Resource Allocation in The Healthcare Sector

An aid for ethical decision-making

CATHOLIC HEALTH ASSOCIATION OF CANADA
ASSOCIATION CATHOLIQUE CANADIENNE DE LA SANTÉ
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An aid for ethical decision-making
Research and design: James Roche

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Catholic Health Association of Canada
1247 Kilborn Place
Ottawa, Ontario
K1H 6K9

Tel. (613) 731-7148
Fax. (613) 731-7797
E-mail: chac@web.net
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WHY THIS WORKBOOK?

BACKGROUND

In November 1994 and 1995, the Catholic Health Association of Canada (CHAC) held Ethics Symposia devoted to the theme of resource allocation in the healthcare sector.

Symposia participants suggested that the CHAC could assist members by preparing a resource booklet that would provide information and criteria for use when addressing ethical issues related to healthcare resource allocation.

This booklet represents our response to this recommendation.

OBJECTIVES

- To deepen our understanding of the factors influencing resource allocation in the healthcare sector.
- To present criteria for evaluating methods of allocating healthcare resources based on Catholic social thought and ethical traditions.
- To provide case studies and a decision-making model.
We begin with an overview of the stresses and pressures influencing the movement to limit or ration healthcare services and to limit resources directed to the healthcare sector. The content of this section has been developed primarily from *Sustainable Health Care for Canada*, a Queen’s-University of Ottawa Economic Projects publication.

Section two presents eight criteria, based on Catholic social values, which can be applied as standards against which proposals for healthcare rationing can be measured. These criteria are presented in *With Justice For All? — The Ethics of Healthcare Rationing*, published by the Catholic Health Association of the United States.

These eight criteria were drafted for the purpose of appraising specific government proposals to ration healthcare (macro level issues). We believe, however, that they are applicable at the regional and municipal levels as well, and can be of assistance when making allocation decisions involving individual patients/clients and healthcare providers.
Section three presents a number of case studies developed by the National Forum on Health and entitled *Stories of Choice.* Three scenarios are presented which deal with decision-making at the macro, meso and micro levels. Each case is followed by a series of questions which aim to clarify the issues and challenges encountered in the three stories.

A decision-making tool is presented in the final section of the workbook. It was developed by Kevin G. Murphy, Director of St. Joseph's College Ethics Centre, University of Alberta, Edmonton. The tool aids in the analysis of an ethical dilemma by bringing greater clarity and understanding to the decision-making process. This analysis helps the user to identify the structure of the conflicting values and interests in an ethical dilemma.
**INTRODUCTION**

The future of our healthcare system is on the minds of many Canadians today. News of hospital closures, uncertainty about the future of Medicare, and debate over the advantages and disadvantages of a two-tiered health system have all had a prominent place in the Canadian media in recent months.

Over 70 per cent of healthcare expenditures in Canada are financed from public funds, with the remainder coming from such private sources as insurance premiums and out-of-pocket funds.

There are those who argue that Canada's healthcare system is underfunded. Others say there are sufficient resources within the system, and that what is needed is better management and distribution of existing resources.

The efforts of the federal and provincial governments to balance budgets and to address growing public debts through spending cuts is also beginning to dramatically affect the level of resource allocation to the healthcare system. As a result, many fear that what is in store is serious rationing — a downward redefining of needs — in order to meet the political goal of saving money.
Healthcare reform and the redistribution of existing resources are also fueled by questions about the link between healthcare and health status. For decades the emphasis in health has been on improving healthcare systems; an effort that has called for the allocation of a large portion of society's wealth and energy to institutional healthcare facilities and programs. Current research challenges this focus on institutional healthcare by illustrating that the major determinants of health lie elsewhere.

In a recent discussion paper entitled *The Public and Private Financing of Canada's Health System*\(^\text{4}\), the National Forum on Health concludes that, as a result of this combination of health reform and fiscal restraint, rationing is now a fact of life. The question "is not whether the supply of health services is rationed or limited, but whether the limits are reasonable, affordable, ethical and able to meet the health care needs of the population, and whether the criteria that determine access are appropriate."

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![Pie chart showing where health dollars came from, 1993](chart1.png)

![Pie chart showing where the money went](chart2.png)

*Source: Health Canada, as reported in the Globe & Mail, Aug. 21, 1994.*
PRESSURES INFLUENCING RESOURCE ALLOCATION IN THE HEALTHCARE SECTOR

The National Forum on Health suggests that the continued success of Canada's healthcare systems will depend, in large part, "on how governments respond to the extraordinary pressures and tensions that are now setting in."

The figure below illustrates the points of tension resulting from the various pressures at work within the healthcare system. The traditional way of relieving these tensions has been to increase funding. The message being presented to Canadians, from a number of fronts, is that this option is no longer available and, as a result, new ways of addressing these pressures have to be found.

Healthcare System Pressures

Financial Pressures

Beginning in the late 1950s comprehensive healthcare financing shifted from the private sector to the public sector. By 1970 warnings began to be heard that, if the growth rate of health and education expenditures of the mid 1960s were to continue, all of Canada's GNP could be consumed by these two sectors by the end of this century.

While healthcare expenditures did stabilize in the early 1970s, warnings about the rapidly rising levels of expenditures and costs were soon heard again, primarily from economic advisory groups and councils. As a result of the national price and wage controls established between 1976 and 1978, Canada was able to bring healthcare costs under control.

Costs have been a central issue again since the 1980s. Today, all governments are facing deficit and debt problems. While inflation may be under control, slower revenue growth and increasing debt mean added pressure on the healthcare sector, largely in the form of cutbacks to many health services.

Federal healthcare funding

1977: Federal government was funding 50 per cent of healthcare in the country.

1980-81: Federal spending on healthcare was $6.8 billion. Three years later, it had jumped to $9.5 billion.

1984: When the Conservatives came to power, the federal government was paying 31 per cent of the national healthcare bill.

1989 to 1992: Federal contribution toward the healthcare tab inched up, from $14.1 billion to $14.6 billion.

1990: Tories freeze healthcare transfers to the provinces until the end of 1995. In 1991, the federal share of the tab slips to 24 per cent.

1994: Federal government provides $16 billion in healthcare funding to the provinces.

February 1995: Liberal Finance Minister Paul Martin brings down budget, announcing that federal government would transfer $26.9 billion to the provinces in 1996-97 for education, welfare and health. That will decline to $25.1 billion the following year.

Source: Ottawa Citizen, March 12, 1995
**Knowledge Pressures**

The issues raised within this category of pressures can be summarized in two questions:

- What impact does the healthcare system have on the health status of the population?
- What is the most cost-effective way to allocate healthcare dollars?

In the healthcare field, the lack of appropriate health outcome measures makes decision-making very difficult. Furthermore, little information is available about how alternative methods of healthcare delivery (e.g., outpatient services, complimentary treatment, community-based services) can be integrated with existing services.

**Regulatory Pressures**

Efforts to control overall healthcare expenditures have given rise to regulatory tensions within the system. There are mechanisms to regulate funding, insurance, the degree of centralized management, and budgetary allocations among regions and groups of healthcare providers.

The challenge in restructuring the system is to find a way to regulate and, at the same time, to balance efficiency, equity and freedom of choice.
**ETHICAL PRESSURES**

Limited resources and the need to make choices also creates ethical pressures. *Sustainable Health Care* suggests that in deciding fair outcomes in the distribution of healthcare resources, the main criteria are need, equality, utility, liberty, and restitution. The implementation of such principles is a complex task. "If people should have equal access to a minimum of healthcare, how does one determine which these should be. What is essential, what is medically necessary?"

Concerning the process by which such allocation decisions are made, procedural principles of justice are highlighted: these include the transparency of decisions, authority, consultation, and the rights of stakeholders.

**THE CITIZEN**

Canadian citizens are at the centre of these pressures. They are directly involved in healthcare as taxpayers, as voters, and as patients. Through their taxes, Canadians, who pay for about three-quarters of the cost of providing healthcare services, legitimately ask: "Are we getting value for the money?" At the same time, as patients, Canadians want quality healthcare to be available and accessible.
The real question for Canadians is not whether the supply is limited (rationed), but whether the limits are reasonable, affordable, ethical and able to meet the healthcare needs of the population.

*The Public Financing of Canada's Health System*

**RATIONING HEALTHCARE RESOURCES**

This combination of financial, knowledge, regulatory and ethical pressures is pushing policy-makers to consider various practices and proposals to ration healthcare resources. The Catholic Health Association of the United States defines *rationing* as:

> the withholding of potentially beneficial services because policies and practices establish limits on the resources available for healthcare.

We have chosen this definition because it clearly identifies what is problematic about the notion of rationing, that is, the possibility that people will be harmed by the denial of services. In addition, the definition is broad enough to cover direct as well as less intentional forms of rationing.

Attempts to deny people access to potentially beneficial services suggest a need for a set of ethical criteria by which proposed forms of healthcare rationing can be evaluated. Before examining the criteria suggested in *With Justice for All*, we will review the Catholic social values that direct the formulation of ethical criteria. Those values are:

- Human dignity
- The common good
- Preferential option for the poor
- Responsible stewardship
CATHOLIC SOCIAL VALUES

HUMAN DIGNITY

The basic principle underlying ethics is respect for the dignity of each human person. This principle has become enshrined in law as the fundamental basis of all codes of individual human rights. This dignity is based on the spiritual uniqueness of being a person.

In Catholic healthcare, differences of age, race, religion, social and cultural background, intelligence, economic status, employment or other qualitative distinctions do not take away the fundamental dignity shared by all.

THE COMMON GOOD

Throughout the scriptures, the earth is presented as God's gift for present and future generations of humanity. The resources of the earth are to be developed to serve the needs of all people for a more fully human life. The common good is that ideal situation in a society where all persons have equitable access to the balance of basic human goods necessary for the growth and flourishing of individuals, groups, and society as a whole. These goods include: education, shelter, work, transportation, healthcare, domestic and international security, art and recreation, and a healthy environment.
The needs and rights of the poor, the marginalized, and the oppressed are given special attention in God's plan for creation. In his ministry, Jesus identified with the poor and the outcast. He also took a critical attitude towards the accumulation of wealth and power that comes through the exploitation of others. This has become known as a preferential option for the poor. It does not mean mere hand-outs for the poor. It calls for an equitable distribution of wealth and power.

**Responsible Stewardship**

As subjects of creation, we are called to be responsible stewards of the natural and social resources in the socio-economic order. This requires the just use of resources at all levels of human endeavor.

Jack Glaser, of the Centre for Healthcare Ethics in Orange, California, commenting on the behaviour of North Americans, suggests that we seem to be unwilling to accept limits regarding healthcare. He believes this attitude is contrary to responsible stewardship. "A grounding assumption of Catholic tradition is that health care, like all other areas of life, must live within severe limits — it will always leave much good undone."
ETHICAL CRITERIA FOR RATIONING HEALTHCARE RESOURCES

1. The Need for Healthcare Rationing Must Be Demonstrable

Because healthcare rationing can threaten the health of individuals, it requires strong ethical justification. The setting of limits to healthcare resources itself implies value judgements. Governments must be able to demonstrate the validity of their proposals to ration.

All steps must be taken to ensure that the resources directed to the healthcare sector are used as efficiently as possible. Government also has an obligation to raise sufficient resources through taxation to provide a basic level of healthcare for all.

2. Healthcare Rationing Must Be Oriented to the Common Good

Healthcare is a social good belonging to all citizens. The healthcare system must be directed toward the common good.

The development of modern medical technology should not blind us to the fundamental fact that we must come to terms with limitation. We cannot attempt to satisfy every healthcare need to the disregard of rapidly rising costs.

An ethically acceptable rationing scheme may require, for example, limiting access to very expensive treatments that serve only a few in order to expand the availability of more basic services to all.
3. A Basic Level of Healthcare Must Be Available to All

Justice demands that any public policy initiative for rationing should ensure at least a basic level of healthcare for everyone as a fundamental right.

What core services should be included in a basic package is a question currently attracting much attention in this country. A basic level of healthcare must include services that are "sufficiently comprehensive to promote good health, to provide adequate treatment for persons with disease or disability, and to care for persons who are chronically ill or dying".

4. Rationing Should Apply to All

The danger of healthcare rationing is that those most likely to be denied healthcare will be those who are most in need. It is also probable that the decision to withhold this healthcare will be made by the relatively affluent.

Healthcare rationing must promote and not undermine the sense of solidarity that makes the realization of human dignity possible. When it applies to all, rationing can be the occasion for sharing a common hardship rather than an occasion for deepening the gaps between wealthy and poor, old and young, healthy and sick, and among racial groups.
5. **Rationing Must Result From an Open, Participatory Process**

The healthcare system affects all of us, and everyone must have a say concerning changes that are to be made to that system. All individuals in a community should have a way to participate in a process that distributes the burdens of rationing.

People who are at the margins of society lack the political power to participate in decisions that will have a significant impact on their lives. If they cannot be empowered to participate, advocates will be required to bring their perspective to discussions.

6. **The Healthcare of Disadvantaged Persons Has an Ethical Priority**

Any rationing proposal must be evaluated according to its impact on the lives of the poor and the disadvantaged. Given the life-threatening conditions in which the powerless and vulnerable are forced to live, their claims on the healthcare system are ethically more compelling, not less.
7. **Rationing Must Be Free of Wrongful Discrimination**

Neither the process of rationing nor its outcomes should embody any wrongful discrimination based on age, gender, race, religion, national origin, education, place of residency, sexual orientation, ability to pay, or presumed social worth.

Rationing of healthcare services must be based on a public commitment to respect the human dignity of every person.

8. **The Social and Economic Effects of Healthcare Rationing Must be Monitored**

A policy to ration healthcare will have the foreseen and intended consequence of withholding needed healthcare services from some people. Even the best-intentioned public policy initiatives can have unacceptable and unexpected consequences. The nature and extent of the harmful effects created by such decisions must be closely monitored.

Rationing should not be allowed to impair the relationship of trust between healthcare provider and patient. Patients/residents must be able to trust that the healthcare providers recognize a professional obligation to put the interests of the patient/resident first, even if some forms of medical intervention must be withheld.
In this discussion, a value is defined as something which is held to be very important because of its worth, desirability and utility. It usually can be named in a single word (such as freedom, efficiency, courage, comfort or fidelity).

Criteria give expression to values and provide a standard by which something can be judged or decided. Applying criteria such as those provided in this workbook is a complex task. Some criteria may have more priority in one situation than another. It is not always easy to determine what level of agreement should be required before endorsing a proposal.

**Questions for Reflection**

1. This paper describes four pressures that are influencing resource allocation decisions. Are these factors relevant to your particular situation? Are there other pressures/tensions that could be added?

2. Eight criteria for evaluating forms of healthcare rationing are presented in the paper. Do you agree with these criteria? Are there other criteria that should be added?

3. How would you apply these criteria to institutional and clinical situations?

4. What criteria are now being used in making rationing decisions in your institution/region/province?
CASE STUDIES

Making Allocation Decisions at the Regional Level (macro level)

After waiting 3 weeks for an appointment, Mr. S., a 55 year old independent truck driver, met with a heart specialist, who advised him he needed coronary bypass surgery. Unfortunately, it would take up to 10 weeks. Mr. S. was told that his angina was stable and not immediately life-threatening, but serious all the same. For his safety, and the safety of others, the specialist said he should not return to work, and that she would review his fitness to work following the surgery.

Mr. S. complained that being laid up would bring him financial ruin. The doctor listened carefully and sympathetically, but responded that there was nothing she could do. Dejected by the news, Mr. S. pulled some strings with an old friend and got a meeting with a specialist in another major city. That specialist said he could get him in for surgery in about two weeks.

Mr. S. was pleased about this, but curious about the reason for the difference in waiting lists between the two cities. He investigated, and discovered that 5 years ago the Regional Board for the city in which he lives decided to spend more money on prevention, and consequently to spend less on acute care. The Regional Board in the other city, however, considered and rejected this option, and decided instead to ensure that programmes like the coronary bypass programme were well funded.

According to a recent newspaper article, the prevention programme has been very successful, and the incidence of heart disease in Mr. S.'s region has decreased by 5 per cent, and is a full 10 per cent lower than in the region to which he travelled for the bypass. “Maybe the Board in my region made the right decision,” he remarked to his wife, “but I'm sure glad I won't have to suffer its negative consequences.”
Macro Allocation — Questions

1. Given the information above, which Board do you think made the right decision, and why?

2. How would you rank the various criteria listed below for prioritizing people in a waiting list for a medical service? Are there any that you feel should definitely not be used, and why?
   - medical urgency
   - benefit to the individual
   - benefit to society
   - age
   - lifestyle factors
   - first come, first served

3. Would it be appropriate to treat Mr. S. before others on the grounds that his economic livelihood is at stake?

4. Suppose there were a private clinic where Mr. S. could get quicker treatment:
   a) Are private clinics delivering more timely health services to those able to pay for them inconsistent with the principle of equal access?
   b) Is it unfair if people with money can get more timely or higher quality healthcare than people who have to rely on the public system?

5. How is healthcare different from other services in our society that are bought and sold in the marketplace? What, if anything, is so special about healthcare?

6. How do the eight ethical criteria introduced earlier in the text apply in this situation?
Allocating Resources in a Healthcare Facility (meso level)

The Summergreen Patient Care Organization services the primary care needs of a large urban population. In revising its mission statement, it hosted a panel discussion featuring its administrator, a nurse practitioner, and a patient.

Patient: If I am sick, I want the best healthcare possible. Cost shouldn’t be a factor. I think others here would say the same.

Administrator: I think you’re right, and that’s where the problem lies. All of us would want the best care possible, especially if we don’t have to pay for it. But if in every case you get your “money is-no object” healthcare, the next patient in need of treatment after you might find his or her options limited because you were treated as if money were no object. And is that fair?

Nurse Practitioner: The fairness question highlights a basic conflict between the perspective of the administrator and that of the individual patient. The administrator’s job is to make sure resources are used to maximum effect so there’s enough to go around and everyone gets a fair share.

Patient: And what do you think as a healthcare provider? Are you prepared to limit our options in order to achieve fairness?

Nurse Practitioner: Neither I nor your doctor should limit your options. You can trust healthcare professionals to provide the best care they can. However, that doesn’t mean that your options shouldn’t or won’t be limited by policy decisions taken previously based on costs and fairness.

Administrator: Let me add that all of us have a stake in making these policy decisions and ensuring that resources are distributed fairly.
Meso Allocation — Questions

1. Do you agree that the “money-is-no-object” perspective of the individual patient may be unfair and unwise from the perspective of fairness to the group? How can these two perspectives be reconciled?

2. Do you agree that in some instances it may be necessary to limit the options available to an individual in order to ensure that resources are shared fairly among all patients?

3. Do you believe your caregiver should always do everything possible to benefit you as an individual, regardless of the cost of doing so, and even if doing so means that you will be using up resources that otherwise could create an even greater benefit for others?

4. If money could be saved and used to good purpose, and quality of care preserved, would it bother you if, in place of seeing a physician for your health problems, you were directed to a nurse practitioner, who would refer you to a physician only if necessary?

5. Some people claim we have become too reliant on government, and that our families and communities have become less giving because of this. How would you respond to this claim?

6. Which of the eight ethical criteria are most applicable in this situation?
Doctor-Patient Decisions (micro level)

"It's hard to say at this time how serious the heart attack was," the younger doctor said. "I think she'll be fine with the streptokinase." Let's hope so," the older doctor replied. "I'm happy with the new guideline. If this happened a week ago, we would have used TPA, and I would have felt better about that."

The doctors must not have realized that the woman in the elevator with them was the daughter of the 62 year old woman they were talking about. Mary L. had eavesdropped intently on their conversation, but hesitated to identify herself and ask the questions that were burning in her mind. She had decided to return to the floor and ask the nurse. The answers she received troubled her.

The nurse explained that there are currently two drugs available for treating heart attacks; streptokinase and r-TPA. R-TPA is slightly more effective in severe heart attacks. Some research shows that it saves about 1 additional life for every 100 uses. However, the cost difference between the two drugs is very great. Whereas streptokinase costs $460.00 per dose, r-TPA costs $2,500 per dose, more than 5 times as much.

The nurse explained that, given budget constraints, the hospital pharmacy had recently examined its policy on this issue. A compromise was reached that the hospital would carry the more expensive drug, but that doctors would only use it when they thought the heart attack was severe. That was probably the guideline that Mary heard the doctors talking about, the nurse figured.

Mary went back to her mother's room. She was a strong woman, Mary thought. She'll be home and back out in her beloved garden in no time. Still, it troubled her to think that her mother might not have received the best treatment possible.
Micro Allocation — Questions

1. Suppose the money saved from this guideline could be used to achieve greater benefit (save more lives) in the hospital by being allocated in other ways. Do you think it is acceptable to use the cheaper but slightly less effective drug? Why?

2. Suppose that the money saved by using the cheaper drug was enough to fund a nurse to offer low-income families prenatal care in their homes, and that more lives could be saved by such a programme than by always using the more expensive drug. If you had to choose between these options, which would you choose, and why?

3. Should we always do what is best for the individual patient, regardless of costs, or should we try to ensure that scarce healthcare dollars are used to produce as much benefit as possible?

4. Do you feel that the doctors have compromised their professional ethic by using the arguably second-best treatment?

5. If a physician is aware of a treatment that would be more beneficial for you than any he or she is able to offer, is he or she obliged to disclose this information to you?

6. Should physicians ever be put in a position where they are required to do anything less than what they believe is in the best interests of their patients?
Introduction:

The complexity of value conflicts within an ethical dilemma often overwhelms those with the responsibility of decision-making. This reflective tool has two purposes. First, it aids in the analysis of a specific ethical dilemma by identifying the structure of values and perspectives implicated. This analysis can be accomplished through a self or group reflective process. Once the value structure is clarified, the decision-maker can clearly articulate which values to prioritize in working toward a solution.

Second, the continual use of this tool as a type of journal allows the user to identify the recurrent types of dilemmas faced as well as the recurrent approach adopted by the user and/or organization in addressing ethical dilemmas. Identifying these recurrent patterns allows the user to better prepare for and evaluate the dilemmas they consistently face.

Explanation:

The first THREE steps of the reflective tool are an ANALYSIS of the dilemma. Each step aids the user in clarifying conflicts within the dilemma. The next FOUR steps are a combination of DECISIONS and IMAGINATION which form a resolution to the dilemma. The reflective tool is NOT a “recipe” which automatically gives the user “the solution”. It is a reflective decision-making process wherein the user integrates their experience, perception and judgement. The solution created includes an awareness of the values upon which those judgements and decisions are founded.

1. Key Considerations of Case History

You face an ethical dilemma or value conflict which needs to be addressed and resolved. In this first step, the key background elements of the “story” are explored. This involves a presentation of the case. List the elements of the conflict which need to be taken into consideration when forming a solution.
2. Players Involved and Interests/Values Implicated

- Within this grid the user identifies, in the top horizontal row of squares, the major players involved within the dilemma (For example: self (user), organization, patient, board member, etc.).

- Within the far left vertical column of squares the values or interests implicated within the dilemma can be identified (For example: justice, autonomy, trust, fiscal responsibility, the common good of the organization). These values identify what is at stake in the dilemma.

- The user will checkmark within the central squares which values, interests or concerns are implicated for the players or stakeholders in the dilemma. One value (say autonomy) may be an interest of the self or the patient but not, for example, the organization or the board.

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Reflective Tool for Decision-Making

3. Identification of Dilemma

Using the **structure** identified in step two, the user in step three will articulate the foundational or "root" value conflict which best describes the dilemma. For example: an administrator must decide on whether to allow the use of the mailing list (compromising confidentiality) or not allow the use of the mailing list (compromising potential benefit of affordable insurance to patient).

4. Orientation of the Solution — Players and Values Prioritized

In step three the user identified the foundational value conflict creating the dilemma. In step four the user will choose which perspective and values will be prioritized in their attempt to address and resolve this dilemma. It may be their own perspective, or they may be acting on behalf of the organization or the patient. Whatever the case, their solution is proceeding from a certain standpoint and it is important to be aware of this priority, bias or perspective. This step asks the user to identify the perspective they will take and to explain their decision.

5. Identification of Alternatives and Their Implications

In step five the user seeks realistic, alternative solutions by integrating their experience, perception and judgement with imagination. The creation of three alternatives is developed from the analysis of the first three steps and the decision taken in the fourth step. The question asked within this step is: "What are the alternatives for resolving the dilemma identified (step 3) from the chosen perspective (step 4)?".

Alternative 1: ________________________________________

Alternative 2: ________________________________________
Alternative 3: 

6. Identification of Values Within Alternatives

Step six attempts an analysis of the alternatives created in step five. In the left vertical column are listed the values identified in step three. Reflection on the three alternatives (step 5) may have identified additional values which can also be included within this column. These specific values are to be checked as to whether they are Supported, Violated or not applicable NA within each of the three alternatives. This grid allows you to see how the various values identified can be addressed within the three alternatives. This provides you with some criteria as to whether a potential alternative solution will address the values identified in step four.

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</tbody>
</table>
7. Manner of Implementing Chosen Solution

Within step seven the user articulates the chosen, potential solution. Although you now have a chosen solution, it is not yet realized. It is potentially realizable. How the solution is implemented can have considerable ramifications on whether the solution will be realized. The user identifies the important issues that need to be considered when attempting to implement the chosen alternative or resolution to the dilemma.

8. Evaluation of Solution and Overall Approach to Dilemma

Within step eight the user states their evaluation of the implementation of their chosen alternative. It is only through a review of this implementation and its outcomes that successes and mistakes can be identified and learned from. A review will highlight whether the solution has been adequate and will not have to be dealt with again in two weeks or two months time.

SUMMARY OF REFLECTIVE METHOD

The reflective method attempts to address three types of questions:

1. What is at conflict within this particular case or dilemma?

2. What are the recurrent ethical patterns:
   - within my approach to work dilemmas?
   - within my work dilemmas themselves?
   - within the structure of this organization?

3. What type of approach and solution best addresses the consistent dilemmas that arise?
REFERENCES & BIBLIOGRAPHY
REFERENCES


BIBLIOGRAPHY


