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Improving Ethical Decision Making in Health Care Leadership

Paul Bruning[1]* and Timothy Baghurst[2]

[1]*Summit Orthopedics, United States*
[2]*Oklahoma State University*

Abstract

Purpose: The purpose of this article discussion is to describe the application of ethical decision-making and the three primary relationships within health care leadership. Healthcare change occurs rapidly and increases tension and mistrust between payers, providers, and patients. Application of ethical standards to decision-making and change decreases healthcare cost and improves trust in change processes.

Approach: Health care challenges occur among three primary relationships. These relationships include the patient and provider, patient and payer, and provider and payer. A plethora of leadership models exist with regard to leading change; however, these models do not consider that leaders are not always concerned with the ethical decision-making process. Evaluation of the ethical principles, healthcare relationships, and recent healthcare changes found in the Patient Protection and Affordable Care Act guide the article's discussion.

Findings: Application of ethical principles to transformational leadership improves healthcare relationships and alleviates stress and tension produced by change. Healthcare leaders have an expectation to provide ethical considerations during change management and the decision-making process which influences the various relationships found in healthcare.

Value: Healthcare leaders are in the unique position to improve healthcare using ethical principles. Because health care reform requires ethical decision-making from leaders, the application of ethical principles to the various relationships health care leader's influence creates fundamental and successful change in health care.

A major concern for health care leadership is the increasingly tenuous relationship between the primary stakeholders within the system that include patients, providers, and payers. Decreased trust between stakeholders changes the very culture of interactions and communication which in turn leads to a relationship breakdown between the stakeholders [1-3]. Movement toward patient-centered care allows physicians to act as a "fact provider" in the physician-patient relationship which permits patient autonomy and self-determinism [3]. Consumer-driven health care requires increased participation from patients regarding care decisions; this requires access to understandable information that directly compares options [4]. Unfortunately, patients do not always have adequate and transparent information on costs or quality of care to make ethical and appropriate decisions regarding health care [5,6]. Thus, they must rely on others to ethically select the best options with respect to care and cost.

Health care leaders perform an essential role in the success or failure of relationships between the various stakeholders. Ethics integrates features required to promote positive relationships. Voges [7] described five principles involved with health care leadership decision-making. Beneficence is the first principle, and can be considered as the obligation of benefiting staff, patients, organization, and community. Health care leaders' decisions must advance stakeholders' various positions and promote population health. Decisions must meet the second principle of non-maleficence, the responsibility to bring no harm to patients, staff, organization, or community. Poor economic decisions lead to potential loss for health care organizations including service lines or even failure of the organization. These decisions require obligation to stakeholders of the particular organization. Either patients of the organization, providers, or other community members suffer when poor economic decisions are made and organizations fail.

Respect for individuals and their autonomy is the third principle of ethical decision-making for leaders. Ethical dilemmas occur between providers, payers, and patients. As a result, tension occurs as conflicting priorities transpire around individual decisions regarding patient care and autonomy. This challenge occurs as patients expect certain treatment options that payers do not want to provide payment for or providers do not feel are warranted.

The fourth principle of justice requires that leaders provide fair and unbiased concern when making decisions. One of the primary roles of health care leaders is to promote the organization and improve function and margin. Decisions that negatively influence the organization decrease the organization's ability to continue meeting its mission. Development of sustainable relationships among the stakeholders improves the probability of success.

The previous four principles are combined into providing for a maximal competence in decision-making or the fifth principle of utility. Health care leaders have a responsibility to the community in which the organization functions. A poor relationship between the various stakeholders threatens the organization's ability to remain functional. Organizations that fail negatively influence and harm the community to which the organization means to serve. Leaders that understand and work to improve the three primary relationships improve the community.

This article reviews the three stakeholder relationships that occur in health care, and discusses some of the ethical issues that strain those relationships. Payers are the organizations which provide payment for services rendered. These payers may include government, primary

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insurance, and work compensation payer organizations. Providers are the individuals or organizations that provide various components of care or work to improve individual health. Patients are the individuals seeking care for various illness, injuries, or detriments to wellbeing. Leaders who identify and understand these ethical dilemmas are empowered to positively influence the relationships among these primary stakeholders and improve the healthcare system. Northouse [8] explained that promotion of a collaborative climate requires expected standards of excellence; these standards of excellence require ethical decision-making.

Leadership Role in the Health Care Relationship Triad

Leaders must understand the three primary relationships in health care to determine what changes can be made to improve the effectiveness of these relationships. The following sections contain a guide to the leadership role in the various relationships. The three relationships considered within the model are patient–provider, patient–payer, and provider–payer. Leadership influences these various roles and participates in helping direct the challenge of introducing and leading change.

Patient Physician Relationship

As patient and physician relationships become increasingly strained, patients grow increasingly suspicious of providers [1-3]. Leadership in health care must work to engage ethical decision-making in the patient and physician relationship. The application of ethical decision-making improves working relationship and trust for both the patient and physician. Physicians provide facts in patient-centered care permitting shared decision-making between patient and provider [3]. Patients must trust providers to offer the best options for care without influence of economic benefit for the provider. However, without trust patients are less-confident that decisions made are in their best interest. Balint and Wayne [9] identified six principles that influence patient and physician relationships that include the "Basic Fault…Apostolic Function…Mutual Investment Company…Drug Doctor and Therapeutic Agents…Deeper Diagnosis…and Conspiracy of Anonymity". These principles explain how patients react to life experiences and how these experiences define individuals. Because communication influences understanding and cooperation increases trust between both parties, physicians must monitor their interaction with patients to avoid a false sense of security. This false sense may cause potential harm to patients because alternative treatments are not offered. Thus, to alleviate this concern the provider must understand and listen to the patient's life circumstances. A failure to do so may limit how much the patient's concerns are considered in the decision making process.

Leadership influences and improves relationships when a mutual relationship of the provider and patient occurs. Portman [2] indicates that patient physician interactions are consensual and not obligatory. Both parties have a responsibility to the relationship and must be willing to negotiate during conflict. The patient and physician may both benefit from improving their interaction and relationship. Managing this relationship requires ethical decision-making based on core competencies and characteristics of the leader.

Payer Patient Relationship

Challenges to the prayer and patient relationship occur because insurance companies profit from collecting premiums and not paying health care costs. Patients who obtain insurance desire benefit from premiums through access to effective health care. Although premiums decrease the sense of health care cost, they also create a culture of entitlement to health care [10]. Several processes and problems occur that increase the challenges of health care leadership with respect to payers and patients. Two of those challenges include moral hazard and insurance companies creaming or skimming patient populations. First, moral hazard results when insurance insulates a patient from health care costs. This process of moral hazard increases the volume of services sought. Refusing treatment or insurance coverage of patients with illness potentially increases costs above premium or contracted payment and introduces the concept of dumping. Removing the pre-existence or denial of health care insurance coverage within the Affordable Care Act of 2010 has proved popular within the United States. This provision eliminates payer ability to deny coverage or for dumping to occur.

Another challenge for leadership in the patient and payer relationship comes from the payers creaming or skimping on coverage. Creaming occurs as payers seek healthy patients who demand fewer services than premium cost paid. Providing less quality of care for a condition during a specified length of time is skimping. These actions increase tensions between payers and patients, but occur commonly, and aid in increasing the profit-margin within the insurance industry.

Leadership within health care can improve this patient – payer relationship by providing patients with adequate and transparent information on costs or quality [2,3]. Challenges occur when costs vary based on health care provider. Currently prices are negotiated between providers and payers and are based on market leverage rather than outcomes or true value of service provided [11]. However, ethical decision-making applied to leadership characteristics can improve the relationship of patient and payer when appropriately addressed.

Payer Provider Relationship

Health care leaders function on both sides of the provider and payer process creating an opportunity to reduce health care costs and more efficiently control resources. The decisions of a physician can shape the quality, quantity, and costs associated with the health care system [12]. Unfortunately a physician's decisions in this regard are often based on market trends while the decisions and practices of the provider generally adopt a "follow the pack" mentality [12]. Thus, peers play a vital role in influencing practice which contradicts the evidence-based practice preferred by payers.

Many factors influence the health care industry's reimbursement of healthcare providers. For example, reimbursement rates for physicians are calculated using complex formulas including elements such as physician time, skill required, and intensity of work [2]. Various payer calculations are used to determine payments to providers. Diagnosis-related groups provide payment levels based on diagnosis, surgery, patient age, discharge destination, and patient sex. Other payment schemes include ambulatory payment categories, resource-based relative value scale, and resource utilization groups. Fee-for-service payments provide conflict to the provider and payer relationship. Franzini et al. [13] suggested that the current system of reimbursement creates a culture of money where some providers overuse more profitable services. This system of various payments occurs through numerous agreements including per diem rates, capitation, and fee-for-service adding complexity and conflicting incentives to provider [4,11].

The Massachusetts attorney general conducted a study on price differences paid by insurers to providers and found that, compared

to the lowest-paid physician group, the highest paid physician group received 145% more for the same procedure [11]. This imperfect free market increases the complexity of the health care system and provides avenues for unethical behavior and practices. Multiple payers create different requirements for reimbursement [14] and it is therefore unsurprising that administrative costs in health care contribute significantly to the United States health care spending [15]. Aggregate costs for administration in health care that include documentation, coding, billing, and dealing with multiple insurance payers exceeded 31% of total health care costs in the United States [15,16]. Blanchfield et al. [15] estimated that a typical 10 physician practice accrues administrative costs exceeding $250,000 per year.

Challenges to health care leadership come from reducing the variation in payments and payers. Health care leadership is challenged through contracting payment plans through multiple payers nullifying any chance for clear and transparent cost of care comparisons. Individual payers are able to pay different rates for the same services depending on contracts arranged with providers. This pricing variance interferes with the three relationships defined within this article. Further challenges come from helping providers accept evidence-based medicine that potentially decreases reimbursement but also cost to the system. Health care market forces stray considerably from ethical free market economics. Price transparency does not exist, individuals often do not have the ability to choose when seeking care or treatment, and individuals most often do not bear the full cost of accessing the health care system. Vladeck and Rice [6] stated that health care reimbursement and economics does not provide an ethical market as providers, even those with virtuous intentions, may guide patients in the wrong direction caused by incentives within a fee-for-service payment structure. The creation of a model constructed to address this issue by fostering ethical decision-making based on solid leadership characteristics has the potential to improve the health care system.

Ethical Decisions

Health care leaders encounter ethical situations concerning resource limitations, quality of care, cost-effectiveness, efficiencies, and organizational need to produce profit margins [17,18]. Further ethical dilemmas in health care occur when leadership must balance employee and patient rights [18]. The present health care dilemma increases ethical challenges for leadership [18,19], yet it is evident that leadership within health care requires guidance on ethical decision-making.

Ethical Reasoning within the Patient Protection and Affordable Care Act (PPACA)

According to Lachman [19], several issues are addressed through ethical justifications in the Patient Protection and Affordable Care Act of 2010. The lack of distributive justice is a primary validator of the need for change in the relationship of the patient and payer [19]. The U.S. Census Bureau identified over 46.3 million uninsured individuals in the United States. Thus, the decision to require insurance coverage proves challenging ethically, as the expense could cause significant harm to financially struggling individuals. Individuals invariably require health care services, and the Emergency Treatment and Labor Act of 1986 prohibit hospitals from denying care based on inability to pay or lack of insurance. This uninsured care costs approximately $100 billion annually [19], and hospitals face challenges from uncompensated care and the need to generate revenue to provide care for other individuals. Unfortunately, this dilemma causes cost shifting and increased charges for those individuals with health insurance which results in

an approximate $1,000 annual premium increase for individuals with insurance [19]. Requiring affordable health insurance, as described in the PPACA, promotes the ethical concepts of beneficence and non-maleficence whereby individuals are required to obtain health insurance to reduce cost shifting [19]. This coverage proves affordable when purchased through health care exchanges.

A growing ethical dilemma in health care results from a high resource demand system with an increasingly aging population. Hosseini [17] raised the ethical dilemma of age-based rationing of health care services. Individuals over the age of 65 consume four times the per capita cost of health care as those under the age of 65. Lachman [19] described that 30 percent of Medicare dollars are spent during the last year of life and half of those funds are spent in the last 60 days of life. Younger individuals are cheaper to insure and require limited resources from the health care system. The elderly use a disproportionately larger apportion of health care resources. These resources tend to include more complicated and expensive technologies and treatments [17]. This places an ethical burden on health care leaders to make decisions that support, promote, and transform change.

National policy and reform within health care are driven by ethics. Senator Kennedy, in his last letter to President Obama regarding health care reform stated that "what we face is above all a moral issue: at stake are not just the details of policy, but the fundamental principles of social justice and the character of our country" [20]. The challenge for leadership is because ethics overlaps with regulations, law, and compliance but these are not the same or equal.

Ethical Decision Making in Health Care Economics

Health care market forces stray considerably from ethical free market economics. Vladeck and Rice [6] suggest that health care reimbursement and economics does not provide an ethical market as providers, even those with virtuous intentions, may guide patients in the wrong direction due to incentives within a fee-for-service payment structure. This system of various payment schemes through numerous agreements including per diem rates, capitation, and fee-for-service adds complexity and conflicting incentives to providers [4,11]. For example, Franzini et al. [13] reported that Medicare spending in McAllen, Texas was 86% higher than in El Paso, Texas. At the same time Blue Cross patients in McAllen, Texas cost 7% less to cover than patients in El Paso, Texas. Franzini et al. [13] indicated that the current system of reimbursement creates a culture of money where some providers overuse more profitable services. According to Kaufman, the system of incentives causes potential challenges to the behavior of providers. The Massachusetts attorney general's study noted that, "instead prices reflect the relative market leverage of health insurers and healthcare providers".

Health care leaders must apply the concepts of ethical decision-making when confronted with the questions of economic influences. The complexity of reimbursement and the various revenue streams create distrust in relationships. Further complicating the relationships are the reality that the combinations of moral hazard and entitlement insulate individuals from costs of health care. This causes individuals to have difficulty appreciating the value and price of health care until needed.

Practical Steps to Improve Ethical Decision Making in Health Care

Health care change continues to move forward at an exponential

rate with no indication of slowing. The new road to success in an environment of instantaneous access to information requires organizational ability to adapt [21]. Former models of organizational administration, gathered from the manufacturing system, do not apply neatly to the complex atmosphere of individual patients. Humans are much more complex than automobiles or stereo systems. Individual patients have comorbidities, experiences, and complex emotions that influence the interactions. Providers and payers have different visions, goals, and experiences that further complicate the very nature of the relationships. One only needs to look at various health care policies, which are put in place to improve the system, that result in downstream problems and potential crisis. Leaders must understand these complex relationships and provide ethical principles to decisions made regarding the relationships within health care.

Trusting Relationships

Dye and Garman [22] argued that "developing trust is vital for highly effective leadership; in many ways, it is the glue that holds work groups and organizations together". Earning trust requires remaining accessible, continuing authenticity, and modeling of behaviors expected [21,22]. These characteristics help develop trust from staff and other stakeholders. Building trust in the relationships provides framework for change. This trust advances the ability to provide visions and goals each of the three relationships can believe.

Trust also builds with focus on similarities, shared principles, common vision and goals, and clear benefits from collaboration [20]. Physicians desire autonomy in decisions and take pride in their offerings of patient care. Patients want to improve their health status and have some level of decision-making within their own care process. Payers desire to decrease the cost of care while providing the insured with access to evidence-based medicine. While on the surface there is a common goal of improving the individual's health there is a great deal of mistrust between the stakeholders. Health care leaders have the ability to improve this trust with the use of evidence-based and ethical decision-making.

Common Vision

While a common vision seems implied within health care the various stakeholders' goals create differences in perceptions of how to reach the common vision. Physician's desire for autonomy regarding treatment decisions may be at odds with a payers desire to reduce the cost of care. Payer's rationale to deny coverage of a controversial medication may be at odds with a patient's desire to use the medication to fight their ailment. Patient's emotional state or asymmetric information creates conflict within the relationship of patient and provider.

Health care leaders must provide the common vision of these relationships and define these shared visions based on ethical standards and principles. Without appropriate modeling of ethical behaviors vision and values are lost. Providers, patients, and payers that do not display behaviors consistent with the common vision threaten the relationships. The challenge for stakeholders comes from forgetting the past and failures of ethical behaviors and moving forward to build and model the common vision.

Cooperation

Health care leaders must identify, describe, and reinforce the benefits of collaboration between the various health care relationships. This includes clarification of the ethical standards around decisions. Decisions based on ethical principles increase collaboration and help develop understanding of the consequences of failure to collaborate. When providers collaborate with patients on care decisions the similarities and differences of opinion are able to be discussed and understood from each perspective. Focusing on the similarities helps develop shared decisions and mutual respect. These processes improve the outcomes of care.

Conclusion

Health care leaders must have the courage to act and act ethically. Decisions are complex and influence the various relationships in health care. Atchison and Bujak [21] wrote, "Healthcare leaders today understand that the complexity of change issues demands courage to stay on the right course. Any systematic change process will offend at least one constituency. Courage in its simplest form is the capacity to act. Talking, analyzing, and processing are all good only if they lead to action".

Basing decisions on ethical process helps progress the three most common relationships in health care. Leaders using ethical decision-making are able to defend and hold strong to how these decisions influence the relationships of patient, physician, and payer. Ethical decision-making encourages leader's ability to act and improve health care decisions and relationships.

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