



CHAPTER 9

# Ethics Conflicts in Rural Communities: **Allocation of Scarce Resources**

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### **Handbook for Rural Health Care Ethics: A Practical Guide for Professionals**

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# Ethics Conflicts in Rural Communities: Allocation of Scarce Resources

Paul B. Gardent, Susan A. Reeves

## ABSTRACT

Allocation of scarce resources is a reality for health care professionals and organizations. Resource allocation issues can be particularly challenging for rural communities, where resources are not enough to meet all needs and fewer alternatives exist to resolve conflicts between competing needs. In addition, the ramifications of decisions may be more visible in the rural setting. Decisions regarding allocation of resources can be troubling for clinicians and administrators to make, at both the personal and professional levels. Such decisions can be at odds with providers' deeply held beliefs about benefiting others without harm. Resource allocation decisions can create conflicts for personal, professional, organizational, and community priorities and commitments. Though resource allocation issues are economic in nature, they inherently raise issues relating to organizational mission and ethics. The philosophical method chosen to resolve resource allocation conflicts can influence both the way in which decisions are framed, and how the decisions are made. When responding to resource allocation conflicts, it is difficult to prioritize and identify a primary fiduciary duty or responsibility. Resource allocation conflicts are characterized by multiple constituencies, complex relationships, and myriad benefits and harms—which may or may not be apparent. All of these factors make resolving ethics conflicts related to scarce resources in rural settings both difficult and emotionally troubling.

## CASE STUDIES

### **CASE 9.1** | Granite Hospital budget restrictions

Granite Hospital owns and operates a small, two-provider primary care practice in a community 25 miles from its main campus. Within the remote practice, two highly regarded family medicine practitioners provide practically all of the primary care to the small town. The hospital has received numerous comments over the years, attesting to the quality of the physicians and the secure feeling that is provided by their presence. The hospital originally established the primary care practice at the edge of its service area in response to anticipated capitation contracts that never materialized. Granite Hospital serves a large geographical area that has a low population, and the facility has received accolades and awards for its efforts to meet community health needs and offer preventive services to residents. The hospital is not strong financially, but has been able to subsidize its primary care businesses with extra income from its acute care services. Recently, deep Medicaid reimbursement cuts have negatively impacted the financial condition of the hospital and, in response, the Board of Trustees and administration have had to consider cutting operating costs. Questions have been raised about the hospital's ability to continue to subsidize the distant primary care practice. Board members are distressed by the devastating impact such a decision could have on the small town. Of course, if the community were to find out, they too would be devastated, and their anger might create a PR nightmare for the hospital.

### **CASE 9.2** | Moving procedures from hospital to office

Dr. Patel is a general surgeon in a rural community. He has seen his financial situation slowly deteriorate over the last several years, due to reduced reimbursement. He currently does many procedures in the small hospital's operating rooms, despite the fact that they could be done adequately in an office-based procedure area. Dr. Patel is thinking of moving the procedures to his office where he would receive greater reimbursement. The hospital administrator is

very upset because the hospital relies on this revenue to support charity care and primary care services for the community. Dr. Patel understands this, but feels a financial obligation to his family. He also feels that the hospital has other opportunities to regain lost revenue. Finally, he believes he could charge less than the hospital, and thereby more directly benefit his patients.

## OVERVIEW OF ETHICS ISSUES

Despite the fact that we live in one of the wealthiest nations in the world, the access to adequate health care continues to challenge many communities. These challenges are often magnified in economically disadvantaged geographic locales. For example, rural communities, in particular, struggle to recruit and retain qualified health professionals who are capable of providing basic health services to residents.

Rare is the rural health care professional who believes that there are adequate resources available to meet the demands for patient care. Decisions regarding the allocation of scarce resources are part of the everyday work life of rural health care professionals. Such decisions are often troubling, as they often result in the creation of “haves and have nots.” The majority of health care professionals, who by definition have chosen to devote their careers to meeting the health care needs of others, are driven by a strong sense of beneficence. These are individuals who possess strongly ingrained personal and professional values. Such values are often enhanced during professional education, which dictates that harming or wronging others is to be avoided at any cost. This philosophy can include a belief in the right of all individuals to needed health services. The professional’s inability to provide adequate health care services to all residents of the community may cause him or her to suffer moral distress. Therefore, the provider’s need to consider allocating scarce resources can create conflict between deeply ingrained values and the realities of modern hospital financing in an era of managed care.<sup>1</sup>

### Resource Allocation Decision-Making

The first step in ethical decision-making involves identifying the nature of the conflict that surrounds the allocation of scarce resources. The nature of such conflicts can be described in a conflict typology along two

dimensions, the focus of moral conflict and locus of values, shown in Figure 9.1. Such value conflicts are often expressed by citing principles of obligation, loyalty, and duty to others.

**FIGURE 9.1**

<b>ALLOCATION OF SCARCE RESOURCES CONFLICT MATRIX</b>					
		<b>Locus of Values (Perceived Obligation, Loyalty or Duty)</b>			
<b>Focus of Conflict</b>		Personal	Professional	Organizational	Community
Stakeholder 1					
Stakeholder 2					
Stakeholder 3					

The “locus of values” may manifest among any combination of personal, professional, organizational, and community values. Deeply held beliefs typically express themselves as personal values, which often are a result of faith, culture, upbringing, and life experiences. Professional values are expressed as professional Codes of Ethics in medicine, nursing and other health professions, and become ingrained during the individual’s professional development and formation (e.g., American Medical Association Ethics Manual; Code of Ethics for Nurses; American College of Healthcare Executives’ Code of Ethics). Organizational values are expressed through the sense of obligation felt to an organization. These values often relate to an individual’s sense of responsibility for supporting the organization’s mission, value statements, and policies. Finally, and particularly for people living or working in rural communities, there can be a deep cultural sense of dedication and obligation to the community.

The focus of the ethics conflict is on the competing values of the various stakeholders. The stakeholder conflict can be an internal personal conflict; a conflict among professionals; a conflict between professionals and the organization; a conflict between the organization and the community, or some combination of these. A personal conflict may be experienced when an individual is confronted with trying to adhere to competing values.

Inter-professional conflicts occur among and between professionals due to conflicting personal moral principles or while trying to adhere to values held within a different locus. Often conflicts are heightened when the priorities between these dimensions vary among the professionals involved in decisions regarding allocation of scarce resources.

Frequently, trying to allocate limited resources becomes a problem of deciding how to rank the various competing values within the context of the organization's priorities. A suggested ranking is outlined in Box 9.1.

### BOX 9.1

#### PRIORITY RANKING OF COMPETING ORGANIZATIONAL VALUES

- Patient's quality of care
- Professional excellence
- Organization's financial stability

Professor Werhane has noted that the stakeholder theory of decision-making should drive the reflection process for ethical decision-making done by health care organizations, in cases when there are competing values within the context of organizational decisions. The stakeholder theory, she writes, "...argues that the goal of any firm and its management is, or should be, the flourishing of the firm and all (of) its primary stakeholders,"<sup>2</sup> as compared to a goal of maximizing the welfare of the shareholders. This line of priority setting would require that the primary mission of the health care facility be to provide quality patient care. Therefore, excellence in patient care is the first priority. Because the integrity, and possibly the survival of the organization, is dependent on the professional's ability to offer competent, quality care, the staff would be the second priority. The third priority would be the long-term organizational viability, including its financial stability.<sup>2</sup>

The process of applying Werhane's proposed priorities is complicated by the fact that specific situations vary. For example, an acute financial crisis may require heightened attention to the organization's financial priorities. The proposed ranking is not an absolute algorithm. But it can provide a starting point for providers and administrators to reflect and

discuss the concept of setting priorities, such as in situations when the “locus of values” matrix highlights stakeholder differences, e.g. in conflicts between personal and organizational values.

### **General Ethics Approaches for Consideration**

Despite the proposed priority ranking of competing values, there is no quick answer to the problem of inadequate health care resources. Conflicts surrounding allocating resources will continue to be a reality for those charged with the distribution of available resources. Therefore, the questions become: What approach should be the basis for allocation decisions? What type of process would be best used to mitigate the negative impact of such decisions? And are there strategies to reduce the inevitable moral distress perceived by those with decision-making responsibilities?

The philosophical approach chosen by providers and administrators to resolve resource allocation conflicts can impact both the way decisions are resolved and how decision-making is approached. For example, the health professional may use a utilitarian approach (based on the theory that if an action or practice is right, when compared to an alternative action, it leads to the greatest possible balance of good consequences), which would call for the delineation of derived benefits by the recipients, with a choice to favor the decision that ultimately benefited the most people.<sup>3</sup> Such philosophical approaches tend to leave out disadvantaged groups with small numbers (e.g., a small town or an individual practitioner).

A “communitarian” approach is used to derive decisions which benefit the community as a whole over decisions that benefit individuals.<sup>4</sup> Each of the cases introduces the complexity of defining “community.” For example, the community of interest for the Granite Hospital is the patient population it serves, comprising several towns around the hospital, whereas the remote small town that would be impacted by the primary care center closure is defined much more narrowly. For the practicing clinician, the community of interest may be even more restricted. Again, it is important to be clear around the definition of “community.”

Deontological approaches, unlike utilitarianism, are used to decide what is right according to a duty to basic beliefs. These types of approaches



are expedient, but often ill-suited for providers to apply to resource allocation issues, because of the focus on an action's intent rather than its result.<sup>5</sup> Deontological approaches by nature are contextual, and they often fail to resolve conflicts among competing values. As such, the application of this type of ethics approach is difficult.

### **Health Care Ethical Principles**

In addition to the general ethics theories just discussed (philosophical, communitarian, utilitarian and deontological approaches) there are widely accepted and applied health care ethical principles, which include beneficence, nonmaleficence, autonomy, justice, veracity, and fidelity<sup>4, 6</sup> —all discussed in Chapter 3. These principles are frequently captured in a hospital's mission, vision and values statements, as well as in the staff practice standards.

The principles of veracity (honesty), fidelity (loyalty), and justice are also embedded into many resource allocation cases, including those presented here. The various providers and the hospital have many loyalties. The plight of the individual physician who attempts to juggle personal, professional, community and organizational loyalties is particularly difficult. Hospitals are torn between serving the community and surviving in a business market, and thus may not always be completely honest with the community. When designating programs or funds, honesty is typically the best policy, particularly when financial situations change. An "honesty" policy will reduce the amount of public relations backpedaling that the hospital will need to do if programs must be cut. For example, Granite Hospital may have entered the remote community market as a business strategy, with the intent to make a profit, but likely did not communicate the establishment of the practice as such to the local townspeople. It is more likely that the strategy was described as one that fulfilled the hospital's care mission. While both strategies are likely true, the marketing of the clinic establishment may have been less than forthcoming.

When confronting decisions regarding the allocation of necessary yet scarce resources, a number of moral issues are raised that challenge these core principles. Such decisions often challenge a provider's values and beliefs about what is morally right and wrong, particularly

in situations where there are no good alternatives. The resulting moral distress can be debilitating to the decision-maker. And, such distress can be divisive and destructive within organizations and communities. So what happens when there are both good and harmful effects of such decisions? How does one decide what is the right thing to do?

### **Decision-Making Methodologies for Situations That Involve Scarce Resource Allocation**

Making decisions in situations where scarce resources must be allocated is inherently difficult, and often challenges the clinician's desire to do what is right. The methods that providers use to make such decisions, including cost/benefit calculations, can be helpful in resolving allocation issues, although they do not entirely resolve providers' feelings of moral distress. In cost/benefit calculations, the clinician or administrator must first identify all the parties who may be involved and impacted by a decision. Ideally, representatives of the various parties would contribute to the cost-benefit discussion process to gain the best and most comprehensive inventory of costs and benefits. A listing of the costs and benefits that accrue to each of the parties should be clearly identified, taking care to include costs and benefits that are non-financial in nature. Relative measures of risk/harm and benefit/good should be made as objective and quantifiable as possible. Often, the use of a skilled facilitator to work with the various parties is a useful adjunct to this type of process.

The decision-making team should always conduct a further evaluation after an open and inclusive cost/benefit analysis. Their evaluation should examine whether a severely disadvantaged or marginalized group has borne a disproportionate burden of harm or cost as the result of the decision. Members of such groups, and their needs, are often poorly represented in medical decision-making processes. For example, Granite Hospital might argue that it is preferable to require the citizens of the remote community to drive the 25 miles to the hospital for services, as opposed to having the hospital go out of business all together. But for members of a disadvantaged group (e.g., those without any transportation), there is little difference between losing their primary care practice and being able to access the hospital, as the hospital would effectively be inaccessible to them.

When confronted with allocation decisions, the concept of distributive justice can be employed in a manner that allows the allocation methodology to promote equity and fairness.<sup>5</sup> While there are various methodologies that health care management can apply in decision-making, transparency is essential when choosing the type of methodology, and the consistent application of that methodology. Potential justice distribution methodologies include those listed in Box 9.2.

## **BOX 9.2**

### **POTENTIAL JUSTICE DISTRIBUTION METHODOLOGIES<sup>3</sup>**

- To each person an equal share
- To each person according to need
- To each person according to effort
- To each person according to contribution
- To each person according to merit
- To each person according to free-market exchanges

A related justice concept, procedural justice, is defined as, “The belief is that if the process is fair, the outcome will likely be fair as well.”<sup>7</sup> Procedural justice, akin to stakeholder analysis, attempts to describe and understand the impact of a decision, including the costs and benefits to all who may be affected by it.<sup>2</sup> Important characteristics of procedural justice include consistency, objectivity, representation and transparency. For instance, a hospital’s diminishing reimbursement may require budget reductions in various programs and services. However, prior to any decision, the executive leadership and clinicians need to explore and understand the ramifications of such a decision on all the related stakeholders. For the long-term health of the organization, it is important for the process to be conducted fairly and for decisions to be perceived as just by those affected by such decisions. Specifically the process for budget reductions should include the criteria provided in Box 9.3.

Health care leaders should seize the opportunity to structure a process so that it is fair, inclusive, and transparent.<sup>8</sup> Again, the use of a qualified facilitator, skilled in drawing out difficult issues, would enhance the process and outcome.

**BOX 9.3****BUDGET REDUCTIONS DECISION-MAKING PROCESS**

- Clear criteria, which are consistently applied
- An objective process for determining the facts related to the impacts upon the targeted programs and services
- Opportunities for affected parties to have their voices heard and for all parties to consider alternative ideas and proposals
- Complete transparency of all processes and decision-making elements

At the beginning of any decision process, the organization's leadership should make clear to all the involved parties how the decision will ultimately be derived and what criteria will be used, since a path forward does not always emerge from a discussion that entails ranking competing priorities among multiple constituencies. This is an important step to ensure that all parties know the ground rules and how power is distributed. A procedural-justice approach should never be considered if, in essence, a decision has already been made, and the process of involving stakeholders is simply being used to co-opt the participants. Inevitably, such processes backfire, creating an even bigger backlash against the decision-makers than what might have occurred initially, had they been honest and forthcoming at the outset.

**CASE DISCUSSION**

The discussion for the following cases is based on the analysis method discussed in Chapter 4 in this *Handbook*.

**CASE 9.1** | Granite Hospital budget restrictions

Due to limited resources, Granite Hospital is faced with closing a primary care practice in a distant community in order to protect the viability of the rural hospital. This raises concerns about ethical responsibility among communities, to individual communities, and to an organization.

The hospital had initially established the primary care practice during a different Medicare reimbursement environment, intending to earn a

profit from the practice, and perhaps, having a secondary motive to demonstrate commitment to the medical needs of a distant community. The community need is still apparent, and the hospital's focus on community service has become an important hallmark and expectation. It is not clear how acute the financial situation is for the hospital, or what alternatives exist to address these problems. Whatever the original reason was for establishing the primary care practice, the hospital has a responsibility to its board, staff, and its local and remote community to make decisions based on current circumstances.

The case also suggests that there may be differing feelings by clinicians, administrators, and the board about whether the distant community is really as important as the local community in which Granite Hospital is located. This raises questions about the boundaries of professional and organizational duty. Do we have a higher responsibility to our local community than to a more distant community? Also, there may be different perspectives among the administrative, trustee, and clinician leadership regarding whether to close the remote practice.

While the resource allocation conflict is framed from the perspective of the hospital organization and its members, there is also the perspective of the distant community and its two primary care physicians to consider. In a rural environment, resource allocation conflicts are intensified by the visibility of the benefit and harm to the individuals involved. These decisions can impact friends, neighbors, and colleagues. A characteristic of rural communities is that residents tend not to be transient and, as a result, the long-term memories of rural community members remain remarkably vivid—often spanning generations. Accordingly, resource allocation decisions have not only an immediate impact on the community, but may have long-term impacts on future relationships, with and within the community, that may last decades. These impacts can include the way the hospital is perceived, future contributions to fund-raising, staff recruitment and retention, and patient and physician loyalty to the hospital.

Granite Hospital leaders are unsure about how to proceed. They are deeply distressed by the idea of closing the distant clinic, but know that the hospital does not have the funding to continue the clinic's

operation. Can they close the clinic without causing undue risk to patients, without undermining the hospital's mission, and without damaging the hospital's image?

### **CASE 9.2** | Moving procedures from hospital to office

In the case of Dr. Patel, the surgeon considering the relocation of some procedures to his office, personal and inter-professional conflicts are raised, as well as conflicts of loyalty and duty. Dr. Patel is confronted with personal conflict when he has to weigh the benefits for his family and patients versus the potential harm to the hospital and possibly his community. He is also confronted with an inter-professional conflict with the hospital administrator.

For Dr. Patel, it will be beneficial to his practice (and thus, to him and his family) to move the location of his procedures to his clinic. However, for the hospital, the loss of procedural revenue will cause a significant financial strain. This conflict arises from the difference in the locus of the perceived duty that each party has to their constituencies. The surgeon may feel a deep responsibility to his family and patients, while the administrator feels a duty to the community hospital for which he has a fiduciary responsibility, and to its trustees and financial stakeholders.

Dr. Patel knows that moving some of his procedures to his office will hurt the hospital, but this would be beneficial to him and his patients. Dr. Patel's ultimate allegiance is to his patients, but he knows that the hospital is important to them as well, and to him since it would likely provide many of his referrals. Can the surgeon move his procedures to his own clinic, and still maintain support for the hospital and a good relationship with the hospital staff?

## **RESPONDING TO RESOURCE ALLOCATION ETHICS CONFLICTS**

### **CASE 9.1** | Granite Hospital budget restrictions

Granite Hospital leaders are considering the closure of the distant ambulatory practice. Is the closure of the primary care practice one of several options available to control Granite Hospital's operating

losses? Are there other options for expense reductions that might respond to the financial crisis, or is the financial situation dire enough so that any source of operating loss is intolerable, thereby placing the viability of the hospital at risk? The answers to such questions are highly relevant and will serve to better inform the decision-making process.

The governing board of the hospital can play an important and helpful role in larger decisions affecting the broader community. An active and broadly representative board of trustees is able to simultaneously embrace two critical roles. First, a representative board can reflect the values and articulate the interests of the community. Also, a board member from the local community is able to communicate more easily with that community, and to explain the challenges and trade-offs facing the hospital. In situations such as the one facing Granite Hospital, it is important to involve the trustees in the decision regarding the ambulatory practice. It conveys to the community that the hospital understands the significance of the decision, and will use a process that is fair and thoughtful.

Neither the utilitarian nor the communitarian approach adequately addresses the degree of harm or benefit to the various parties in this case. While there may be small benefits to each individual of a large group, there may be extraordinary harm to a small group. In addition, neither approach adequately deals with differences in the perceived degree of loyalty or duty that the decision-makers feel. Such differences can exacerbate inter-professional conflicts, and make it difficult to reach a resolution that is morally justified in the eyes of the participants.

The establishment of the primary care clinic in the remote town has been very positive for the Granite Hospital organization, as it has not only been profitable until recently, but also affirmed the hospital's value of acting beneficently. Clearly, closing the primary care practice and the resulting lack of access to care has significant potential to cause harm to the residents of the community. However, as discussed, it may be preferable to lose a remote primary care practice than to risk losing the entire hospital to the region.

While Granite Hospital may have entered the remote community market as a business strategy, it likely did not communicate the establishment of the practice as such. It is probable that the strategy was described as one of fulfilling the organization's care mission. While both strategies may be true, the marketing of the care facility establishment might have been less than forthcoming.

Given that the decision to potentially close the ambulatory practice raises not only economic but also organizational mission and ethics issues, Granite Hospital leaders decide to involve the board in the decision-making process. Fortunately this includes a board member from the community where the practice is potentially to be closed. The hospital forms a small ad-hoc board committee to develop a process, collect facts, and make a recommendation to the full board. The process is widely communicated to all participants. It includes an opportunity for a public meeting to explain to the community the financial difficulties the hospital is facing. Throughout the process, several potential savings are identified that might be implemented via significant changes in the ambulatory clinic's operations. Although such changes would be disruptive and not particularly provider-friendly, the local physicians decide they are willing to try them.

In addition, the hospital sets specific milestones and timelines that need to be met in order to keep the practice open. This particular process step insures that everyone knows what financial performance levels must be achieved for the practice to remain open. Interestingly, the hospital includes a member of their clinical ethics committee on the *ad hoc* board committee. The *ad hoc* committee finds that many of the concepts used in clinical ethics decisions turn out to be helpful in crafting this organizational resource allocation decision.

### **CASE 9.2** | Moving procedures from hospital to office

Resolving the conflict of the surgeon who is considering moving his procedures from the hospital is more difficult if it is viewed simply as the result of financial motivation. It would be easy to see Dr. Patel as just wanting to enhance his finances. Similarly, the administrator may be viewed as concerned only with the bottom line of the hospital. Framing



the differences in this limited manner, though, minimizes the important moral reasoning that supports each of the player's views. If the conflicting positions are instead examined and addressed in a positive manner, the sense of isolation and unhappiness that professionals in rural settings frequently feel could be reduced. This might then lead to more stability in professional turnover and, thus, to improved health care.

In this case, Dr. Patel is troubled by the thought that the hospital administrator and the board might not understand his situation or motives. While he knows that he might make the decision to move his procedures to his clinic without the permission of the hospital, he doesn't like the idea of disrupting what has been a positive relationship of several years' duration. Thus, he decides to meet with the hospital's chief executive and chairman of the board to discuss his situation. He approaches the meeting with a clear understanding of his own needs, but also with a willingness to discuss alternative approaches.

During the discussion it becomes apparent to Dr. Patel that the chief executive and chairman have not appreciated the challenges of the present situation. Dr. Patel is also surprised that the hospital executive acknowledges the long-term benefit of moving services to an office-based setting, including lower costs and ease of access for patients. The executive notes that the hospital can focus on procedures that require an acute-care setting. They discuss a cooperative physician-hospital relationship which provides the opportunity for more coordinated planning for the community's needs and the possibility of some type of shared joint arrangement where both parties benefit. Dr. Patel and the chief executive agree to work together to move some procedures to Dr. Patel's office, while keeping some in the hospital. They also agree to meet on an annual basis to discuss planning for other services that should be moved out of the hospital. A year later, these discussions ultimately will evolve into an ambulatory facility joint venture between the hospital and some other physicians, including Dr. Patel.

In both of these cases, it is difficult for the clinician or administrator who is faced with resource allocation conflicts to identify a primary fiduciary duty or responsibility. When determining responsibility, it is important for such individuals to explicitly define what ethics and economic questions

are being raised. Multiple constituencies, complex relationships, and myriad benefits and harms often characterize resource allocation conflicts. For example, these conflicts can impact hospital staff, physicians, payors, departments and services, providers in the community, and the community itself. There are a number of steps that individuals and groups can take that help them arrive at more ethical decisions. It is particularly important to make the process transparent to all of the individuals involved, as openness and honesty build trust among the participants. For a helpful overall process for resolving conflicts, see Chapter 4.

### **ANTICIPATING ALLOCATION OF SCARCE RESOURCE CONFLICTS**

As with most situations, prevention of conflict is always preferable to having to solve conflict once it occurs. When establishing business strategies, organizations and individuals can work to both anticipate future conflicts and challenges, and to proactively eliminate or mitigate them—these steps are noted in Box 9.4.

#### **BOX 9.4**

#### **MECHANISMS FOR HOSPITAL ADMINISTRATORS AND CLINICIANS TO PREVENT AND MITIGATE RESOURCE ALLOCATION ETHICS CONFLICTS**

- Consider the long-term implications of decisions
- Maintain ongoing communication and dialogue
- Be deliberate when establishing service-area boundaries
- Identify the extent to which community service is owed or expected for service area(s)
- Promptly address imbalances in benefits and harms
- Consider the addition of an ethicist to the strategy/leadership team

#### **Consider Long-Range Implications of Decisions**

Rural health care providers, hospitals, and clinics should always consider the long-range implications of organizational decisions, particularly when such decisions are financially based. When Granite Hospital initially elected to establish the remote primary care practice,

the decision was based on market and financial factors, with anticipated reimbursement conditions. The improvement of health care in the remote community was congruent with the hospital's mission; however, it was not the main reason behind the clinic's opening. Ironically, the decision to discontinue the practice is now one of mission and community service, because closing the clinic is expected to help keep the main hospital open. However, for patients in the remote area, the decision to discontinue the practice will be perceived as inconsistent with Granite Hospital's mission and values. Thus, this case should serve as a good warning for non-profit, service-based groups who also have businesses to run. In the future, financial strategy should always first be tied to mission, then second to market conditions, due to the volatility of such markets. People will remember that an organization is committed to improving care in their community. They won't recall that it was only there for as long as the venture was remunerative.

### **Maintaining Ongoing Communications and Dialogue**

Health care providers and institutions should also publicly communicate specific quality and financial performance reports to the communities they serve, so that there can be broad understanding and engagement in support of the organization in an ongoing way—not just during a crisis. Such communication can take the form of town meetings or other special events that mesh with the culture of the community. In addition, the organization's trustee configuration should continue to broadly represent the service area.

Once established, service areas should not fluctuate according to short-term strategic imperatives. They should be entered for the right reasons, with the proper investments, and service continued until there is a mutual decision to make different arrangements.

### **Promptly Address Imbalances in Benefits and Harms**

The legal structure among hospitals and providers may take many forms, but mutual interdependence is common, and this provides the foundation for successful, long-term, sustainable relationships. There should be routine, transparent reporting of financial and quality measures between related health organizations and providers, so that as market and reimbursement conditions fluctuate, each partner can support

the other(s). Similarly, regular communication that centers on building relationships is critical to weathering those times when conflicts occur. Routine communication and meetings are essential for establishing trust, respect, and rapport among providers, patients, and administrators during non-crisis situations. Creating such positive relationship elements is essential during conflict situations to balance the benefits and harms to the parties involved, particularly regarding patients. These elements are also helpful to clarify the motivations and commitments of all parties.

It is much easier to resolve ongoing conflicts when it is clear that the parties share trust, respect, and common interests. For example, Dr. Patel ultimately decides to openly discuss his concerns for his patients, himself, and even the hospital with the hospital administrator. As he transitions some procedures from the hospital with the chief executive's blessing, Dr. Patel should communicate with his patients and the administrator to ease any tensions surrounding this change, while maintaining his own (Dr. Patel's) support for the hospital and its goals.

### **Consider the Addition of an Ethicist to the Leadership Team**

Since resource allocation issues in health care inevitably raise ethics questions, it may be a good preventative measure to routinely include an ethicist as a member of the organization's operating or strategy team. For instance, it may be helpful for an ethicist to join the hospital's governing board. Also, ongoing training for administrators and providers on the ethical dimensions of governing and decision-making will enhance the effectiveness of health care organizations' governing boards and senior management teams.<sup>9</sup> The role of the ethicist in such forums is to make more explicit the ethics questions that emerge from various allocation methodologies. If used proactively during strategy-formation sessions, a more thoughtful strategy may be the result, and a more informed decision may be the ultimate benefit.<sup>10</sup>

Of course, it may prove challenging for a rural health organization to access a qualified ethicist. Often, local clergy or college-employed philosophy professors with the requisite expertise are available. While these professionals may not understand the nuances of health care per se, their command of ethics knowledge is what they bring to the table. And, as is often the case, those who are not involved with the intricacies

and emotion of resource allocation decisions may be better able to introduce insightful and unbiased thoughts and questions.

Increased ethics help is also available via technology. This might include teleconferencing with ethics professionals based at an academic medical center, or conducting web seminars with ethicists associated with professional organizations or with philosophy professors based at large universities. Finally, if there is an operating ethics committee at the local hospital or health agency, often the baseline expertise exists within the group, and can easily be expanded and modified to apply to more administrative-based ethics conflicts or challenges.

## **CONCLUSION**

Decisions on how to allocate limited resources are always difficult, particularly in rural areas where community relationships, as well as geographic and economic limitations, can create unique challenges for health care providers. Choosing a philosophical and methodological approach that is appropriate to the resource situation is a key part of the decision-making process.<sup>11</sup>

Identifying the nature of the conflict when resource allocation decisions are involved is an important first step for clinicians and administrators. The “conflict matrix” can be helpful in clarifying both the locus of values and the involved stakeholders in these conflicts. Having a basic understanding of the concepts and processes for dealing with ethics conflicts is a good start, but it can be particularly helpful to involve an expert in organizational ethics to facilitate significant or intractable conflicts.

Finally, anticipating allocation of scarce resources conflicts through preventive strategies may be the most important way to prevent and mitigate ethics conflicts for clinicians and administrators. Open and honest communication within the health care organization, as well as with the communities served, will ultimately prove the most important preventive strategy to reduce the ethics challenges associated with allocating limited resources that inevitably face all rural health care providers and administrators.

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