Chapter 2
A Matter of Justice:
Building Trust among Hospital Managers and Physicians

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ABSTRACT

A crucial aspect of a fair allocation of scarce resources in hospital is the close cooperation of hospital executives and physicians. This chapter has three aims. Firstly, it provides an analysis of basic elements of medical and hospital executives' ethics. Secondly, it discusses the role of concepts of justice in hospital decision-making. Thirdly, it reflects on process criteria and structures that might support coping with allocation conflicts in hospitals. While hospital executives mainly act according to economic, legal, and strategic considerations, physicians are traditionally obliged to professional ethics codes. These include patient welfare as the primary concern with economic aspects a secondary priority. Therefore, implementing and applying ethical principles for the allocation of scarce resources requires an ongoing constructive discourse between hospital managers and physicians. Furthermore, in order to build trust between the two stakeholders, an effective structure for solving ethical conflicts and a fair decision-making process is paramount.

INTRODUCTION[1]

Financial constraints have widely affected the provision of health care. Universal coverage and the access to decent health care has become a crucial issue in more and more Western countries, prioritisation and rationing issues are tackled with varying success, and cost containment has been on the agenda for a long time and will remain so. The demand for an ever more powerful medicine is increasing and usual market mechanisms cannot be applied to the health care system, which generally is described as a "market failure" (Daniels, Light, & Caplan, 1996, pp. 101-102; Spencer, Mills, Rorty, & Werhane, 2000, p. 62). Therefore, the individual demand for health care has to be balanced against other societal demands (e.g. education spending or housing policy), as health care is not the only significant political section for a good population health (Powers & Faden, 2000). The problem of how to do this properly has filled the literature in recent years (Lorenzoni,

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Belloni, & Sassi, 2014; Powers & Faden, 2000; Quentin, Scheller-Kreinsen, Blümel, Geissler, & Busse, 2013).

During the past decades it became apparent that hospitals, even in Western countries, are increasingly struggling with the allocation of scarce resources (Davies & Harrison, 2003). A hospital management will try to either increase earnings or reduce costs by rationalisation and rationing measures (Marckmann, 2007). Earnings can be raised by increasing the number of procedures (e.g. surgical procedures) or by installing new centres or departments. Costs can be reduced by optimising patients' pathways, restructuring measures, outsourcing, or other rationalising measures. Costs can also be lowered by cutting down on staff or a reduction in salaries. Thus, on the administrative level, limited resources influence pending strategic considerations.

Whatever decision is taken by the management, the available resources have to be allocated – "justly allocated" according to the overwhelming majority of hospital staff, "efficiently" according to the hospital management or "according to need" as expressed by patients. It is quite obvious that medical and nursing performance, economic effectiveness and medical need conflict with each other when the allocation of available resources entails a range of very different issues such as fixed budgets for diagnostics, treatments, patient care and buildings, treatment facilities (especially intensive care beds and operating theatres), as well as time for care, talking and training.

Hospitals are under "market pressure", they are restructured, and consolidation processes occur. The former charity-orientated hospitals have been transformed into businesses to a large extent, increasingly subsumed under the keyword "health care industry" (Daniels et al., 1996, pp. 101-102; Spencer et al., 2000, p. 62). In Germany, the development from fee-for-service to diagnosis-related groups (drg) has caused a dramatic change in the internal financing structures. In the United Kingdom (UK), the opening of an internal market in the National Health Service (NHS) drove hospital managers to introduce strategic measures and plans (Davies & Harrison, 2003). Thus, hospitals have to set financial goals and balance them against other goals (e.g. clinical efficacy, quality, sustainability). Multidimensional goals have to be selected, judged and evaluated. All this requires an excellent internal accounting system to create the relevant data for the generation of financial indicators and patient pathways for cost calculations, as well as quality management of patient pathways (Fleßa, Laslo, & Marshall, 2011).

A crucial aspect of a fair allocation in hospitals is the close cooperation of physicians and hospital managers. However, this cooperation often seems difficult in many respects. This chapter, firstly, intends to analyse the professional background of physicians and hospital executives. Secondly, it points out possible reasons why conflicts arise. Thirdly, it reflects criteria and structures which could support coping decently with allocation conflicts in hospitals. This chapter focuses on traditional hospitals and uses the word "organisation" for a legally organised group of people working together towards a common goal (Emanuel, 2000). It will use the terms "hospital executives", "health care executives" and "hospital managers" interchangeably for persons of different educational backgrounds who are responsible for the administration and running of a hospital.

BACKGROUND

The main challenge for hospitals seems to be allocating its resources in a way that is widely accepted both internally and externally. This implies a good and close cooperation of the health care executives with the hospital's clinical staff, especially with physicians. Studies tell the opposite (Forbes, Hallier, & Kelly, 2004; MacIntosh, Beech, & Martin, 2012; Taylor & Benton, 2008;