7-30-1997

Rethinking the Nursing Paradigm: The Ethics of Gatekeeping in American and British Nursing

David C. Grandy
Western Michigan University, david.grandy@hdrinc.com

THE CARL AND WINIFRED LEE HONORS COLLEGE

CERTIFICATE OF ORAL EXAMINATION

David Grandy, having been admitted to the Carl and Winifred Lee Honors College in 1993, successfully presented the Lee Honors College Thesis on July 30, 1997.

The title of the paper is:

"Rethinking the Nursing Paradigm: The Ethics of Gatekeeping in American and British Nursing"

Shirley Bach

Dr. Shirley Bach
Philosophy

Diane Hamilton

Dr. Diane Hamilton
Nursing

John Martell

Dr. John Martell
Lee Honors College

Rethinking the Nursing Paradigm: The Ethics of Gatekeeping in American and British Nursing

David C. Grandy

A Thesis Presented to Fulfill Requirements for the Lee Honors College
Western Michigan University

June 1997

Dr. Shirley Bach, Professor of Philosophy, Western Michigan University
Dr. John Martell, The Lee Honors College, Western Michigan University
Dr. Diane Hamilton, Professor of Nursing, Western Michigan University

For Lillian, whose infectious enthusiasm never failed, whose love for language instilled in me a similar passion, and whose unparalleled willingness to listen propelled me over many an obstacle. Would that all persons could have such an ardent muse.

Sometimes you have to go a long distance out of the way in order to come back a short distance correctly.

-Edward Albee, *The Zoo Story*

Table of Contents

Introduction

In the British National Health Service (NHS), the general practice physician (GP) serves as gatekeeper to resources.[1] In the United States, managed care physicians, who attempt to contain health care expenditures by establishing priorities and strictly regulating treatment accessibility, necessarily employ gatekeeping responsibilities in practice.[2] However, both systems of health care generally overlook the potential contribution of nurses in identifying and implementing effective methods of resource allocation. The central focus of this thesis includes two primary assertions. First, I will argue that nurses currently function as gatekeepers both in England and the United States, and that the traditional nursing paradigm includes skills which naturally facilitate the gatekeeping role. For clarification, my argument is not that nurses should *replace* physicians as gatekeepers, but rather, that the nurse-gatekeeping model offers a viable *alternative* with merit significant enough to justify further investigation and potential incorporation into health policy. My second argument is one of philosophy and applied ethics. I will argue that the traditional ethical constraints of nursing do not necessarily preclude nurses from the practice of gatekeeping.

The content of this paper is divisible into four distinct, yet interrelated sections. They are as follows: (1) Scholarly literature fails to clearly and succinctly enunciate the roles and responsibilities required of the gatekeeping-clinician. Because the function of gatekeepers affects the ethical considerations associated with the role, prior to assessing any normative claims, I will discuss the more prominent definitions of gatekeeping from the perspective of both British and American medicine. In an attempt to delineate some parameters fundamental to the practice, I will argue that gatekeeping is currently understood as both the process of distributing resources for the treatment of disease, as well as the process of facilitating access to resources for people with disease. For

clarity, because gatekeeping is generally associated with doctor/patient interaction, and not nursing, I will confine this particular discussion to gatekeeping in medicine. (2) Due to reforms and reorganizations in the NHS subsequent to its inception in 1948, the district and home health visiting nurses have evolved to the status of professionally autonomous health care providers. In this capacity, British nurses participate in the management of patient care and clinical decision-making, functions which necessarily embrace the practice of gatekeeping. Because the historical development of British health delivery is fundamentally dissimilar to that of the United States, I will trace the evolution process in some detail. (3) Nursing practice in the United States, especially in managed care and community health, currently relies on nurses to distribute health care resources through case management, referral to external care, and, in limited cases, the independent determination and administration of medically appropriate interventions. Using the definition of gatekeeping established in the first section, I will argue that these "expanded practice" nurses perform some duties within the rubric of gatekeeping that are generally reserved for discussions of physician/patient relationships. (4) As with other methods of dispensing limited resources, the ethical considerations of gatekeeping are characterized by conflicts between competing obligations. In this section, I will employ some traditional philosophies of ethical theory and distributive justice as a backdrop against which gatekeeping can be discussed. I will argue that nurses can cultivate competent, effective, and ethical strategies for apportioning resources without simultaneously compromising their duty to advocate for patient needs.

I
Gatekeeping Within the Scope of British and American Medicine

Discussions of gatekeeping often occur concurrently with those addressing the rationing of health care resources. Rationing is defined as the equitable distribution of scarce resources.[3] In general, health care appropriation is labeled effective and ethical when no one group absorbs all, or even the majority of any deleterious repercussions produced as a result of inequitable rationing. Furthermore, ethically defensible modes of distribution imply that some concept of fairness governs how an affected population will share the resulting burdens equally. Gatekeeping emerged in response to the need for effective facilitation of the rationing process in clinical settings. Thus, the practice of gatekeeping fundamentally assumes that unlimited health care resources do not exist or are unavailable, and charges clinicians with the duty to distribute procurable resources in a just manner.

Reigle (1989) differentiates two types of rationing: macro and micro.[4] According to Reigle, macro-allocation pertains to the allotment of those services considered beneficial for social improvement. Applied specifically to health care, macro-allocation might include distributing services for emergency care, public health, immunization, and HIV research, which are generally regulated at the governmental, institutional, or policy-making levels. In contrast, micro-allocation generally occurs in clinical practice when decisions regarding which individuals will receive a particular resource or which resources will be distributed to a particular patient are required. As with generic discussions of rationing, micro-distribution assumes that fulfilling the needs of all patients is impractical or impossible. By definition, then, clinical gatekeepers engage in the process of micro-allocation.

The gatekeeping model was first associated with the British system of health care delivery.

From the British perspective, a limited, albeit fundamental, definition of the gatekeeping role is discernable. The British system of medicine differs from decentralized health care plans, like fee-for-service plans common in the United States, in that it acknowledges the economic view of health care as a limited resource, while simultaneously recognizing the critical importance of providing those services requisite for a minimum standard of public health. To achieve the goal of offering universal health care within stringent budget constraints, administrators have developed and implemented a myriad of strategies to manage escalating costs. One such approach involves the practice of gatekeeping. In this role, the general practice physician is charged not only with the diagnosis and treatment of disease, but with the micro-allocation of health care resources as well. This role requires the GP to consider both the efficacy of a particular treatment for the individual patient, as well as its cost-effectiveness across a patient population. Costs are contained, according to the British philosophy, when the GP enacts any combination of three strategies: strictly regulating the administration of interventions to ensure that only those with legitimate needs receive treatment, eliminating any services deemed medically futile or so ineffective as to not justify funding, and trimming potentially beneficial, yet expensive therapies. Through this process of delimiting access to resources, the NHS is able to manage costs and maintain a comprehensive system of basic health services.

Although the logistics of NHS operation are foreign to most Americans, understanding a patient's movement through the system, as well as the function of the primary care physician within the system, helps to illuminate more clearly some additional nuances of gatekeeping. A patient wishing to initiate non-emergency medical care must first consult his/her GP. The GP assesses the patient to determine the type and severity of his/her disorder, and subsequently enacts one of two

alternatives: immediate treatment or referral. If the GP believes a viable remedy can be achieved at the primary care level, this option will generally be elected. If the severity of a disorder is substantial or if clinical standards indicate treatment at this initial stage is inappropriate or imprudent, the GP may refer patients to a specialist for consultation or recommend a therapy that is unavailable in primary care and which requires administration in a particular hospital. This process, which I term "selective continuance", ideally filters out only those patients with the greatest health needs, as determined by the primary care physician, and allows them to advance within the system.

Further responsibilities, either actual or implied, arise in conjunction with the pursuance of either treatment or referral. Because the NHS relies on capitation, in which practices receive funding on a per-patient basis, GPs are able to precisely account for all incoming monies, expenditures, and total number of patients in their care. In general, GPs must consider their entire patient population when selecting patients for advancement, as well as during the delivery of treatment at the primary care level. Consider, for example, a practical application involving a recommendation for an advanced intervention. Primary care facilities begin each fiscal year contracting an exact number of procedures with the independent trusts which comprise the NHS. Thus, a clinic in London might purchase only ten hip replacement procedures from a local hospital to be distributed throughout a year. Physicians must therefore carefully consider, based on demographic data and logical prediction, a population's predisposition for hip replacement need. Knowing that an absolute number of procedures are available forces the GP to select those ten individuals with the greatest need and who stand to benefit the most from this specialist therapy. It follows then, that in order to reduce costs, potentially beneficial treatment will be denied to some individuals with legitimate needs, but whose condition is not so severe as to justify treatment when only limited numbers of corrective procedures

are available. In terms of the British system of delivery, health care provision is allocatively efficient to the extent that resource access is restricted to only those with the greatest needs and who display the greatest potential to benefit from a given treatment.

From the British model, two primary responsibilities of the gatekeeper are elucidated: to act as a funnel to medical resources beyond primary care and to incorporate a cost-benefit calculus into the management of a patient population. These goals are achieved through the selective advancement process, by eliminating unnecessary treatments, and by regulating the availability of potentially beneficial procedures to ensure that only those with the greatest needs are served. Enacting and maintaining this standard of care relies on two basic assumptions.[5] The first is that patients with the greatest need are identifiable. The second requires that a specified quality and quantity of care is delivered to only these patients. As such, gatekeeping clinicians must first determine if an individual's condition is amenable to the effective use of resources for prevention, treatment, or cure. If this is the case, gatekeepers must then seek to allocate the appropriate resources to only these individuals by facilitating the process of distribution.

Managed care in the United States operates with a similar philosophy of distribution. For this discussion, I rely upon Clancy and Brody (1995) who suggest an ideal model for managed care. Their model closely resembles the British system in its inclusion of a population-based approach to health care delivery, advocacy of collaborative relationships between primary care physicians and specialists, and its equation of good care with cost-effective care.[6] If we adhere to this paradigm, it is reasonable to argue that managed care physicians perform duties similar to those of British GPs, and therefore function as gatekeepers. Importantly, though, Clancy and Brody include some additional criteria in their model, which I believe is both valuable and necessary to expanding the

fundamental parameters of a gatekeeping definition.

First, Clancy and Brody suggest that optimal care results from "personal and long-standing relationships between patients and [their] primary [care] provider."[7] If this assertion implies that superlative care is directly proportional, within reason, to a personal knowledge of patients, then what information is most relevant to the provision of efficacious and cost-effective care? Most importantly, the primary goal of medicine is healing and the promotion of health.[8] When healing is possible, it is generally the product of clinical competence at minimum. Competence results when clinicians apply formal training in diagnostic procedure and treatment toward effectively ameliorating disease and dysfunction. The promotion of health, however, requires a more inclusive ethic, primarily because the concept of health extends beyond the treatment of disease. According to the World Health Organization, health is defined as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."[9] If this definition is reasonable, then health promotion is enhanced when clinicians rely upon practical and professional experience to elucidate those factors adversely affecting a patient's psychological and social well-being, which in turn are manifest as physical disorders. To approach health holistically, then, health care providers must evaluate those factors which fall outside the clinical diagnosis of disease and consider the promotion of health as inextricable from any number of external influences. Relying on Benjamin, Miller and Brody (1995) aptly argue that we should view human lives as "organized narratives" in order to determine an individual's "set of core values and principles."[10] Understanding these values and principles affords health care providers insights into the influences most intimately affecting a patient's health. (For a complete discussion of Benjamin, please see Appendix I).

Wing (1993) applies this approach to gatekeeping. She argues that gatekeepers must assess

not only health concerns, but the larger context in which patients experience health care.[11] According to Wing, health care providers should engage in a process of evaluation and interpretation to determine the personal values of the patient in order to provide optimal care. Except under unusual circumstances, value patterns are more readily recognizable in long-standing professional/client relationships primarily because they demand the piece-by-piece assembly of information into a comprehensive picture of life-styles and behaviors. This process occurs deliberately over time because it relies upon the cultivation of trust which is rarely abundant when relative strangers interact in a professional environment.[12] Wing argues that when gatekeepers are privy to information regarding the value patterns of patients which affect health, they are better able to make clinical judgements regarding the distribution of resources.

Clancy and Brody further suggest that public health considerations be factored into patient care. According to this position, community health resources should be considered when formulating "the optimal mix of interventions" for each patient.[13] In other words, Clancy and Brody recognize that competent care is not confined to hospitals, but that it must occur within the community as well. Clancy and Brody seem to acknowledge the somewhat limited purview of some physicians, and therefore encourage the development of "collaborative relationships between primary care physicians and sub-specialists" as necessary for propagating a comprehensive approach to the delivery of competent, efficacious, and cost-effective health care. Here, an additional responsibility of gatekeeping is implied. The gatekeeping clinician is charged with acting as a liaison to community health resources, as well as coordinating care among available health care services.

The roles and responsibilities of gatekeeping are generally not well defined; they are implied at best and certainly not standardized. The previous discussion is not intended to suggest an absolute

definition of the practice, but rather to demarcate some fundamental guidelines for gatekeeping clinicians. For the purposes of this paper then, gatekeeping should be understood to include the dispensation of resources for the treatment and prevention of disease, as well as the process of facilitating access to resources and coordinating care for people with disease. Gatekeeping aligns with the process of micro-allocation and is, at least ideally, governed by some concept of just distribution. Gatekeepers should attempt to assemble comprehensive pictures of health and engage in long-standing relationships whenever possible. These particular qualifications aid the understanding of a patient's health influences and better enable the clinician to make more informed decisions regarding allocation.

II
Foundations: The Historical Development of the "Gatekeeper Nurse" in Britain*

While many scholars focus on the GP as the keystone to the allocation and delivery of services in British health care, two other constituents, the district and home health visiting nurse, enact similar roles. Due to an increased recognition of professional autonomy, achieved as a result of reforms and reorganizations which created separate supervisory agencies for nurses and GPs within the NHS subsequent to its 1948 inception, the present system entitles both groups of nurses to act as autonomous agents in the delivery of health care. The resulting professionalization of these specific facets of nursing under the current NHS thus enables the advance of an intricate system of checks and

*Portions of this section were submitted to fulfill requirements for PHIL 491/HST 487 (Medical Ethics and the History of Health Care in London) seminars through Michigan State University. That paper has since been revised and its final form appears herein. I am grateful to Profs. Judith Andre and Peter Vinten-Johansen for their guidance, enthusiasm, and inspiration in guiding that paper which was to serve as the impetus for sections II and IV.

balances within the doctor/nurse relationship, creating a gatekeeper function for nurses similar to that of the GP. For example, the district nurse retains the authority to determine which treatments to administer based on various considerations, including cost, while the health visitor serves as a patient advocate, acting as liaison between the community and available resources. Both illustrations reinforce a nursing equivalency, at least to the extent that nurses function as gatekeepers of health care resources, to the GP when examining the primary players involved in the micro-allocation of health services. The focus of this section will examine the historical evolution of nursing in Britain and those factors most intimately influencing the development of the nurse as gatekeeper to health care resources.

The British home health visiting nurse emerged in the mid-eighteen hundreds during a period of high mid-industrial infant mortality. In an attempt to combat this increasing social trend, an elevated level of attention focusing on the crucial importance of mothers arose, primarily in an attempt to recast preventative measures in terms of individual health concerns, especially for the poor, rather than society in general. However, this maternal emphasis failed to produce a significant alteration of infant mortality primarily due to the inadequacies of welfare reform, which focused exclusively on economic factors, rather than addressing the multitude of health concerns affecting the poor. Despite their high numbers in the work-force, economically disadvantaged women attained few actual benefits from these reforms as most women possessed little power in the marketplace. This governmental failure to respond adequately to the plight of working-class women figured into the need for increased community intervention, developed predominantly through volunteer visiting programs designed to focus care on personal interaction with poor populations. The most prolific of these groups was the Ladies Section of the Manchester and Salford Association which undertook

to spread health information among the poor of the community.[14] These women, known as "visiting nurses," also responded to the infant mortality crisis, interacting with poor mothers and promoting the care and welfare of young children, especially in domiciliary environments.

As the need for general nursing practice both evolved and became more pronounced, public health concerns shifted beyond children and the poor to other sectors of health care. In general, the main facets of 19th century reform in British health care were initiated with Florence Nightingale, and are well documented in nursing literature. The increased educational and professional demands suggested by Nightingale marked the need for leadership in nursing. Smith (1960) characterized the historical climate underpinning this need, stating, "There was a body of skill and knowledge in the care of the sick which justified the division of labour [between physician and nurse]."[15] This professional separation between medicine and nursing provided the initial impetus toward nursing autonomy characteristic of 20th century practice. In fact, as early as 1892, the House of Lords declared that reviews of nursing performance should be shielded from the influence and authority of male-dominated medical staffs.[16]

A marked increase in nursing professionalization occurred toward the end of the nineteenth and early twentieth centuries as numbers of nurses increased and a shift toward structured "training" developed. By 1919, health visitors numbered more than 1000 and standardized training requirements were implemented. MacPherson (1996) argues that the incorporation of formal training furthered the professionalization process.[17] While training prepared nurses for the delivery of health care services, the visiting nurse also played a supervisory role, as she was "expected to befriend and gently influence, but also...monitor and report" to the Medical Officers of Health overseeing the implementation of public health strategies.[18]

Following a divergent path to that of the visiting nurse, but with a similar intent to cater to poor populations, the district nurse emerged. Initiated under the direction of religious organizations, District Visiting Societies were commissioned to promote social justice and assert the argument that various pressures of industrialization undermined the care of in-need populations. In general, these nurses grew-up in working-class families, thus positioning them as the social equivalents of their patients. This characteristic caused some tension between district and general nurses, as each group argued for increased professional and social recognition. Eventually, both groups followed separate educational and professional paths. Subsequent to this divergence, a noticeable split surfaced between the general nurse, employed within the hospital sector, and the district nurse, largely responsible for extending domiciliary care within the community. This provided the initial foundation for the present-day nursing division in the NHS.

With the separation of nursing specialities established by the early nineteen hundreds, an increased demand for coordinated services arose in response to the patchwork of available services and criticism of clinical standards throughout the entirety of Britain's health care system.[19] In an attempt to reconcile public perception and systematic efficiency, the Dawson Report, published in 1920, argued for the "integration and coordination of preventative and curative services" through the establishment of health centres.[20] Although an unrealized vehicle for centralized health care implementation until the late 1960s, the concept did appear within the visionary framework of the original NHS. The health centre, initially developed under public health legislation between 1918 and 1939, was to serve as the coordinating agency among the facets of the original NHS tripartite system: hospitals; a GP, pharmacist, and optometrist group; and local health authority teams which included both the district and home visiting nurses. However, this initial vision failed to immediately

materialize due to unanticipated challenges of implementing a new system of health delivery.

With the desire to provide a universal and comprehensive health delivery system free at the point of entry, the British system was one of the most generous in its basic design. However, it remained plagued by some intrinsic weaknesses. Cost was one such deficiency. Aneurin Bevin, the minister responsible for implementation of the new health service, was committed to shifting the ethos of health care from religious and legal governance to one of political service. Therefore, NHS policy eliminated direct charges to patients. Eventually, however, this strictly maintained cost containment resulted in some political embarrassment over the resulting long waiting lists, slow delivery of services, and an increasing state of disrepair within the nationalized system of hospitals. This final consideration drew the greatest attention, and economic emphasis was placed on updating and refurbishing under-resourced hospitals to compete with those services available in other industrialized nations. In fact, between 1950 and 1965, government-financed NHS hospitals enjoyed a 13 percent increase in general medical spending.[21] Thus, plans for the implementation of centralized health centres dissolved, victims of monetary reallocation to the hospital sector. The stage was now set for the professionalization of both the district and home visiting nurse.

In 1958, with 11 percent of the population aged 65 and older, increased investigation and implementation of community care dominated political discussion. In response to the steadily growing need for geriatric care, and relying upon the recommendation to establish local home-aid services under the 1946 NHS Act, the Minister of Health stated, "...the underlying principle of our services for the old should be this: that the best place for old people is in their own homes, with help from home services if need be."[22] Based primarily on these recommendations, community care evolved to encompass three primary precepts: (1) to integrate the elderly and recovering patients into

the community, (2) to foster reliance upon non-institutional services, and (3) to provide quality in-home medical care. Despite the need for nursing within the community in the 1950s, and the establishment of guiding principles in response to that need, many services experienced growing pains; they were generally inadequate in their ability to meet the needs of an aging population. Difficulties in administering community care remained until the late 1960s when legislators again looked to the health center for the coordination of efficient and cost-effective health services.

The idea of the health centre as the linchpin in health service delivery began its initial resurgence under the Family Doctor's Charter of 1966. This document, developed by Parliament in conjunction with the General Medical Service Committee of the British Medical Association, presented strategies for health care cost containment, placing the primary responsibility for improvement upon the GP. Essentially, the government's official position encouraged GPs to "work in common premises and to employ support staff...The attachment of other health providers to general practices was [also] encouraged."[23] From this plan, two key issues surfaced. First, based in large part on widespread support among GPs, the health centre was deemed the logical choice to house a common premises in which to practice. Second, "the attachment of other health providers" included both the district and home visiting nurse. For the first time under the NHS, the GP, district nurse, and home health visitor united to provide primary care services. As time passed, the popularity of the health centre and the primary health team increased as more GPs aligned themselves with the fundamental tenets of the Family Doctor's Charter. This new trend focused on a team approach to primary health. The adoption of this philosophy in the 1970s coincided with a shift away from single GP practices and toward group practices consolidated within health centres.

While primary health teams organized their services, the political debate furthered the

reorientation toward health centres. The debate was prompted in response to public opinion, which demanded better services with a more efficient cost management plan. The popular belief included a shift toward primary care and community health which arguably provided a more cost-effective response to health needs than did treatment in hospitals. This belief was held well into the 1990s, as underscored by two publications — the King's Fund and Tomlinson Report. These documents advocated replacing hospitals with improved primary care facilities, including health centres. In particular, the elderly, the disabled and the mentally ill were targeted for improved health. The greatest change in delivery occurred as community care regimens gradually replaced hospital care for these populations in particular. In general, both the district and home visiting nurse administered these in-home services to patients. The GP continued to function as the quarterback of health care delivery, while all nursing employees served as subordinates.

The first reform to reorganize British primary health care occurred in 1970 under the Social Services Act which effaced control of social services from local authorities and from the NHS in general. The home visiting nurse now reported to a different supervisory body, external to NHS control, thus forging the first rift in the doctor/nurse professional relationship. As nursing elevated its professional rapport, GPs turned their focus away from community health and shifted almost exclusively toward primary care. The establishment of District Management Teams (DMT) in 1974, supported greater equality among professional groups (doctors, nurses, and administrators), although both the GP and nursing staff remained accountable to the same administrators. In 1984, however, the formation of District Health Authorities (DHA) replaced DMTs as the governing body to which the district and home visiting nurses reported. The GPs, however, "insisted on [a continuation of] separate administration for their sector," a practice sustained, under various titles, since prior to

1948.[24] With nursing practice accountable to the DHA, the GP now reported, through the Family Practitioner Committees, and later Family Health Services Authorities, directly to the Department of Health. In essence, the GP and nursing staff were no longer responsible to the same authority. Nurses and physicians were now governed by separate councils and accountable to separate bodies for regulation. Through the implementation of additional health care reforms, the professionalization of British nursing continued. The evolution of this process dates to the Salmon proposals of 1966, which argued in favor of recognizing an equal professional status among members of management teams in which nurses played significant roles. Osborne and Lorentzon (1995) report that NHS reforms have gradually formalized the need for nurses in management.[25] Current NHS policy requires that governing boards within individual trusts must employ at least one nurse with equal voting status. In addition, many trusts are calling for more nurses to enter into management positions and obtain appropriate training for this newly emerging role. In essence, the elevation of professional equality among primary health providers, coupled with the formation of separate administrative sectors for physician and nurse constituencies, together redefined the doctor/nurse relationship, and created the potential for British nurses to assume the responsibilities of gatekeeping within the current NHS.

Professional Roles and Responsibilities in British Nursing

Prior to discussing the doctor/nurse relationship and its impact on the development of nurse-gatekeepers within the NHS, an overview of the health visitor and district nursing roles will prove useful. The health visitor focuses primarily on child health and welfare, a responsibility with roots in the political and social climate that informed the emergence of the visiting nurse. At present, this

role includes four duties: identification of health needs, encouragement of healthy activities for both expecting mothers and children, increasing health awareness, and influencing health policy at both the local and national levels.[26] The district nurse also services a multitude of health concerns by providing general nursing care, administering medication and prescribed therapies, monitoring patient care, and offering bereavement support. In general, a fundamental aim of district nursing is to help sick or disabled persons of any age group achieve optimal levels of health and independence. If nurses adhere to the roles and responsibilities outlined in NHS nursing standards, they will be primed to function as gatekeepers.

While the GP serves as the initial diagnostician and coordinator of care in the NHS, referrals to specialist treatment may include in-home care by the district nurse. Although nurses generally carry out a physician's orders, the relationship between doctor and nurse ideally models a shared decision-making or team approach in determining appropriate treatments, a stark contrast to the superior/subordinate relationship characteristic of the early NHS. While the presumption should be in favor of maintaining professional discretion and upholding accepted clinical standards, the district nurse is held accountable for his/her decisions by a peer review committee under the Health Authority and not by the physician prescribing care. In fact, the House of Lords adopted a pro-nurse stance, arguing "it is important that neither the medical staff nor any other male head should have power to punish nurses for disobedience."[27] As long as nurses rely on accepted standards of practice, no punitive repercussions will result from a nurse's decision to alter a physician's prescribed treatment. If nursing discretion can supplant a physician's prescribed order, it follows that nurses have the potential to act as autonomous agents in the delivery of health services. As such, they necessarily function, or have the potential to function, as gatekeepers. Consider the following example. An

alteration in a patient's treatment regimen may be based in part on the patient's desires and the nurse's professional opinion regarding the administration of optimal care. For example, while the GP may believe Medication X offers the best available therapy, the district nurse may administer Medication Y without seriously jeopardizing his/her professional standing, provided that this substitution fits within the established parameters for acceptable care; however, a nurse may not subject patients to experimental or medically inappropriate treatment. Various considerations may influence this decision including, but not limited to, the belief that Medication Y provides an equally efficacious alternative, but is more cost-effective than Medication X; or, that despite its relatively high cost in comparison to Medication X, Medication Y significantly fulfills more of the patient's needs. In this capacity, the district nurse functions as a gatekeeper to medical resources. With this level of professional autonomy, the district nurse may essentially trump the recommended method of care suggested by the GP and pursue another viable treatment option.

While dissimilar to the district nurse in the specific method of gatekeeping, the home visiting nurse allocates resources by identifying community health needs and referring patients to appropriate services, thereby fulfilling the second aspect of gatekeeping established at the onset. In this capacity, the nurse functions as a liaison between community resources and the primary health care team. Through membership in organizations and advising policy-making committees, the home visiting nurse is able to advocate on behalf of individual patients, as well as patient populations, by directing health concerns through the appropriate channels. This process may include drafting letters to various social services on behalf of in-need individuals and families, securing funds to better implement public health campaigns, identifying prominent health concerns within a population, devising strategies to facilitate cost-effective resolutions to those problems, and lobbying policy-

makers in the legislature. Like the district nurse, the health visitor is not accountable to the GP, but attempts to work with physicians in assessing community needs. Acting as both an advocate for patients and a funnel to community resources, the home visiting nurse necessarily incorporates gatekeeping responsibilities into daily practice.

The gatekeeping clinician, either nurse or GP, plays a critical role within the present NHS, both in maintaining cost-effectiveness and facilitating access to health care resources. While the original vision of the NHS employed the GP as the primary gatekeeper to resources, the present system allows for similar practices of both the district and home visiting nurses. This change evolved though a series of reforms and reorganizations of British health care policy which gradually instigated the emergence of these nurses as both professionally autonomous providers of health care and as coordinators of access to community-based health resources.

III
Expanded Nursing, Managed Care, and the "New" Nursing Paradigm: Nurses as Care Coordinators

The profession of nursing has historically been discussed in terms of providing humanistic care. From this perspective, nurses care for patients by helping individuals achieve optimal levels of health, facilitating the maintenance of good health, and caring for patients as individuals with unique attributes.[28] If nurses are charged with the responsibility of providing cost-effective care through the practice of gatekeeping, there are two questions of critical importance: first, how can nurses continue to advocate for patients and deliver exemplary care within cost-cutting environments and second, should nurses continue in roles, like gatekeeping, which necessarily conflict with some tenets of nursing? The former question lends itself to the kind of policy-making inquiry that falls outside the

scope of this paper, but which does provide opportunity for significant study and policy recommendation. Based on their experience in identifying and addressing the health care needs of individuals and patient populations, I believe that nurses should become active and involved participants in determining those policies governing distribution. Importantly, the complexities of this question are outside both the scope of this study and the expertise of the author. The later question, however, is fundamentally one of applied ethics which requires examining some normative claims, derived both from an inquiry into operational reality and philosophical discussion.

The most common gatekeeping function in British nursing is witnessed in nurse-practitioner roles. In this hybrid between traditional nursing and medicine, nurses function as autonomous clinicians, both in terms of prescribing treatment and managing individual caseloads.[29] Caines (1996) reports that nurse-practitioners in various clinical settings, including emergency care, pediatrics, and geriatric care, currently exercise personal judgement in administering patient care. Although protocol demands that physicians subsequently "rubber stamp" these decisions, Caines suggests that the role of the autonomous nursing clinician should be legitimized throughout the NHS, primarily because clinical understanding and practical experience serve as invaluable tools when coupled with the managerial expertise these nurses already possess.[30] It is unclear whether or not British standards dictate any specialized advanced education, beyond what is required for general nurses, for nurse-clinicians; but it seems reasonable to argue that any clinician engaging in diagnostic procedure should be formally trained. Again, questions aimed at elucidating the specifics of an educational model should be left to those in the profession.

In the United States, managed care closely resembles British medicine. Managed care emerged as a means of containing rapidly increasing health care costs in the United States. Behind

this institution lies the philosophy that high quality care and cost-effective care are not mutually exclusive. Instead, managed care attempts to curtail costs by providing heath care to an enrolled population while limiting a patient's ability to chose providers and medical options. The assumption underlying managed care is that expenditures can be reduced by approaching health care preventively, decreasing hospital stays, providing quality home care, and coordinating care among secondary resources within the community.[31] In an ideal program, integrated networks offer a complete continuum of services allowing clinicians to facilitate movement among several cost-effective choices. In this capacity, the provider of services acts as gatekeeper for the patient by "determin[ing] appropriate care and refer[ing] [patients] to providers who can manage resources in the most cost effective manner while ensuring positive patient outcomes."[32] The successful managed care provider, according to Doolan (1995), is defined as the clinician who balances high quality care with cost effectiveness.[33]

In recent years, managed care organizations began utilizing nursing expertise as a means of uniting cost-effectiveness and quality care. As such, these nurses are currently facing a shift in role characteristics toward the inclusion of managerial and coordination responsibilities, as well as, in limited circumstances, the authority to make autonomous determinations of therapeutic interventions. This level of nursing expertise is termed "expanded practice." Graff, et. al (1995) outline several hallmarks of expanded nursing practice in managed care. The most relevant of these roles includes: "the analysis of health care services and systems to determine accessibility, sensitivity to client needs, and cost effectiveness for the target population; care coordination across the health-illness continuum; consideration of organizational, community, and societal implications of events and decisions related to care coordination; and emphasi[zing] the [establishment of] networks of colleagues and

resources."[34] The primary focus of the nurse-clinician, then, is to coordinate patient care from illness to health, utilizing a cost-effective mix of clinically appropriate interventions while simultaneously employing a population-based approach to the distribution of resources.

Conway-Welch (1995) contributes another important addition to a comprehensive definition of expanded practice in nursing. Citing the advent of *TennCare*, an alternative health care funding program in Tennessee, she reports that this particular program "specifically legitimized the role of the advanced practice nurse as a gatekeeper in managed care organizations." According to the constitution governing this program, expanded practice is "characterized by the assumption of specified medical aspects of patient care and by the authority to order or otherwise initiate diagnostic and ancillary services" relying on standard protocol.[35] Thus, the nurse-gatekeeper, at least in this particular managed care program, is charged with clinical diagnosis and treatment of patients.

Beyond the advent of advanced nursing practice in managed care, clinical nurse specialists are emerging in a variety of clinical settings. As defined by the American Nurses Association (ANA), clinical nurse specialists represent a subgroup of advanced practice nurses educated at the master's or doctoral levels in a defined area of clinical nursing practice.[36] Working in conjunction with other health care providers, the clinical nurse specialist determines, provides, monitors, and coordinates patient care with the intent of maximizing salubrious outcomes and cost-effectiveness. According to the ANA, cost-effective care is the product of several factors. First, in order to fulfill the clinical nurse specialist role, nurses must have a client-based practice, within which patients are evaluated "in the context of his or her social environment." This particular role characteristic aligns well with the first tenet of Clancy and Brody's gatekeeping model discussed above. Second, the nurse plans therapeutic interventions in collaboration with patients in order to enhance self-care whenever and

to whatever extent possible. Patients able to care for themselves will, at least in theory, access health care less often thereby lessening the drain on medical largesse. Finally, in an attempt to increase the range of resources available to patients and families, the nurse consults with an interdisciplinary array of professionals and coordinates patient care through referral to those resources providing appropriate care in a cost-effective manner.

Many scholars argue that nurses were thrust into executive and clinical practice roles both in England and the United States during the 1990s, primarily in response to escalating costs.[37] However, the benefits of relying on nurses in this capacity seems to extend beyond purely economic considerations. MacPherson (1995) argues that by decentralizing care responsibilities to nursing staff, patients consistently receive the highest quality of care.[38] Patient focused care, as this process is termed, relies on the premise that nurses are involved in more aspects of service delivery, from clinical interaction to case management, than other health professionals and therefore have more experience in coordinating care; thus, nursing expertise, according to MacPherson, is founded on operational reality, making the practice of nursing more amenable to gatekeeping.

Currently, nurses control nearly 80 percent of patient contact in clinical settings, across a wide range of health concerns both in the United States and United Kingdom.[39] In simple terms, nurses interact with patients significantly more than do other health care professionals, like physicians. As such, nurses are able, at least potentially, to assemble comprehensive overviews of those factors influencing a patient's health, thus fulfilling an important factor of the gatekeeping calculus as established by Miller and Brody. Curtin (1979) and Michaels (1992) argue that nurses attend to patients beyond their immediate medical concerns, allowing greater interpersonal interaction between nurse and patient.[40] Based on one study conducted by Michaels, when patients feel unrushed and in

a trusting environment, they are more apt to reveal those intimate details that enhance the restoration of their physical and emotional well-being. Nursing, according to Michaels, contributes to a safe environment, primarily because nurses interact with patients more often than do other health professionals. Furthermore, because of their holistic approach to care, nurses are often able to assemble a comprehensive understanding of those factors affecting a patient's health and devise care strategies around these determinants. As a model, Michaels outlines the structure of an actual nursing HMO, designed to implement community nursing care while relying on capitation for reimbursement. The study tested the hypothesis, that based on their ability to view health holistically, nurses would improve the efficacy of treatment while simultaneously reducing costs. Michaels reports that initial statistics confirm a savings of $800,000 in relation to the physician-operated HMO, while substantially increasing positive patient outcomes.[41] Other studies support Michaels' findings. Graff (1995) indicates that nurse-clinicians servicing three patient populations (diabetics, patients with multiple sclerosis, and pregnant adolescents) were also able to improve patient outcomes.[42] Nyberg's (1990) study concluded that a hospital's ability to provide quality "human care" ensured economic viability for the hospital, and was dependant on nurse-clinicians for success.[43] Based on empirical data, she theorizes that economic considerations and human care are interrelated forces affecting clinical decision-making.

Wright (1993) places nurses in the forefront of resource allocation, both in policy development and in clinical settings. He believes that nurses impact, more than any other health professional, the funding of health care resources and the quality of patient care, based on both practical experience and their collective size within the health care industry.[44] According to this argument, nurses are able to lend unparalleled clinical experience to the micro-allocation of health

care resources because of their expertise in dealing with the front lines of patient care. Auchterlonie (1995) extends this position and argues that nursing experience is necessary to lend clinical credibility to both the purchasing and distribution of resources because of the significant patient contact involved in practice.[45]

IV
The Ethical and Philosophical Foundations of Gatekeeping in Nursing

As previously discussed, gatekeeping emerged in response to the increasing demands placed upon health care resources and the need for equitable and ethical modes of distribution. In some sense, gatekeeping assumes that individual (and perhaps natural) rights guarantee at least minimal access to health care resources for those who contract for services. If the opposite were true, gatekeeping clinicians could deliver goods and services to any individual for any reason and simultaneously deny others without rational justification. However, this position seems counter-intuitive to any sense of morality; such discriminatory practices, especially in health care, are generally considered egregious violations of ethical norms. Importantly, some scholars might argue that this particular discussion slips into addressing the much older and more complex question of a guaranteed right to health care — a question which philosophers, theologians, lawyers, and health care professionals have been unable to adequately resolve. However, I believe the assumption central to my argument is equally as applicable to patient populations and can be considered independently of questions pertaining to the universal and comprehensive provision of health care. Patients who contribute financially to health care systems, either by enrolling in managed care in the United States or through general taxation in the United Kingdom, are entitled to some compensatory return on their investment. Moreover, they entrust health care providers to use monies prudently and expect that if services are

not unlimited, resources will be allocated fairly.

Although the practice of gatekeeping was developed to ensure fair distribution, it has nevertheless been the indirect recipient of harsh criticism. Questions regarding the ethics of managed care often accompany discussions of gatekeeping. The standard model of managed care enjoins the primary care clinician, either physician or nurse, to restrict access to speciality and ancillary care in an attempt to curtail expenditures and, in some cases, to maximize profit. Professionals charged with this responsibility actively participate in gatekeeping. Arguments against gatekeeping suggest that financial incentives, which are often bestowed upon clinicians who reduce expenses, abrogate the fundamental ethic of health care. Therefore, prior to examining ethically appropriate methods of distribution, it is important to address several of these concerns.

Hospitals and clinics can be assigned two fundamental economic classifications: for-profit and non-profit. By far, the most pronounced criticism is aimed at for-profit organizations which operate in accordance with business-like objectives. Kuttner (1996) observes that "in a purely for-profit enterprise or system, there is no place for uncompensated care, unprofitable admission, research, education, or public health activities."[46] In the spirit of capitalistic business, for-profit health care organizations seek to maximize financial gains and minimize financial losses. In an attempt to more readily accomplish this goal, clinicians are routinely granted monetary incentives for reducing ambulatory and long-term care, as well as referring patients to services administered by the organization,[47] each of which advances the organization closer to economic viability.

Accusations of ethical misconduct arise when clinicians, either physicians or nurses, allow promises of financial reward to influence bed-side decisions. To combat such practices, the American Medical Association (AMA) issued guidelines prohibiting physicians from referring patients to "a

facility in which he or she has a direct financial interest."[48] To date, no such norm exists for nurses. Importantly, Kuttner (1996) reports that, under federal "safe harbor" regulations, clinicians are exempt from legislation preventing these self-interest referrals if the hospital is owned and operated by a "public company worth at least $50 million in which the [clinician] is a shareholder."[49] Although this legislative loophole grants some legal immunity to opportunistic health care providers, physicians and nurses who engage in such practices still violate established ethical norms; codes of professional ethics dictate that such practices should be avoided and professionals should be held accountable to these guidelines. Despite the apparent ethical reprehensibility of such actions, Kuttner concedes that there is no reliable statistical evidence to suggest that for-profit organizations compromise patient care. He does insist, however, that some negative effects of the system may have evaded the traditional methods of gauging such a claim.[50] Perhaps only time and improved research methodology will adequately resolve this question.

Ethical considerations for gatekeepers are not isolated to for-profit organizations. In order to remain competitive in the health care market, non-profit institutions must limit losses and gatekeepers are often called upon to help facilitate this goal. As such, clinicians are at times threatened with termination if their diagnosis and referral process increases expenditures and fails to produce significant monetary gain.

While ethical dilemmas do arise at institutional levels, the system is not irrevocably damaged; rather, the potential for misconduct has prompted some scholars to propose models for a managed care reform. Bodenheimer (1996) advocates a return to prepaid-group-practice models characteristic of early managed care organizations. The advent of such a resurgence would, according to Bodenheimer, have three primary benefits: "(1) Over 90 percent of the premium dollar could be

dedicated to patient care; (2) Patients could have access to services purely on the basis of clinical criteria; and (3) Physicians could be well paid, with neither the opportunity for large bonuses nor fear of termination for economic reasons."[51] Hasan (1996), who contends that for-profit plans are designed in the best interest of society, offers suggestions aimed at mitigating both the ethical and practical failures of managed care. He argues in favor of reforms intended to include: "(1) Guaranteed access to care for all consumers; (2) elimination of all limitations of coverage based on preexisting conditions and medical-risk ratings; (3) establishment of a process for determining which procedures are effective, particularly among expensive new forms of technology; (4) guaranteed coverage for all effective procedures; and (5) third-party consumer protection."[52] Alexander Capron (1996) believes that capitation offers sound resolution to economic and moral concerns. Under capitation, "a physician or other provider promises for a fixed monthly payment to provide...care. Capitation is among the changes at the heart of health care [reform] which aim to cut waste and hold down health care spending — and which enjoy broad public support."[53]

Given the apparent need for reform, a question critical to this paper should be addressed: Is the potential for ethical misconduct significant enough to prohibit gatekeeping? I contend that the most relevant and soundly reasoned complaints focus on the ethics of the systems in which gatekeepers are employed. What I mean to suggest is that these particular ethical shortcomings are intrinsic to the organization of care and are products of the rules which govern allocation in clinical practice; they will be mitigated more effectively at the institutional level and not by prohibiting gatekeeping. In reality, these ethical considerations do pose problems for health care professionals, including nurses, and clinicians should be cognizant of them when actively participating in gatekeeping. However, no empirical evidence indicates that gatekeeping clinicians adversely affect

the health and well-being of their patients despite accepting financial incentives or receiving threats of employment termination. If gatekeeping does not necessarily cause injurious effects, then the more significant question to consider is, since nurses function as gatekeepers, how can they, both collectively and individually, develop methods of equitable appropriation without violating the fundamental standards of nursing practice.

Nursing has as its fundamental purpose the promotion of health and well-being of patients and their families.[54] As the practice of gatekeeping becomes increasingly more prevalent in clinical practice, ethical considerations will be cast in terms of a nurse's obligation to provide quality human care while functioning as a gatekeeper. Thus, the ethical backdrop for gatekeeping in nursing practice is predicated upon the potential conflict between several professional duties (fidelity, due care, and advocacy) and what may be the competing obligations of gatekeeping.

In recent decades, an interesting philosophical debate has surfaced in an attempt to articulate a fundamental definition of justice and establish guidelines governing the fair distribution of scarce resources. Veatch and Fry (1987) argue that, applied to the nursing paradigm, justice issues fall within three categories: (1) the rationing of time resources, (2) the distribution of services among clients and non-clients, and (3) the allocation of care to individuals or populations through the implementation of social policy or in clinical practice.[55] While the first two classifications give rise to some substantial ethical questions which could be explored in depth, they are not within the scope of this particular inquiry; the final position, however, embraces issues of justice relevant to a discussion of gatekeeping in nursing practice.

In the current debate, one of three principles generally informs how resources are dispensed.[56] Some scholars argue that gatekeepers should employ the utilitarian calculus when apportioning

resources. This argument stems from the belief that health care providers should seek to produce the greatest possible benefit for the largest number of persons while avoiding potential harms. A second group of theorists attempts to act with fairness by appealing to justice as a separate principle with merit equal to that of other moral principles. The final approach is derived from theories of autonomy-based ethics. According to those who align with this view, maximizing benefit should not be overlooked, but autonomy wields greater import; distribution should follow in accordance with the choices of those individuals who control or own the goods to be offered. The argument can be constructed as follows. When health care is provided to those in need, goods and services are exchanged because patient and clinician have agreed to an implicit or explicit contract. Regardless of how a particular bargain is reached, either in a fee-for-service exchange or because the clinician is willing to offer care out of a sense of charity, decisions regarding allocation are dominated by the free choices of those involved in the process of care. Essentially, client and provider are free to bargain for whatever they can obtain. Justice is therefore attained when patients are granted access to resources they should reasonably possess--they are entitled to these goods and services and perhaps have a right to them because of their contractual agreement. Although well-respected Harvard philosopher, Robert Nozick, is generally considered the founder and champion of this particular theory of justice, I do not believe that considering autonomy moves discussions of distributive justice any closer to sound resolution. Theories of justice grounded in autonomy assume that conflicting principles do not exist; if a patient has a right to a procurable good, then he/she is entitled to that good. But what happens when resources are available in limited quantities? Consider the following example. Suppose that several patients have contracted with a clinician for care, all of whom are candidates for heart transplant. If only one organ is available for distribution, the reasons

in favor of allocating to one patient over the other will arguably conflict. The questions for gatekeepers are (1) how to resolve this conflict fairly and (2) what principles should guide such a decision. Because autonomy-based theories do not consider the existence of conflicting factors of equal merit, I do not believe they contribute to this particular discussion as significantly as do considerations of utility and fairness.

As the primary focus of this section, I will discuss the philosophical underpinnings of the distributive justice methodologies suggested by Jeremy Bentham and John Rawls. I will argue that the utilitarian calculus lends a sound framework to resource distribution within which gatekeeping nurses might work. Additionally, I will explore aspects of Rawlsian theories of distributive justice and explain how Rawls and Bentham actually suggest similar ideals when their theories are applied to apportioning scarce resources. I conclude with a discussion of nursing standards designed to illuminate an apparent compatibility between the fundamental philosophy of gatekeeping and the advocacy role in nursing.

I begin with Jeremy Bentham, whose principle of utility has historically served as the ethical looking-glass through which gatekeeping is examined.[57] In general terms, utilitarians advocate morally assessing choices and actions in terms of the aggregate benefit they produce. Bentham, widely considered the first scholar to articulate and promulgate the fundamental construct of utilitarianism, asserts that maximal benefit is achieved by adhering to utility, defined by Bentham as:

> ...that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question: or, what is the same thing in other words, to promote or to oppose that happiness...Utility is that quality in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness.[58]

Bentham's concept of utility is often termed hedonistic consequentialism; hedonistic because of its goal to achieve the greatest happiness, and consequential, based on its determination of right in wrong in terms of good and bad outcomes. Simply stated, Bentham's utilitarian vison enjoins moral agents to find the greatest good by balancing the interests of affected individuals, a judgement largely dependant on an estimate of the probable outcomes of actions and choices.

Applied to the allocation of limited resources, Bentham would arguably support distribution guidelines which attempt to produce the greatest happiness over time for the greatest number of persons. The utilitarian strategy suggests that clinicians debating among options for treatment and distribution should examine the potential benefits of a particular action and its potential harms. The sum of all benefits should then be recorded, from which the sum of potential harm is then subtracted. According to this consequentialist model, the method of allocation most likely to maximize benefit should be pursued. It follows then, that if gatekeeping is primarily utilitarian, gatekeepers should allocate resources only to those individuals who stand the greatest chance to show significant return on any medical investment, expressed both in the patient and any other affected person, thereby ensuring the greatest overall benefit.

Beyond the theoretical design of utility, Bentham offers a seven-step calculus to be used as a basis for achieving maximal benefit. It is this practical dimension of the utilitarian calculus which I believe makes the theory particulary useful for gatekeepers in clinical environments. According to Bentham, the aggregate benefit of a particular decision is determined by taking into account the following conditions:[59]

1. Its *intensity*.
2. Its *duration*.
3. Its *certainty* or *uncertainty*.
4. Its *propinquity* or *remoteness*.

5. Its *fecundity.*
6. Its *purity.*
7. Its *extent.*

While the first four conditions are fairly straightforward, the final three considerations may require further clarification. Fecundity refers to the probability that an action will produce additional pleasures or pains. Purity is defined as the tendency an action has of not being followed by sensations of the opposite kind. An action is pure, therefore, if, when the intended outcome is pleasure, it can be reasonably assumed that it has a relatively small chance to produce pain. Extent takes into account the number of persons who will potentially be affected by the consequences of a particular action.

At first glance, the utilitarian perspective seems to offer a sound methodology for achieving moral ends. The fundamental argument appears compelling and rational and few would disavow any theory purporting to reduce pain and maximize pleasure. Despite the systematic approach to achieving general community benefit contributed by the utilitarian perspective, however, some intrinsic dilemmas and traditional objections often arise that should be examined.

By far, the most common objection raised in response to utilitarian claims addresses potential allowances for actions considered immoral by general standards of ethics.[60] Should the liberties of some individuals be sacrificed by a given action, utility may uphold that action as just if it simultaneously produces benefit shared by the majority of the population it serves. Consider the following example. Suppose a group of leading virologists determines that the only method of eradicating a particularly infectious virus is to quarantine all seropositive individuals and force them to ingest anti-viral medications with particularly painful side-effects. After applying the calculus, utility may indicate that such an action is not only just, but morally obligatory as well if it maximizes benefit for the greatest number of persons, presumably in this case, uninfected persons who would

have otherwise contracted the disease from this now isolated population.

Beauchamp and Childress (1994) extend common objections to utility and apply them to justice issues. They argue that "utilitarianism in principle permits the interests of the majority to override the rights of minorities and cannot adequately disavow unjust social distributions."[61] According to their position, if an already thriving group could increase their happiness more so than a less well-off faction, then utilitarians must recommend appropriating resources to the flourishing group. In other words, Beauchamp and Childress seem to charge utilitarians with ignoring an appeal to an independent principle of fairness. John Arras (1984), an economic philosopher, apparently agrees with this position when he argues against the utilitarian perspective on the grounds that it "is not likely to encompass all citizens, especially those whose needs place great strains on public largesse while at the same time preclude[s] any sort of 'return' on...social investment."[62] Incorporating utilitarian practices into the distribution of health care may, according to Arras, necessarily exclude certain groups — the elderly, premature newborns, and critical care patients, for example.

Perhaps what Beauchamp and Childress, as well as Arras, fail to consider is Bentham's concept of equality. Initially, Bentham does argue that "equal increments of a good will not produce equal increments of utility." We can reasonably construct this premise to reflect the views of the aforementioned scholars. Importantly though, Bentham suggests that, in general, "provision of a particular good will provide more utility for those who already have less then those who already have more; hence a general tendency toward providing goods to those least well-off." It would seem the more significant question is how to accurately identify the interest group and calculate potential benefit.

According to Bentham, "the community is a fictitious body, composed of the individual

persons who are considered as constituting its members. The interest of the community is [therefore]...the sum of the interests of the several members who compose it."[63] If we accept this premise of Bentham, it follows that the general welfare of the community results from attending to the needs of its individual members. From this particular premise, two fundamental principles of bioethics have been derived: beneficence and non-maleficence. In contrast to general utility, under which the aggregate of communal happiness is of utmost importance, beneficence generally includes an obligation to do the greatest good for individuals. Non-maleficence redefines beneficence in negative terms, requiring clinicians to do no harm. Traditionally, nurses are advised to adhere to beneficence by cultivating and maintaining strong allegiances to individual patients, achieved at least in part through the promotion of health.

Reigle (1990) differentiates two tiers of beneficence: the patient level and the societal level.[64] While each considers beneficence in the allocation of resources, outcomes of distribution are prioritized differently. Patient-centered care focuses solely on attaining good health for the individual patient while largely ignoring epidemiologic factors. When individual patient benefit provides the primary criterion for resource allocation decisions, the result may be what Reigle terms short-sighted beneficence. Short-sighted beneficence occurs when individual patient benefit is measured episodically, rather than cumulatively, in the larger context of all clients. In terms of allocation practices, guidelines which advocate distributing any available resource to individual patients without consideration of other patients in the care of a particular clinician rely on short-sighted beneficence. By definition, the limited scope of short-sighted beneficence conflicts with the primary obligations of gatekeeping which require gatekeepers to consider populations when distributing resources.

In contrast to short-sighted beneficence, full beneficence assumes a prospective and

comprehensive approach to health care delivery and considers societal concerns, or the needs of a given patient population, as the primary criterion for resource distribution. By definition, full beneficence aligns more exactly with the practice of gatekeeping outlined at the onset of this paper. Reigle argues that full beneficence is preferable, especially in systems of limited resources, because long-term benefits generally maximize the maintenance of good health across patient populations. I suggest that this element of Reigle's position is in the spirit of Bentham's calculus — specifically *duration* and *extent.* Importantly, Reigle's full beneficence should not be confused with general utility. Scholars equating the two offer an inaccurate interpretation of Reigle's argument. While Reigle does claim that populations should be considered when apportioning resources, rather than individuals alone, she offers no concrete methodology for distribution as does the utilitarian perspective, thus rendering her theory somewhat less applicable. Instead, Reigle suggests that gatekeepers in general, and nurses specifically, devise prospective guidelines to edify allocation decisions in clinical settings, keeping in mind that serving patient populations is necessary to producing salubrious outcomes within the framework of some viable theory of distributive justice.

Positions like Reigle's often fall prey to criticism on the grounds that nurses are primarily responsible to the individual patients within their care and not to patient populations. According to such an argument, the nursing paradigm requires adherence to patient-centered beneficence. However, in 1990, the American Nurses Association enunciated a guiding set of standards generic to all nurses employed in clinical practice. One aspect of this policy, the Social Policy Statement, identifies the responsibility of nursing as "[service to] the interests of the larger whole of which it is a part."[65] This assertion means that the goal of nursing at least partially embraces public health and social good. It is reasonable to argue that in some nursing specialities, community care for example,

social good is the primary goal since interventions are targeted toward public health. But are social concerns restricted to particular facets of nursing only? The ANA is clear in stating that the intent of the Social Policy Statement is applicable to all nurses and nursing specialities. If this interpretation is accurate, then allocation and treatment decisions must be targeted to patient populations, rather than individual patients alone.

At this point, it is important to consider if beneficence should guide the governance of resource distribution. Regardless of which definition of beneficence we adopt, the duty to uphold this principle is not absolute. In principle-based ethics, principles like beneficence should be employed as guides rather than as absolute rules; that is, they offer a rough vantage point from which to examine the conditions under which certain actions may be prohibited as unjustifiable or reasonably allowed. In general, principles such as beneficence are termed *prima facie* obligations. These duties allow for violation of certain rights, expressed as principles, when specific conditions are fulfilled. Deliberating over these conditions generally involves weighing the proportionality of competing values to determine when curtailing rights is defensible. This manner of conflict resolution involves a deontological argument. According to such theories, we have certain *prima facie* duties and at times these duties conflict. Under such conditions, the moral objective is to discern which of our conflicting duties takes priority in that concrete situation. Ethically sound resolutions are achieved when abstract principles are quantified and shaped to inform practical judgement. Consider the obligations of the gatekeeping nurse. If gatekeepers are trustees of equitable distribution, then beneficence alone may not offer a sound principle for allocation. Especially in systems of limited resources, doing the most good for one patient may seriously jeopardize the well-being of another. Thus, especially those nurses who engage in gatekeeping must attempt to delineate acceptable

standards for treatment based at least in part on the fundamental duties of nursing practice.

The ethical considerations of nursing generally include obligations to fidelity, due care, and advocacy. Fidelity is defined as the obligation to honor implicit and explicit promises, act in good faith, maintain confidentiality, and fulfill fiduciary responsibilities.[66] Erlen and Mellors (1995) argue that fidelity embraces beneficence,[67] thereby consigning nurses to first attain salubrious outcomes for individual patients without recognizing the legitimate needs of patient populations. The inadequacies of short-term beneficence are applicable here as well. Due care refers to the process of optimizing care for both patients and their families through the application of proper nursing training, skills, and diligence to clinical decisions.[68] Due care enjoins nurses to employ professional standards when administering care that meet or exceed expected norms and consequently produces positive outcomes. While due care is important for nursing, it provides no compelling justification to prevent nurses from gatekeeping, nor does it supply concrete guidelines to govern allocation practices.

Gatekeeping in nursing is characterized by a *prima facie* conflict between a belief in the intrinsic worth of each individual, reflected in the philosophies of fidelity and due care, and the demand for lowering costs accomplished through gatekeeping. If the end purpose of nursing is the welfare of patients and families, then the science of nursing is coupled with the art of caring to achieve an essentially moral end.[69] Models of advocacy offer a middle ground in which I believe this *prima facie* conflict can be reconciled.

Advocacy, considered from a moral perspective, is amenable to several interpretations and Fry (1996) offers three models.[70] The first, termed the rights protection model, views the nurse as a defender against flagrant infringements on a patient's guaranteed rights. As such, the nurse is expected to identify rights, inform patients of those rights, safeguard against violation, and report any

inappropriate breach of these rights. The values-based decision model, employs the nurse as a counselor of sorts who helps patients elucidate personal values and elect a course of action consistent with those values. Ideally, the nurse does not impose personal values upon the patient, but helps the patient explore the long and short term ramifications of a particular decision. The final interpretation is the respect-for-person model which encourages nurses to respect and advocate on behalf of individual human dignity. According to Fry, this final model encompasses the essential elements of the previous two, while remaining consistent with the ANA Code for Nurses.

Recall that the philosophy underlying gatekeeping assumes that health care is a limited commodity with a significant enough need to necessitate rationing. Rationing refers to the process of placing equitable limits on the delivery of health care to individuals.[71] Again, health care resources include both treatments for disease and disorder as well as care for persons and families experiencing disease and disorder. Thus, gatekeeping clinicians are charged with the responsibility, and perhaps the dilemma, of facilitating the process of fair distribution. If the primary obligation of nurses is to advocate on behalf of patient dignity, then we must determine if the duties of gatekeeping necessarily preclude the practice of advocacy.

In order to best serve the needs of patients the gatekeeping-nurse must first consider a cost-benefit analysis of available treatments in order to promote equality and justice in allocation. The cost-benefit analysis that I mean to suggest includes two components: economic factors that limit available resources, as well as an essentially human element. According to Allan Williams, an economic philosopher, in fixed market systems like Britain's health service and managed care in the United States, "the system should stop providing health care when the extra health benefit to be gained is of approximately the same value as whatever has been given-up to provide the extra

resources." In other words, medically futile interventions counteract the economic purpose of gatekeeping. Recognizing that in a system of limited resources, selecting any treatment necessarily means deselecting another, patients who show no significant benefit are simply draining funds which could be redirected to provide care for other patients. In addition to economic considerations, the medical benefits of care must also be examined. Essentially, a nurse debating among treatments is ethically required, according to Williams, to engage in a needs assessment, investigating "what is beneficial and what is not, and just how beneficial the beneficial things are...," as well as "...how benefits to one patient are to be weighed against benefits to another."[72]

What Williams suggests is arguably in the spirit of Rawlsian reflective equilibrium. According to 20th century philosopher John Rawls, ethical deliberations should begin with what he terms considered judgements, or the moral convictions in which we place the greatest confidence. Examples of such judgements include the wrongness of discrimination, intentional homicide, and religious or social persecution. In general, these judgements serve as rules which shape our moral thinking. However, the goal of reflective equilibrium is achieved when individuals adjust and revise judgements of moral rightness and wrongness so that a general theory is developed. This theory is then applied to a concrete situation, scrutinized on a casuist basis, and tweaked for consistency. Within this model, the determination of ethical practice is analogous to testing a hypothesis in science through experiment and critical thinking. Perhaps dissimilar to scientific inquiry, though, Beauchamp and Childress (1994) suggest that "there is no reason to anticipate that the process of pruning, adjusting, and rendering coherent will either come to an end or be perfected."[73]

Nurses should recognize this reality and both collectively and individually engage in a reflective process that examines the implications of distributive justice in health care. Again,

according to Rawls, justice in distribution derives from two basic principles. First, Rawls defines his "fair opportunities rule," that the basic benefits of a society must be available to all its members. Once this goal is accomplished, secondary goods, like health care, should be distributed equally, unless two fundamental conditions are met. If inequality is inevitable, then all persons must stand an equal chance of gaining the benefits of treating some unequally, and, second, inequalities must benefit the least well off within the system. If the Rawlsian theory of distributive justice is implemented into nursing practice, allocation by gatekeepers would not rely solely on social utility or beneficence, but would consider the least well off, or those with the greatest need as well.

Rawlsian distributive justice seems to be compatible with advocacy, which suggests that nurses protect patient dignity. Human dignity can be safeguarded when nurses (1) identify the least well off, (2) determine if available resources will benefit those within this group, (3) offer equal chances of obtaining resources whenever possible, and (4) rely on principles of justice and fairness to guide distribution when achieving absolute equality is impossible. This view also seems to fit Bentham's understanding of equality — that a general preference toward allocating resources to the least well off should govern the distribution of goods and services. It is important to recognize that Rawls addresses fairness while Bentham considers benefit. As economist and ethicist John Broome (1994) suggests, we are left with an apparent conflict between fairness and doing the most good.[74]

What I suggest is by no means an absolute resolution of this conflict, but rather, a middle-ground of each end. The gatekeeping-nurse should first cast his/her role in terms of advocating for the collective and individual health concerns of all patients under his/her care. As an advocate, a nurse must first attempt to distribute resources equally. When goods are limited, the gatekeeping nurse must identify those who are candidates for receiving a particular resource. If goods are

available, then each individual within this group will have some claim to that resource, or a reason why he/she should be privy to some amount of appropriation. The relative strength of these claims should then be evaluated by the nurse in terms of Bentham's seven-point calculus. Fairness, or justice, seems to dictate that each candidate's claim be satisfied relative to its strength. Inevitably, unfairness will at times result. During such times, justice should serve as the primary guiding principle.[75]

Gatekeeping nurses are charged with an unique responsibility — to balance human dignity and equitable resource distribution which may at times curtail individual rights. Because nursing provides an essentially moral end, ethical standards must govern how nurses appropriate goods and services to clients. I believe that Bentham's utility and Rawlsian distributive justice provides sound moral reasoning and convincing guidelines to prompt bed-side decisions regarding allocation, primarily because they align with advocacy, a fundamental tenet of nursing practice. As gatekeeping in nursing becomes more prevalent in clinical environments, policies should be developed to guide distribution that keep in mind the theoretical frameworks of Bentham and Rawls.

APPENDIX I

Martin Benjamin offers some poignant insights regarding personal integrity and its moral significance, which Miller and Brody in turn apply specifically to health care. According to Benjamin, personal integrity precipitates identity and both concepts can be understood interchangeably. For the purposes of this discussion, I will use identity primarily because its connotation aligns more exactly with the ideals of patient care in clinical environments. It seems more accurate to say that clinicians should and do consider the manner in which an individual expresses his/her unique identity, rather than considering integrity which generally implies how morally praiseworthy an individual is.

Benjamin proposes that identity is comprehensively defined by integrating the following characteristics: "(1) a reasonably coherent and relatively stable set of highly cherished values and principles; (2) verbal behavior expressing those values and principles; and (3) conduct embodying one's values and principles and consistent with what one says."[76] It follows, then, that identity, at the most fundamental of levels, stems from a set of core values and beliefs which an individual relies upon in decision-making. Consistency occurs, according to Benjamin, when the third qualification is applied; that is, when individuals express their values and act in accordance with them. For example, it would be inconsistent for me to declare a steadfast belief in the sanctity of life and then commit murder.

Benjamin insists that human lives should be examined and assessed in terms of completeness, or expressed another way, as organized narratives. Following Benjamin, Miller and Brody conclude that identity should be considered primarily as a bridge between "thinking and doing."[77] In other words, individuals, and patients more specifically, should be viewed as moral agents who ground their actions in their own personal dogma. Furthermore, Benjamin argues convincingly that identity is

"especially important in social organizations involving a great deal of interdependence." According to Mitchell, (1982) hospitals and clinics are arguably two such institutions.[78] If one goal of health care is helping patients achieve optimal health, then it is reasonable to suggest that clinicians employ medical and nursing skills to reintegrate patients into their normal environments. It follows, then, that an objective, and perhaps a duty, of clinicians is to elucidate the values most intimately affecting a patient's decision-making primarily because those values contribute to an individual's conception of themselves in society.

In the context of this paper, understanding identity is crucial when clinicians consider options for apportioning resources. If patients act upon their values, then treatments intended to alleviate dysfunction, promote health, and prevent the onset of additional disorder should not, at minimum, contravene those values, and should, ideally, help patients act upon those values. Because sharing some elements of personal identity involves exchanging intimate and confidential information, relationships initiated in social institutions, like hospitals, are enhanced by trust. Trust is generally the product of long-standing relationships. Therefore, we can reasonably conclude that long-standing relationships are necessary, but not sufficient, to facilitate the process of resource distribution.

REFERENCES

1.Henry Aaron and William B. Swartz, "Rationing health care: the choice before us" *Science*, 247 (1990): 418-422.

2.David. M. Eddy, "Broadening the responsibilities of practitioners" *JAMA*, 269, 14 (1993): 1849-1855; Thomas Bodenheimer, "The HMO Backlash — Righteous or Reactionary?" *NEJM*, 335, 21 (1996): 1601-03.

3.Pamela Mittlestadt, "The Future of our Nation's Health Care--Will Rationing Be Needed?" *The American Journal of Occupational Therapy*, 39, 4 (1985): 229-232.

4.Juanita Reigle, "Resource Allocation Decisions in Critical Care Nursing" *Nursing Clinics of North America*, 24, 4 (1989):1009-1015.

5.Rod Sheaff, "Needs and justice in health resource allocation," from *Ethical Issues in Caring*, Fairbairn and Fairbairn, eds. (Aldershot: Avebury, 1988), pp. 119-133.

6.Carolyn M. Clancy and Howard Brody. "Managed Care: Jekyll or Hyde?" *JAMA* 273, 4 (1995): 338-9

7.*IBID*

8.Starr, Paul. *The Social Transformation of American Medicine.* (New York, NY: BasicBooks, 1982), pp. 4-6.

9.From the Declaration of Alma-Ata. Cited in Garrett, Laurie. *The Coming Plague.* (New York: Penguin Publishing, 1994), pp. 211-212.

10.Franklin G. Miller and Howard Brody, "Professional Integrity and Physician-Assisted Death" *Hastings Center Report*, 25, 3 (1995): 8-16.

11.Donna M. Wing, "Resource allocation in health care: An example from the United Kingdom" *Nursing Administration Quarterly*, 17, 4, (1993): 72.

12.Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics.* Fourth ed. (New York: Oxford University Press, 1994), p. 470.

13.Clancy and Brody (1995), pp. 338-9.

14.Webster, Charles (ed) *Caring for Health History and Diversity* (London: Open University Press, 1993), p. 69.

15.Smith, Abel. *A History of the Nursing Profession* (London: Heinemann, 1960), as cited in Wilma R. MacPherson, "Nursing in the NHS: the executive nurse director," *British Journal of Hospital Medicine*, 55, 8, (1996): 522-4.

16.*IBID*

17.*IBID*

18.Webster (1993), p. 73.

19.Webster (1993), p. 89.

20.*IBID*

21.Webster (1993), p. 118.

22.Townsned, P. and Bosanquet, N. *Labour and Inequality* (London: Fabian Society, 1972), pp. 211-212.

23.Jefferys, M and Sachs, H. *Rethinking General Practice. Dilemmas in Primary Medical Care* (London: Tavistock, 1983), pp. 314-336.

24.Webster (1993), p. 132.

25.S. Osborne and M. Lorentzon, "From 19th century nursing reform to current practice," *Journal of Nursing Management*, 3 (1995): 75-80.

26.Anne Boulin, "Health Visitors: Roles and Responsibilities," NHS publication.

27.MacPherson (1996), pp. 522-4.

28.Jean MacFarlane, "Nursing: a paradigm of caring," from *Ethical Issues in Caring,* Fairbairn and Fairbairn, eds. (Brookfield: Avebury, 1988), pp. 10-19.

29.MacPherson (1996), pp. 522-4

30.Karen Caines, "Here to there," *Nursing Standard*, 10, 45 (1996).

31.Judith Erlen and Mary Mellors, "Managed Care and the Nurse's Ethical Obligations to Patients," *Orthopaedic Nursing*, 14, 6 (1995): 42-5.

32.Mary-Jo Doolan, "Managed Care: A Primer for nurses," *The Massachusetts Nurse*, 65, 10 (1995): 2, 6.

33.*IBID*

34.Wendy L. Graff, et. al, "Population Management in an HMO: New Roles for Nursing," *Public Health Nursing*, 12, 4 (1995): 213-220.

35.Colleen Conway-Welch, "At the table: nursing in managed care," *Nursing Policy Forum*, 1, 5 (1995): 11-16.

36.American Nurses Association. *The Role of the Clinical Nurse Specialist.* (Kansas City: ANA Press, 1986).

37.Cathy Michaels, "Carondelet St. Mary's Nursing Enterprise," *Nursing Clinics of North America*, 27, 1 (1992): 77-85; Graff, et. al (1995), pp. 213-220.

38.MacPherson (1996), pp. 522-4.

39.S. Wright, "Management as an integral part of nursing," *Journal of Nursing Management*, 1 (1993): 129-132; Carol Auchterlonie, "A Significant Change in NHS Structures," *Nursing Standard*, 9, 28 (1995): 20-1.

40.Leah Curtin, "The nurse as advocate: the philosophical foundation for nursing," *Advances in Nursing Science*, 1, 3 (1979): 1-10; Michaels (1992), pp. 77-85.

41.Michaels (1992), pp. 77-85.

42.Graff, et. al (1995), pp. 213-220.

43.Jan Nyberg, "The effects of care and economics on nursing practice," *JONA*, 20, 5 (1995): 13-17.

44.Wright (1993), pp. 129-132.

45.Auchterlonie (1995), pp. 20-1

46.Robert Kuttner, "Ccolumbia/HCA and the Resurgence of the For-Profit Hospital Business -- Part 1," *NEJM*, 335, 5 (1996): 362-7.

47.Bodenheimer (1996), pp. 1601-03; *IBID.*

48.Kuttner (1996), pp. 362-7.

49.See Kuttner (1996), p. 367.

50.Robert Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business -- Part 2," *NEJM*, 335, 6, (1996): 446-451.

51.Bodenheimer (1996), pp. 1601-03.

52.Malik Hasan, "Let's End the Nonprofit Charade," *NEJM*, 334, 16, (1996): 1055-7.

53.Alexander Morgan Capron, "Between Doctor and Patient," *Hastings Center Report*, 26, 5 (1996): 10-11.

54.Curtin (1979), pp. 1-10.

55.Veatch, Robert M., and Sara T. Fry. *Case Studies in Nursing Ethics.* (Philadelphia: J.B. Lippincott Company, 1987), p. 270.

56.*IBID*

57.John Arras, "Utility, Natural Rights, and the Right to Health Care," *Biomedical Ethics Reviews*, Humber, J.M., and Almeder, R.L., eds; (Clifton, NJ: Humana Press, 1984): 23-45.

58.Bentham, Jeremy. "Of the Principle of Utility," from *An Introduction to the Principles of Morals and Legislation*, as reprinted in *Introductory Readings in Ethics*, Frankena and Granronse, eds., (Englewood Cliffs: Prentice Hall 1977), p. 131.

59.Frankena and Granronse (1977), p. 136.

60.Beauchamp and Childress (1994), p. 53.

61.Beauchamp and Childress (1994), p. 54.

62.Arras (1984), pp. 23-45.

63.Bentham (1977), pp. 130-7.

64.Juanita Reigle, "Resource Allocation Decisions in Critical Care Nursing," *Nursing Clinics of North America*, 24, 4, (1989): 1011

65.American Nurses Association. "Nursing: A Social Policy Statement," (Kansas City: ANA, 1990).

66.Beauchamp and Childress (1994), p. 54.

67.Erlen and Mellors (1995), pp. 42-5.

68.*IBID*

69.Curtin (1979), pp. 1-10.

70.Sara T. Fry, "Ethical Dimensions of Nursing and Health Care," from *Professional Foundations of Professional Nursing Practice,* Creasia, J. and Parker, B. eds; (St. Louis: Mosby, 1996), pp. 265-7.

71.Mittlestadt (1985), pp. 229-232.

72.Alan Williams, "Cost-effectiveness analysis: is it ethical?" *Journal of Medical Ethics*, 18 (1992): 79-95.

73.Beauchamp and Childress (1994), p. 22.

74.John Broome, "Fairness versus doing the most good," *Hastings Center Report*, 24, 4 (1994): 36-9.

75.I suggest that following this formula does not necessarily compromise the dignity guaranteed each individual for two reasons: (1) patients' rights are not compromised because they have claims to resources rather than rights, or constraints, and (2) gatekeeping nurses are able to help patients elucidate their values and pursue treatment options even when a particular resource is not available.

76.Benjamin, Martin. *Splitting the difference: Compromise and integrity in ethics and politics.* (Lawrence: University Press of Kansas, 1990), p. 51.

77.Miller and Brody (1995), p. 9.

78.C. Mitchell, "Integrity and Interprofessional Relationships," from *Responsibility in Health Care*, Agich (ed.) (Dordrecht, The Netherlands, 1987), p. 163-84. Cited in Benjamin (1990).