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The meaning of urgency in the allocation of scarce health care resources; a comparison between renal transplantation and psychogeriatric nursing home care

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Abstract

In the juridical and ethical literature on patient selection criteria it is an unargued premise that those who are most urgently in need of treatment or care will be given priority. The aim of this study is to gain insight into the medical practice of waiting list problems and patient selection at the microlevel, especially with respect to urgency. Thus, the study intends to contribute to the medical ethical discussion on patient selection for scarce resources. The results of qualitative research into the meaning and occurrence of urgency in two health care services, renal transplantation and psychogeriatric nursing home care, are discussed. In the first sector, patients are seldom considered urgent. Criteria for urgency are technical dialysis problems or severe psychological burden due to protracted dialysis treatment. In contrast, psychogeriatric patients are often considered urgent, with the principal criterion being too

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heavy a care load for informal carers. Both health care services show variation in assigning urgency codes. It appears that the exact meaning of urgency is not self-evident and that admission of urgent patients to nursing homes can be negotiated by professionals or informal carers. This points to the necessity of a discussion within these services as to the actual content matter of urgency. Further, professionals involved in renal transplantation raise several moral and practical arguments against giving patients priority, even if they need treatment urgently. It shows that distributive justice cannot always be applied. Occasionally non-urgent patients are rated urgent as they have been waiting very long due to specific allocation procedures. In these cases urgency is granted in an unexpected way that is ultimately in accordance with the notion of procedural justice. © 1998 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Selection; Waiting list; Urgency; Psychogeriatric nursing home care; Renal transplantation; Qualitative research

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1. Introduction

Scarcity in health care leads to long waiting lists and long waiting times. Procedural justice presupposes that everyone should await his or her turn. However, patients may urgently need treatment or care, and it is, therefore, considered legitimate that they jump the queue. Most waiting lists make allowances for such patients with special urgency categories. In debates about patient selection for scarce medical resources, urgency and the chance of the treatment being successful are both mentioned as acceptable selection criteria. In a textbook on medical ethics it says: “We assume, as an unargued premise, that in rationing scarce medical resources it is morally imperative to consider medical utility, understood as maximisation of the welfare of patients in need of treatment. The differences in patients’ urgency of need and prospects of successful treatment are both relevant considerations” [1]. Likewise, in Dutch literature, urgency is presented as an unargued and generally accepted selection criterion. The underlying idea is that care should go first to those who need it most [2,3]. However, the actual content matter that falls under the term urgency is usually left undefined. For some health care services urgency is associated with situations in which patients will die or suffer serious harm if no immediate action is taken. Other services, in particular in the care sector, agree that the social situation of the patient, like informal carers being overburdened, should be taken into account. For still other services it is not immediately clear how to define urgency.

In this article we explore the meaning and occurrence of urgency in two different health care services in The Netherlands: renal transplantation as a ‘cure’ service, and psychogeriatric nursing home care as a ‘care’ service. These health care services differ as to the character of the disorder and the character of treatment, the possibility of alternative treatment and the cause of scarcity. The study is part of a larger investigation into selection criteria and selection procedures for scarce health care services [4–6].

The questions are:

- What criteria are used in assessing urgency for renal transplantation and for psychogeriatric nursing home care?
- Is there consensus about urgency criteria among professionals within the two health care services?
- What are the differences and similarities in the use of urgency criteria between renal transplantation and psychogeriatric nursing home care?

Answers to these questions will shed light on the relation between daily medical practice and ethical theory.

The decision process regarding specialised medical treatment or care usually consists of four successive decisions (Fig. 1). Referral and indication concern admission to the waiting list. Positioning on the waiting list and allocation of treatment or care concern waiting time. Urgency is assessed to determine a patient's place on the waiting list, i.e. to put the patients on the list in a certain order.

1.1. Renal transplantation

For end stage renal disease two treatment modalities exist: renal transplantation and dialysis. Both are covered by medical insurance. Patients with a transplant report a better quality of life than dialysis patients [7,8]. Dialysis is often experienced as a burdensome treatment. Some patients decide to discontinue dialysis treatment because of comorbidity and psychological factors [9]. Not surprisingly, most patients prefer transplantation. Usually, patients start with dialysis treatment. Later, the possibility of transplantation is considered.

Indication criteria for both dialysis and transplantation have been broadened in the past decades. The total number of patients with end stage renal disease has risen from 2359 in 1980 and 5767 in 1990 to 7903 in 1996 [10,11]. About half of them have a functioning transplant. Yearly about 400 patients in The Netherlands undergo cadaveric renal transplant. Besides, an increasing number of patients, in 1996 about 80 patients, undergo living donor transplant [12]. Due to an absolute shortage of donor organs, the waiting list increased from 977 patients in 1985 to 1412 in 1991. Since then the growth of the waiting list has diminished [12]. In 1991 the average waiting time for patients transplanted was 1 year and 8 months

Fig. 1. Decisions concerning treatment or care.

(unpublished statistical data, Eurotransplant, Leiden, 1994). The actual waiting times for individual patients, however, vary considerably and can be extremely long. In 1991 5% of the patients on the waiting list had been waiting for more than 5 years [13].

1.2. Psychogeriatric nursing home care

Indication criteria for psychogeriatric nursing home care include the presence of an irreversible syndrome of dementia in combination with (shortly expected) insufficient formal or informal home care. Admission is open to everybody provided an advisory committee has given a positive recommendation. The costs are covered by the Dutch 'Exceptional Medical Expenses Act'.

The number of elderly people in the Dutch population is growing, especially the number of people over 80. The period 1978–1992 showed a steady rise in the use of nursing home care facilities and semimural facilities, which serve as a partial substitute for intramural services. Still, in 1991 the number of psychogeriatric patients on the waiting list was up to 4860 and the average waiting time for psychogeriatric nursing home care was 23 weeks. From 1993 on, the number of patients on the waiting list and the average waiting time declined. In 1995, 3910 patients were on the waiting list for psychogeriatric nursing home care and the average waiting time was 14 weeks [14].

2. Methods

In the present study qualitative methods were employed to explore patient selection and to reveal underlying arguments and considerations for professionals' use of selection criteria. The emphasis of the study was on variation in criteria and arguments. Data were obtained in 1991 and 1992.

There are seven renal transplantation centres in The Netherlands. Fieldwork was done at two centres. A third centre decided against participation because the research questions were considered irrelevant. Clinical discussions, medical pre-transplant examinations and staff meetings were observed. Interviews were conducted with 33 professionals working either in the transplant centres or working in nine dialysis centres that refer patients to these transplant centres. The interviewees were selected so as to cover a broad range of professions involved in the decision making regarding transplantation. All professionals selected agreed to participate. The interviewees included six nephrologists working as transplant doctors, nine nephrologists working as dialysis doctors, two surgeons, one cardiologist, three immunologists, five social workers, five nurses, one transplant coordinator, and the medical director of Eurotransplant. Eurotransplant is an international organisation for the allocation of donor organs.

For psychogeriatric nursing home care data were collected in two health care regions. In total, there are 27 such regions in the country. Permission to carry out research in a third health care region was not obtained, due to organisational

problems. Home visits and staff meetings were observed. Thirty-nine persons were interviewed: six physicians and 16 social psychiatric nurses of the regional institutes for ambulatory mental health care, one physician of an advisory committee, one medical adviser for social insurance funds, two physicians and two social workers of central admission offices, and 10 social workers and one physician of nursing homes. All interviewees selected agreed to participate.

Data consist of observation reports and interviews. They were typed out verbatim and then analysed with a computerised program for qualitative data [15]. The first step was to compile a list of topics for analysis. These were inferred partly from medical ethical literature on patient selection and partly from the process of data collection itself. Thus 'doubtful cases' proved to be a topic that produced detailed information on considerations and arguments of professionals. Subsequently all data were sorted according to the list of topics, and the topics were summarised in matrices [16]. These matrices served as a basis for the description of the results. In order to verify the results, the research reports were presented to the two transplant centres and to health care workers in the two regions for psychogeriatric nursing home care. They agreed with the findings of the study.

3. Results

3.1. Renal transplantation

The waiting time for a renal transplant depends on both the patient's position on the waiting list and the allocation of a donor kidney. These involve two interdependent decisions. One cannot understand the first without understanding the second. The main threat to the success of renal transplantation is rejection of the implanted organ by the patient's body. The risk of rejection is reduced by a high immunological (HLA) tissue match between donor organ and receiving patient. This is the rationale of the organ allocation system and of Eurotransplant: by pooling donor organs from several countries and employing an international waiting list, a higher tissue match is achieved. Patients are admitted to the Eurotransplant waiting list as well as to the regional waiting list of their transplantation centre. In The Netherlands about 75% of the donor organs are allocated by Eurotransplant, and about 25% by the regional transplantation centres.

The Eurotransplant waiting list distinguishes the following categories:

- Highly urgent (HU)
- Highly immunised (HI), i.e. antibody level higher than 85%
- Immunised (I), i.e. antibody level between 5% and 85%
- Transplantable (T), antibody level lower than 5%

With the exception of HU, the categories are not real 'urgency'-categories in that they refer to the need of patients for immediate treatment. The categories HI, I and T differ as to the patient's antibody level. Patients with a high antibody level rarely qualify for donor organs, and often have to wait for a very long time. By placing these patients in a higher 'urgency'-category like I or even HI waiting times may be

reduced. When allocating donor organs, Eurotransplant uses four criteria in a hierarchical order: (a) high urgency (HU), (b) tissue match, (c) antibody level, and (d) waiting time. This means that HU patients with a good tissue match are considered first. In the absence of HU candidates the next allocation criterion is tissue match: patients with none or a few mismatches with the donor organ take precedence over patients with more mismatches. When the number of mismatches are equal, the allocation criterion is antibody level, with HI coming before I, and I coming before T. If a number of patients have an equal tissue match and equal antibody level, the fourth allocation criterion used is waiting time.

About 25% of the donor organs are allocated by the regional transplantation centres instead of Eurotransplant. This allocation follows more or less the same decision procedures as mentioned above¹.

In actual practice, patients are rarely rated highly urgent (HU) on the Eurotransplant waiting list. Real urgency — not in the sense of antibody level — is decided on by the transplantation doctor in consultation with the attending dialysis doctor of the patient, and often with an immunologist or Eurotransplant. Although patients on regional waiting lists are more often classified as urgent than patients on the Eurotransplant waiting list, the overall number is still small: one or at the most a few a year in each of the two transplantation centres. Urgency assessments for the regional waiting list are organised in a rather informal manner.

The Eurotransplant criteria for the urgency code HU are ‘a very poor physical or psychological condition’ [10]. These criteria are also used in the regional allocation. Vascular shunt problems are mentioned as the most relevant characteristic of a poor physical condition. They render haemodialysis problematic or impossible. However, in the case of shunt problems and the accompanying bad vascular condition, dialysis doctors differ as to even taking transplantation into consideration. A dialysis doctor stated: “It happens often that we can’t dialyse people any more because their cardiovascular situation is too bad. That is at the same time a contraindication for transplantation.” Thus some patients with a bad vascular condition will be placed on the waiting list with a high urgency code, while for others transplantation is not even considered an option.

The second, most often mentioned reason for urgency is the psychological burden dialysis treatment entails, which increases with the duration of treatment. This concomitant of treatment is called ‘dialysis fatigue’. When talking about a patient labelled urgent because of dialysis fatigue, a transplant doctor observed: “This is someone who is actually quite a balanced person, but who for understandable reasons is so much in need of it (a transplant), who threatens to stop ... When this man or woman gets such an aversion to dialysis treatment that it just does not work

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¹ In 1996 a new Eurotransplant kidney allocation procedure was implemented. In this procedure all kidneys are allocated by Eurotransplant. Furthermore, the above-mentioned hierarchical system is replaced by a point score system. In this system six factors are weighed simultaneously: HLA-antigen mismatch, mismatch probability, waiting time, distance between donor centre and transplant centre, national net kidney exchange balance, and urgency code ‘High Urgency’. The frequency of the assignment of the HU code has not been changed.

any more, while you know this man or woman to be a reasonably reliable person with whom you can talk, who complies with the therapy, and then doctor X (the dialysis doctor) phones: ‘Listen, this man is at the end of his tether. Would you be so kind as to give him an urgency code?’. Dialysis doctors differ in their attitudes and approaches to urgency codes in cases of dialysis fatigue. Some will never ask for such a code, others will do so once or several times a year. When asked whether psychological problems, such as a patient’s suicidal tendencies, or protracted dialysis treatment, are reasons for urgency, one dialysis doctor replied that this had never occurred in his dialysis centre. He had had suicidal people, but they had just stopped treatment and, consequently, died. A transplant doctor said, with respect to dialysis doctors telephoning about patients who are so desperate that they threaten to jump off the roof: ‘Then I tell them ‘It is better to jump off the roof without a new kidney than with a new kidney.’ That is no argument for me’.

Some patients have to wait for a very long time, for instance because of a rare tissue type or a high antibody level. Except for patients with an extremely high antibody level, there are no formal procedures for procuring organs for these patients. Sometimes they get an urgency code on a regional waiting list. Or other informal procedures are followed. For example, in the Eurotransplant system a patient’s urgency category is upgraded by according him a higher antibody level than he actually has.

Several arguments are raised by professionals against giving priority per se, or against specific urgency criteria. A common argument is that people with end stage renal disease, as there is an alternative treatment, i.e. dialysis, are seldom urgently in need of transplantation. Another often mentioned argument is that, in general, giving priority is not in the best interest of the patient because immunologically the transplantation has less chance of success. Dialysis fatigue as a criterion for urgency is rejected by several respondents, because it cannot be assessed objectively. Patients differ in the way they experience the burden of their treatment, and some are braver than others, which makes it difficult to compare them. One social worker remarked: ‘What do you mean dialysis fatigue? Every patient has dialysis fatigue!’. It is also argued that patients who because of non-compliance experience the treatment as extremely burdensome have only themselves to blame. Another reason for reluctance towards giving a patient priority is that it will lead to conflicts with other patients. When asked whether marital problems, or difficulties in combining dialysis treatment with a job should be used as criteria for urgency, one dialysis doctor answered: ‘Well, once you start making allowances for that, you get of course a hell of a row at the (dialysis) department’.

3.2. Psychogeriatric nursing home care

The use of urgency criteria in positioning patients on the waiting list and the allocation system of beds in nursing homes are interdependent processes. The latter must be explained to understand the former. When a bed becomes available in one of the nursing homes in the region, either the central admissions office is informed and selects a patient from the waiting list, or the nursing homes select a patient

from their respective waiting lists. Usually, this will be a patient with a preference for this particular home. The patient has to meet certain criteria regarding gender and amount of care needed: the patient has to fit a 'patient profile'. For patients with the highest urgency code the central admissions office will make an effort for a place.

The main urgency codes are: A1, A2, B1, B2 and C. Except for the A2 code, the global meaning of the urgency codes is the same for both regions. A1 urgency is the highest code, admission is immediately necessary, therefore it is not possible to stick to a preference for a nursing home. B1 is a normal urgency code for patients who are waiting at home and have to be admitted in the short term (but they actually may have to wait 3–6 months). Then there is a special category, B2, for patients who wait in hospitals or observation clinics. They are allowed to name three nursing homes they do not want to be admitted to and have to accept every other offer. This code is also for patients who wait at home and do not want to be admitted soon. When patients in hospitals wait for a long period, they can receive code B1. The C code is for patients who are on the waiting list out of precaution or because they are admitted to a substitution project. These patients are not yet waiting for nursing home admission. In one of the regions the A2 code is for highly urgent patients who are allowed to have a preference for a nursing home. They wait longer than patients with A1 code, and shorter than patients with B1 code. This urgency code was meant for special occasions where the preference is important, for example because the spouse can be admitted to another department of the same nursing home. There is a lot of discussion about this urgency code, because it is questioned if the situation is that urgent, when patients have to wait for months because of their preferences. In the other region, patients with A2 code may not have a preference and will have to wait for a week or less. However, in this region a 'B1 with mark' code emerged, which resembles the A2 code in the other region. Urgency is determined by a nurse from the regional office for ambulatory mental health care in consultation with a geriatrician, after visits to the psychogeriatric patient and the informal or formal carers. During the waiting period the urgency code can be changed. Besides upgrading the urgency code, admission can be speeded up by just 'requesting attention' for a case during the weekly urgency meetings with the central admissions office. For instance, patients waiting in hospitals cannot have an A1 or A2 code, because there is at least professional help available. However, when a patient is wandering a lot or is dangerous because he pulls out drips of other patients, a fast admission can be asked for.

Criteria for urgency are the overburdening of informal carers, for instance partners, or inadequate formal care. Overburdening can be caused by a worsening mental or physical condition of the patient (e.g. loss of mobility, incontinence), or behavioural disturbances like aggression and wandering in the streets. Another reason for granting a patient an urgency code is the loss of informal care due to e.g. a carer's disease or death. Admission to the nursing home can be postponed, in spite of a worsening situation, if formal home care can be utilised. This depends on a variety of factors, such as insurance, housing, and the willingness of the patient or family to have strange people in the house. One reason for holding on to a low

urgency code, in spite of a worsening situation, is that the family wants to maintain a preference for a particular nursing home.

Although the urgency criteria are detailed on paper, differences in interpreting similar situations occur. Nurses indicate that each situation is unique and needs careful consideration of the appropriate urgency code. One nurse said: “I think it will always be somewhat arbitrary ... I’m the kind of person who, when carers say that it is unbearable, is more inclined to say that something should be done, than other colleagues”. The nurses may also have their own strategy: “It is in the end a kind of game, it is a technique that you use, you have to make use of all the contacts you have. Rules should be flexibly applied every now and then”. A colleague sees the problems of such a strategy: “It makes the system vulnerable, because everybody is going to shout as loud as possible for his own patients”. Further, there are two interpretations of the intention of the urgency list. Some say that it is meant to prevent a situation from escalating. Others say that the urgency list is meant to make a fast admission possible after the situation has escalated.

Pressure from family or primary care can have an effect on the professionals involved in urgency procedures. A family who phones daily complaining that the situation has become unbearable, is likely to acquire a high urgency code. The reason, some respondents argue, is that on inspection the situation really shows to be unbearable. However, a geriatrician states: “Sometimes, may be once a year, we are so pressurised by the environment that we say, ‘For God’s sake, lets give in’. ...We are manipulated and threatened by ‘We are going to the media’..., the family saying ‘We leave her on the street, and then it’s over’. In such a case you could say that somebody is admitted too soon into the nursing home ... That happens, but not too often”.

Informal care givers, family doctors or other primary health care workers are sometimes advised by nurses or social workers involved to contact the admissions office when they want the patient to be admitted quickly. As a nurse remarked: “It helps when they (the family) telephone 10 times a day. Then they (the admissions office) get fed up with them”.

Some patients have to wait for a very long time or they are expected to do so. For instance, severely disabled patients, who require much care, are not a nursing home’s first choice. Very long waiting times, actual or expected, may be an additional reason for giving a highly urgent code: “He was for a long time on the waiting list, we knew this man for a long time, this man has an abundantly clear indication, in that case I find it a reason for giving him an A2 code.” As a nurse said, “one actually has to go very high with urgency” to force admission for a patient requiring much care.

4. Discussion

4.1. Differences and similarities in urgency assessment

A comparison of the urgency assessments for renal transplantation and for

psychogeriatric nursing home care reveals several differences. Criteria for urgency in renal transplantation may be medical or psychosocial: technical dialysis problems or psychological burden due to protracted dialysis treatment. These are patient-centred criteria. Renal patients are seldom considered to be urgent. The determination of urgency is often an informal procedure.

In contrast, the main criterion for urgency in psychogeriatric nursing home care is psychosocial and not patient-centred: overburdening of informal carers. Psychogeriatric patients are often considered to be urgent and urgency is most of the time formally decided on by means of fixed urgency codes.

Considering these differences in the meaning and occurrence of urgency between a cure and a care service, the similarities in urgency assessments are the more striking. Both services lack consensus regarding the exact criteria for urgency. Renal transplantation shows inter-doctor variation in giving priority to patients with technical or psychological dialysis-related problems. In psychogeriatric nursing home care it is arbitrary how overburdened informal carers must be to legitimise a high urgency code. Furthermore, in both services there are informal ways of upgrading urgency. With renal transplantation, urgency assessment for regional waiting lists is in itself a rather informal procedure, and the official Eurotransplant urgency codes may be upgraded to shorten the waiting time. With psychogeriatric nursing home care 'requesting attention' during weekly urgency meetings is done informally. Further, family or primary health care workers can stress the need for admission to a nursing home by contacting the admissions office or the nursing homes. For both health care services it holds that there are two distinguishable reasons for granting an urgency code. The first is that the situation is urgent: the patient is in dire need of treatment or the situation at home is escalating. The second is that the patient has been waiting much longer than the average waiting time.

4.2. The meaning of urgency is not self-evident

It appears that the concept of urgency is ambiguous in both the care and the cure service. There is inter-doctor or inter-nurse variation in the granting or withholding of urgency codes. Formal distributive justice requires that equal patients are treated equally. Interprofessional variation however, precludes equality. Variations appear to be attributable to several causes. First, there are two different interpretations of the goal of an urgency code: to prevent a situation from escalating, or to offer treatment or care after the situation has escalated. Second, and this is especially relevant for cure services like transplantation, patients in dire need of treatment, for instance because of a vascular condition that makes dialysis problematic, may also be high-risk patients in that there is little chance of the treatment being successful. It is because of this dilemma that doctors differ in considering transplantation in such cases. Offering treatment to these patients is the opposite of a utilitarian approach to allocating scarce resources. Other cure services, e.g. heart surgery, are confronted with the same dilemma [17]. A third reason for variation is again rooted in a scarcity-related dilemma. It concerns the professional's loyalty towards the

individual patient they know, versus loyalty towards all patients on the waiting list. Professionals who sympathize a lot with their own patients are more likely to get them a high urgency code, whereas others tend to be more reserved because they realize that all patients have to wait a long time. These conflicting attitudes lead to arbitrary decisions, the more so when urgency can not be assessed objectively. It is interesting to note that both services employ a mechanism for checking demands for high urgency. Psychogeriatric nursing home care does so by imposing a sanction on urgency: patients have to give up their preference for a certain nursing home. Renal transplantation has a 'natural' sanction: patients are running the risk of receiving a less well-matched kidney.

With a view to the variation within each health care service, we conclude that, in order to prevent arbitrariness, medical services should try to develop more uniform criteria for urgency assessments.

4.3. Practical and moral constraints on granting urgency

Many arguments raised by professionals against granting an urgency code for renal transplantation are more or less convincing. Giving priority is not always in the best interest of the patient as the kidney may match less than optimally. An argument against giving priority on psychosocial grounds is that differences in suffering from dialysis treatment may be due to non-compliance. Some professionals felt that it was not morally justifiable towards other patients to give non-compliant patients priority. Another reason for the relative lack of urgency for renal transplantation may be found in a singular aspect of the transplant waiting list: many of the patients know each other. Patients who receive dialysis treatment twice or three times a week do so in the company of others, many of whom are on the waiting list. When one of them gets priority, this may well cause feelings of envy especially when priority is given on not very objective grounds.

In sum, patients who are in urgent need of treatment or care do not always receive a high urgency code, because of practical or moral considerations.

4.4. Urgency for patients who are not urgent

In contrast to the above, patients may also receive a high urgency code without being urgent. A prominent similarity between both sectors is that one reason for giving a high urgency code is that the patient has been waiting for an extremely long time or is expected to do so. This points to an under-explored aspect of waiting lists: the extremely long waiting time of some patients.

In the literature on health care the queue is the most common metaphor to explain the dynamics of waiting lists: patients are being treated one after the other [18]. It accords with the premise of procedural justice that everybody should wait one's turn, and with the notions from everyday life that people spend a substantial part of their lives in queues and learn from childhood on that it is normal to do so [19]. However, this metaphor does not explain why

some patients have to wait longer than others. Frankel [20] uses the metaphor of a mortlake to explain why patients especially with conditions like piles, bad hips, varicose veins or cataracts have long waiting times. A mortlake is a pond that comes into being in a meandering river. While most patients move along with the flow, patients with these conditions stay behind in the mortlake, because these disorders do not have professional priority, or the general public doesn't show much interest in them, because they are associated with old age or embarrassment. The metaphor of the mortlake is illuminating for our present study in that it shows the waiting list as a 'pool of waiting patients which can be dipped in' [18]. This is how waiting lists are managed both for renal transplantation and psychogeriatric nursing home care. In the first, the waiting list is used to select the patient who matches best a donor organ, in the interest of the patient and of the patient population. In the latter, the waiting list is used to select that patient who fits in best with the nursing home, in the interest of the nursing home and of the patient. The waiting time criterion proves to be less important than these 'fitting' criteria that are not even mentioned in discussions on the ethics of selection criteria.

Nevertheless, it is an interesting phenomenon that, for those patients who are not urgent at all, who otherwise would have to wait a very long time, the concept of urgency is used to shorten waiting times. Ultimately, this accords with the idea of procedural justice.

5. Conclusion

In daily medical practice the meaning of urgency is ambiguous. Formal distributive justice requires equal treatment of equal patients. Thus, in order to minimise variation in decision making, the urgency criteria should be defined more precisely and the goals of urgency categories should be discussed. On the other hand, medical ethicists should realise that an urgency code is sometimes withheld for convincing moral or practical reasons. Finally, attention should be given to allocation procedures in medical practice, as these occasionally cause extremely long waiting times. Recently, changes in this direction have been made in the allocation of donor kidneys.

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