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ORIGINAL ARTICLE

Evidence, Emotion and Eminence: A Qualitative and Evaluative Analysis of Doctors' Skills in Macroallocation

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Abstract In this analysis of the ethical dimensions of doctors' participation in macroallocation we set out to understand the skills they use, how they are acquired, and how they influence performance of the role. Using the principles of grounded moral analysis, we conducted a semi-structured interview study with Australian doctors engaged in macroallocation. We found that they performed expertise as argument, bringing together phronetic and rhetorical skills founded on communication, strategic thinking, finance, and health data. They had made significant, purposeful efforts to gain skills for the role. Our findings challenge common assumptions about doctors' preferences in argumentation, and reveal an unexpected commitment to practical reason. Using the ethics of Paul Ricoeur in our analysis enabled us to identify the moral meaning of doctors' skills and learning. We concluded that Ricoeur's ethics offers an empirically grounded matrix for ethical analysis of the doctor's role in macroallocation that may help to establish norms for procedure.

Keywords Macroallocation · Priority setting · Ethics · Paul Ricoeur · Grounded moral analysis · Physicians · Skills

Background and Rationale

The just allocation of healthcare resources is an area of expanding study in the bioethics literature [6, 22, 39, 44, 68]. Whilst a range of views has been expressed on

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the ethics of doctors' involvement in socially engaged actions [10, 18, 34, 66], the doctor's role in resource distribution policy processes has not been comprehensively explored from an ethical standpoint. In this analysis, part of a larger empirical study undertaken in NSW, Australia, of the ethical dimensions of doctors' participation as technical experts in macroallocation, we consider the question of the skills doctors apply in the role.

Macroallocation decisions determine the amount of resources available for particular kinds of healthcare services and, hence, the mix and volume of services provided to communities [32, 40, 60]. Macroallocation generally entails competing policy goals, requiring choices to be made amongst many defensible options [11] and is, consequently, often conceptualised as priority setting [40, 43]. Where we use the term macroallocation in this report it signifies priority setting between programs by governments and delegated health authorities.

For its potential to impact on persons and society, policy-making for resource allocation has been characterised as a moral endeavour [28, 39, 41]. Satisfactory substantive and procedural approaches to establishing and defending priorities that give due weighting to values, evidence and legitimate process in macroallocation have proven elusive due to the complexity of the economic, political and ethical challenges involved [12, 39]. Given the need for resource distribution policy to meet standards of justice and accountability it is reasonable to pursue an examination of the ethical aspects of doctors' involvement in them.

The specialised knowledge of experts has a privileged role in policy-making, reflecting the respect for professional specialisation that goes hand in hand with the structure of contemporary society and the current organisation of work [26, 27, 45]. In healthcare policy, doctors are the dominant experts [4, 16, 33, 39, 47]. In Australia, the doctor's expert role in health policy is included in the Australian Medical Association's (AMA) code of ethics as an enjoinder to 'use your knowledge and skills to assist those responsible for allocating healthcare resources, advocating for their transparent and equitable allocation' [3]. That the technical expert generally promotes certain values and rarely functions in a purely technical role [46, 53, 61] contributes to our interest in understanding the ethical ramifications of doctors' engagement in policy.

Little has been written about the skills exercised by technical experts when participating in policy-making. It is not known whether skills other than those inherent in professionals' core roles are called upon and if so, what they are, and how they affect the process and its outcomes. In the case of macroallocation, although empirical data concerning doctors' skills in the promotion of 'transparency' and 'equity', as stipulated by the AMA, are absent, several commentators have recorded doctors' lack of special expertise in determining policy outcomes likely to promote social justice [35, 36, 48, 63, 67]. As contributors to the policy process, doctors' individual competences and values are material to the success of the enterprise and the trust in which the community holds it. The skills they exercise in the policy role and their commitment to acquiring them are, thus, matters of ethical significance [15].

We situate this analysis in the 'little ethics' of Paul Ricoeur. Ricoeur is unusual amongst the philosophers of the twentieth century in valuing the generative possibilities of institutions [62], for whom the apportioning role of institutions answers

the ethical subject's need for justice and completes the communitarian level of the ethical intention of 'aiming at the "good life" lived with and for others in just institutions' [54]. Thus, we characterise the process of macroallocation as an institution, or 'structure of living together', that has the right of distribution of society's goods equitably [62], according to 'a sense' of justice [54]. In this analysis, we explore the extent to which the skills valued by doctors enabled their engagement in *phronesis*, the Aristotelian concept of practical reason that, in Ricoeur's ethics, is mediated by the institution as it addresses matters of justice [62], and test how Ricoeur's ethics might be used to enhance understanding of the moral significance of doctors' practices in mobilising skills and knowledge in the macroallocation setting.

Taking the position that theorising about priority setting as a practice should be based on practitioners' experience, we determined to undertake a qualitative interview study of doctors who engage in it. We wished to obtain a rich picture of their understanding of the social process of policy and to bring their intuitions to bear on our ethical analysis [19, 37]. Thus our enquiry elicited reflection on the skills used in macroallocation policy work, on the importance of being skilled, and on efforts to acquire skills, in order to illuminate participants' self-understanding of their skills and the effectiveness of those skills. In this report we consider doctors' conceptual understandings alongside some of Ricoeur's ethical concepts in order to arrive at a better appreciation of ethics in macroallocation policy work.

Methods

Methodology

We used a qualitative methodology with sampling, data-collection, and analysis strategies selected to answer our research questions. The study method was closely based on grounded theory as described by Charmaz [9], modified to accommodate the principles of the empirical bioethics methodology grounded moral analysis (GMA) as devised by Dunn et al. [17], in which conceptual and normative analysis proceed in parallel with data collection and analysis in order to inform normative claims that are grounded in the practice setting. To enable this descriptive component we modified our open-ended questioning format, including in the interview schedule direct questions on their perspectives on the skills they used and valued.

Participants and Sampling

We conducted semi-structured interviews with 20 doctors, all of whom had participated in priority setting at one or more levels of the Australian health care system. Initially, participants were recruited through an invitation issued by the Agency for Clinical Innovation, which hosts clinician networks that work on aspects of health policy in NSW. From this invitation 10 doctors came forward, of whom 1 withdrew before an interview date could be set. The remaining 9, and an additional participant recruited by passive snowballing, were interviewed. In order to enable elaboration

of categories emerging from the analysis theoretical sampling was used to recruit a further 10 participants from the researchers' networks [5]. In this stage, 18 invitations were sent out, from which 12 affirmative responses were received. Ten doctors were interviewed, while for 2 potential participants, interview arrangements had not been concluded before the point at which theoretical saturation was reached and data collection was terminated.

Most participants had engaged as technical experts in multiple policy-making processes, contributing concurrently or over the course of a career to macroallocation policy decisions at the local, state, national, and in some cases, international levels. Their activities centred on: participation as members of committees, attendance at meetings with bureaucrats and decision-makers, lobbying, construction of independent processes designed to advance policy debate, and preparation of submissions, applications and correspondence, all in the context of processes such as technology assessment, service development, and determination of high cost care access.

The sample was similar in its distribution of age, sex, and country of training to the general cohort of specialist doctors in Australia [1, 2]. All of our participants were employed by, or in a small number of cases, retired from, public sector institutions. The characteristics of participants and their policy activities are presented in Table 1.

Data-Collection

We used a semi-structured interview format, with questions and prompts designed to elicit participants' experiences and encourage reflection on the ethical dimensions of the role. The first author, who has experience in the field under investigation, conducted the interviews, which lasted from 30 to 90 min, with an average of 64 min. The interviewer used probing to follow up on key ideas offered by the participants. For this component of the study participants were asked about their skills and skills deficits in the area of policy work, and the training they had undertaken for the role. In addition, relevant codes were extracted from participants' responses to questions touching on the skills of colleagues and on medical training. The interview schedule was revised twice during the study, in response to the analysis, in keeping with the principles of GMA [17]. We used these iterations to probe the ethical concepts emerging from our analysis and explore our theoretical insights with participants.

Analysis

Inductive and abductive data analysis was undertaken progressively from the commencement of interviewing, involving detailed coding, comprehensive memo-writing, exploration of the relationships between codes, and creation of analytic categories by combining codes [9]. The first author conducted the analysis, discussing emergent findings with the second and third authors, and reflexively drawing upon her own experiences to understand their potential to inform or bias interpretation of the data.

Table 1 Characteristics of participants and policy activities

Clinical specialty[a,b] (number)	Paediatrics (3)
	Endocrinology (1)
	Plastic Surgery (1)
	Rehabilitation (3)
	General Practice Academic (2)
	Rheumatology (1)
	Clinical Pharmacology (1)
	Gastroenterology (2)
	Intensive Care Medicine (2)
	Neurology (2)
	Cardiology (1)
	Radiation Oncology (1)
Age range (number)	≤ 45 (3)
	46–55 (4)
	56–64 (10)
	65–80 (3)
	Average age: 58
Sex (number)	Female (5)
	Male (15)
Country of initial training	Australia (16)
	Europe (3)
	Asia (1)
Policy activity (number)	Policy with multiple national governments or international bodies on public health programs (2)
	Australian government policy on healthcare research priorities (2)
	Australian government policy on the allocation of resources to high cost health care interventions (3)
	Australian government policy on the allocation of resources for priority healthcare programs (4)
	Australian government policy on the allocation of resources to participant's specialty (2)
	NSW government policy on the allocation of resources to the participant's specialty (13)
	Local health administration policy on the allocation of resources to the participant's specialty (11)
	University administration policy on the allocation of resources to health research and education programs (4)

[a]Some participants were qualified or practiced in more than one specialty; the one listed is the one on which the majority of their policy work was focussed

[b]For the sake of maintaining anonymity, participants' subspecialties, where they exist, are not provided

Salloch et al.'s [58] criteria for the selection of ethical theories in empirical bioethics, in particular, the criteria of suitability to the issue at stake and alignment with participants' actual moral deliberation, guided us in our choice of ethical framework. We developed the later iterations of our interview guide in the direction of virtue

ethics on the basis of its long association with the study of medical professionalism [51], and in response to our early inductive analysis, which showed that participants were strongly concerned about practical reason, distributive and procedural justice, the golden mean—characterised in our data as moderation—and the virtues of self-efficacy, particularly patience and persistence. After the interviewing phase had concluded, and towards the end of our analysis, whilst seeking a framing of virtue ethics that would be helpful in drawing together the normative themes in our data, we observed a striking resonance between our categories and Paul Ricoeur's 'little ethics'—a variant of virtue ethics that incorporates the notion of the just institution—which we included from that point in our normative deliberations.

Ethics

The study received approval from the University of Sydney Human Research Ethics Committee. Each participant gave written consent, was assured of confidentiality and was free to withdraw from the study at any stage. All data were de-identified, and stored and analysed under alphanumeric codes.

Results

The doctors in our sample shared a notion that their capacity to be effective in policy was linked to their skills in areas outside those covered by their medical training, and they expressed a strong commitment to acquiring the skills they held to be essential for the role. They identified communication skills, strategic thinking, finance and data skills, and the ability to combine these to make a good case as the skills they possessed and applied in the policy-making process.

Valued Skills

Communication Skills: 'The Capacity to Bring People Together'

Most participants considered themselves to have superior communication skills, both as listeners and speakers. The response of P5, active at multiple health system levels, to a question about her abilities encompassed the communication skills that were commonly identified by participants.

> What are my skills? I'm a good communicator I think. I'm quite a good facilitator. I can pick up on a vibe if I'm chairing a meeting and I'm very inclusive, like I listen to everyone that's got a voice because you get some incredibly good ideas from little voices if you listen to them and so I like that. And then I also make sure I recognise everyone as best I can. I know I upset people sometimes but try to give acknowledgement where it's due and make sure people know that they've been appreciated and recognised.

Strategic Thinking: 'Looking at the Big Picture'

Many participants said their ability to be strategic, see the big picture, and understand how the elements of the system interact was a significant enabler of their policy work. A number focused on the human side and valued their ability to understand the way the system impacts on managers and policy makers, or as P10, active at the local and state levels, put it, 'what they've got to deal with'. These doctors were sensitive to the location of power and how to influence its holders.

Skills in Health Data and Health System Finance: 'No Data, No Disease'

Skills in health system finance and data were held to be critical to success in the policy role. For P13, active at the state and national levels, advanced financial knowledge enabled engagement with complex policy issues.

> I think what is important is that I have a reasonable understanding of financial literacy and an understanding of how budgets work and how the - both the bureaucracy works but also how the finance flows within the bureaucracy and what generates money and what doesn't and what - how patient care is funded and lots of clinicians don't have the vaguest idea of any of that, don't know how. They don't have an idea of how their own bank account works, let alone how a state level bank account works. So I think that's been advantage.

Whilst most participants considered their capacity to identify, derive, work with, and present pertinent health data to decision-makers as a strength, many reported having had to overcome data system deficiencies and lack of administrative support in order to exercise this strength.

Some doctors in our sample felt that having to rely on experts diminished their own effectiveness and some felt guilty that they had not mastered finance and health economics adequately, but others did not show an appreciation of the gap between their skills in finance and data and those of professionals in those disciplines:

> P10 So you've got to make up – not make up, but try and work out demographics, look at population growth, look at the incidence of different conditions and how that might have an impact and if we did have this service how could it shorten your length of stay.

Making a Good Case: 'We had All the Arguments Lined Up'

For the doctors in our sample, the ability to pitch a case was the most valued skill. As a foundation for this skill, early in their policy work doctors came to realise that health administrators and health bureaucrats were not the enemy, or as P12, a seasoned participant in priority setting, put it, they 'really just want enough evidence to argue with Treasury'. It was the doctor's role to craft a case that captured the bureaucrat's attention and enabled them in turn to convince the decision-maker.

Many participants spoke of learning the right language to speak. P12 gave an historical perspective:

> So there was a big move in the 90s to communicate with patients and learn to speak clearly and express complex ideas but people, I think, didn't realise you also needed to learn to speak clearly to administrators and health executives in a language that they could – that they thought was valid, in a way they thought was valid. So I did a distance learning course in health economics which gave me a lot of the – I don't want to say jargon – a lot of the intellectual tools that people [use].

P6 was conscious of needing to learn the skill:

> So you need to kind of speak a different language when you're speaking to these various groups. So trying to get the nuances and then understanding what changes you need to make, you know, how you pitch your information, that's something that I'm trying to learn. I wouldn't say that I'm an expert or anything with this.

Participants considered that decorum in delivery was as important as the message. Decorum involved anticipation of the hearer's needs and a subtle style that avoided arrogance and aggression. Over-egging the pudding, emotivism, and deficiencies in logic were frowned upon. P13, a doctor with 3 decades of experience in macroallocation policy work, attributed his success to:

> Common sense. Trying to be objective and you're not only pushing whatever it is my view is. Being prepared to listen to other people and being prepared to articulate a case that's not aggressive or harsh or over hyping and doesn't have the bullshit metre going up.

While making a case was underpinned by reason and logic, the ability to deploy clinical narratives in support of a position was highly prized. For P7, an academic, this skill was critical:

> Look if I sit at a table, to be honest, the main thing I bring actually is my standing and credibility as a clinician…I know that when I sit at a table whether it's at the faculty or in various committees, the moment I say, "Oh, the patient I saw last week" changes the whole conversation. So I know that makes a difference and that's part of it.

Skills Acquisition

Almost all participants had acquired most of their skills on the job, by watching and listening to others, and by absorbing how systems and hierarchies functioned.

> P3 Most of…my ability in that area, whether it's good or bad, came from experience, I think. Seeing how things are done. Seeing how other people work and so forth.

In the case of numerical skills, however, formal learning was common. In seeking mastery of the business language of decision-makers so that they could craft well-targeted messages, the doctors in this study undertook programs that featured health economics, health data, and epidemiology, such as master's degrees in public health, health management, clinical epidemiology, and health policy. One participant undertook formal learning in fundraising, and one in health economics. Two participants had undergone orientation and training related to specific policy processes. Some of the participants who relied on their acumen in financial and health data analysis and presentation were self-taught, sometimes enlisting the assistance of friends and acquaintances. Those who had elected to pursue formal qualifications had done so in response to the challenges they encountered once they had begun to be involved in policy-making, rather than as a stepping-stone to entry into the role. All participants reported that the educational programs they had chosen had been helpful to them in their engagement with policy-making. Only 2 participants stated that they had never done any training related to the role.

Whilst the majority of participants were uncritical of the processes by which they had acquired the skills and knowledge necessary for policy work, a small minority reported a lack of support from administration, whose active input into their development would have accelerated their progress, reduced the personal cost of learning the necessary skills, especially in terms of time, and limited the stress they felt when performing in roles for which they felt inadequately prepared. P18, a younger doctor, active in policy at the local level, regretted not having had mentoring and formal training in people management:

> [It] would have been very helpful in terms of managing, you know, your personal wellbeing, which unfortunately often gets ignored as well.

The younger participants, and some others with special responsibilities in medical education, said that the changing face of medicine necessitated a more formal approach to imparting the skills needed in the policy role. They believed that skills development programs in the areas of people management, health system structure, function and financing, advocacy skills (especially understanding how to approach decision-makers), and strategic thinking should be offered to the increasing number of doctors whose roles expand beyond the clinical. P18 believed that such training 'would make better department heads, better hospital leaders and ultimately better outcomes for the patients'.

Some older participants reported implementing graded experiential learning for younger colleagues who showed an interest in policy, while one participant suggested succession planning for policy roles had been neglected, especially in specialties that enjoyed a thriving network of engaged doctors.

> P13 One of the system's failings is that we haven't grown a whole heap of people who are interested in this. So there are a whole heap of - there are lots of senior people who have dabbled in the space, but we haven't nurtured another rung, I don't think. So look in [my specialty] and maybe it's because we've been too successful and anyone that's interested just gets put off because it's all taken care of already, I don't know. But there aren't - I think there's a potential

problem within the system that there's a whole heap of people that could be doing this stuff as the leaders in 10 years' time aren't.

Discussion

We found that the doctors in our study took for granted the special status of their medical knowledge and training. They linked their effectiveness in macroallocation, however, to their skills in the areas of communication, strategic thinking, and numerical data, and to their ability to integrate these in order to make a cogent argument directed towards persuading bureaucrats to represent their interests to political decision-makers. They were assiduous in acquiring the skills they considered to be necessary for the role. Their formal learning efforts were directed in the main towards skills in the use of numerical data, in some instances in order to compensate for lack of access to the relevant experts. The younger doctors in our sample, and those concerned with education, perceived an unmet need for formal education in interpersonal and strategic skills, and considered that employers should provide educational support.

Valued Skills

Whilst the account of skills in our data is consistent with those of the small number of prior qualitative studies concerned with the policy skills of healthcare experts [14, 31], this is the first study, to our knowledge, to focus on macroallocation and to explore doctors' accounts of learning in this context. Thus it provides an opportunity for doctors and policy-makers to review the relationship between extant skills and the requirements of the policy process.

The valued skills suggest that the doctors in our sample shared a holistic conceptualisation of argumentation that accorded with the Aristotelian concept of rhetoric as the capacity to see and communicate the 'possibly persuasive', aiming at, but not necessarily achieving, persuasion [29, 45]. Each of the three components of classical rhetoric—*logos*—logic and coherence; *pathos*—the feeling or emotion conveyed; and *ethos*—the personal credibility or trustworthiness of the speaker [13]—was strongly represented in our data. This finding was surprising, since healthcare policy-making strongly favours neopositivist, technocratic approaches that focus on scientific data and rational arguments [23, 29, 50, 57] for reasons that include the positivistic commitments of the doctors who dominate advice-giving in this sector [8, 26, 30, 38, 41, 42, 61, 65] and the valorisation by neoliberal governments of evidence and priority setting tools for their putative rationality and usefulness as correctives to provider power [23, 61]. The form of argumentation shown in our data is suited to postpositivist deliberative models of policy-making, which have a focus on language, encompass context and practitioner experience [23, 24, 59], integrate the empirical and normative [25], and acknowledge the constructed nature of claims, norms, and arguments [25, 39].

The unexpectedly textured model of argumentation suggested by our participants' appreciation of their skills led us to hypothesise that doctors who are committed to roles in macroallocation embrace a rhetorical position akin to that of the 'client advocate', as theorised by Throgmorton [65], a role integrating both scientistic and political interpretive values, that cultivates sensitivity to the perspectives of political decision-makers, and translates technical jargon into language they can understand, in an attempt to overcome the rhetorical impasse that scientists historically face in policy. Doctors' willingness to elaborate arguments integrating the financial and economic business language of bureaucrats [61, 64] with their own technical knowledge dominated our data. Thus, at the heart of our theoretical model explaining doctors' approach to skills for macroallocation work is the notion that they perform the role of expert as an argumentative practice [45], thus claiming a full, rather than auxiliary, place in the valued phronetic process of determining just allocations. In the account of expertise as argument, expertise entails arguing as an active participant in phronetic deliberation, presenting justifications of judgments that respond to problems in their contexts, rather than less influential statements of technical reason derived from subject knowledge [45].

Even though postpositive conceptualisations of policy-making recognise that argumentation is at its core [13, 29, 46], most scholars have treated it as synonymous with *logos* [29]. That our participants, although members of the scientific interpretative community and operating in a largely technocratic policy environment, displayed subtle and holistic rhetorical sensibilities, encompassing *ethos* and *pathos* along with *logos* in their argumentation, provides support for Gottweis's [29] assertion that accounts of argumentation in policy that tie it to *logos* alone miss the reality of the nuanced practice of persuasion in policy-making and the performative function of *ethos* and *pathos* in exposing the situational and personal consequences of different courses of action.

Our participants intuitively constructed policy-making as practical reason, engaging a combination of technical and persuasive skills, practiced with the pragmatic positioning, judgment, and decorum cultivated in these fora. The Aristotelian concept of practical reason—*phronesis*—is a form of prudence exercised in 'the art of a fair decision in situations of uncertainty or conflict' [56] that emphasises responding to problems in their particular contexts [23]. Our participants' construction of *phronesis* resonates with Ehninger's [21] influential description of argumentation, in which the wise arguer implements 'restrained partisanship', voluntarily limiting persuasive tactics to those that will withstand examination and criticism.

The moderate persuasive practices valued by the doctors in our sample also align with the centrality Ricoeur gives to respect for others' convictions in the context of deliberation about just distributions [55]. It is by no means certain, however, that through sincere engagement in *phronesis*—as evinced by our participants—in the role of 'restrained partisan', or of Throgmorton's [65] 'client advocate', doctors obtain justice for themselves or the interests they represent. There are no gauges with which to measure the success of any sort of rhetorical practice individual doctors use in priority setting deliberations; the efforts of 'restrained partisans' exist alongside those of 'naked persuaders' [21], who use less moderate tactics and are often rewarded for it [15]. We suggest that our participants have constructed a 'best-case'

for doctors' participation in macroallocation, and we consider it significant that their ideal is not in alignment with the technocratic models prevalent in health care, nor with the political focus often observed in medical professional activism.

Skills Acquisition

This study challenges the commonly made claim that doctors overestimate their abilities in domains for which they have had no training [7], relying on their experience rather than embracing new skills [15]. The doctors in our study took the matter of skills acquisition seriously, purposefully learning from experience and pursuing costly qualifications. Only in the matter of underestimating the proficiency inherent in the roles of other professional groups did the doctors in our study evince the stereotype. Our participants aimed for skill in types of numerical data that are normally the responsibility of other professionals, such as accountants, economists and health data experts, often in response to difficulties in accessing practical support or collaboration within their employing organisations. When preparing their arguments or assessing those of others, the doctors in our study tended to rely on their own emerging skills in areas requiring numerical competence. Doctors' willingness to arrogate the roles of other professionals may expose them to exploitation and, even though well intentioned, may propagate imperfect analysis capable of affecting the quality of decisions [20].

Our data suggest that reliance on doctors' estimation of the skills needed, and on their self-development according to these assessments, may be insufficient. Despite their reliance on these skills, we found no evidence that the doctors in our study had contemplated either logic or argumentation in any formal way, nor of guidance by policy-makers in their skills development choices. It is also surprising that our participants did not report learning or using skills in ethics, given the place of justice at the heart of health policy deliberations [11, 42, 49, 68].

These gaps, along with the pressure doctors in our sample experienced to develop a wide portfolio of skills in which numerical skills were prioritised for development ahead of other valued skills, may be a response to inadequately specified deliberative processes and ill-defined concepts of the technical expert role, themselves reflective of uncertainty arising from ongoing debates about effective health policy-making models and what counts as evidence in policy [13, 25, 29, 30, 50, 59]. Our findings suggest the presence of a gulf of misunderstanding between policy-makers and participants on the objectives of the expert role in macroallocation, and the skills required to perform it, which leaves expert participants to guess at the skills they might need and to fend for themselves in acquiring them. Elucidating what doctors' expertise consists in in the macroallocation milieu would be a prerequisite to the development of pedagogical guidance for doctors or organisations wishing to offer training for the role.

Our work suggests that common assumptions about doctors' abilities and interests in macroallocation, and policy-making generally—notably that they are staunchly committed to positivistic reasoning—may misinterpret their values, motivations and epistemological stance, and underestimate their acumen and diligence. Our findings

illuminating experts' objectives, preferences, and capabilities have implications for those who design policy processes, promoting consideration of the need for well-specified and clearly communicated processes, irrespective of the prevalent policy-making model.

Ricoeur's 'Little Ethics' as a Framework for Doctors' Learning for Macroallocation Work

Our exploration of virtue ethics with participants, which was centred on the normative themes of justice, moderation and the virtues of self-efficacy, established that this ethics system offered a persuasive account of the moral significance of the doctor's role in macroallocation, and of doctors' intuitions about the skills needed to be effective in the role. In order to finalise our analysis, we sought a framing of virtue ethics that would be helpful in drawing together the particular constellation of virtues our participants considered to be important in macroallocation work. We found this in Ricoeur's 'little ethics', which is encapsulated in 'aiming at the "good life", with and for others, in just institutions'. Ricoeur's treatment of just institutions as fundamental to the constitution of the ethical subject [56] and comprehensive exposition of practical reason resonated strongly with our data's prominent theme of confidence in macroallocation as an institution, which was shown in participants' commitment to developing skills for policy work and purposeful adoption of macroallocation's rhetorical conventions.

To 'just' Ricoeur assigns the meaning 'equitable' [55]. The just possibilities of the institution—its strivings for justice—are mediated by the concerted efforts of its members [62], invoking a communitarian ideal. Deliberation in the just institution on matters of distributive justice is an ethical act of cooperation founded on the exercise of practical wisdom [54] and supported by obligations to make the best possible argument [56] and to engage respectfully with the convictions of others [54], commitments that were prominent in our data. Ricoeur's concept of 'linguistic hospitality' in argumentation [56]—respect and mutuality, fostered by the generous act of translation from one's own language into that of the other—figured strongly in our data through the centrality in our participants' rhetoric of sensitivity to audience [52] and efforts to bridge the communication gap. Our findings thus support the claim that participants perceive that the institutions they participate in ought to be virtuous, and act so as to maintain, reinforce or achieve virtue in those institutions.

We found amongst participants in macroallocation a thinking system that is consistent with Ricoeur's ethics. By virtue of the purposeful and comprehensive efforts the doctors in our study made to engage with practical wisdom for the benefit of others, their commitment to sustaining the virtues of the institutions with which they were involved, and the ethical satisfaction they derived from acting in the expert role, they might be understood as paragons of its enactment. This finding provides an empirically derived basis for suggesting that Ricoeur's ethics might illuminate the gap between medical professional ethics and the performance of the technical expert role in macroallocation, where its foundation in practice might make it better suited to enabling moral reflection than other ethical systems commonly used in

bioethics. At the individual practitioner level, it might aid doctors confronted with opportunities to participate in macroallocation in determining whether they meet the conditions that support the ethical intention and the virtuous functions of health care institutions, since it prompts questions concerning the adequacy of the process as a vehicle for bringing about just distributions of resources, the sufficiency and aptness of their skills, and the availability of support to do the task well.

Limitations

That our sample contained only doctors who self-selected or were selected on the basis of their commitment to priority setting activities and their interest in participating is a limitation of our study. The distribution of age, sex, and place of training in our sample mirrored the profile of the general cohort of specialist doctors in Australia [1, 2]. Thus, although our findings might not be widely generalisable, we believe that they are likely to reflect the experiences of a broad range of doctors involved in priority setting in publicly funded health systems. We did not draw out fine distinctions between sub-groups of our participants, and so cannot say to what extent such distinctions impact upon the priority setting role. That we sought data only from doctor participants in priority setting causes a limitation due to the representation of a single social perspective.

Conclusions

As part of our empirical work on the ethical issues entailed in doctors' participation in priority setting, we set out to understand what skills doctors used in macroallocation, how they were acquired, and how they influenced performance of the role. We found that doctors who were committed to roles in macroallocation performed expertise as argument, bringing together rhetorical skills and profession-specific expert knowledge in a way that was sensitive to social and political context. In this way they enhanced their influence in the phronetic process of priority setting. Our findings were unexpected since they challenged common assumptions about doctors' preferences in argumentation, and suggested a commitment to practical reason that is out of step with the technocratic policy models that predominate in health care.

We found applying the principles of GMA to be useful in allowing us to develop normative insights grounded in accounts of our participants' experiences. Using Ricoeur's ethics in our analysis enabled us to explore macroallocation as an ethical practice, and to identify the social and moral meaning of doctors' learning for priority setting work.

Our contribution in this work has been to identify in Ricoeur's ethics an empirically grounded matrix for moral analysis of the doctor's technical expert role in macroallocation that may help to establish norms for procedure in that setting and contribute to the development of criteria for evaluating both the substance and the process of doctors' engagement in the role.

Ricoeur's 'little ethics' and his work on medical ethics have yet to be widely considered in the bioethics literature. The communitarian ideal encompassed in working 'with and for others' to achieve the just possibilities of institutions suggests that it might have broader application in medicine and health care as a yardstick by which to evaluate processes and outcomes.

Our contribution is also relevant to the debate regarding the serviceability of stereotypical technocratic models of policy-making in health care since it provides insights into the performance and preferences of key participants. At the very least, the existence of untested assumptions about the doctors' role in macroallocation should be acknowledged openly.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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