' understanding of their responsibility to the public interest, the distinction between legal/contractual responsibilities and the relationship between individual and organisational responsibilities. We found that, in particular, the responsibility to the public interest provides a useful lens through which to view decisions which affect the public.

As well as the content of decisions, we also looked at aspects of the organisational context that bear on decisions, and affect how those decisions are made and implemented. We found that five aspects of organisational context have a particular bearing on decisions. These are:

- *Clarity and openness*, allowing a variety of viewpoints to be put across openly and without fear of reprisal.
- *Representation* of stakeholder groups among decision-makers.
- The willingness to listen to, and to actively seek, *challenge* to the prevailing view.
- The willingness to devote *time* to a decision, proportionate to its complexity and impact.
- *Consultation* which is justified, genuine and honest.

Conclusions

In this report, we have tried to set out some simple, practical advice that can help NHS organisations to make better, more effective ethical decisions. However, this is only a first step in this process. The challenge for trusts is to spend time working with this advice, considering what are the key ethical concerns that drive their own decisions, and practising applying them in real decisions. Doing this not only improves the way those particular decisions are taken, but builds awareness and ethical reasoning skills, so that ethical considerations become easier to recognise, analyse and address effectively. We also believe there is a need for further attention to be paid to the very many ethical decisions which take place outside of senior management.

Table of contents

1. Introduction

The National Health Service is the largest, and certainly one of the most structurally complex, employing organisation in the UK. Taking in hundreds of hospitals, primary care organisations and management units, its structure is difficult to grasp fully for those who do not work for it, and the fact that that structure has been subject to repeated change since the NHS's inception in 1948, complicates matters further. As a public health service, the NHS is an object of pride, frustration, and great and sometimes contradictory expectations on the part of the public and the government.

Within the NHS, thousands of decisions are made every day, by everyone from its senior management to individual doctors, nurses and other employees. Each decision is taken by an individual or group of individuals with their own value set, but it is also taken in the context of the immediate environment – the expectations of colleagues and managers, for example – of the local trust, and of the NHS as a whole. And because the NHS is about the health and wellbeing of its patients first and foremost, every decision has the potential to have deep repercussions for the people who use its services every day. Resource limits in the NHS mean that every deployment has an opportunity cost: money and staff devoted to one activity cannot be devoted to another. All of this means that NHS decisions, inescapably, have difficult and far-reaching ethical dimensions.

In a publicly funded organisation with social aims, staffed and run by professionals, making financially sound decisions is not the only imperative; there are also social and moral values to be fulfilled. The ethical responsibility of NHS staff extends not merely to making and implementing decisions, but to *delivery* through decision-making. NHS leaders will rightly be judged on the real-world outcomes of their decisions – in other words, on their effectiveness. However, the first step towards effectiveness in implementation is effectiveness in decision-making. In this report, which is aimed primarily at senior managers in the NHS, we hope to offer some practical guidance on how to recognise, analyse and respond more effectively to ethical decisions.

1.1 The NHS Core Principles

Of course, attempts have already been made at several levels to bring consistency to the way decisions are made. By clarifying the aims of the organisation, the NHS Constitution sets out the following guiding principles:

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. NHS services must reflect the needs and preferences of patients, their families and their carers.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients it serves[1].

These 'seven key principles', which 'guide the NHS in all it does... are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public.'[2] These values are as follows:

1. Respect and dignity.
2. Commitment to quality of care.
3. Compassion.
4. Improving lives.
5. Working together for patients.
6. Everyone counts.

While these principles and values offer a useful first step, their application is likely to lead to difficulties in three principal ways. Firstly, the proper interpretation of each may not always be clear. Secondly, there may be cases of tension between certain of these principles and values, particularly given the limited resources available to trusts, and trusts will need to prioritise one over the other on occasion, leading to difficulties of comparison between values. Thirdly, they need to be held alongside other, equally pressing considerations: limited resources, limited time, the inertia and distortions caused by organisational structures, and so on. The translation of abstract principles into practical decision-making and action will, therefore, present inevitable challenges.

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[1] The NHS Constitution for England, 21 January 2009, pp3-4.

[2] Ibid., p3.

The Health and Social Care Bill: An Ethical View

At the time of writing, the coalition government's Health and Social Care Bill 2010-11 is at the Committee stage at the House of Lords, and has been through a number of changes already. It is useful to note the top-level concerns as set out in Part 1 of the current version of the Bill, in the section entitled 'The Health Service: Overview' (Health and Social Care Bill, pp2-3). In all, six duties are ascribed to the Secretary of State with regard to the NHS:

1. To promote a comprehensive health service.
2. To secure continuous improvement in the quality of services.
3. To reduce 'inequalities between the people of England with respect to the benefits that they can obtain from the health service' (p2).
4. To promote autonomy among providers and administrators.
5. To promote research and the use of research.
6. To protect and improve public health.

The responsibilities of NHS employees are also set out in detail in the Bill, deriving from these broad overarching duties. Many of these appear to be based on ethical assumptions about the aims and purpose of the NHS, or otherwise have implications that are important in the context of this report, but two bear particular attention. Firstly, note that the reduction of inequalities is retained as a central concern in the Bill. There is a key notion here (which is repeated elsewhere in the Bill) of a responsibility actively to *promote* equality. Merely seeking to mitigate the negative impacts of decisions on equality will not be enough: decisions need to be made (and to be seen to be made) in a way which actively contributes to equality. Note also, however, the careful wording of the phrase in which this duty is set out. Later in this report, we will look at equality (and the closely related concept of equity) in more detail, and see that there are several possible ways of interpreting these ideas.

For now, it is worth noting that the reference to 'the benefits that they can obtain' can be understood in several different ways. Are the 'benefits' here to be thought of as health outcomes, or access to services? Do the words '*can* obtain' indicate that services are simply to be made available, or that particular efforts should be made to increase take-up of services among groups who may have difficulty accessing them? Note also that the Bill enjoins the promotion of *autonomy*, another ethically loaded word, among those doing the work of running the NHS. This aspect of the Bill suggests that the burden of judgement on questions of ethics (including, but not limited to, questions of equality and equity) will, if anything, be placed more than ever on the shoulders of individual clinicians and managers. Add to this the current intention to give responsibility for commissioning to general practitioners – individuals whose professional attention up until now has been focused exclusively on the needs of individual patients, and who have not needed to concern themselves with the kinds of ethical questions, such as those to do with distribution of resources, which only arise at a macro level – and the need to think deeply about these questions becomes clear.

1.2 What are (our) values?

As well as the NHS core principles and values, and the legislation that sets out expectations of trusts, many individual trusts have their own mission statements and statements of principles and values. There is a lot of variation in the way trusts have approached these. Some favour a relatively simple statement of intent[3]; others have a mission statement, plus a list of values, visions and goals.

Among all of these, there are two groups of closely related ethical values that are more commonly referred to than any other[4]:

- Equity, equality, justice.
- Openness, honesty, transparency.

The reasons for the prevalence of these particular values are clear. Firstly, the NHS is responsible for the distribution of limited resources among a wide variety of treatments and interventions, and among a wide variety of different service users and societal groups. It is vital that it is seen to do this, as far as possible, in a fair and equitable manner. Secondly, the NHS is owned and funded by the public. It is therefore accountable to the public, and must strive to be honest, open and transparent in everything it does.

As with the NHS Constitution, these statements of values and principles are supposed to play an important role in guiding decision-making in the NHS, and there is frequently some attempt on the part of trusts to set out what they should mean in practice for NHS employees. However, it would be impossible for guidance of this kind to cover in detail every decision that is made in the NHS. Similarly, a report of this kind cannot hope to fulfil this role. Instead, we intend in this report to offer some suggestions as to how decision-makers in NHS organisations might move towards a better understanding of value concepts, and improve the clarity with which those concepts are integrated into decisions made at different levels.

In Chapter 4, these two key sets of values are examined in more depth, both in terms of philosophical research into their proper interpretation, and through analysis of the interviews we carried out for this research. This analysis has informed the design of the checklist presented in Chapter 2, which is intended as a practical tool which can be applied in a range of contexts.

1.3 Aims of this report

In designing this inquiry into ethical decision-making, we set out to examine how decisions are made in practice within NHS trusts. In particular, we were interested in two aspects of ethical decision-making.

Firstly, we wanted to know what ethical considerations underlie decisions as they are made in practice, and how (and how well) these considerations are understood. When decisions are approached, what ethical concepts are being used? How are they being employed, and what bearing do they have on discussions? In summary, what is the ethical *content* of decisions?

Secondly, we wanted to know how various features of the organisation bear on decisions. How does the structure of the organisation affect the way decisions are made? Are the right voices being heard at the right times? Do authority structures have an effect on decisions? In other words, what is the organisational *context* in which decisions are made? These two aspects of decision-making informed the design of the interview schedules we used, the way in which we analysed the results of the interviews, and the structure of this report.

In terms of scope, it should be noted that our research focused on decisions made by senior managers in trusts, and therefore the specific guidance in this report is primarily aimed at informing decisions made at this level. However, as noted above, ethical decisions are made at all levels in trusts, and we recommend that trusts spend some time considering how the insights in this report can be applied to decisions made throughout the organisation.

As noted above, many trusts have already spent time deciding what their 'value set' is and should be. One aim of this report is to recommend a move from *identifying* a value set towards *implementing* those values in practice. In reality, the only way to come to a true understanding of our values – professional, organisational or individual – is to allow those values to emerge through their influence on decision-making, and the only practical purpose of coming to such an understanding is to enable us to make better decisions. Making decisions in a clear, informed way, and reflecting on the role of values in those decisions, enables organisations and individuals to become more consistent, more focused and, ultimately, more effective.

Separating data from values, understanding the interplay of these related but distinct aspects of ethical decision-making, and paying proper attention to the interpretation of value terms, are all essential to approaching ethical decisions in a rigorous and informed way. Another aim, therefore, is to build awareness of the following three aspects of decisions:

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[3] E.g. "Barnet and Chase Farm Hospitals NHS Trust will continually strive to deliver excellent patient care, of which patients, the public and staff can be proud" [NB this trust was chosen as an example from a scan of websites and is not a participant in the research.]

[4] ... though it should be noted that, significantly, there is considerable disagreement between trusts, even those whose remits are broadly similar. Many PCTs, for example, do not mention equality or equity at all, while others make these the central theme of their statements.

1. **Understanding that, while accurate data is extremely important, decisions can rarely, if ever, be taken effectively on the basis of data alone.**

We found repeatedly that managers' discussion of decisions implied a belief that, if enough data could be accrued, the right decision would become obvious. However, while data is clearly important, it is equally important not to ignore the role of values in a decision, or to assume that these are obvious or do not merit attention. The importance of being aware of the role of values is apparent, for example, in decisions which involve allocating resources to a particular area, inevitably at the expense of another. The basis for these decisions cannot be entirely empirical or data driven, but must involve a value judgement.

To see this point clearly, look at Table 2 on page 26. In this table, we have set out some of the value and data considerations that play into the particular decisions we examined in this research. These are intended as examples to guide analysis of other decisions.

2. **Understanding the interplay between data and values in a decision, and the way each informs the other.**

Having distinguished data from values, it is important to pay attention to the sometimes complex relationship between the two kinds of consideration. For example, if equity is a key consideration in a decision, what does this say about the demographic data that needs to be collected, and the consultation that needs to be carried out before the decision can be made? Having gathered this data, how do we know what an equitable distribution would look like, or how we should try to achieve it? Effective decision-making means holding both kinds of consideration in mind simultaneously, and being alive to the effect of each on the other, a skill which takes practice to perfect. The discussion of examples in Chapter 3 is intended as a starting point in achieving this.

3. **Striving to understand, interpret and apply values through discussion with other decision-makers.**

Finally, it is important to be aware that reaching an agreed *interpretation* of values is neither simple nor impossible, the two extremes which often underlie 'common-sense' views on these issues. In Sections 4.2 to 4.4 of the report, we have tried to show how careful analysis of value terms can help decision-makers to reach a better understanding of their own and others' views, and to move towards the kind of shared understanding which is essential for truly informed decision-making. These sections take insights from the philosophical literature into the interpretation of value terms, and apply them to the kinds of decisions made in NHS trusts. Hopefully, they offer a useful starting point in analysing these questions, which is best approached through discussion with other decision-makers.

To see how awareness of these factors can improve decision-making, consider a decision that is made fairly routinely in certain trusts, and which was discussed by participants in our research: where to target provision of a particular facility, say breast-feeding programmes. This is a decision that requires various pieces of data. Where are existing facilities located? How is take-up of facilities distributed among different groups? Where is need greatest? It also, however, involves some important values, for example equity in distribution of facilities, or responsibility to particular groups. These two types of consideration will affect each other; for example the data might suggest that the distribution currently looks unequal. In that case, it will be important to consider what is meant by 'unequal' and what the trust should be trying to achieve. Is it equality, or equity, or justice? In access to, or take-up of services, or in health outcomes? Whatever interpretation is made will then have implications for the data that is needed. And so on.

Building awareness of these issues takes time, and can only be achieved through practice. In this report, we aim to provide practical guidance that can help trusts to begin to develop this kind of awareness, and the skills to tackle ethical decisions more effectively.

1.4 Structure of the report

With the above aims in mind, we have set out in Chapter 2 of this report a simple, clear methodology for approaching ethical decision-making in NHS trusts. This methodology takes the form of a checklist, and a recommended process for implementing the checklist in a real organisational ethical decision.

In Chapter 3, we have set out two case studies arising from the research which illustrate particular aspects of this methodology.

In Chapters 4 and 5, we present evidence from the interviews which illustrates the state of play as we found it in the trusts we spoke to, firstly from the point of view of the understanding of ethical concepts, and secondly from the point of view of the practical elements of ethical decision-making.

In Chapter 6 we present some brief closing thoughts.

Finally, the research methodology is included as an appendix to the report.

2. Making more effective ethical decisions

The interviewee below, a director in a PCT, summarised how they thought important ethical decisions ought to be taken.

"My thought is that you get to a point, if you actually really spend time… you… move towards a consensus which is as thought-through as is possible to get…. You need to lock a bunch of people away… with some real specialist support and really rigorous information. And then what emerges out of that, at least you can say, 'look, we did everything we could to consider it.' There's that real… hard slog of thinking things through."

Our interviews suggested that the reality of how these decisions are taken does not always live up to this ideal. We found examples of decisions where little time had been given to the decision, where key people who would be expected to have a useful point of view to contribute had not been involved, and where people who had been in the same meeting recalled that meeting in importantly different ways.

Decision-makers are frequently operating in an environment which is extremely time-pressured, where they do not have access to all the information they would like, and where channels for implementing decisions are imperfect. Ethical decision-making will never reach an optimal point. However, there are ways of improving decision-making effectiveness so that situations are clearly analysed and understood, and decisions are subject to a clear, comprehensive justification. Part of this is about understanding that all, or very nearly all, decisions taken in trusts have an impact on people, and involve values, and are therefore ethical decisions.

Moreover, the ethical elements of decisions are not just 'a matter of personal opinion' – decisions need to be justified and defended, and can be subject to scrutiny as much as financial or management decisions. As noted above, NHS managers will rightly be judged on the delivery of their decisions as well as on the decisions themselves. In this chapter we present a checklist for ethical decision-making, a practical tool to help improve the decision-making process in NHS trusts.

2.1 A checklist for ethical decision-making

In our research, we carried out a set of interviews within seven different NHS trusts (see the Appendix for more details of the research methodology). Through analysis of these interviews, a set of observations emerged with regard to the two aspects of the interview noted above: the ethical *content* of decisions and the organisational context. In order to make these results as practical and constructive as possible, we have distilled them into a checklist for ethical decision-making. Because of the way the items in this checklist have emerged from analysis of the interviews we conducted, we consider them to be empirically supported, and to represent best practice, at least as we found it in the trusts to whom we spoke.

Through the interviews, we were concerned to identify both where trusts could point to aspects of decisions that they had addressed particularly well, and also where they felt that some aspects could have been better addressed. Insights of both kinds have informed the development of this checklist.

As well as representing themes that have emerged from the research, these items are united by their contribution to the *dialectic process*, a method of constructive debate which is a central feature of philosophical discourse, but which can improve clarity in all kinds of decision-making, particularly where values are involved alongside scientific or otherwise empirical data. Each item on the checklist is therefore designed to ensure that this process is able to work as effectively as possible.

In the dialectic process, ideas are expressed, and then subjected to questioning and criticism, the intended outcome of which is a better understanding of the ideas concerned. However, it should be stressed that, while the dialectic process works by considering different and sometimes opposing viewpoints, it is not necessarily about arguing or resolving conflicts or disagreements between people. It is important that a variety of possible answers to a question are considered, but not that any of these possible answers represents the opinion of any particular person in the room. One of the items in our checklist is around openness to challenge, but what is important is that ideas are challenged, and not that the actual opinions of decision-makers are in conflict. To put this another way, a particular candidate answer to a question, or solution to a problem, might not be anyone's preferred answer, but it is important that it should be considered anyway if it has reasonable plausibility.

The checklist items are divided into *decision-making* content and *organisational context*. The *content* items are about what considerations should feed into dialogue and how it should be structured. The *context* items are about how to set conditions so that dialogue is open and productive. Table 1 summarises the eleven elements of the checklist. Section 2.3 contains a more detailed explanation of each one.

2.2 How to use the checklist

Each item on the checklist is not intended to result in a simple 'yes' or 'no' answer. Nor is it intended as an exhaustive list of considerations which, when checked off, will inevitably lead to an ethical outcome. Rather, the intention is to channel thought in productive directions, and to prevent blockages and blind spots which can adversely affect clarity in decision-making. The optimum outcome for a decision of this kind is an outcome that is fully informed, fully thought through and justified to the best abilities of the decision-makers.

Our recommendation is that the checklist should be used as a reference tool in meetings at which decisions are taken. Board meetings and meetings of executive teams are perhaps the paradigm scenario here, but there is no reason why the checklist could not be used to influence decision-making at all levels of the organisation. Wherever there is an element of ethical complexity to the decision in question, we think these considerations are important, and we hope the checklist is flexible enough to be used in a number of different contexts.

What is being recommended here is to some extent a new way of approaching these issues. Facility and clarity in using value terms comes with practice. For this reason, good quality ethics training, particularly centred around the discussion of case studies, can help here, as can employing an ethicist to facilitate discussions. However, there is also much that organisations can do themselves.

As an exercise to help an organisation move towards this way of approaching decisions, we suggest that the board or executive team should identify a key decision which has an element of ethical complexity and important consequences for the trust. The team should then devote a significant amount of time to that decision alone; how long exactly will require judgement. One fruitful approach might be to approach the decision in two stages: at the first meeting, the decision is analysed to the best of the team's ability with the information at hand, identifying what additional data will be required and which team members ought to be involved; the team then reconvenes after all of the necessary information has been gathered, and perhaps with additional colleagues having been invited to attend if necessary. Use the checklist firstly to ensure that the context is optimised for effective decision-making, and then to guide the actual discussion. Rather than an invented exercise, we recommend that this should be a real decision, as this is the only way the real complexities of decisions can be made to emerge. As the discussion progresses, record your answers to each question in the checklist. At the end of the meeting, you should hopefully have arrived at a decision with as complete an ethical justification as you can achieve.

Table 1: A checklist for ethical decision-making

Decision-making content
1. Have you agreed on the aims of the decision?
2. Do you understand the separate roles of values and data in your decision?
3. Have you considered and defined the key value terms involved in the decision?
4. Do you have access to the relevant data, and are you interpreting it correctly?
5. Have you fully considered your roles and responsibilities?
Organisational context
6. Are you spending enough time on this decision, proportionate to its impact and difficulty?
7. Are you involving enough people, and the right people, in the decision?
8. Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?
9. Is the process set up in a way that is genuinely conducive to challenge and debate?
10. Have you fully considered the relevant guidance, regulations and legislation?
Delivery
11. Have you set up systems/measures to show that you have delivered and not simply implemented?

2.3 Explanation of checklist items

1. Have you agreed on the aims of the decision?

Deciding on the aims of a decision may sound simple, but can actually be quite complex in practice. For example, when a decision has a bearing on the distribution of healthcare among a population, is the aim of the decision to maximise the equity of the distribution, to make the most effective use of resources, or something else? This question relates closely to Items 7 and 8, since another way of understanding the aim of a decision is in terms of the *values* it serves, which may be either ethical or otherwise.[5]

Since there may not be immediate agreement about this question, it is useful to spend some time discussing it at the beginning of a meeting, and then revisiting it later. Disagreements on ethical issues are often disagreements about the aims of the discussion, so it is important to be clear about any differences in understanding up front.

2. Do you understand the separate roles of values and data in your decision?

A key step in analysing a decision with an ethical dimension is to separate out those elements of the decision which involve measurable data, and those which involve questions of value. In our research, we found (see Chapter 4) that interviewees were much more comfortable talking about data than talking about values. The assumption sometimes appeared to be that, if all the relevant data were known, the right decision would become obvious or inevitable. However, in reality this is not at all the case.

To see this, imagine two people, A and B, are having a disagreement over whether the current rate of inheritance tax is fair. Imagine that they both have access to all the information that could possibly be relevant to this question: they know what the current rate of tax is, they know everything there is to know about the distribution of wealth in society, how much the new tax will bring into the Treasury, and so on, and yet still they disagree. After discussing the issue for some time, they realise that the reason for their disagreement is not over any factual question, but derives from their different understanding of what fairness is. For A, fairness in this context means that people should, with certain limits, be able to do what they want with their money, leaving it to their children or friends, or to charity, with relatively little interference from the state. For B, on the other hand, fairness means that wealth should be distributed as evenly as possible between different individuals in society, meaning that the notion of inherited wealth is, to an extent, seen as inherently unfair. There is no simple way of resolving this dispute by gathering more data: it is a genuine ethical difference of understanding centred on the value term ‘fairness’. We can now see how this value term plays a key role in influencing the opinions of A and B on a concrete issue, something which might not have been obvious at first to either A or B.

Questions of value play a key role alongside data in all decisions with ethical dimensions. In Chapter 4, we have set out, as examples, some considerations of each kind that feed into four specific types of decision. While discussing a decision, it is a useful exercise to think carefully about the role of values and data in that decision, and to make a list of each. How would a change in interpretation of the data, or of the key value terms, affect your decision? Where there is a disagreement between different points of view, is it a disagreement over a question of data, or over the correct understanding of a value term (e.g. equity, honesty, fairness)?

3. Have you considered and defined the key value terms involved in the decision?

Having identified the key value terms that have a bearing on the decision, decision-makers should try to articulate an understanding of what they mean. In the example above, A and B have a different understanding of what fairness is, but this does not mean that the discussion stops there. For example, A might question why the state should have a right to interfere with people’s control over their own property, while B might question how it can be fair that some people inherit large amounts of money without doing anything to earn it. By being forced to defend and justify their position, each comes to understand their position better, as well as that of the other person. They may eventually resolve their disagreement. If not, they can at least agree that a particular understanding of fairness implies a particular outcome to the decision. As members of an organisation, we sometimes need to agree on an ‘organisational view’ that supersedes our individual views on particular questions.

In the context of the NHS, there may be resources which can help to resolve disagreements of this kind, including those discussed under Item 10. However, it is likely that these resources will themselves require interpretation, which will emerge through discussion of the issues.

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[5] It is tempting to oppose ethical values to financial values, but this is to ignore the fact that, in the public sector especially, money is far from an ethically neutral commodity. The use of public money is inevitably ethically loaded, and the inefficient use of public money is a failure of an ethical responsibility.

4. Do you have access to the relevant data, and are you interpreting it correctly?

Having separated the roles of values and data, it is important that all of the relevant data is available. Our research suggested that many decision-makers are happier with this aspect of decisions than with the value side. It is worth noting however, that as well as interpretation of value terms, differences in opinion around the interpretation of data are a frequent source of disagreement among decision-makers.

In addition, it is important to be aware of possible bias in the data deriving from its provenance: for example, does data about a drug's supposed effectiveness come from the company that owns and markets the drug, or from an independent trial? More generally, is the data framed in a way that gives the best, most objective answer to your question, or in a way that serves some other agenda?

Bias is also possible in data from consultation. For example, it is easy to be persuaded by whichever group of colleagues is making the most noise, and while this may accurately reflect the needs of service users, frequently it will not. Maintaining a focus on public value aids awareness of this issue – the value of a service derives from its value to the public, not to the organisation or its employees.

5. Do you understand your roles and responsibilities?

It is useful for each member of the team to consider the responsibilities conferred on them by their role and position in the organisation, as well as any additional professional responsibilities they may have, including an overarching responsibility to the public interest. This is a big subject, but some key responsibilities that are likely to have a bearing on decisions are as follows:

- A professional responsibility to take account of the public interest in decisions.
- Specific professional responsibilities set out in codes of practice.
- Responsibilities defined by law.
- Contractual responsibilities, either of individuals or of the trust as a whole.
- Ethical responsibilities not defined by any of these categories.

There may sometimes be tensions between these responsibilities. For example, a doctor has a professional responsibility to act as an advocate to individual patients. However, as a decision-maker at trust level, that same doctor might find themselves making decisions that may not maximise the interests of their individual patients – an ethical responsibility for someone who must take account of the interests of whole populations. The key here is to be aware of these tensions and clear about the role one is playing in the decision-making process, since responsibilities are defined by roles to a great extent. The complexity of role responsibilities means it is useful to spend some time separately considering these responsibilities, and essential to keep them in mind when making decisions.

6. Are you spending enough time on this decision, proportionate to its impact and difficulty?

Some decisions are complex in nature but only affect a relatively small number of people while others, perhaps equally complex, have an impact on a very large number of people. It is important to consider both the complexity and the impact of decisions when judging how long to spend on each. Looking at this objectively reduces the tendency for decisions which have a more immediate impact, on identifiable people, to be given more time. For example, if the decision is about whether or not to authorise an intervention for a particular patient, our tendency to empathise with the patient might lead us to spend a long time on this decision, while a decision concerned with the distribution of resources at a macro level, which affects many more people, may be taken more quickly.

As noted above, it may be necessary to approach a decision in two stages: on the first occasion, analysing the decision as deeply as possible given the available data; on the second occasion, reconvening with further data if necessary to finalise the decision.

7. Are you involving enough people, and the right people, in the decision-making process?

The representation of a variety of viewpoints in the debate increases the likelihood of ethical decisions being made, so it is important to seek out a range of views, and to take particular care to listen and respond to, or consider deeply, those views which depart from the consensus view. Consensus views can emerge for a number of reasons, not all of them to do with the correctness of the view, so it is important that they should be challenged (see Item 9).

Furthermore, the views of particular stakeholders should usually be represented within the decision-making team. For example, if the decision is likely to have an impact on nurses, there should usually be someone present whose role is to represent the views of nurses. Similarly for clinicians, service users, and so on.[6]

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[6] The representation of stakeholders is also discussed under Item 5.

However, two qualifications should be added at this point. Firstly, it may be that some stakeholder representatives are apt to act like 'pressure groups', who want to pursue a particular agenda rather than help to make the right decision overall. In that case, while their views will need to be listened to and understood by decision-makers, it may not be helpful for them to be actually present in the decision-making process. Secondly, the need for the presence of stakeholder representatives should not be confused with a need to reach a compromise decision that balances the priorities of everyone present: it may simply be the case that the most ethical decision makes certain stakeholder groups unhappy. Judgement will be required on both of these issues.

Finally, there may be other key people who should be involved. For example, if a particular member of staff has led the process whereby data relevant to the decision has been collected, that member of staff should preferably be involved in the final decision, since it will be necessary to subject the data to interpretation, and the presence of the person who has collected the data will help prevent this interpretation from going awry. Again, however, the caveat should be added that those who collect data are themselves not immune from bias.

The key thing to bear in mind here is that each decision is different, and that while the standard executive team, for example, is likely to represent a reasonably wide spread of viewpoints, there may well be aspects of the particular decision which are not covered by the usual team. This aspect of the organisational context therefore merits careful consideration.

8. Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?

Consultation with stakeholder groups is usually part of the decision-making process in NHS trusts, and is often mandated by legislation (see Item 10). However, our research suggested that clarity is sometimes lacking in defining the role of consultation, and that this might sometimes result in communication that is not entirely open. Inevitably, the opinions of stakeholders form only one consideration among many, and may be outweighed in the eventual decision. Furthermore, the views expressed may be raw and unreflective, and may not be fully informed. Steps should be taken to improve this situation, for example by giving those consulted time to be more reflective, support to gather their own data or help to specify what data and ethical considerations should count. It is also important to be clear in advance exactly what the role of consultation is, and to communicate honestly about this with those consulted.

Arnstein's analysis of citizen participation[7] provides useful background reading in this respect. The key questions to keep in mind have to do with both the purpose of consultation, and the manner in which it has been carried out:

- Is consultation merely the fulfilling of a legal requirement, an attempt to add weight to a decision which has already been taken, or a genuine attempt to gauge the opinions of stakeholders in a way which has a realistic chance of affecting the decision?
- How confident are you that the outcomes of consultation reflect the informed views of stakeholders?
- Is it possible to get a more informed view from stakeholders, for example by conducting a longitudinal study, giving participants time to fully understand the process on which they are being consulted?
- What role does the outcome of consultation play in relation to other considerations (see Item 7)?
- How well do those consulted understand the purpose of consultation?

9. Is the process set up in a way that is genuinely conducive to challenge and debate?

Communication within the decision-making group needs to be open and transparent. It is the responsibility of senior decision-makers to demonstrate that they value disagreement and challenge, if it is reasonable and properly expressed, and to respond to it openly.

It will be useful for leaders to consider the power relationships that exist and how these might impede the transmission of potentially important insights. For example, it may be that ultimate responsibility for the decision rests with the chief executive of the trust. If so, a consensus may form around the chief executive's views on the issue. This may happen unconsciously, so it is important to be aware of this tendency if it occurs. At key points in the discussion, it is useful to stop and consider the opposing view to any consensus that has emerged. This may not actually be the view of anyone around the table, but it is still a useful exercise because it forces the prevailing view to be defended against all possible objections.

As well as encouraging challenge within the decision-making team, channels also need to be open to allow challenge from all areas of the organisation.

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[7] Arnstein, 1969.

10. Have you fully considered the relevant guidance, regulations and legislation?

As noted above, individual and collective responsibilities are defined by statutory duties, contractual duties, regulatory requirements enforced by professional organisations and governmental bodies, and guidance (including lists of values and principles) provided by the NHS and by individual trusts.

It goes without saying that decision-makers have a responsibility to be aware of their statutory, contractual and regulatory duties, and it is beyond the scope of this report to set these out. It should be noted, however, that this network of responsibilities, which is particularly complex in the NHS, is frequently open to interpretation. What, for example, is implied by a duty to promote equity? Knowledge of these duties, therefore, is a necessary but not a sufficient condition for fully informed decision-making.

A useful starting point here is the NHS Constitution, which sets out not only values and principles (as noted in the introduction) but also a long list of rights, responsibilities and 'pledges' to which NHS employees are committed.

11. Have you set up systems and measures to know if you have delivered and not simply implemented?

The other items in this checklist concentrate on the actual process by which decisions are made. However, it goes without saying that the story does not end here. As was noted in the introduction, managers have a central ethical responsibility not only to make decisions and to implement them, but to ensure that the aims of decisions are achieved through delivery. This means ensuring that the decision is properly communicated, paying attention to the implementation of the decision at all points along the chain, and putting in place measures to ensure that delivery is effective on the terms of the decision itself.

- **How will the decision be communicated?**
  How the outcome of a decision is communicated has important implications for how it is viewed by stakeholders, including trust employees, clinicians and service users. Since one of the outcomes of the decision-making process should have been a justification for the ethical aspects of the outcome that has been chosen, this justification should form part of the way that outcome is communicated.

- **How will the decision be implemented by others in the organisation?**
  If the decision in question is a relatively high-level one, it will need to be implemented by many other people in the organisation, and each instance of implementation represents a decision in its own right. Part of the aim of communicating the ethical justification for the decision is to ensure consistency in each decision along the chain of implementation. It might be useful to ensure other measures are co-ordinated, including for example individual targets and objectives.

- **What is the process for monitoring the impact of the decision?**
  Data and consultation feed into the decision, and the outcome of the decision aims at achieving a particular impact. It is therefore essential that some process is designed for ensuring that this impact is as expected. Follow-up consultation or data gathering should be designed with the ethical aspects of the decision in mind.

3. Case studies

In the previous chapter, we recommended a particular way of approaching decisions that have an ethical dimension. In order to demonstrate how we see this methodology working in practice, we offer in this chapter two case studies, drawn from the research, which demonstrate this approach. It should be noted that the way both of these case studies have been written inevitably represents the perspective of those we interviewed: the intention here is not to present a definitive or objective account of the events in question. Nor is it to criticise the way decisions have been approached in these instances. What we hope to achieve by discussing these cases, rather, is to show how attending to the particular aspects of decision-making we have highlighted can make a difference to the process and potentially the outcomes of a decision.

3.1 Case study 1: Discontinuing a service

This case, which emerged through interviews in an acute trust, concerns a decision about whether to discontinue providing a service which had for many years been provided within one of its hospitals.

"The detailed proposal was sent through our critical care business unit which line-manages that service. Ultimately… it was a discussion with the CEO and deputy directors about, 'What did we all think about this?'. Because it's the first time we've really had that debate about 'do we disinvest in a service?' The general consensus was [that we should]."

One interviewee noted three 'fundamental issues' with the service which prompted the trust to consider discontinuing it. These were:

- The trust was failing national targets in terms of timeliness for patients.
- The trust felt that the service could be provided at a lower cost by a different provider.
- Feedback from consultants suggested that they did not see this service as core activity, and providing the service was affecting productivity on other services.

The outcome of the decision was that they gave notice to the commissioner that they would no longer be providing the comprehensive service, though there is the possibility that some aspects of the service would continue to be provided.

In the remainder of this section we consider how each item in the checklist bears on the case, both in theory and with some observations about how the case was approached in practice.

1. Have you agreed on the aims of the decision?

The way the aim of a decision is phrased can have a profound effect on the way it is approached. In this case, the decision might have been expressed in a number of ways, for example:

- Should we discontinue this service in part or altogether?
- How should we address the problems with this service?
- What are the real problems with the service? Are they inherent to the service or a product, for example, of the staff who are currently managing it?
- How do we best ensure that the area's patients' needs are met with regard to this type of service?
- How do we ensure that we as a trust are providing services to as high a standard as possible?

Each of these questions might lead the discussion in a particular direction, making some considerations more salient – more present in decision-makers' minds – than others. One interviewee did express concern that the issue was presented to the team in a way that assumed a certain kind of solution before the discussion had begun:

"[It] worried me at the time that we almost had a decision that was 'here is a problem department that was irritating people for whatever reasons and we're going to reduce the consultants on that and sort it out.'"

While this approach may have been justified, a justification should perhaps have been given to all decision-makers.

2. **Do you understand the separate roles of values and data in the decision?**

Below are a number of considerations of both kinds which play into this decision:

Value questions:

- What responsibilities does the trust have to existing service users, or to the wider public?
- Does the trust have a duty to consult with patients before making a decision?
- What would the effect of each option be in terms of fairness, equity and/or equality?
- Would each option be in the public interest?
- What does "value for money" mean in this context, and would value for money be provided by each option?

Data questions:

- What is the cost of the service?
- Is the service sustainable?
- Is the service meeting its objectives?
- Is the service meeting a minority need?
- Are alternative providers available?

Unsurprisingly, the interviewees did not volunteer the value/data distinction themselves, and tended to emphasise data considerations when asked what kinds of consideration they had in mind during the decision-making process. When pressed, however, they were able to use value concepts reasonably fluently, citing for example duties of care, public value and the value-laden notion of a "core service", which perhaps stands in for "a service which we have an absolute responsibility to provide".

3. **Have you considered and defined the key value terms involved in the decision?**

Some but not all of the value terms mentioned above were raised by interviewees, and there was some evidence that efforts had been made to consider what these amounted to, although this had perhaps not been done in a systematic way. Interviewees were pressed on the issue of public value, and responses suggested that this idea was certainly a live consideration, but that the role of public value in this particular decision had not been rigorously discussed and debated prior to or during the decision-making process.

As has already been noted, the related concept of the public interest plays a key role in this decision. Thinking carefully about the meaning of this concept might have made a difference to the way the decision was made and even to the outcome of the decision in two ways. Firstly, there is the question discussed above of how a concern for the public interest translates into responsibilities for different trusts. Did responsibility in this case fall wholly on the PCT, on the provider trust, or on some combination of the two? Secondly, there is the question of how the public interest is to be determined. Ultimately a judgement will have to be made, but one might question whether this could be done effectively in the absence of systematic consultation with patient groups.

4. **Do you have access to the relevant data, and are you interpreting it correctly?**

One interviewee described a 'taxonomy' of measures by which services could be judged, e.g. whether the service is financially sustainable, what level of patient satisfaction the service was getting, what safety risks was it experiencing, etc. which were broadly data considerations rather than value considerations. In other words, not unusually, there was a concerted effort to gather the relevant data before making the decision.

On the other hand, interviews raised doubts in two key areas. Firstly, as has already been mentioned, there was no patient consultation on the idea of discontinuing or changing the service. Secondly, there was disagreement between interviewees over whether other providers in the area would be able to step in to provide aspects of the service, suggesting that there had not been a piece of research to establish beyond doubt whether this was the case (or if there had, that this had not been disseminated to all decision-makers). As noted above, depending on one's interpretation of the trust's responsibilities, this may be a key question. The question remains open, therefore, whether the decision could have been made more effectively with access to this information.

5. **Do you understand your roles and responsibilities?**

This is a particularly interesting question in the context of this case, not so much at an individual level but at a trust level. The commissioning trust appears to have been of the opinion that the provider trust had a responsibility to continue providing the service. This may amount to a substantive disagreement between the two trusts about where a trust's responsibilities begin and end.

Later, after the trust had given notice of discontinuation, the commissioner made an argument against discontinuing – that (in the words of an interviewee) 'if you don't provide it, nobody else will and your patients will suffer' – which was interpreted by the interviewee as 'almost emotional blackmail'. Is this characterisation accurate? The commissioner's argument makes sense – and is more than 'emotional blackmail' – if and only if two conditions are met: firstly it must be the responsibility of the provider to ensure that the service is provided, and secondly it must be the case that alternative providers, who can provide the service as well or better for patients, are not available. The second is a factual consideration which can be investigated and determined empirically. The first, on the other hand, is an ethical consideration: while the contractual relationship between commissioners and providers is clearly relevant, requiring in this case only that the provider gives sufficient notice before discontinuing the service, it does not settle the question of whether the trust has an additional ethical responsibility, derived, perhaps, from a wider duty to the public interest. Settling this question of responsibility is important because, if it is accepted that the trust has an ethical responsibility to ensure that the service is provided by someone, then the question of whether someone else exists who can provide the service becomes crucial, perhaps warranting extra investigation before the final decision can be made.

6. **Are you spending enough time on this decision, proportionate to its impact and difficulty?**

This decision is a complex one which will potentially have an impact on a large number of patients. As such, it warrants a substantial relative time commitment. In practice, this does appear to have been given: from the point at which the trust set up a working group to look at this issue to the point at which notice was given to the commissioner was a period of roughly four months. A decision was taken to recommend partial discontinuation firstly at a working group of consultants, and then this decision was endorsed at a meeting of the trust board, with significant time allocated to the issue at both meetings.

7. **Are you involving enough people, and the right people, in the decision?**

The decision has the potential to have an impact on a range of different groups, including clinicians, nurses and, of course, patients. As noted above, the decision was initially driven by consultants, but there was also involvement from representatives of other groups, through the membership of the trust board, which included a chief nurse, medical director etc. The exceptions to this appeared to be patients and the commissioner, neither of whom were consulted by the trust as part of the decision-making process (see Item 8).

8. Has consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?

There was no consultation with patients in this case. Interviewees seemed unsure of their opinion on whether there should have been consultation, which suggests that this aspect of decision-making may not have been fully scrutinised. One interviewee thought that they "probably need to consult more with patients and get some patient input earlier on", though noting also that, "the difficulty as always with patients is that if they don't understand the clinical implications… patients probably would want a service at a hospital because they think that's the place they want to go; they've never known anything different."

This highlights a problem with consultation already noted in this report: it needs to be as fully informed as possible if it is to give a clear picture of the preferences of those consulted. However, carrying out some kind of consultation would certainly have strengthened the trust's case as presented to the commissioner, one aspect of which was that continuing the service in its current form would not be in patients' best interests. This is a difficult claim to make convincingly without having carried out some form of consultation. The commissioner agreed in this case, and asked the provider to hold off on their decision until they had been able to do some consultation with patients.

9. Is the process set up in a way that is genuinely conducive to challenge and debate?

There was disagreement among interviewees over whether the decision that had been taken was the right one, but there does appear to have been a very strong steer from leadership in a particular direction, at least according to one interviewee:

"Was there a minute detailed analysis of what the issues are? I would say no there wasn't. There was a very strong opinion given by the director of operations that this needed sorting supported then by the CEO."

On its own, a strongly expressed opinion from leadership is not a bad thing, as long as there is plenty of opportunity to make opposing views known. The suggestion in the above quotation that this may have prevented a "detailed analysis of what the issues are" however, if true, does suggest that the decision could perhaps have been approached more openly.[8]

10. Have you fully considered the relevant guidance, regulations and legislation?

Interviewees demonstrated that they were well acquainted at least with the trust's statutory and contractual obligations with regard to the decision. One interviewee also raised the issue of professionalism and professional regulation with regard to the decision, suggesting that those decision-makers subject to this kind of regulation may have approached the decision differently as a result.

While this claim may or may not be true, it is interesting to consider that a professional obligation to promote the public interest may give professionals, for example doctors, a different perspective on these questions. On the other hand, all managers in the NHS have a similar obligation, since ultimately they are spending public money.

11. Have you set up systems and measures to know if you have delivered and not simply implemented?

In reality, the outcome of this decision was a resolution to give notice that the service would not be continued in its current form. The implementation of the decision, then, is perhaps a relatively simple matter: notice was given. However, the responsibilities of the trust do not stop at this point. There is a responsibility to ensure that the outcome of the decision, including its ethical basis, is communicated effectively to its stakeholders: the commissioner, clinicians, and ultimately the users of the service. There is also a responsibility to ensure that the outcomes for patients are as expected and intended, though it is not immediately clear with whom this responsibility lies: with the provider, the commissioner or both?

However, if the trust decides to continue to provide some aspects of the service itself, it will need to ensure that delivery of the reformed service is effective in terms of criteria agreed in advance. This means collecting data, including consultation with service users, against these criteria, to ensure that aims are met.

Summary/conclusions:

The above discussion of the case suggests that, perhaps more than any others, the question of responsibility and how this relates to the public interest was a key factor in this decision. However, we also saw that considerations such as fairness and equity had a role to play.

The aim of describing this case was not to criticise the way it was made in practice, but to show how systematically addressing the kinds of concern we have been alluding to in this report may have made a difference to the way the decision was approached in

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[8] Note also the lack of specificity in "this needed sorting", reinforcing the need for clarity in the aims of the decision (Item 1).

practice. It is certainly striking, however, that there was a difference in understanding between interviewees on certain aspects of the case. This suggests that a more systematic approach to the decision might have resulted in greater clarity, at least, in understanding, whether or not it would have changed the outcome of the decision.

3.2 Case study 2: Board membership selection policy

In this case, two existing provider trusts were to be brought together to be overseen by a single new merged board of directors. The merger was orchestrated by a primary care trust, which at the time was itself being brought together with other local PCTs to form a cluster. As a result, the Strategic Health Authority that was overseeing this wider process was able to influence the selection criteria for some positions on both the PCT board and the merged provider board.

Problems began to appear when some directors from one of the existing provider trusts were told that they would not be eligible to apply for posts on the new PCT board, without a reason being given for this decision. In the meantime, people who had previously been in Head roles at the PCT were moved into director positions, which had not been openly advertised, thereby becoming eligible to apply for the new positions.

The initial communication indicated that, after the process of selection had been carried out, those who were not selected for new positions would be made redundant. However, this position was later rescinded, with an indication given that unsuccessful candidates would instead be required to work their notice or be moved into other roles, apparently due to a desire not to be seen to be making highly skilled people redundant. This almost led to a complaint being raised at an Employment Tribunal, though the employer settled with the complainant before this stage was reached, but after three months of legal argument.

The complexity of the organisational context in which this was played out means decisions were difficult to make effectively. How should the SHA and the PCT have approached the decisions around designing selection policies for the new boards?

1. Have you agreed on the aims of the decision?

The ultimate aim of the decision – to design a process for recruiting a new merged board, is compatible with further aims which would help the decision-makers to set out what would be a successful result, for example:

- How do we ensure the process represents value for money for taxpayers?
- How do we ensure the process complies with law and regulations?
- How do we ensure the process is equitable, fair, transparent, etc.?
- How do we get the best people for each role?

As with other considerations, carefully thinking through the aims of the decision helps to identify the key values, financial, ethical or otherwise, that play into the decision.

2. Do you understand the separate roles of values and data in the decision?

Below are a number of considerations of both kinds which play into this decision:

Values:

- What does a fair and equitable process look like?
- What does an open and transparent process look like?
- What outcome would represent value to the public?

Data:

- Who might be eligible for inclusion in the new board?
- What are the relevant items of employment law?
- Contractual information, including salaries, etc.
- What other positions are available to those involved in the process?

3. Have you considered and defined the key value terms involved in the decision?

Each of the value terms mentioned above would benefit from time spent on interpreting and defining them.

There is at least *prima facie* reason to believe that this case was not handled in a way that was entirely fair and equitable, and that communication may not have been as open as it should have been. It does not appear, for example, that criteria for eligibility for recruitment to the new board were set out clearly and openly. Similarly, it may be that these criteria, whatever they were, were not consistently applied, resulting in an inequitable process. What would equity have meant in terms of this process? The answer to this question is not obvious[9], but setting

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[9] See Section 4.3 for a detailed discussion of the value of equity.

equity out as a key value in the decision, and tackling it head-on at the start of the process, would at least have ensured that a justification would have had to be given, for example, for the exclusion of certain people from the process. It may also have meant that the situation was avoided where promises were made and then rescinded, ultimately leading to settlement of an Employment Tribunal case.

4. **Do you have access to the relevant data, and are you interpreting it correctly?**

Again, we do not know what data decision-makers were using. In order to ensure equity in this process, however, it may be necessary to consider in detail the potential impact of possible solutions on individual applicants and potential applicants, to ensure that they were not being unfairly treated.

5. **Do you understand your roles and responsibilities?**

One important set of responsibilities to consider here is towards the applicants who missed out on roles in the new structure. The fact that the organisation rescinded their initial position of making these people redundant suggests that these responsibilities had not been thoroughly considered in advance. There also seems to have been a question of a responsibility to the public interest, or at least a desire to avoid public reproach, involved in the decision to rescind the redundancies. Again, the way this became a live issue late on in the process suggests that it perhaps had not been fully considered at the time of the initial decision.

Finally, there appears to have been some inconsistency in the way eligibility for inclusion on the new boards was decided, with the SHA influencing this in some cases but not others. This suggests that role responsibilities were perhaps not effectively worked out at the start of the process by the two trusts.

6. **Are you spending enough time on this decision, proportionate to its impact and difficulty?**

It is not known how long this decision took to make in reality. However, it is worth noting that decisions of this kind are often more complex than they at first appear, and that the ethical dimensions of a decision such as this one can be easily missed.

The impact of a decision of this kind is clearly wide ranging, having an effect not only on those included in or excluded from the selection process, but also on the employees of the affected trusts, and ultimately on the populations overseen by those trusts. These two factors taken together suggest that a reasonable amount of time at least ought to be given to this type of decision.

The unfortunate fallout from this decision illustrates the importance of addressing these issues thoroughly and rigorously at the time, in order to avoid worse consequences later on.

7. **Are you involving enough people, and the right people, in the decision?**

Again, it is not known exactly who was involved in the decision, which was presumably made at different points by the PCT and the SHA. As has been noted above, it is a good idea where possible to ensure that groups who are stakeholders in the decision are in some way represented among decision-makers. However, there may have been good ethical reasons, such as confidentiality or potential conflicts of interest, why representatives of particular groups could not have been directly involved in this decision. However, the opportunity to have an effect on the decision could certainly have been ensured through proper consultation.

8. **Has any consultation been genuine, and clear and honest in terms of its role and the expectations of those consulted?**

In this case, there was consultation on the form that the new organisation would take which, according to the contributor, 'felt genuine'. However, there was apparently no consultation on the process for recruiting to the new board. While this may have been a deliberate decision with an ethical justification given, in purely pragmatic terms it does seem that some consultation would have been useful, particularly in view of the issues that later arose.

If the SHA had sought to consult on the specific issue of forming the new board, it would have been important to be clear about what the role of this consultation was, i.e. how this data would have fed into the final decision, and to communicate this to those consulted.

9. Is the process set up in a way that is genuinely conducive to challenge and debate?
Again, we do not know exactly what form the decision-making process took, and therefore whether it was open and encouraging of challenge and debate. However, again, the fact that issues with the process were only raised after the fact, with unfortunate consequences for all concerned, illustrates the importance of ensuring that challenge is not only possible but encouraged at the time of the decision being made.

10. Have you fully considered the relevant guidance, regulations and legislation?
Clearly relevant considerations here include employment law, and the policies of the organisation with regard to equitable recruitment practices. However, since the decision is of a unique kind, the guidance will not provide a complete answer; what is fair, equitable, open and transparent in this case will require individual judgement.

11. Have you set up systems and measures to know if you have delivered and not simply implemented?
There appears to have been inconsistency in the way the decision was made, which is perhaps why there was also apparent inconsistency in the way outcomes were communicated: people were told that they would not be able to apply for roles without being told why this was.

On the question of delivery, it is perhaps useful to think more abstractly about decisions of this kind, rather than focusing on this particular case. Thinking back to the aims of the decision as discussed under Item 1 gives a basis for assessing delivery of the decision after the fact:

- Did the process represent value for money for taxpayers?
- Did the process comply with law and regulations?
- Was the process equitable, fair, transparent, etc.?
- Did we get the best people for each role?

Each of these questions could usefully be included in a review of this kind of process by the decision-making team.

Summary/conclusions:
As with the first case study, the aim here was not to criticise the organisation that made this decision, but to show how consideration of the items in the checklist can improve ethical decision-making effectiveness. Ultimately, however, it should be noted that, according to our contributor, the consequence of this decision being taken and implemented in this way was ‘a deterioration in the trust in which the organisation was held, by employees, patients and the public at large’.

Unlike the first case, this case has had clear consequences which, it is probably fair to say, the organisation would have liked to avoid. What the above discussion hopefully shows is the importance of thinking these issues through thoroughly at the time of the decision being made in order to avoid these consequences.

4. Evidence from the interviews: decision-making content

4.1 Data and values

As has already been noted, the distinction between data and values is a key one in ethical decision-making. We found that many interviewees were extremely fluent in discussing data and evidence as a basis for decisions. However, they were less aware of the need for judgement on value questions, often ignoring this aspect of decision-making when asked what general considerations fed into decisions:

"I would have said most decisions have to be data driven.... You start to look at those services… that aren't addressing your major health needs, that are [raising] questions about whether they're good value for money, that are not clearly giving you the outcomes that you're expecting. And I think then you start to collate almost a hierarchical list of what those services are." (Chief Operating Officer)

To be clear, empirical considerations such as those alluded to in the above quotation are of course very important, and the focus on these is not evidence that value considerations were ignored. However, it is striking that in this and many of the other interviews, the interviewee only addressed value questions such as 'is it fair?' or 'is it in the public interest?' when pressed by the interviewer.[10]

In some cases, it is possible that too much of an emphasis on evidence over judgement can have a distorting effect on decisions. This was shown clearly in the discussion of Quality Accounts, where there was occasionally a suggestion that something's not being measurable might lead to its not being addressed as a priority:

"Certain things that perhaps the stakeholders want us to look at we… didn't have ways to measure. There's no point having a priority you can't measure because you don't know what your progress is. So that filtered some of the priorities out." (Chief Medical Officer)

This interviewee was quick to point out that something's not being a priority in Quality Accounts did not mean that it was being ignored by the trust. However, it is worth noting that the relative measurability of a phenomenon is not necessarily correlated with its importance, and that inclusion of particular objectives as "priorities" in documents such as Quality Accounts must inevitably have some effect on their relative salience in decision-making.

Table 2 shows four particular kinds of decision on which we focused in the research, giving for each some examples (not an exhaustive list) of data and value considerations that feed into the decision overall.

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[10] It should be noted also that data itself can be ethically loaded. Even direct observations can serve a particular ideological viewpoint if they are "framed" in a particular way. Great care should therefore be taken in the interpretation of data.

Table 2: Data and value considerations in ethical decisions

Addressing inequities in access to healthcare	
Data considerations	**Value considerations**
What is the current availability of services?	What is the operative interpretation of equity/fairness/justice?
What is the relative take-up of services between different groups?	What interventions are justified in order to drive up take-up?
What factors explain low take-up among particular groups?	What is the relative importance of equitable take-up compared to other ways in which resources might be used?
	What are the (role or liability) responsibilities of the trust? Of individuals?
Completing Quality Accounts	
Data considerations	**Value considerations**
What is the data on quality of services within the trust?	Is the information presented an honest representation of the state of affairs in the trust?
Have the objectives from the previous account been met?	Where information is left out, are the reasons for this openly communicated?
	Are the objectives sufficiently challenging?
	What are the (role or liability) responsibilities of the trust? Of individuals?
Decommissioning/discontinuing services	
Data considerations	**Value considerations**
What is the cost of the service?	What would represent value for money in provision of the service?
Is the service sustainable?	Does the trust have a (role) responsibility to ensure provision of the service?
Is the service meeting its objectives?	What responsibilities does the trust have in respect of service users?
Is the service meeting a minority need?	What responsibilities does the trust have to the commissioner?
Are alternative providers available?	Would decommissioning/discontinuing the service be in the public interest?
Covering staff shortages	
Data considerations	**Value considerations**
What skills and abilities are required?	Are demands placed on staff fair and reasonable?
What skills and abilities are available among remaining staff?	Is there a responsibility to consider the development of those asked to cover shortages?
What is the availability of staff to cover shortages, through various channels?	Is communication with staff open and honest?

These four areas are presented as examples to illustrate the content of particular decisions in terms of data and value considerations. The exercise of distinguishing these aspects of a given decision is an important first step in improving ethical decision-making.

4.2 Defining ethical concepts

Having separated data from values, it is important to work towards clear and unambiguous use of ethical concepts. To avoid speaking at cross-purposes, two people who are discussing an ethical issue must be aware of differences in their understanding of the relevant ethical terms, and seek to resolve those differences. The ethical models that we employ, whether consciously or unconsciously, have a profound effect on the way we make decisions. In the interviews, we looked for evidence of the models people were employing, of the extent to which the interviewees had a shared understanding of concepts, and for evidence that trusts had taken steps to foster such an understanding.

In the next two sections, we examine the two sets of ethical concepts we identified in the introduction as being particularly relevant to NHS trusts. The first sub-section of each section sets out some theoretical perspectives on these concepts. The next sub-section illustrates by means of examples how the concepts might be applied in practice in trusts. The final sub-section discusses the extent to which we found a shared understanding of the concepts among interviewees, and identifies some ethical models that interviewees appeared to be employing.

As noted in the introduction, the particular ethical concepts discussed in this chapter are likely to be of relevance to a lot of decisions made within NHS trusts. The specific discussion in this chapter will therefore hopefully be helpful to trusts. However, there will inevitably be many ethical concepts (e.g. integrity, confidentiality, objectivity, accountability, environmental and social responsibility) which are not covered here. The intention is also, therefore, that the general approach taken in this chapter should be taken as a template for discussion of other issues with ethical elements.

4.3 Equity, equality, justice

4.3.1 Meaning

The NHS's core principles state that (1) "'the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief'", that (2) "'access to NHS services is based on clinical need, not an individual's ability to pay"' and that (6) "'the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources"'.

These principles do not entail that absolute equality (of whatever kind) should be achieved. However, the latter principle in particular does suggest that equality is an ideal towards which the NHS should be working.

Equality can be interpreted in several different ways in this context. Trusts will need to decide whether they are trying to achieve:

- Equality of outcome (levels of health across socio-economic groups).
- Equality of take-up of services (so other factors beyond the scope of trusts' responsibility may affect outcomes).
- Equality of availability of services (so other factors beyond the scope of trusts' responsibility may affect both take-up and outcome).

Equality of outcome may look like the most desirable goal here. Realistically, however, some inequalities between groups may be such that it would be impossible to get close to eliminating them through the means at trusts' disposal. Moreover, it may be undesirable to seek health equality at all costs, for example if achieving this would infringe on patient autonomy: patients cannot be coerced into accepting treatment even if clinicians judge the treatment to be in the patients' interests.

The third option is perhaps the most realistic, since there will always be other factors to contend with that trusts cannot hope to eliminate. However, what counts as availability? Is it enough that services are theoretically available, though some people may not be aware of them, or may be reluctant to take advantage of them for various reasons (religious beliefs, cultural factors, etc.)? Many would think that trusts have a duty to communicate the availability of services to their constituency, and perhaps to encourage their take-up. But how far does such a duty extend? Cost is a factor here: extensive schemes aimed at educating people about the health services available to them may be extremely expensive for the results they achieve, thus potentially reducing the availability of services overall. In that case the issue becomes a trade-off between equality of availability and quality of provision, and trusts will need to choose between these two values. This is a particularly stark example of potential tension between values, since Principle 6 enjoins seeking both the most fair and the most effective use of resources – two superlatives that might (depending on how the concepts are interpreted) turn out to be as incompatible as an unstoppable force and an immovable object.

A prominent line of argument in favour of universal access to some forms of health care appeals to general principles of equality of opportunity. John Rawls puts forward such a principle in the Theory of Justice[11], and Norman Daniels and James E. Sabin[12] have built on this to argue for universal access to healthcare as a requirement of justice.

Beyond universal access, there are the questions of whether, in order to be just, access has to be distributed equally or equitably, and of what this would entail in practice.

Distributive justice

The type of justice perhaps of most interest to the NHS is distributive justice. Though this might seem prima facie to imply equality, there are in fact several approaches to distributive justice to be found in the philosophical literature, only one of which takes equality to be the main requirement.

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[11] Rawls, 1971

[12] Daniels and Sabin, 1997, 2002, 2008

According to the Equality View, it is bad if some people are worse off than others, in respect of some given metric or currency of goods (in this case, either health, or availability or uptake of healthcare services).

One criticism that has been made of this view is that it makes a fetish of equality. According to this "fetishism objection"[13], it is not the relations between people's lives that are important, but the actual content of those lives. The Equality View seems to imply that inequalities among the well-off should be as much of a concern as inequalities between the well-off and the poor and needy, as long as the level of inequality is the same.

A second objection is the Levelling Down Objection, which points out that inequality could be combated by simply reducing the well-off to the level of the poorly-off, an approach which would benefit no-one in material terms. In the context of the NHS, imagine that a primary care trust sought to eliminate health inequalities by simply removing health services from advantaged groups, until they were driven down to the level of health of the disadvantaged, without also increasing access among the disadvantaged.

These objections and others have motivated two recent alternative candidates for an account of distributive justice: the Priority View and the Sufficiency View. Derek Parfitt offers this description of the Priority View:

"[O]n the Priority View, benefits to the worse off matter more, but that is only because these people are at a lower absolute level. It is irrelevant that these people are worse off than others. Benefits to them would matter just as much even if there were no others who were worse off."[14]

The Sufficiency View has been proposed by Harry Frankfurt[15]. According to this view, what matters is that everyone should be guaranteed a certain 'sufficient' level of goods. Beyond this level, inequalities cease to be important. This view can be seen as related to the concept of rights. It may be believed that each individual has a *right* to a certain standard of care. Above this level, inequalities might not be considered to be important. This would still justify directing large amounts of resource at the worst off in society, as long as it is considered that the standard of care currently experienced by these people falls below the minimum sufficient level, or the level to which those people have a right.

While NHS trusts will be explicitly committed to equality or equity as a goal (often through their mission statements, and always as parts of the larger NHS), NHS leaders may wish to consider the force of the above considerations. Firstly, is it the case that any inequality of an equal size is equally important, whether or not those on the losing side can be considered, in absolute terms, to be deprived or poor? Secondly, would it ever be a justifiable approach to combating inequality to reduce the level of the better-off without also raising the level of the worse-off? Finally, is it the case that trusts should be striving to achieve a minimum sufficient level of healthcare across the board, beyond which inequalities cease to be important?

Utilitarianism

It is worth noting another interpretation of justice which has traction in philosophy: the utilitarian view. While there are many varieties of utilitarianism, broadly speaking this is the view that the just act is the one that maximises the total amount of some value or set of values in the world, where candidate values include pleasure, wellbeing, or the satisfaction of desires or preferences. The NHS guiding principles could be seen as endorsing this view in part, at least if one took a simplistic interpretation of the injunction to use resources in the 'most effective' way.

Perhaps the most common objection to utilitarianism is that, at least in its most simple form, it fails to take account of the interests of minorities. In a healthcare context, for example, one can imagine situations in which a simple form of utilitarianism would recommend, say, ignoring the ability of disabled people to access services when this would be very expensive, and funds could be directed towards the needs of able-bodied people, a much larger group, so that the total sum of needs would be met more effectively in this way. Utilitarianism is a big subject, and there have been many attempts on the part of utilitarian philosophers to address this and other objections. However, without further development, utilitarianism does not look like a particularly promising approach to distributive justice in healthcare.

Equity and distribution according to need

Rather than true equality, or the maximisation of utility, trusts may consider that what they are aiming for is *equity* of access to healthcare.

According to the Stanford Encyclopaedia of Philosophy[16], "The dominant conceptualisation of equitable access to health care among health service researchers builds on the idea that the utilisation of services should reflect actual needs for care (Aday and Anderson 1974, 1975, Aday 1975, Aday, Anderson and Fleming 1980, Aday 2001, Aday et al 2004)." This is the Use-per-Need View, contrasted with the view (more popular in the US than Europe) that only a basic minimum standard should be guaranteed, the rest being left to the market.

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[13] E.g. Crisp 2003

[14] Parfitt, p13.

[15] Frankfurt, 1987.

[16] Daniels, 2008

Justifications of the Use-per-Need View often appeal to an argument from function. The thought is that, since the main function of health-care services is to prevent and cure illness, the distribution of those services should primarily be determined by considerations of health and illness. A version of this argument is foreshadowed by Bernard Williams:

"'Leaving aside preventive medicine the proper ground of distribution of medical care is health; this is a necessary truth."[17]

However, proponents of this view still need to explain why meeting healthcare needs matters as a concern of justice or equity, in contrast to other needs where we are inclined to accept that ability or willingness to pay are justifiable grounds for distribution (for example we don't think that lawnmowers should be distributed according to who has the most unkempt lawn). It should be noted, however, that a use-per-need interpretation of equity is, if not entailed, then suggested by points 2 and 4 in the NHS Constitution.

This still leaves, of course, the question of what counts as a "need" in this regard. Some consideration will need to be given to the question of whether various forms of treatment for non-life-threatening conditions can be considered to be 'needed', and it will be helpful if distinctions can be made on principled grounds.

One plausible first attempt at defining need in this context would equate it with a health deficit relative to an established norm of health. It is worth noting that this would make equity on the Use-per-Need View very close, if not identical, to equality of outcomes as defined above, since it would imply focusing on outcomes rather than availability or take-up of services.

4.3.2 **Application**

It is perhaps useful at this point to consider how the various ethical models outlined above might affect a decision about just distribution of resources in NHS trusts. Say, for example, Trust X, a primary care trust, becomes aware of an inequality in the provision of hip replacements among its population group. Specifically, those from low income families are far less likely to take up hip replacement operations than those from middle or higher income families. How might Trust X's decision as to what to do about this inequality be affected by the ethical models being used within the trust? Of course, the decision is further complicated by the fact that provision of hip replacements needs to be weighed alongside other interventions in a health economy of limited resources. Some way would therefore need to be found to compare hip replacements to other treatments, and the results of this calculation will also be influenced by the ethical model being employed. However, for simplicity's sake, let us consider hip replacements in isolation.

Firstly, consider equality as an aim. An initial distinction was made above between equality of outcome, equality of access and equality of take-up.

- If equality of outcome were the aim, this would suggest that data should be sought as to the general level of health in the population, and managers should seek to drive up hip replacements among low-income groups in order to equalise health outcomes across the whole population.
- If equality of access were the aim, this would suggest that Trust X does not need to take action to increase take-up of operations, as long as those from lower-income groups are able to access operations if they choose to seek them out.
- If equality of take-up were the aim, this would suggest that Trust X ought to seek to drive up the number of operations among the lower-income groups, using data on the number of operations, rather than health outcomes, as a measure of success.

Secondly, consider the other views of distributive justice that were examined above.

- According to the Priority View, the interests of the worse off matter more because of their position in absolute terms. This would probably suggest that efforts should be directed at increasing take-up among lower-income groups, since it does appear that their interests are not being met. However, the relevant data would be that which demonstrated the individuals' interests rather than general levels of health or take-up of operations across socio-economic groups.
- According to the Sufficiency View, what matters is that everyone has a sufficient level of the resource. This again suggests focusing on the needs of individuals, and determining whether the level of resource directed at them is sufficient. Again, this may suggest seeking to drive up operations among lower-income groups, since it is likely that there are individuals whose quality of life is 'insufficient' due to their current health problems.

Finally, consider equity, on the use-per-need model, as an aim. This would suggest that resources should be directed towards increasing interventions where they are most needed. Since it appears that those from lower-income groups have needs at least as great as those in

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[17] Williams, 1971, p27

other groups, and that those needs are not being met to the same extent, this conception of equity would appear to recommend directing resources at increasing take-up among those groups. It is relatively uncontroversial that hip replacements are responding to a need in the patient. More difficult cases arise where, for example, the aim of an intervention is to improve the patient's appearance in some way. It can be difficult to determine when, if ever, these interventions can be thought of as responding to needs.

Considering the implications of interpretations of ethical concepts on concrete cases in this way shows us a number of things.

Firstly, we can see that while a number of different interpretations of value terms will often result in the same recommended course of action, often they will differ. This shows, simply, that this is not merely an abstract philosophical exercise, but a process with real implications for practice.

Secondly, we can see that ethical considerations – *value* considerations – inevitably play a role alongside empirical data in decisions of this kind. In the above example, the data around health outcomes, availability and take-up of services could be exactly the same, and a different interpretation of the value of equity, say, or justice, would result in a different decision. This shows that no decision with an ethical dimension (and therefore very few if any decisions taken within the NHS) can be driven by empirical data alone. Moreover, the ethical model in use will have implications for which data is relevant and should feed into the decision, and for determining the success or otherwise of the decision. Being clear about the ethical considerations is therefore important even at the stage before evidence has been gathered, and continues to be important long after.

Finally, where decisions are taken by multiple people, we can see the importance of reaching a shared understanding of concepts. Since the answers to practical questions like the one discussed above depend on one's understanding of concepts, two people discussing such an issue with an unrecognised difference in understanding of the relevant terms, can find themselves speaking at cross-purposes. Digging under the surface of the concepts therefore helps us to make clearer, more effective decisions.

4.3.3 **Understanding**

We sought in the interviews to test the extent to which interviewees had a shared understanding of ethical concepts, and what ethical models might be underlying their decisions.

We found some variation in the degree to which trusts have thought through how to interpret these terms. In general, when asked to define the terms, interviewees were able to make a reasonable attempt, some (but not all) understanding that equity differs from equality in that it takes account of relevant facts about the people concerned, or is concerned with outcomes.

We found evidence of some understanding of several of the interpretations outlined above, though this was often tentative and sometimes contradictory. For example, one interviewee had some grasp of the distinction between equity and equality, but appeared to get the two terms confused:

"Equity is treating people equal [sic] but equality is taking account of a lot of the things we've talked about, to do with age and race and disability and sex."

Another interviewee thought of equity as implying equality of availability:

"Equity to me would be… how we… make the service available to everybody no matter what their background is…. That's all services, all treatments."

On the other hand, another interviewee defined equality in these terms, and defined equity as equality of take-up of services:

"I'd say equality is when everything is equal... if you provide a service and you invite everybody to access that service then that's equal because it's even to everybody. Equity is when... everybody is accessing the service to the same extent so you might have to make things unfair in order to get the outcome. You might have to make things unequal in order to achieve equity."

The interviewee who came closest to the interpretation of equity on the use-per-need view gave a clear and articulate definition which illustrated the close relationship between this view and equality of outcomes:

"Equity is more outcome-based I suppose. Equality to me would be like giving everybody one pound each whereas equity would be about looking at what everybody already had and making it up to a pound. That fits with healthcare in that you're trying to return everybody to… a reasonable standard of function and health…. Equity might mean you do an awful lot more to some people…. Whereas equality [means] you give the same to everybody."

The above quotations are all taken from the same trust. The fact that such a variety of interpretations appears to have been operative within this trust suggests that the trust would benefit from working towards a better shared understanding of the terms, despite the fact that, as one interviewee explained, discussions in the trust frequently employed the term "equity":

"It is [used a lot]. Particularly when you're looking at commissioning decisions and policies… and funding requests."

Despite the confusion over the meaning of terms, we did find that the actual model underlying decisions was fairly consistent between the two trusts to whom we spoke about these issues. Most interviewees revealed through their discussion of cases that they were implicitly employing a use-per-need model, or the closely related idea of equality of outcomes:

"I think there's something about whether or not a particular service is meeting a particular need, particularly around a minority group. So we have had decisions before whereby there are only a small number of services that might be specifically meeting [the needs of] that minority group, but therefore if we were to decommission those that would leave no services available [to that group]." (Chief Operating Officer)

"Essentially I think the outcomes that we're trying to get to are that… there is equality of access…. And that might mean that we pay more money to develop a service for a person with disabilities [for example]…. But then the other bit is equality of outcomes, so you can access a service… but it's actually about what happens to you in that service that gives you the full opportunity to benefit from that service." (Director)

Occasionally, an interviewee made a comment that appeared to imply a utilitarian approach. For example:

"When you've got limited resources [you need to] have the maximum benefit to as many people as possible." (Deputy Director)

As noted above, a utilitarian approach or an exclusive focus on the "most effective" rather than "most fair" use of resources as suggested by the NHS's guiding principles (see the discussion in Section 4.3.1) might lead one to target resources where they are most effective, i.e. at groups among whom take-up is higher. However, this would be to ignore the interests of minorities and the NHS remit "to provide healthcare for all". Ultimately, no interviewees wholeheartedly recommended this approach, and trusts were clearly and explicitly spending money on schemes aimed at groups where take-up was low:

"Although we have to provide services for everybody, we know that certain groups, if the information is there, they access it and they use it and they are able to pay to go and have services themselves, to go to the gym or to have a personal trainer or whatever but we know that other groups don't so those are the ones who struggle the most to make differences to their health." (Programme Manager)

As well as directing resources in this way, interviewees were able to give many examples of innovative approaches, suggesting that significant mental as well as financial capitol was being spent in the name of equity. However, interviewees also recognised that there will be limits to how much money trusts are willing to spend in this way:

"I made it sound like I'm a complete fanatic about equality and I think that equality should be achieved at the expense of everything else and I don't, necessarily. I still think it's very important to have a good quality, comprehensive health service and sometimes that will be at the expense of equality or equity…. We haven't got a bottomless pit of money to provide services." (Senior Manager)

There is however no obvious principled basis for where this line is drawn, suggesting that trusts would benefit from the opportunity to talk through these issues in more depth.

Finally, as noted above, the use-per-need view of equity requires judgement as to what constitutes "need" in a patient. Again, the question of where to draw the line on principled grounds arose in this context:

"There is a big gap between need and want, so I think a lot of doctors get a bit hung up and feel uncomfortable with the sort of thing I do, because they're saying, 'the patient needs a breast reduction' and I say, 'well, the patient wants a breast reduction and I would argue the patient doesn't actually need it.'…. [When there are functional impairments] there's a bar for whether you qualify for treatment that's low but when it comes down to things that are purely cosmetic then the bar is higher." (GP and Medical Adviser)

In the above quotation, the interviewee identifies a specific case – breast reductions – and abstracts from that to a general principle: that functional impairment should take precedence over appearance. When pressed to provide a justification for this principle, however, the interviewee defers to guidance from government:

"Interviewer: Is that how it should be?

Well I think in a sense it's a political decision.... I think at the end of the day we have someone who is paying the bill, which is the government and I think they're gathering the taxes and I think they have to tell us where they would put that line."(GP and Medical Adviser)

Though the interviewee is right to point out that government guidance is in practice the arbiter on this question, it would be preferable if this 'political decision' were made on principled grounds, and understood as such by practitioners. It is also possible that understanding of what these grounds are would help with decisions on difficult, borderline cases.

4.4 Openness, honesty, transparency

4.4.1 Meaning

Openness, honesty and transparency are often used interchangeably or at least with significant overlap between their definitions. Nonetheless, there exist important distinctions which will have consequences for the outcome of decisions involving these terms. While these concepts have received considerably less philosophical attention than the ideas of justice, equity and equality discussed above, there are resources in the literature than can help here.

Honesty, perhaps, consists in a lack of deception. James Edwin Mahon offers the following definition of deception:

"To deceive [is defined as] to intentionally cause another person to have a false belief that is truly believed to be false by the person intentionally causing the false belief."[18]

While this definition is not uncontroversial[19], it offers a useful way of looking at the issues. Imagine, for example, a student submits an essay for assessment, and then subsequently realises that part of the essay closely resembles part of a published article which he had read prior to writing the essay. There had been no intentional plagiarism, but it is likely that, subconsciously, the essay was influenced by the article. Now imagine the student says nothing about it, hoping that the issue goes away by itself. According to Mahon's definition, the student would not be guilty of deception, since he would not have caused a false belief on the part of the examiners. The examiners are unlikely to have a belief that no subconscious influence had taken place; they would not have formed a belief either way. Even if we accept that they do have such a belief, this belief would not have been caused by the actions of the student. At worst, the student would be guilty of allowing the examiners to continue to have a false belief that they already had.[20]

If we equate honesty with a lack of deception, the student would not be guilty of dishonesty. He would, however, plausibly be guilty of a lack of openness, or transparency.

To take another example, imagine a company that fails to publish its financial accounts. Since nobody may have any particular beliefs about the financial status of the company, the failure to publish may not cause, or even allow to continue, any false beliefs, and so the company would not, on Mahon's definition, be guilty of deception. On the other hand, it would certainly be guilty of a lack of openness, and a lack of transparency.

What these examples suggest, perhaps, is that openness and transparency go further than mere honesty. As well as not deceiving, the duty to be open and transparent requires a thoroughgoing willingness to reveal facts about oneself if they would have implications for others, even when those others may be unaware of the implications. As we will see, this distinction has consequences for decision-making in NHS trusts.

4.4.2 Application

Trusts' commitments in terms of openness, honesty and transparency are largely set out in the Code of Practice on Openness in the NHS. This states that NHS trusts must make available:

- Information about what services are provided, the targets and standards set and results achieved, and the costs and effectiveness of the service;
- Details about important proposals on health policies or proposed changes in the way services are delivered, including the reasons for those proposals (this information will normally be made available when proposals are announced and before decisions are made);
- Details about important decisions on health policies and decisions on changes to the delivery of services. This information, and the reasons for the decisions, will normally be made available when the decisions are announced;
- Information about the way in which health services are managed and provided and who is responsible;
- Information about how the NHS communicates with the public, such as details of public meetings, consultation procedures, suggestion and complaints systems; information about how to contact Community Health Councils and the Health Service Commissioner (Ombudsman); information about how people can have access to their own personal health records.[21]

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[18] Mahon (2008)

[19] See for example the objections raised in Mahon's article.

[20] Fuller (1976), p21, argues that this type of action would in fact count as deception.

[21] Department of Health (2003), pp2,3.

Nonetheless, there is room for interpretation and judgement in respect of some of these commitments. Firstly, how widely should this information be distributed? Secondly, to what extent do trusts have a duty to make it available in a format which can be understood by everyone (e.g. people with literacy problems, learning disabilities, speakers of other languages, etc.)? Beyond this, how far should trusts go in seeking to interpret data on behalf of the audience? On the one hand, offering an interpretation might be seen as hampering openness, by insisting on one of potentially many possible interpretations. On the other hand, data presented without interpretation can be difficult to understand without both expertise and effort on the part of the reader, and so this too may act against openness.

The recently introduced requirement to produce Quality Accounts, which builds on the first bullet point in the Code of Practice, provides an interesting case study here, which is why we have made it a focus of this research. The purpose of quality accounts is to make trusts accountable and transparent to the public in terms of quality. In order to ensure consistency, much (though not all) of the content of quality accounts is mandated. However, there are still decisions to be made by trusts in terms of how to present this data so that it can be readily understood by the public, and how open to be in setting objectives for the coming year. Judgements around openness, honesty, transparency and accountability are clearly very important here.

Thinking in terms of the definitions of honesty and openness offered above, it would for example be possible for a trust to be honest in its Quality Accounts by setting objectives that it believes can be easily met, and ignoring aspects of service where it is more challenging to bring about improvements. However, arguably this would not be fully open or transparent behaviour on the part of the trust, since it might leave out aspects of service which are equally, or more, important, and where improvement is needed more.

4.4.3 Understanding

Within the discussion around Quality Accounts, there was widespread recognition of the role of these in increasing openness and transparency:

“It's meant to be something that is quite a truthful presentation of quality and what improvements can be made and it is a very publicly visible document. Then those changes can be measured to see if they're actually in place.” (Medical Director)

Nuances in understanding of the nature of these terms came up in particular areas of discussion. One interviewee in particular recognised that openness and transparency are not simply a matter of providing large amounts of information. In fact, they were concerned that, in Quality Accounts, too much data might actually compromise transparency:

“It just is a requirement... this production of data. And I can understand part of it… I think it is very useful for the trust but I don't think it meets the initial objectives of the Quality Accounts. Because I don't think that makes sense to any member of the public. And the idea of the Quality Accounts was to be a transparent way for the public to be able to assess where we were. And I don't think that helps.” (Head of Patient Safety)

As discussed above, openness differs from honesty in that honesty consists in not deceiving, whereas openness is about what is left out as well as what is left in. In one particularly interesting case, an interviewee who had made various recommendations for what should be included in a Quality Account found that, “when I saw the final one it was nothing like how we'd have done it, they'd missed out a big chunk.” This interviewee felt that information had been left out without an explanation for why this had happened, a failure of openness if not of honesty. Openness, in the interviewee's opinion, would have required being clear and explicit about the basis on which decisions had been made around what to leave in and what to leave out of the Quality Account. Simply leaving the information out without explanation may not have counted as deception or dishonesty, but it was not fully open or transparent.

An interviewee at a different trust spoke of intentionally including objectives that were a particular challenge for the trust:

“This year we've got an even harder target to meet, but we've still put it in our Quality Account. Our chance of meeting that harder target is small but we are determined, because we think it's important to the patients, to put it in our Quality Accounts. And we are going to do our best to try and achieve it.” (Chief Medical Officer)

The interviewee recognised the risk of the trust incurring bad publicity as a result of not meeting this target, but saw the inclusion of the target as an integrity issue.

Because trusts are able to set their own targets, these contrasting examples show that for Quality Accounts to achieve true openness requires integrity on the part of those creating them. On the other hand, review by external organisations can help in this respect. One of the interviewees we spoke to worked at a primary care trust and had been involved in reviewing Quality Accounts produced by provider trusts:

"Supposing [a trust] had 12 things they could choose from. Would you go for the one which was less taxing and probably more doable at the end of the year or would you go for the one that's really a challenge because you've got to work hard with other providers and you don't have all the factors under your own control?... It's always important for the Commissioner to know what range is being chosen from…. Our Internal Audit reports were looking for challenges – where is the documented evidence of the telephone conversations, a meeting or whatever that showed that stretch?... I think our board has at some times made the comment that there could be the desire to paint a rosy picture and there have been a few conversations where [it has been pointed out that] that is not the purpose of the Quality Accounts." (Medical Director)

As well as Quality Accounts, transparency also arose in the discussions around covering staff shortages. Answers to these questions suggested that some of the interviewees were unused to thinking about these kinds of questions:

"I think [about] fairness all the time, but I don't know about transparency. I'm not quite sure what you mean by that." (Ward Sister)

In general, our interviewees were quite clear about the importance of not only honesty, but openness and transparency in relation to their work. However, as the quotations above demonstrate, some were able to tell stories which suggested that this view was not ubiquitous in their experience.

4.5 Responsibilities

As well as identifying and interpreting value concepts, an important part of the content of the ethical decision-making process is to fully consider the responsibilities, both of individual decision-makers and of trusts as a whole, and how these bear on the decision in question. In this section we offer three contributions to this process: firstly a discussion of one key professional responsibility – to the public interest – and then two important distinctions: between ethical and legal/contractual responsibilities, and between individual and organisational responsibilities.

4.5.1 Responsibility to the public interest

There is a substantial literature examining different types of organisation from a teleological point of view, i.e. analysing organisations according to their goal. The NHS is a public sector organisation and therefore has contribution to the public interest as its ultimate goal. This increases the range and type of responsibilities pertaining to its staff and in particular to its leadership, in comparison to, say, a commercial business. The 'classical' view[22] of the responsibilities of a commercial business is that it has a primary responsibility to its owners or shareholders (usually defined as the duty to maximise long-term shareholder value), accompanied by a number of other responsibilities which act as side constraints on the ways in which the business can operate. These may include duties to employees, to the environment, and to communities of people directly affected by the operations of the business. Against this, some, originating with Freeman (1984) have argued that the true purpose of a business ought to be to serve in a balanced way the interests of all of its stakeholders, i.e. of all those who bear a substantial relationship to the business.

A public sector organisation such as the NHS has all of the 'side constraint' responsibilities, both legal and ethical, that a business has. It must treat its employees fairly, act responsibly with respect to the environment, respect the rights of local communities, etc. Its central, defining responsibility, however, is not to shareholders but to the public interest. How is the public interest to be defined? Clearly, the NHS is accountable to the public through its relationship with government, but there will be a role for interpretation of government priorities, for the influence of the NHS's core values, and for the NHS's experienced practitioners to influence government policy. All of this makes the public interest a concept which is difficult to define in practice.[23]

In this inquiry we focused on decommissioning and discontinuing services as a prism through which to view public interest considerations. The question of whether to decommission or discontinue a service is complicated by relationships between trusts: both contractual relationships and habitual working relationships. For example, if a provider trust finds that a particular service is losing money, or is not delivering on its objectives effectively, it may wish to discontinue that service, and it may be legally entitled to do so. However, given the public interest remit of the NHS, it is likely that managers, clinicians and other staff within the trust will be reluctant to discontinue that service unless they are confident that it can be provided at least as effectively elsewhere. This extra consideration, essentially a duty or responsibility to take account of the public interest, highlights the essential difference between an NHS trust and a private company, regardless of the extent to which NHS trusts currently operate in a quasi-market.

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[22] A version of this view is to be found in Sternberg (2000) and Friedman (1970) among others.

[23] A good general discussion of the deontic properties (i.e rights and duties) generated by teleologically distinct organisational models can be found in Miller (2001). Different views on the public justification of political institutions can be found in Rawls (1971), Barber (1988) and Habermas (1993). Wide ranging discussion of the public interest and political accountability in the healthcare context can be found in Public Health Ethics Volume 2, Number 2, July 2009, a special edition on political philosophy and public health ethics.

We found that, unsurprisingly, interviewees were in general well aware of the public interest as an important consideration. One interviewee, for example, expressed the idea of responsibility to the public interest in terms of a ‘core service’ and a ‘duty of care’:

“We can’t divorce ourselves of our duty of care to our patients. We might have grand ideas about different ways of delivering things… [but] we can’t just say, ‘Well because it’s not making a profit, or it’s not breaking even, we’ve got to get rid of it.’ … We might have to accept that some of our core services we can’t make any more profitable but we need to keep them.” (Deputy Chief Executive)

The political context also generated some interesting discussion here. Managers in health organisations need constantly to negotiate between their own judgement of what is in the public interest, and the direction from government. The position of government as elected representatives of the people gives it a clear role in defining the public interest. However, the distance of those in government from decisions can mean they may not be best placed to guide individual decisions. This was a source of frustration for one interviewee:

“The problem is the minute the hard cases come up the politicians tend to very much sympathise with the patient and ignore their own guidance so that is really very frustrating indeed.” (GP and Medical Adviser)

There is of course no simple solution to this problem. However, the opportunity to consider and discuss it openly is likely to help.

4.5.2 Ethical and legal/contractual responsibilities

A key distinction exists between ethical and legal responsibilities. While both of these types of responsibility may arise from positions or roles occupied by individuals, and are therefore both examples of role responsibilities, it is important to distinguish between them. Legal responsibilities arise either from statutory laws, or from contractual relationships entered into by individuals or organisations, and their existence is a matter of record. Ethical responsibilities on the other hand can be much more wide ranging, and can only be discerned with judgement. The distinction can be particularly complex in public sector organisations, because of the general responsibility to the public interest discussed above.

This distinction arose in the discussion of the decision to discontinue a service referred to in Chapter 3. As a provider trust, the trust concerned had no legal or contractual responsibility to provide the service – it could simply give notice to the Commissioner of its intention to discontinue the service. However, as we have seen, this fact alone does not settle the further question of whether the trust has ethical responsibilities – to ensure the service is provided, to mitigate the effects of discontinuing the service, to consult with patients, etc. – which may be generated through the wider duty to the public interest discussed above.

4.5.3 Organisational and individual responsibilities

If the trust discussed above did indeed have a role responsibility as suggested, it still remains to be decided how individual responsibility should be divided among the individual decision-makers in the trust. This is another difficult area, which can be made easier to an extent by clear job descriptions and processes, but which also ultimately calls for judgement on individual cases.

Many of these responsibilities are set out in documents at an NHS level, including the Constitution. However, the interviews generated interesting discussion of a number of examples of both organisational and individual responsibilities. Rather than discuss these in detail, it will suffice to note that the following responsibilities were recognised by interviewees in the research. (Of course, this is not intended to be an exhaustive list of the responsibilities of NHS staff.)

- Responsibility to ensure take-up of services.
- Responsibility to work in partnership with other agencies.
- Responsibility to provide a particular standard of care.
- Responsibility to involve staff in decisions.
- Responsibility to communicate clearly with staff.
- Responsibility to develop staff.
- Responsibility of fairness towards staff.

Each of the above organisational responsibilities also translates into responsibilities for particular individuals in trusts. In addition, several interviewees recognised a responsibility to represent the interests of particular people or groups of people, for example members of staff, or service users. The activity of linking individual responsibilities to organisational responsibilities is difficult but clearly important, which is why we have included consideration of roles and responsibilities in the checklist for ethical decision-making.

5. Evidence from the interviews: organisational context

This chapter contains evidence from the interviews with regard to the organisational context of decision-making. It is divided into five sections, each of which has a bearing on the checklist described in Chapter 2.

This chapter therefore functions both as further exploration of the contextual aspects of the checklist, and as explanation for the inclusion of those factors, which are as follows:

- Clarity and openness.
- Representation.
- Challenge.
- Time.
- Consultation.

5.1 Clarity and openness

Effective ethical decision-making requires clarity in terms of the ethical concepts employed. A key part of the dialectic process involves working towards a shared understanding of concepts, and the first step in this process is articulating clearly one's own understanding. Since values are often implicit rather than explicit features of thought and motivation, many people may not be aware very clearly of what their own value set is, until they make the effort to articulate it in the context of a particular decision. As we noted earlier, this process also requires openness and honesty:

"I suppose honesty in what are the goals of the organisation and what is the value that you're desiring to achieve? So the Commissioner would have one set of values, the hospital might have another set of values, the local patient groups might have another set of values, the government another. So openness in what do we really mean by improving quality, what value set are we running on?" (Medical Director)

The ability to articulate and defend a position in ethical terms is something that can be developed with practice. For this reason, training involving case studies can be helpful, giving participants the opportunity to work through decisions without being committed to the consequences of those decisions. However, it is ultimately only by applying this process to real decisions that the true complexities of those decisions can be made to emerge.

5.2 Representation

As described in Chapter 2, the dialectic process involves moving towards greater clarity and understanding through debate among different viewpoints. It will be more effective if a wide range of viewpoints are represented, and some of those viewpoints will represent the interests of different constituencies with an interest in the decision. They should also be as fully informed as possible about different aspects of the decision.

In practice, many decisions are made by executive teams or boards. The constitution of these groups is an attempt to ensure representation in decision-making:

"In a sense… chief executives are informed by the directors who are the experts. You've got the medical director, you've got the nursing director, the director of operations, directors of other things and your chief executive's job of course is to filter all of that information… quite often decisions are a consensus decision." (Director)

In the interviews, we found some ambiguity as to the role of each member of the group. One interpretation might be that each is there to represent the interests of a particular constituency, whether that be doctors, nurses, service users or someone else. Alternatively, the aim might be to provide expertise in a particular area. The interviewees we spoke to generally saw themselves as providing expertise rather than representing constituencies, but there was some blurring between the two:

"I think I give medical advice as someone who is a qualified medical practitioner but I don't think anybody now, if they ever did, sees my opinion as being representative of the GP community... It wasn't a morning I woke up and thought, 'now I'm no longer representing GP opinions for our area.' It sort of went over time really with changing roles and responsibilities and other ways of engaging that opinion." (Programme Manager, Public Health)

"My role as chief medical officer is to be accountable for quality in clinical standards across the organisation. And the professional responsibility for the doctors, although not line manger responsibility for them."

“You might expect me from my professional background to be a bit more sympathetic to those patients who have a need… I would be expected to be the conscience or the clinical conscience of some of those discussions with medical directors. That’s our role.” (Director with a clinical background)

We also found evidence of cases where particular viewpoints were not represented in decisions. Perhaps surprisingly, in both of the trusts to whom we spoke about Quality Accounts, the people who gathered the data for Quality Accounts were not present at the board meeting where the final decision was made about what to keep in and what to leave out. In one trust this resulted in a decision being made with which the interviewee (the researcher who gathered the data) was unhappy, including targets which the interviewee felt were not based on evidence and probably not achievable:

“[When I saw the outcomes of the board’s decision] I felt that there were quite a lot of promises… [which] might be a bit ambitious. Based on the fact that we haven’t done that yet, and the evidence that we did have around the audit that it wouldn’t be achievable. I think it was wrong to put a lot of promises in about quality of care without evidence that it would actually work.”

It may be that the board in this case had good ethical reasons for leaving out this information. However, since the researcher was not represented at the meeting where decisions were made, these possible reasons could not be discussed and debated openly.

5.3 Challenge

For the dialectic process to work requires that positions are challenged by opposing views. Our interviewees varied in the extent to which they believed that challenge was present in the decision-making in their trust:

“What I find myself using a lot is challenge. ‘Challenge me, tell me I’m wrong, give me the counter-evidence, let’s challenge this decision’. I’m not saying the decision is wrong but I want to test it, I think you need that constant tension, I think that tension is a good thing…. I think it’s right that people question what we do and I think it’s right that we should have to defend it….I’m comfortable with my discomfort of being in a role that colleagues challenge because I think that’s right, that’s how you get the answer isn’t it? You have this dialogue and it’s this constant checking.” (GP and Medical Adviser)

It was sometimes seen as the duty of individual board or executive team members to provide challenge:

“I see myself as one of the two people that sit on either shoulder of the CEO, being the voice in [their] ears…. Our job is to keep patients safe and our job is to keep the organisation safe as well. So it’s how you bring those issues to a balanced position and advise the CEO and colleagues on the consequences of certain decisions.” (Deputy Chief Executive)

In the discussion of staff shortages, challenge emerged as a way of avoiding decisions that are made in a purely intuitive and unexamined way:

“There used to be a – oh I don’t know what she’s called, Staffing Coordinator or whatever – it used to be that you rang her and she’d ring out to the wards. And when we rang her she’d never ask, ‘how many of you does that leave on’; she’d just say ‘yes that is fine, I’ll try and find someone for you.’ So there was no finding out anything in the background.” (Deputy Ward Sister)

Another interviewee – a director – felt that there needed to be more “challenge in the system” to force decision-makers to consider staffing decisions in more depth.

One aspect of challenge is ensuring that ethical considerations are raised and taken account of in decisions. We found some interesting attempts to build systems and procedures that force people to consider particular ethical issues as part of the decision-making process:

“In all of our papers that go to [the executive team] and board and all strategies and policies, we have a policy for ensuring we consider the equality issues right from the beginning. So it is built into our policy making…. I think it helps as it raises awareness for everyone to consider when they’re going through their strategies or papers or whatever they’re taking through to board.... I think it’s fairly effective.” (Senior Manager)

However, there was some concern that this on its own does not guarantee that ethical considerations are truly taken into account. Without challenge by individuals, and a proper understanding of the issues, there is a potential for this to become a mere “box-ticking exercise”.

“I suppose people around the table when you take it to [the executive team] or board or whatever, they usually press you quite hard about things, but if they specifically did ask more questions about it then it might be implemented more. I don’t think it is what they focus on when they are discussing the pros and cons of a strategy.” (Senior Manager)

"Because of my responsibility in that area, then I will ask the questions: 'who did you consult with?' and, 'when did you meet with them, where did you meet with them?' I will refer you back to where you comment on [for example a] literature review, a body, from a website." (Programme Manager, Public Health)

In general, this approach to systematising value considerations – building stages into the decision-making process where consideration of ethical issues is actively prompted – appears to be more effective than attempts to 'score' value considerations, which are often shallow and artificial, and masks the true complexity of value considerations.

5.4 Time

Another key factor in the dialectic process is taking the time to work through decisions properly. Time was seen as a challenge in all of the decisions we examined.

Perhaps the clearest indication of the influence of a shortage of time on ethical decision-making came in the discussion of Quality Accounts, where there was a huge difference with respect to the time spent on building evidence between different trusts. One trust spent the whole year building a detailed evidence base, whereas another spent about two weeks pulling together existing data:

"My line manager went on holiday. We just thought we'd get it to where it should be so… if it was in the Quality Account we had to find evidence. So we were getting panicked that we hadn't actually got any evidence [for some things]… or that we didn't have it in a way which put it simply." (Researcher)

This problem was also noted by an interviewee who had been responsible for reviewing Quality Accounts by provider trusts:

"One of the difficulties was that they were tending to be written quite close to the date required so the turn-around for the review was quite often quite fast because a provider was trying to get it to their board and the commissioner to their board with the timeline narrowing…. So starting the process earlier rather than later is good." (Medical Director)

Lack of time was also seen as a distorting influence in the discussion of staff shortages:

"You know what you do on the day but most of it is very reactive. So your decisions are based on what patients you've got on your ward sometimes and that can vary from day to day. You've got to balance a lot of things in your head before you make a decision." (Director)

… of equity in access to healthcare:

"I suppose a lot of it goes back to… targets and how we're very busy, we're relatively short in numbers of people so to do the most good, is it best just to… get as many people through the doors for the services as possible? And therefore sometimes equality can get sidelined I suppose or be thought of as an afterthought." (Senior Manager)

… and of decommissioning and discontinuing services:

"The only issue is that it's just a question of sheer time and capacity really. Because if you're sitting on the board you can't effectively scrutinise fifty or sixty proposals properly, you kind of resort to your gut instinct. So I think when it comes to the crunch people are just doing the best they can, but it hasn't been shaped in a way that can really get to the nub of the issue." (Director)

Clearly, staff in trusts are extremely busy, and time is and always will be limited. However, there are a number of approaches that can help in this respect.

Firstly, ethical decision-making skills can be developed in such a way that decisions can be made more quickly but still in an informed way. As previously noted, training decision-makers using case studies provides an opportunity to develop these skills using hypothetical situations before transferring them to the real world.

Secondly, we found some evidence that time is not always being apportioned rationally between different types of decision:

"The interesting thing is, when it comes to individual cases, people really agonise over it. [For example] IVF treatments. Someone might ask for a third cycle, or something like that, and people really agonise over those. But I don't think, funnily enough, they … really agonise over the… big commissioning decisions in the same way. I think because it's personalised, it's about how you shape the decision that people are going to be asked to make. If it's one person and it's going to affect whether they can have kids or not, you can really see [the importance]. Whereas if [it's a question] like, 'ok we are going to halve the budget of this area and put it somewhere else,'… it's too abstract." (Director)

Greater awareness of the relative complexity and impact of decisions would help managers to approach them more effectively, which is why we have included this consideration in our checklist.

5.5 Consultation

One particularly important type of evidence-gathering is represented by consultation, with staff, service users or the wider public. Consultation is a process with various ethical aspects which are worth exploring here.

In the interviews, we found a real mixture in the extent to which trusts consulted with patient groups before making decisions:

“I will usually sit down together with stakeholders and develop the strategy which I then take to various committees, local council implementation teams, probably go to the Commissioning Committee and board and [we] might even go to the Health Overview and Scrutiny Committee depending on whether we feel it is appropriate or not. So we try and… get as many people as possible onto the strategy. Then… usually you develop the strategy with stakeholders.” (Senior Manager)

This contrasts with the first case study in Chapter 3, where a major decision to discontinue a service was made without any systematic consultation with service users:

“I don’t think there was a formal consultation process if I’m honest. I think some discussion did take place with some patients but I think it was pretty random, I don’t think it was a big piece of work….”

The interviewee above, and others from the same trust, recognised that this lack of consultation was potentially a problem:

“I do think we should speak with patients. Why? Because it’s their care, it’s easy for a bunch of managers to say they don’t want to do it anymore for whatever reason without understanding the ethical, moral and social consequences of the decision you take.”

This discussion raises two important points with regard to consultation. Firstly, it is important to be clear about the role of data from consultation in the decision as a whole. As we have already seen, any empirical information has to feed into a decision alongside value considerations. In the above quotation, the interviewee stresses the importance of consultation, but also of a value judgement, namely whether it is “right, fair and proper” in this case to have patients who are dependent on services. The role of consultation here is to determine patients’ attitudes to services, but answering this question will not completely settle the question of whether the status quo is ethically acceptable, since patients’ views are developed in the context of that status quo. This also requires judgement on the part of decision-makers. Secondly, given this fact, there is an ethical responsibility on the part of decision-makers to be open and honest with those with whom they are consulting, about the role played by the consultation. It may be, for example, that even if the consultation reveals that service users are happy with the service, the trust will still quite properly decide to discontinue the service. Openness requires that those consulted are made aware of this possibility, and more generally of the role their opinions will play in the overall decision. In more extreme cases, it may be that consultation is sometimes done simply so that it can be said to have been done, and that data from the consultation will in fact play no role in the decision. This would be a clear case of dishonesty and therefore an unethical act.

6. Summary and conclusions

In this report, we have tried to set out some practical advice that can help NHS organisations to make better, more effective ethical decisions. What we have recommended is to some extent a new way of thinking about organisational decision-making, but it is hopefully possible for trusts to integrate this approach into their existing processes and procedures. As well as a general approach, we have looked in detail at some ethical issues – fairness, justice, equity, equality, openness, honesty, transparency – which will inevitably play a role in decisions made by all trusts at some point.

What we have offered, however, is necessarily a starting point on the road to better ethical decision-making, and it comes with a challenge to trusts: to spend time considering what are the key ethical concerns that drive their own decisions, and to begin applying them in real decisions. Doing this not only improves the way those particular decisions are addressed, but builds awareness and ethical reasoning skills, so that ethical considerations become easier to recognise, analyse and address effectively.

This report has concentrated on senior management decisions. However, as we noted at the very beginning, decisions with ethical dimensions are by no means restricted to the top of organisations. We believe there is a need for further work to be done on widening the scope of this approach, perhaps by adapting the principles and considerations highlighted in this report, to guide decision-making in all areas of the organisation. While further research would certainly be helpful here, much of this work can be done by trusts themselves.

As we have tried to emphasise, and as the case studies in Chapter 3 hopefully demonstrate, not spending time on these issues is a false economy, since the consequences of unethical decision-making can take much more time to address further downstream.

It is worth noting, however, that building ethics and values into decision-making is not just a way of avoiding pitfalls. As we have tried to show, effectiveness means positively pursuing ethical values as well as more familiar concerns such as quality and value for money. Finally, ethics can also be a strong motivator, building a sense of organisational identity and purpose, and connecting individuals to the social and moral, as well as the financial, consequences of their decisions.

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Appendix: methodology

Interviews

We used semi-structured interviews in this research. This approach allowed us to examine specific decisions in detail, using open-ended questions to look for the considerations that were being taken into account by decision-makers, and the influence of the organisational context on those decisions. This methodology also has the advantage over focus groups that it encourages greater openness among participants, who may be able to speak more freely than they would in the presence of colleagues. It also allows us to look for differences of opinion over how decisions were made, rather than encouraging the emergence of a consensus view.

The following four central themes were identified for the research. For each theme, we identified a particular type of decision to examine, in order to focus the research.

Table 1: Themes and decision types

Theme	Type of decision
Equality, equity, fairness, justice	How to address inequities in access to healthcare
Openness, honesty, transparency, accountability	What to include (and what not to include) in Quality Accounts.
Public value and the public interest	Decommissioning and discontinuing services
Organisational structures and processes	Covering staff shortages

A separate interview schedule was designed for each of these themes, with open-ended questions aimed at elucidating the decision-making content and organisational context of the particular ethical decision concerned.

Sample

We spoke to two trusts under each of the above themes. One trust helped us with two of the themes, so a total of seven trusts were involved in the research. Within each, we spoke to between two and four interviewees, who were identified by the trusts as having played a role in the particular decision we were examining. In total, one interviewer spoke to twenty interviewees for a maximum of one hour each, travelling to their place of work in each case.

The trusts were approached either through existing contacts, or using publicly available contact information from websites. We looked as far as possible to get a geographical spread in the sample, and to speak to a mixture of primary care and acute trusts. We undertook not to name the trusts to whom we had spoken, in order to encourage greater openness in the interviews.

Transcription and analysis

Interviews were recorded and transcribed by two transcribers employed on a temporary basis by the research team. Transcriptions were coded, allowing themes to emerge naturally from the interviews.

Inquiry panel

An inquiry panel comprising an NHS Chief Executive, a Medical Director, an NHS Chair, a Chief Executive of a Social Enterprise, a Union Leader and an academic in Industrial Relations supported the core inquiry team. The panel contributed to the design of the inquiry, the analysis of the evidence and the writing of the report. The panel formally met twice and their contribution was supplemented by regular feedback virtually and face to face.

Validity

This research is qualitative rather than quantitative, and makes use of a relatively small sample of trusts and interviewees. There is clearly, therefore, a limit to the extent to which the empirical conclusions drawn from this research can be said to apply to the NHS as a whole. However, we do believe that the results of this research are generalisable in the sense that the kinds of concern outlined herein are likely to be recognisable and relevant to trusts throughout the UK. The usefulness of the research lies in:

- Presenting NHS directors and managers with a snapshot of ethical decisions as they are found in some NHS trusts;
- Bringing out and elucidating the real normative considerations underlying the issues surrounding these decisions;
- Describing and analysing some approaches to decision-making which exist within parts of the NHS; and
- Commenting on their effectiveness.

The methodology used in this research is, we believe, appropriate for these purposes. By carrying out this research, we hope to have provided insights which will be of use to a great many working in managerial or directorial roles in the NHS.

Centre for Innovation
in Health Management
Leeds University Business School
Maurice Keyworth Building
University of Leeds LS2 9JT
Tel: 0113 343 5599
j.l.paglia@leeds.ac.uk
www.cihm.leeds.ac.uk

UNIVERSITY OF LEEDS

University of Leeds
Leeds, United Kingdom
LS2 9JT
Tel. 0113 243 1751
www.leeds.ac.uk
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