

Ethics education and moral decision-making in clinical commissioning:

an interview study

Abstract

Background

Clinical commissioning involves ethically challenging decisions about health resource allocation. However, commissioners come from a range of professional backgrounds with varying levels of training and expertise in ethical decision-making. Hence, they may lack the relevant training and resources to feel fully prepared for this increasingly demanding role.

Aim

This study aims to provide insight into how prepared commissioners feel in making ethical decisions; what ethics learning needs they might have; and how these might be addressed.

Design and setting

This qualitative interview study explored the experiences of commissioners working for clinical commissioning groups (CCGs) in England.

Method

Eighteen participants were interviewed between December 2017 and July 2018 using a purposive sampling approach to participant selection. Transcriptions were coded and analysed using the constant comparative method of thematic analysis.

Results

Most participants had not received ethics training in preparation for, or during, their commissioning role, and reported difficulties identifying and analysing ethical issues. Participants often felt uncomfortable about decisions they were involved in, attributing this to a number of factors: a sense of moral unease; concerns that CCGs' decision-making processes were not sufficiently transparent; and that CCGs were not fully accountable to the population served.

Conclusion

Commissioners face complex decisions involving ethical issues, and associated moral unease is exacerbated by a lack of ethics training and lack of confidence in identifying and analysing these. This study shows a clear need for additional support and ethics training for commissioners to support them in this area of decision-making.

Keywords

ethics; healthcare rationing; resource allocation.

INTRODUCTION

Clinical commissioning groups (CCGs) are responsible for commissioning local health services in England and allocating approximately two-thirds of the NHS budget, equating to approximately £79.9 billion in 2019/2020.¹ This is challenging in a climate of increasing demands on NHS services^{2,3} and relative budget containment.⁴ Consequently, difficult and potentially ethically challenging decisions about allocation of scarce financial resources will necessarily become more commonplace. These fall to the CCG's elected members, mainly GPs, as well as other healthcare professionals and lay members. Commissioners have varying levels of experience and expertise in theoretical and practical ethics. Therefore, there is an urgent need to understand how commissioners approach the ethical dimension of their role. Identifying and better understanding commissioners' ethics learning needs is necessary for developing suitable educational interventions. These interventions will better equip commissioners to make decisions that are not only financially sustainable but also conform to ethically acceptable principles that inform priority setting, such as justice, impartiality, and fair process.

Although the literature considers ethical issues in commissioning, priority setting, and resource allocation generally, empirical data

are lacking regarding how decision-making takes place, and the ethical components of this.⁵⁻¹⁰ Existing studies are often older, refer to alternative commissioning structures, or describe perspectives of those not directly responsible for commissioning decisions.^{11,12} To date no study has explored whether commissioners receive ethical training, nor the actual approaches taken when faced with ethically difficult decisions in practice.

In this article, the term 'ethical' implies training with the explicit purpose of helping commissioners tackle ethical aspects of commissioning. Some of these aspects might arise in other kinds of training such as equality and diversity training. However, the authors refer to training that makes use of concepts from Western philosophy to help the learner identify and classify, and then resolve or reconcile, philosophical aspects of practice, such as who counts as a person, what is health, what is a health benefit, and how should these be distributed among others.

A preliminary online survey of 38 London CCG commissioners showed significant variation in commissioners' confidence in understanding and applying ethical principles to decisions (see Supplementary Information 1).¹³ Only two had received ethics training for their commissioning role, with a consensus that formal ethics training would

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Submitted: 24 April 2019; **Editor's response:** 17 June 2019; **final acceptance:** 18 July 2019.

©British Journal of General Practice

This is the full-length article (published online 17 Dec 2019) of an abridged version published in print. Cite this version as: **Br J Gen Pract 2019;** DOI: <https://doi.org/10.3399/bjgp19X707129>

How this fits in

Although there is an extensive literature on ethical issues in resource allocation and commissioning, empirical data on how commissioners approach ethical issues in practice are lacking. This study provides insight into the experiences of commissioners when facing ethical issues, and their views on their need for ethics education.

be useful. This study aimed to provide further detail and insight into how commissioners approach their role in terms of prior training and experiences in ethical decision-making, and to identify and understand their ethics learning needs.

METHOD

Study design and participants

Qualitative data were collected through semi-structured interviews with commissioners. Current CCG governing body members and other individuals directly involved in commissioning decisions were accepted as participants.

Thirty-two CCGs were chosen for geographical convenience, and study information was disseminated to governing body members. Interested participants contacted one of the authors directly, and were provided with written information (see Supplementary Information 2). Written consent was obtained from all participants.

Sampling was purposive, ensuring a range of participants from different professions and geographically located CCGs. Some participants were recruited through other participants (snowball sampling). Recruitment continued until the point of theoretical data saturation, where no additional themes were identified.

Data collection

Eighteen participants from 11 CCGs were interviewed from December 2017 to July 2018. One-to-one (audiorecorded) interviews were undertaken by one author. Fourteen interviews were face-to-face and four by telephone, lasting between 25 and 70 minutes.

The number of participants in this pilot study was not an unusually small number for a study of this kind and participants were articulate about their experiences, providing rich data. A lack of insight into ethical aspects of practice was itself considered an important finding rather than impairing the quality of participants' responses.

Interviews were semi-structured based on a predefined topic guide developed by the research team. Careful consideration was given to terminology used, given that participants may not have had a formal ethics background and therefore may have varying understanding as to what constitutes an 'ethical' issue. Rather than using the term 'ethics', terms such as 'challenging' or 'difficult' decisions were often substituted to attempt to capture the broad perspectives and experiences of participants, irrespective of their profession or background (see Supplementary Information 3).

Analysis

Interviews were professionally transcribed verbatim, reviewed for accuracy, anonymised, and imported into NVivo 11. Thematic analysis was undertaken using the constant comparative method¹⁴ to determine and refine overarching themes, following initial familiarisation with data. Three transcripts were initially independently coded by three of the authors. The majority of coding was inductive; where appropriate for answering the aims of the study (for example, whether participants had received ethics training) deductive coding was undertaken using a table for each participant. Codes were agreed through discussion, and the remaining 15 transcripts coded by one author. Codes were subsequently refined and grouped into categories by two other authors. Then the first author returned to the original transcripts to ensure relevance to the original data. Finally, categories were refined into themes through discussion in the team.

RESULTS

Eighteen participants were recruited, 13 of whom were directly employed by the CCG as a governing body member or in other roles (Table 1). Not all who contribute to or influence decision-making are governing board members; for example, those on CCG policy development committees or those called to provide the board with expertise at meetings.

Participant background: previous ethics training and experience

Participants included seven GPs, three nurses, two public health clinicians, one pharmacist, four lay members, and one secondary care clinician. Seven participants were male and 11 were female. The amount of time spent on the CCG ranged from 1 to 5 years, although some participants had prior similar experience on a primary care trust board. The majority of participants

Table 1. Participant information

Participant	Sex	Time working for CCG	Role on CCG	
1	GP	F	2.5 years	Governing body member
2	Nurse	F	5 years	Governing body member, nurse lead
3	GP	M	4 years	Governing body member, CCG chair
4	GP	M	2.5 years	Governing body member, GP lead
5	Lay member	M	Not specified	Governing body member
6	Lay member	M	1 year	Governing body member
7	Nurse	F	Not specified	Governing body member, nurse representative
8	Lay member	F	4 years	Director of commissioning
9	GP	F	4 years	Governing body member
10	GP	F	Not specified	GP regularly attending locality CCG meetings
11	Secondary care clinician	M	1 year	Governing body member, secondary care representative
12	GP	M	5 years	Governing body member, CCG chair
13	Lay member	F	Not specified	Employed by other commissioning organisation
14	Nurse	F	Not specified	Employed by other commissioning organisation
15	Public health clinician	F	Not specified	On secondment to CCG from other health service organisation
16	GP	M	4 years	Governing body member
17	Pharmacist	F	5 years	Member of CCG individual funding request panel
18	Public health clinician	F	Not specified	On secondment to CCG from other health service organisation

CCG = clinical commissioning group.

stated they had not received any training in ethics for their CCG role. Some identified aspects of training received for other non-commissioning or clinical roles that had some relevance to CCG work; however, the perceived usefulness varied considerably, and many described it as having limited applicability. Participants' background experience and training is summarised in Table 2.

Any training relevant to ethics that was found in the data was either partial (for example, diversity training) or led by a local enthusiast. Although there is recognition of ethics in national commissioning guidelines, there is no mandatory or recognised training recommended.

Moral perception

The majority of participants reported personally encountering difficult decisions in their commissioning role. However, their confidence in identifying ethical issues and articulating the nature of the ethical difficulty varied significantly. The majority, while acknowledging that they faced difficult decisions, admitted not generally categorising such issues as 'ethical'. It was felt the term 'ethics' was rarely

used by themselves, or by the CCG as an organisation, often being considered a 'foreign language':

'I can't think of ethical issues coming up very often with me thinking, "ah that's an ethical issue"... But ... sometimes I think we take decisions without consciously saying here's an ethical issue.' (Participant [P] 5, Lay member)

Some participants felt commissioning did not give rise to 'pure' ethical issues, as it did not involve topics considered ethically contentious such as abortion or euthanasia. A small number of participants did not feel they had encountered ethical issues, although other participants from the same CCG identified a significant number:

'I haven't come across something that's ethically controversial ...' (P4, GP)

'I certainly do face [ethical dilemmas] and I'm very conscious of them ...' (P7, Nurse)

For some participants the sheer frequency of ethical issues adversely impacted on their ability to identify or respond to them:

Table 2. Background ethics training and experience of participants

Participant		Ethics training specifically for CCG role	Training for other roles/capacities considered potentially relevant to ethical issues
1	GP	None	Leadership training, medical education training
2	Nurse	None	Caldicott guardian training (confidentiality), clinical ethics as nurse (consent, confidentiality)
3	GP	None	Clinical ethics as medical student
4	GP	None	None specified
5	Lay member	None	Conflict of interest training, equality impact assessment training, judicial review training
6	Lay member	None	Conflict of interest training
7	Nurse	None	Conflict of interest training, mindfulness, governance training, clinical ethics committee member, ethics components in some modules of MSc, personal interest
8	Lay member	None	Equality and diversity training
9	GP	None	Leadership training, equality training, clinical ethics as GP, personal interest
10	GP	None ^a	None
11	Secondary care clinician	None	Conflict of interest training, personal interest
12	GP	None	Online e-learning ethics modules
13	Lay member	None ^a	Training for corporate values, equality impact assessment training, diversity training
14	Nurse	None ^a	None
15	Public health clinician body member	None ^a	Ethics modules in Public Health MSc, research ethics training
16	GP	None	Medical education training
17	Pharmacist	Yes — annual ethics training from academic ethicist observing meetings	Diversity training
18	Public health clinician	None ^a	Training for 'difficult decisions and challenging conversations', ethics modules in Public Health MSc, teaching ethics to medical students

^aNot a governing body member

'We're riddled with ethical dilemmas ... the danger is we become numb to them ...' (P12, GP)

Some participants recognised a need to differentiate between ethically difficult issues versus those that were difficult for other reasons:

'The trouble with shutting hospitals ...they have these tremendous issues and they're all painted as massive great moral things. They aren't really, they're really quite straightforward and in almost all cases they should be shutting the hospitals and concentrating on working in different ways, but the local politics are colossal and it's presented as huge moral issues, but I don't think they are.' (P3, GP)

Moral unease

Participants frequently described a sense of unease, often relating to inherent ethical difficulties in making resource allocation decisions:

'The question raised by one jobbing GP was ... "I feel particularly uncomfortable cutting medicines when people come there to ask you for a prescription ... You're saying no ... and I don't want to know anything about the money or anything, I'm just failing my first role in life.' (P12, GP)

'I mean every penny at the moment is an ethical dilemma for us.' (P7, Nurse)

This sense of unease was often used by participants as a proxy for identifying situations which they felt might raise ethical issues:

'I use the word visceral and sometimes that's when you just feel uncomfortable with something, you may not be able to articulate it necessarily but you can just feel it ... "I don't know, it doesn't seem right" ... that kind of internal voice about whether you're comfortable with things.' (P6, Lay member)

However, participants also identified situations where they felt uncomfortable but not as a result of an *ethical* dilemma, but rather, for example, where decisions were felt to be being heavily influenced by political, financial, or external factors:

'The things that I find really uncomfortable ... [is] the allocation of work to private contractors, or private service provision, that I don't understand what it adds clinically and I don't feel like anyone asks me ...' (P10, GP)

The authors do not necessarily propose that moral unease is a bad thing *per se*. Relevant education could help commissioners identify and classify the moral aspects of that unease as a prelude to resolving or reconciling them. Guidance documents are an inadequate solution as they require both knowledge and understanding for proper application.

Decision-making

Where faced with difficult commissioning decisions, participants referred to two important aspects in the moral acceptability of the decision outcome; the process of deliberation itself, and broader substantive ethical principles:

'How do you handle difficult decisions? Well I mean the main way we do it is we have

Box 1. Facilitators to ethical decision-making with examples

Facilitators to ethical decision-making	Examples	Perceived benefit
Adequate evidence	Clinical evidence Epidemiological evidence Cost-effectiveness evidence	Evidence can be used to justify and rationalise decisions Potentially provides objectivity (for example, quantified cost-effectiveness) — particularly helpful in controversial decisions
Guidelines	NICE guidelines NHS England national policies	Provides a methodology that can be demonstrated to patients/the public as a transparent and tested method of justification
Professional background and experience	Lay members Clinicians Longstanding committee members	Provides alternative perspectives and representative of patients' views Can provide clinical information to inform decisions Collective wisdom and experience of longstanding committee members helps institutional memory
Tools and processes	Systematic approaches to decision-making (for example, conflict of interest protocols, options appraisals, individual funding request frameworks, Quality-Adjusted Life Years) Stakeholder engagement	Provides transparent decision-making processes using seemingly objective criteria that can be demonstrated to patients and the public Provides confidence that decisions are thought through and scrutinised Attempts to address underlying ethical principles such as equity and equality
Decision support	Other CCG governing body members Other non-CCG clinicians Colleagues Family members and personal support	Ensures commissioners feel their voice has been heard and do not feel compromised by the decision, even where they disagree with decision made Provides sense of solidarity and confidence on the CCG board Allows for reflection and opportunity for personal support Attempts to alleviate moral unease
Preparation and pre-empting issues	Sufficient background information provided prior to meetings Pre-empting financial challenges Reviewing decisions at later stage where might not be adequate time initially	Ensures all relevant factors are considered and allows for potential ethical issues to be pre-empted Allows for decisions to be evaluated and learnt from
Accountability	Feeling of responsibility for decisions, and being able to be accountable for decisions made, both as individuals and whole CCG	Contributes to sense of satisfaction and moral comfort Felt to be essential for ethical functioning of CCG and to fulfil ultimate role

CCG = clinical commissioning group. NICE = National Institute for Health and Care Excellence.

processes and those processes have lots of checks and balance in, and then at various stages it's reviewed and people get to have their say. (P6, Lay member)

What makes it easier? ... You can go back to first [ethical] principles because I just find it is so easy to get in a muddle unless you can go back to first [ethical] principles. (P7, Nurse)

Process of deliberation: facilitators and barriers to ethical decision-making.

Participants identified facilitators and barriers that they felt contributed to whether or not decisions were being made ethically (Boxes 1 and 2). Participants described feeling more at ease, even where they disagreed with the overall decision, where an 'ethical' decision-making process had been followed (that is, key aspects that facilitated ethical decision-making were applied and barriers were minimised, as described in Boxes 1 and 2):

'The important thing then about shared decision-making is that at least you feel you had your say and you spoke honestly and you were listened to, and therefore ...perhaps you couldn't vote for a decision, you're able to accept that that is the joint decision ...' (P6, Lay member)

Substantive ethical principles. Some participants referred to ethical principles and theories that they considered when faced with difficult decisions, although because of varying confidence in the language of ethics, these were rarely referred to by name.

The ethical theory most commonly referred to was consequentialism. Many described their role as commissioner as being to make the best overall use of health resources, recognising potential tensions between making the best decisions for individual patients versus the best decisions for the wider population. A consequentialist approach was described as strategically necessary to ensure CCGs continued functioning effectively:

'Our CCG hasn't talked about utilitarianism. I do it every meeting. I say "let's go for the thing which is going to have the most impact for the most people and that's realistically achievable, let's not go for something esoteric over there which is going to just be interesting for a few people ..."' (P16, GP)

Equity and fairness were referred to, particularly in relation to addressing underlying health inequalities. These were also described in reference to individual funding requests, where formal tools and processes that included consideration of ethical principles such as exceptionality and beneficence were often used. Two participants referred to the *7 Principles of Public Life* (Nolan Principles)¹⁵ as a form of ethical framework they found useful.

Some participants recognised that reference to ethical principles alone did not necessarily equate to ethical decision-

Box 2. Barriers to ethical decision-making with examples

Barriers to ethical decision-making	Examples	Perceived difficulties
Unknown consequences of decision	Unable to determine or predict consequences of decision made, for example, predicting financial implications of decisions	Difficulty justifying decisions to public/patients/clinicians on the ground based on harms/costs versus benefits if unable to easily quantify these. Hard to make truly informed decisions
Lack of evidence utilisation	Lack of evidence altogether or barriers to academic access Poor-quality evidence Lack of transparency surrounding evidence (for example, evidence not disclosed by other organisations) Limitations of biomedical evidence when applied to complex systems	Unable to make truly informed decisions
Guidelines	Applicability of national guidelines to real life, for example, NICE recommends 'best practice' but in reality, often because of financial restrictions, only able to offer 'restricted practice'	Guidelines not applicable to current challenges and fail to address ethical issues Difficulty translating clinical guidelines into formal policy
Lack of specific ethics tools	Lack of formal ethics guidelines or frameworks Available frameworks not applicable, too abstract, or involve too many complicating factors	Difficulty formalising decision-making process and identifying and addressing relevant ethical factors
Inappropriate decision makers	Inappropriate, biased, or unrepresentative members steering committee decisions Incorrect or unrepresentative panel on CCG, for example, no clinicians, insufficient expertise	Not feeling able to justify position on board and therefore not able to justify their role and power in decision-making Implications for public accountability
Inadequate time	Rushed decisions and 'knee jerk reactions', often worsened where this is lack of time for reflection and evaluation	Perceived uninformed and unethical decision-making and at times incorrect decisions being made Contributes to sense of moral unease as unable to reflect on decisions
Lack of transparency	Non-transparent decision-making process Commercial factors and commissioning of 'NHS' services to private companies without involvement of public or clear explanation of role of private companies Information not provided to public Lack of general public and patient involvement Inappropriate patient and public involvement (for example, selective or unrepresentative)	Contributes to feeling of moral distress and unease

NICE = National Institute for Health and Care Excellence.

making, but that this was sometimes done to justify decisions without a need to consider the end results:

'We're effectively dividing up a pot ... Going back to the idea of ethics, that sounds like a real get out doesn't it? That's the universal get out clause, "Well I was just dividing up the pot, you know, it's not my fault."' (P6, Lay member)

Accountability

Participants described feeling accountable to multiple agents beyond the CCG: the GP membership they represented, the population the CCG was responsible for, the public generally, NHS England, and, in the case of clinicians, individual patients:

'You sit in boardrooms here and ... after the decision you go back to your practice and you enact those decisions and there lies the dilemma for us. The response from your

colleagues ... makes you feel that you've gone over to the dark side completely.' (P12, GP)

Participants described accountability in two ways: first, individual personal accountability, and, second, a broader organisational accountability of the CCG. Some described a coexisting need for defensibility, with the CCG's decisions needing to withstand legal scrutiny:

'What you have to do is to make sure that [there's a] process you followed and you must be able to document that it's a reasonable one ... How would a judge approach your issue if you go to judicial review?' (P5, Lay member)

Participants described situations where they felt the CCG was being unreasonably held to account; for example, where decisions were made up-stream and outside their

control, often due to political drivers, but where it became the CCG's responsibility to enact and deliver these and thus manage resulting public dissatisfaction.

Some did not always feel adequately equipped to be held accountable for decisions they were required to make, if they had not received sufficient training or felt they lacked expertise to justify their role in making such decisions:

'Here is a group of people who are making a decision about your future, why have they got to do that? Well, because we're appointed by the CCG to do it, but therefore what skills have they [CCG members] got to be able to do it? ... I think patients somehow innocently therefore assume that they [CCG members] know what they're talking about.' (P17, Pharmacist)

Transparency

Many participants felt dissatisfied with the degree of transparency surrounding commissioning decisions. In some cases, there was simply a lack of transparency, with decisions and their rationale not being communicated to the public. In others, participants described instances of incomplete transparency, such as limits being imposed on how much information was shared with the public, or careful planning of how and when information was disseminated. One participant described a practice of cutting services by stealth to avoid public backlash:

'We often find ourselves slightly ducking the issue on those and rather than cutting it, which can lead to a lot of problems ... we'll reduce it or we'll go into some partnership arrangement ... We don't have to go through the same sort of lengthy consultation we'd have had to [have] done if we cut it and we don't end up with people holding placards outside the town hall.' (P6, Lay member)

Participants found such behaviour ethically problematic, considering transparency to be essential to ensure accountability:

'[We] are engaged in some kind of rationing, whether it's seeing a patient and how much effort you're prepared to put into it, or whether it's talking about being on a CCG, and therefore for me it all boils down to making sure you do that with as honest, open, transparent, accountable way as you can ...' (P11, Secondary care clinician)

However, commissioners felt the degree of transparency was satisfactory in some

areas. For example, although participants often identified the issue of conflicts of interest as having potential to be ethically problematic, they generally felt this was handled appropriately, with clear processes for addressing potential challenges.

Future training and support

There was agreement that additional ethics training and support would be beneficial; however, the preferred format for this varied. Suggestions included:

- peer network support;
- face-to-face rather than online;
- process mapping or support tools for decision-making;
- case study-based scenario training;
- external ethics support or advisory service;
- small-group-based teaching;
- theoretical ethics teaching; and
- integration of training into earlier clinical training (for example, GP registrar training).

A number of potential benefits of training were identified, including personal resilience and reduced moral unease. It was felt that training might enable participants to better articulate the issues they faced, and thus be able to justify the decision-making process with resulting improved accountability:

'I'm sure it would make things a lot more explicit that are currently implicit, which would be useful ... you could identify situations where it is a bit difficult and rather than having a general level of unease.' (P12, GP)

One participant referred to potential benefits for such training in avoiding challenges and delays in implementation of decisions:

'Also, it's value for money because what you then avoid is confrontation and you allow smooth passage.' (P12, GP)

Some participants did not feel additional ethics training or support would alter the decision outcomes, but still felt it would be beneficial:

'It may not lead to any better decisions being made, but even if it led to people ... taking a more considered approach ... that would be massively advantageous.' (P18, Public health clinician)

DISCUSSION

Summary

Participants generally did not receive specific ethics training for their commissioning role. Although some received training with a broad ethical component for other health service roles, this was rarely perceived as being sufficiently relevant or adequate for issues faced as commissioners. There was agreement that additional training would be beneficial, although the preferred format and mode of delivery varied. Identification and articulation of ethical issues among participants varied, and there was a lack of confidence in using ethical language and applying ethical frameworks. Participants described a sense of unease, which they used to help them identify ethical issues. Common facilitators and barriers to ethical decision-making were identified, and some participants also applied ethical principles (either implicitly or explicitly) to decision-making, with consequentialism being the most commonly used. Accountability was a concern for many participants, and many described inadequate transparency in commissioning decisions.

Strengths and limitations

Using a qualitative approach allowed a depth of exploration of this complex and potentially sensitive topic that would not have been readily accessible through quantitative approaches. The current authors' multiprofessional research team involving clinicians, clinical academics, and a non-clinician with experience in empirical bioethics, sociology, and qualitative research provided a range of perspectives and experiences through which data could be interpreted.

A variety of strategies were employed to provide rigour to the analysis of the collected data. Participants were recruited from different CCGs, and in some instances more than one from the same CCG, allowing validation of some findings (for example, whether training had been provided). Additional triangulation was undertaken through member checking, with preliminary study findings presented at national and international conferences, attended by commissioners. The diversity of participants and CCGs included in the study offered a range of perspectives and potential for findings to be generalised to other CCGs. Furthermore, having participants from 11 CCGs meant data encompassed those covering different geographical areas and populations, and CCGs with varying financial circumstances.

This study may have been subject to selection bias, as those agreeing to participate may have been more likely to have

an interest in ethics. Moreover, both moral unease and self-reported ethics learning needs depend on the moral perception and subjective insight of participants. Although the study identified some ethical issues faced by commissioners, there are likely to be many additional ethical dilemmas commissioners face, or learning needs that could be addressed, which were not identified by participants. As acknowledged by some participants, some difficulties identified as 'ethical' dilemmas may in fact have arisen from non-ethical issues such as financial, political, or organisational constraints.

An unexpected strength of this study was a 'therapeutic benefit' experienced by some participants, who commented on finding the process of participating itself to be beneficial in helping them consider ethical issues and reflect on their decision-making.

Comparison with existing literature

Varying moral perception and confidence in describing ethical issues and applying ethical frameworks has been described in many healthcare contexts.^{16,17} The variation seen in this study may result from the fact that the ethical dilemmas arising in commissioning are not considered 'traditional', and therefore not seen as familiar, ethical issues. Current ethics education focuses on clinical ethics or research ethics, rather than issues arising from political economies of health care, which have been described as involving a broad and 'vague' set of activities that often do not clearly overlie traditional ethical models.¹⁸

This article distinguishes the sense of moral unease identified in participants' responses from the concept of moral distress described extensively in the literature. Moral distress has been proposed as resulting from constraints (often organisational) hindering agents from following what they perceive as the morally right course of action.^{19,20} In this study, rather than describing overt moral distress, participants described a more subtle sense of unease. This sense of unease signifies the complexities associated with making morally correct decisions in such complex adaptive systems such as health care. Such decisions require an understanding of multiple complex contextual features (for example, economics, public health, statistics). Therefore, emotions such as moral unease might need to be considered differently to those felt in relation to traditional clinical ethical dilemmas that arise through the interpersonal doctor-patient relationship and are, possibly, more likely to give rise to moral distress. Neither moral unease nor moral distress have been particularly

associated with ethical decision-making in resource allocation in the literature.

This study found the process of decision-making itself to be important in determining whether commissioners felt decisions were made ethically. Various priority-setting processes and frameworks have been proposed in the literature. These have a range of approaches: using quantifiable and content-driven measures,^{21,22} procedural aspects of decision-making,²³ applying social values,²⁴ or a combination of these approaches.²⁵ However, no study participants specifically referred to such frameworks. This is consistent with the literature, which has found that those participating in priority-setting decision-making do not use a consistent approach in terms of tools, processes, or frameworks, and are often unaware of these even existing.²⁶⁻²⁸

Many facilitators to ethical decision-making participants described were consistent with those in the literature, for example, the importance of adequate evidence, transparency, shared decision-making, patient and public involvement, ability to reflect on decisions, and ensuring sufficient time for decision-making.^{18,22,27-31}

Most healthcare systems focus on distributive justice or other models such as consequentialism or communitarianism as providing the moral foundation for decision-making.¹⁸ Fairness and equality are frequently cited foundations of ethical decision-making in this area.³² These substantive ethical principles were often referred to, albeit often implicitly, by participants.

Notions of accountability and transparency have been frequently cited as being of key importance in priority-setting decision-making.^{18,23-24,28,30} The notion of accountability described by participants in this study was multilevel, comprising, first, a personal, moral accountability; second, a higher-level organisational accountability of the CCG; and, finally, medicolegal defensibility. These are not generally differentiated within the literature.

Implications for research and practice

The NHS Commissioning Board Authority expects CCG members to have the:

'capability to understand and analyse complex issues, drawing on the breadth of data that needs to inform CCG deliberations and

*decision-making, and the wisdom to ensure that it is used ethically to balance competing priorities and make difficult decisions.'*³³

This study demonstrates that commissioners do face ethical issues in practice, which contribute to a sense of moral unease, but that their ability to identify and articulate the ethical aspects of their decisions varies considerably. There is a clear need, both articulated directly by participants and identified from the analysis, for additional training and support for commissioners to better equip them to address ethical issues faced in practice. This is not necessarily unexpected. Ethics does not constitute a substantial part of medical postgraduate or non-clinical leadership training. Even where ethics training is provided for other roles, issues related to commissioning, priority setting, and resource allocation rarely form a significant component.

This study suggests multiple ways in which training might be designed. The clear identification of facilitators and barriers for ethical decision-making processes is useful in offering a potential starting point for designing a training programme that might make use of these factors in development of a framework or support tool. Although commissioning structures might change in the future, difficult decisions will still need to be made in the context of limited financial resources with increasing demands on health care. Therefore, the applicability and findings of this study will remain relevant, and the importance of improving support for commissioners in ethical decision-making cannot be underestimated.

An important finding of this study was the concern some participants had about transparency in commissioning decisions. Much media and professional discussion about 'ethical' problems regarding the introduction of CCGs related to concerns about commissioners' conflicts of interests. The comments of the study participants suggest that the high profile given to this issue seems to have led to this being addressed effectively, but perhaps to the neglect of other aspects of transparency. The implication that commissioning decisions are taking place in a way that is sometimes intentionally obscured to the public is concerning and needs urgently to be addressed.

Funding

Andrew Papanikitas received additional funding from The Oxford Research Centre for the Humanities (TORCH) knowledge exchange fellowship.

Ethical approval

Ethical approval was obtained from King's College London (REMAS approval number LRS-17/18-5120).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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