

## SECTION II

# GUIDING ETHICAL DECISION MAKING

A significant problem with applied administrative and biomedical ethics is that numerous written and unwritten factors influence management behavior. These factors are a blend of intellect, experience, education, and relationships. The common result is a too-often ill-defined personal code of conduct. A poorly defined personal ethic combined with tolerance for varying views may cause managers to believe that there is no one best answer to questions of administrative and biomedical ethics. Lacking a well-defined personal ethic, managers have no lodestar to guide them as they seek to answer the basic question of normative ethics, “What ought I to do?” The mind-set of a personal ethic helps them to filter out vague, contradictory guidance, and to lead and shape rather than being led and shaped.

Key to a defined, robust personal ethic is self-analysis and introspection. Questions such as “Who am I?,” “What is my bottom line?,” and “For how long, if ever, will I tolerate certain behaviors?” must be asked by managers who wish to understand and hone their personal ethic. Plato asserted that the unexamined life is not worth living. This is also true of a personal ethic.

Managers of health services organizations are ex officio community leaders. This prominence raises for managers (and more generally the profession) questions of the demarcation between private and professional lives. Private conduct that breaches the profession’s code of ethics and the culture of the organization may result in disciplinary action. Beyond the tension between managers’ private and professional lives is that between a manager’s personal ethic and the organization’s philosophy. The philosophy and mission of the organization guide development and implementation of policies, procedures, and rules. An important issue for individuals and organizations is the need for congruence between the organization’s philosophy and the manager’s personal ethic.

Chapters 3 and 4 suggest development and content of an organizational philosophy and examine its importance in the delivery of services. Codes of ethics and their role in guiding health services managers and helping them develop a personal ethic are examined. The dynamic between the organization’s philosophy and the manager’s personal code is analyzed as well.

Assistance for managers and organizations in solving ethical problems is discussed in Chapter 5. Specialized committees that focus on different categories of ethical problems and other assistance are suggested. As leader and moral agent, the manager acts to prevent, identify, and solve ethical problems.

## CHAPTER 3

# DEVELOPING ORGANIZATIONAL VALUES, VISION, AND MISSION

**M**anagers confront a variety of moral and symbolic issues in health services organizations. This chapter focuses on the organization's need to identify and adopt values and principles—a philosophy. It is within the context of this philosophy that a vision and a mission are developed. The vision statement presents the goals the organization seeks to achieve. The mission statement describes its specific activities. Defining the philosophy prospectively minimizes conflicts among competing values. The sequence of philosophy–vision–mission is the theoretical ideal. The reality is that more likely the mission is defined first or that it evolves from historical activity in the context of an implicit, rather than explicit, philosophy. The concept of “visioning” in health services organizations was first used in the 1980s and continues to the present. It is the rare health services organization that does not have a framed copy of its values, vision, and mission hanging in the lobby. This chapter describes the importance of identifying the moral values and principles that provide a context for the vision and mission statements and the necessity of reflecting these values across the organization.

Mission (and vision) is necessarily limited by, and is a function of, the physical location, size, resources, and other aspects of the organization's internal and external environments. These factors can usually be affected only over time. A significant change in them requires review of the mission, many of whose elements directly relate to the moral values and principles identified by the organization's governance and management. The decision of a nongovernmental acute care hospital not to perform abortions, for example, is derived from a determination that such services are incompatible with its moral values and principles. Offering abortion services raises other questions, the answers to which must be consistent with the organization's position on abortion. For example, is performing abortions compatible with legally required efforts to provide medically indicated treatment to live aborted fetuses? Some organizations avoid these questions and the attendant ethical implications by simply adhering to the law—they offer all legal services. This equates legality and morality. Such an approach only partially solves the problem, however, because the law is poorly developed in a number of areas in which administrative and biomedical ethical problems arise.

Although a governing body may adopt a statement of philosophy with certain values and principles, this is no indication that the staff agrees. Generally, staff in organizations pay limited attention to such matters; the health services field is no exception. Many staff may not know the organization's philosophy, despite reasonable efforts to communicate it. Even if the philosophy is understood, many members make no commitment to it. If little attention is paid to the organization's stated moral values and principles (philosophy), it is not surprising that even less attention is paid to what should have been said but was not. For such staff, the organization is but a place to work. They do their work and are unconcerned about what the

governing body and senior management say is the context for or the goals of service delivery. Absent significant discontinuity—when even sabotage is possible—it is rare for staff to overtly challenge what is being done. If challenged, the results tend to be negative rather than positive in outcome and effect.

Consideration must be given to how much more effective the organization could be were it built on a clearly understood system of shared values and goals. Adequately communicated to and accepted by staff, a resource-supported goal as simple as “getting the caring back into curing” could reap rewards for the organization through improved efficiency and patient care and relations. Moving staff in the same direction—a direction known in advance and recognized as important in the organization—will positively affect staff attitude, productivity, and effectiveness.

## **DEVELOPING AN ORGANIZATIONAL PHILOSOPHY**

The starting point for an organization to prevent and, if necessary, solve ethical problems is its philosophy. The statement of philosophy identifies values and principles reflecting the moral right and wrong for the organization, thus distinguishing the acceptable from the unacceptable. It is helpful if the philosophy statement is sufficiently precise that performance in achieving it can be measured. At minimum, the statement of philosophy must be consistent with the law.

The statement of philosophy is different from the mission statement and should be developed separately. The philosophy statement provides a context for the mission statement; the mission statement is subordinate to it. Some organizations include references to values in their mission statements. A mission statement that “the corporation owns and operates hospitals to provide care for the sick and injured” provides no information about the moral context of care. A mission statement that “the hospital provides care for the sick and injured in the context of humanitarian principles” is imprecise but provides a clearer values or moral context than the first.

Health services organizations with no specific, written philosophy nonetheless have an identifiable de facto or operational philosophy. The aggregate decisions and actions taken by the governing body and management reflect implicit, if ill-defined, philosophical bases. Management actions may be contradictory or inconsistent, and this suggests another negative aspect of not determining prospectively a comprehensive organizational philosophy. This lack of continuity and consistency will lead to incompatible, even contradictory, policies, procedures, and rules. The effect is diminished efficiency. Equally important is that the mixed, even contradictory messages that staff members receive will confuse and frustrate them, with a resulting decline in patient focus and quality.

The importance of identified and shared values in organizations is now widely understood, if less frequently operationalized. In the early 1980s, however, it was a new concept, one that was synthesized by Peters and Waterman in their study of successful American corporations.<sup>1</sup> The quote attributed to IBM’s former president Thomas J. Watson, Jr., is instructive: “The basic philosophy of an organization has far more to do with its achievements than do technological or economic resources, organizational structure, innovation, and timing.” That statement’s context was the focus on customer service so important to IBM’s reputation and

financial success at the time. If consumers and service are important to IBM, which has many characteristics of a products-based organization, consider the importance of customers and service in healthcare. The centrality of shared values is shown in [Figure 5](#), the 7-S Framework, developed by McKinsey & Company.

Deal and Kennedy<sup>2</sup> also identified the characteristics of successful companies:

- They stand for something—that is, they have a clear and explicit philosophy about how they aim to conduct their business.
- Management pays a great deal of attention to shaping and fine-tuning these values to conform to the economic and business environment of the company and to communicating them to the organization.
- These values are known and shared by all the people who work for the company—from the production worker right through to the ranks of senior management.

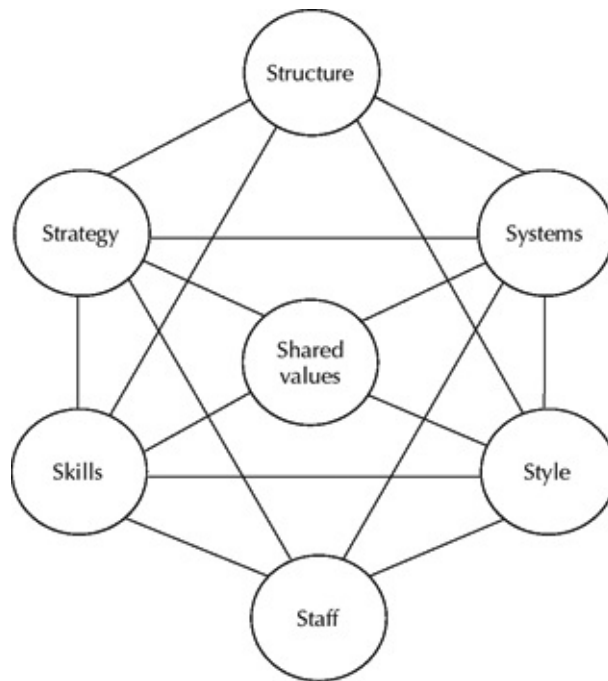
Building on the importance of shared values or philosophy that make up a culture, Deal and Kennedy<sup>3</sup> identified the essential elements of a culture: 1) understanding and fitting into the business environment—the single greatest influence in shaping a corporate culture, 2) values—the basic concepts and beliefs of an organization, 3) heroes who personify the culture’s values and are role models for employees, 4) rites and rituals that show employees the kind of behavior expected of them, 5) ceremonies that provide visible and potent examples of what the company stands for, and 6) the cultural network—the primary (but informal) means of communication within an organization that is the “carrier” of the corporate values and heroic mythology.

In further explaining corporate cultures, Kennedy<sup>4</sup> noted the following:

Culture isn’t a single thing. It’s not a budget; it’s not a plan; it’s not the shape of a building. It is an integrated pattern of all the things that go on in an organization on a day-to-day basis. Each company has its own unique culture, values, and standards communicated internally by style, dress, expectations, and assumptions.

New people in the workplace find out what is expected of them because their peers take them aside and say, “Look, don’t wear jeans here. Come in to work on time, or you do this or that.” They lay out some of the unwritten rules of behavior that are required for entrance into your workplace. That’s how culture transmits itself to each new generation of persons. They don’t come in and invent a whole new style of organization. They come in and learn from those around them what’s going on in the organization and how they are expected to behave.

An organization’s values are inextricably linked to its culture. To transform the organization so that its culture is a living reflection of values that facilitate the mission and vision, management must know which values are present in the culture. This presents somewhat of a chicken-and-egg situation. Regardless, management must biopsy the culture. This can be compared to a financial audit, except it is the organization’s values that are being audited. Direct measures such as observation, staff surveys, exit interviews of departing staff members, and focus groups can be used. Proxy measures of culture include patient satisfaction surveys and service area surveys. Regardless of how it is done, however, management cannot effectively transform the organization’s culture until its present content and course are known.



**Figure 5.** The McKinsey 7-S Framework. (From McKinsey & Company, Inc. Reprinted by permission.)

The barriers to establishing strong corporate cultures in any organization are a particular problem in health services organizations. For hospitals, barriers include:<sup>5</sup>

- Hospitals must serve diverse medical needs of heterogeneous populations.
- The number of external variables (forces outside the organization that affect it) is much greater for hospitals than it is in ordinary business enterprise.
- Hospital outcomes are difficult to define and to measure.
- It is difficult to nurture the keen proprietary sense of individual endeavors among leadership and management staff at all levels.
- Hospital board members are not active participants in its culture.
- Hospital physicians are a subculture, and peer acceptance and recognition, participation in professional activities, and stature based on professional contribution and expertise are more important than the rewards of belonging to a particular hospital.
- Elaborate peer reward systems in nursing are complicated by a deep search for professional identity.
- Support staff and especially allied medical personnel increasingly tend to have a professional identification independent of the hospital.
- Another special subculture in hospitals is the administrators, who are caught between the role of facilitating the delivery of medical care and that of running a cost-effective “business”; as a result, they often isolate themselves from other subcultures.

Beyond these factors, and implicit in them, is the need for managers to view their relationships with staff and patients in a consistent fashion. Paying lip service to the organization’s avowed goal of patient care but in fact focusing on economic or other nonpatient considerations is a contradiction that will not be lost on staff, who will respond to real incentives rather than platitudes. Not only must the decisions and actions of leaders be consistent with organizational



values, but staff must *perceive* that they are consistent, lest the leader be judged a hypocrite. If values and how they are understood evolve over time, managers must solicit feedback to identify any disconnect between what they are saying and what employees are hearing.<sup>6</sup>

Management must know and understand the culture and values in its organization. Just as important, management must know how the culture and values mesh with or diverge from those the organization wishes to develop. The organization can mold a culture, but it can move neither faster than nor in directions that are opposed to or misunderstood by internal stakeholders. This congruence is critical. The organization's philosophy and derivative vision and mission statements are the primary points of reference for its corporate culture and subordinated activities. All efforts to develop excellence are a function of these statements.

A logic is evident in the link between the strength of a culture and organizational performance. The first piece of logic is that of goal alignment—a strong culture causes staff to metaphorically march to the same drummer—the pheromone of the organization. Second, a strong culture aids in performance by creating an unusual level of motivation among staff—shared values and behaviors make staff feel good about working for an organization; the resulting commitment or loyalty makes them strive harder. Third, a strong culture aids in performance because it provides needed structure and controls without relying on a bureaucracy, which can diminish motivation and innovation.<sup>7</sup>

Closely linked to the concept of organizational philosophy and corporate culture is management's view of the organization's staff. McGregor's Theories X and Y, Maslow's hierarchy of needs, and the 14 points enumerated by W. Edwards Deming echo the importance of management's view of its employees, which is likely to be similar to how patients are viewed by a health services organization. Dysfunction is rife in an organization that treats employees as adversaries or as a means to an end and distrusts them while it urges staff to treat patients with dignity and respect. Employees see the hypocrisy and respond negatively. Peters and Waterman<sup>8</sup> sounded this theme, quoting Thomas J. Watson, Jr.: "IBM's philosophy is largely contained in three simple beliefs. I want to begin with what I think is the most important: our respect for the individual. This is a simple concept, but in IBM it occupies a major portion of management time."

## Culture as Pheromone

The values of an organization are reflected in its culture. If they are positive, these values will bind the organization together. The resulting congruence of values will enhance operational and mission effectiveness.

Insects communicate, attract, and repel using pheromones. Bees and ants are the best-known organized insect societies that use unique pheromones to perform many of the tasks needed to survive and thrive. Bees are probably the most widely studied and best understood of organized insect societies.

In many ways, the *api regina*, or queen bee, is the bee colony. She is the center of attention and has a retinue of attendant bees whose sole task is to feed, groom, and support her work. The queen is critical to the hive; only she can lay the eggs that enable the colony to survive and thrive. But the queen bee performs another essential task; she binds the colony into an

organized society. Each *api regina* emits a unique pheromone. This pheromone is spread throughout the hive by the movement of bees' wings. It allows the bees to recognize the queen and one another. Guard bees at the entrance to the hive recognize those attempting to enter by their scent and know that they belong to the hive. The bees that come from another hive to "rob" a hive's honey are driven away. When there is danger, the bees emit an alarm pheromone and the colony immediately acts to defend itself.

Worker bees newly emerged from the comb in which they develop from egg to larva to pupa perform nurse and housekeeping tasks for several days until they are strong enough to become field bees and forage for nectar. Young worker bees have very active wax glands. The liquid wax they secrete is used to build comb in the classic hexagonal shape. The queen lays her eggs in this comb. Other comb is used to store pollen, beebread, and the nectar that is processed into honey. When the honey is ready, the comb containing it is sealed with a wax cover. The natural antibacterial properties of honey allow it to be stored indefinitely.

Their tasks are instinctive; no control or direction is apparent. The average summer life expectancy of a worker bee is about 45 days. Thus, their development must occur in rapid order. When strong enough to fly, nurse and house bees become field bees who forage for nectar-producing flowers, bring the nectar to the hive in their honey stomachs, and add enzymes so that the minute amounts of nectar can be processed into the honey, which is food for the hive and so pleasing to human palates. In gathering nectar, bees pollinate the flowers of plants and trees that produce a wide variety of food for human consumption. About 30% of the U.S. food supply could not be produced without pollinating insects, especially the honeybee.

Of what relevance to the modern health services organization is the pheromone that binds a bee colony? Simply put, the organization's value system is a metaphor for the queen's pheromone. Health services organizations do not have an *api regina* (although some situations might suggest otherwise). But organizations do have a managerial hierarchy with similar characteristics. By their example, managers—especially those who are senior—exude a values pheromone. Those who work in the organization identify one another by their personal value systems—their personal ethic—and this ethic connects them with other staff and largely reflects the value system of the organization. A positive value system enables the organization (the colony) to thrive and produce the output that enables its success. In the case of honeybees, the honey will sustain the hive. In a health services organization, it is the delivery of patient care, for which the organization receives the revenue that enables it to thrive. A health services organization with high-quality services enjoys satisfied customers who return for treatment and recommend it to others.

## **Content of a Philosophy Statement**

**Organizational Content** The values and principles stated in an organization's philosophy establish a moral framework for its vision and mission. The philosophy provides a context and operative values—it gives delivery of health services a life, a meaning—and recognizes that these values are unique and represent more than delivering a product or rendering a service. Policies, procedures, and rules are derived from the mission statement and make the organization operational. The approaches taken by health services organizations are varied. Typically, those that are faith based have a greater focus on values and ethical principles. The

commitment to values and ethical principles is not, however, exclusive to faith-based organizations. The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) recognizes the importance of an ethics framework and identifies specific elements.<sup>9</sup>

Sutter Health is a large, West Coast health services system. Its values include honesty and integrity, excellence and quality, innovation, afford-ability, teamwork, compassion and caring, and community.<sup>10</sup> Its mission, vision, and values are reproduced in [Appendix A](#). These values reflect ethical principles and some of the virtues enunciated in [Chapter 1](#).

Trinity Health is a faith-based health services system that provides services across the continuum, from acute to long-term care and hospice. It has the classic trilogy of mission, vision, and values. Core values include respect, social justice, compassion, care of the poor and underserved, and excellence.<sup>11</sup> Trinity Health's mission, core values, and vision statement are reproduced in [Appendix A](#).

The George Washington University Medical Center includes a teaching hospital, schools of medicine, nursing, and public health, and a physician group practice. Its mission is teaching with creativity and dedication; healing with quality and compassion; and discovering with imagination and innovation. Its vision is to improve the health and well-being of our local, national, and global communities. The specific elements of the institution's vision appear in [Appendix A](#).<sup>12</sup>

MountainView Regional Medical Center is a mid-sized hospital in Las Cruces, New Mexico. Its mission identifies a caring environment, its healthcare team, and service excellence. Stated values include safety, compassion, teamwork, and efficiency.<sup>13</sup> The MountainView mission and values statements are reproduced in [Appendix A](#).

Mayo Clinic is a large, multi-specialty group practice that operates hospitals and a medical school, conducts research, and engages in postgraduate medical education. Its primary value is "The needs of the patient come first." Core principles include practice, education, research, mutual respect, commitment to quality, work atmosphere, societal commitment, and finances.<sup>14</sup> Its mission, values, and principles are reproduced in [Appendix A](#).

Sunrise Senior Living is a nonsectarian for-profit organization that provides a gamut of services to seniors. Its core values include passion, joy in service, stewardship, respect, and trust.<sup>15</sup> Its mission, principles of service, and core values are reproduced in [Appendix A](#).

**Relationship with Patients** One cannot imagine a health services organization that does not identify its role vis-à-vis patients in the context of respect for persons, beneficence, nonmaleficence, and justice, as well as the virtues discussed in [Chapter 1](#). These values mandate delivery of medical services to patients with respect and in a manner that enhances human dignity. Staff members must know their responsibilities and duties toward patients in this regard. Patients are the reason why the organization exists, and all efforts are directed at meeting patient needs by safely delivering high-quality services.

Williams and Donnelly<sup>16</sup> asserted that accountability to the patient takes precedence over all other duties and relationships in health services organizations. They were pioneers when they had the temerity to assert that accountability to patients demanded that hospitals inform them if they had been harmed by medical misadventure. These views are mainstream today; in



fact, the expectation is even broader. The Joint Commission requires that organizations provide information about unanticipated outcomes of care, treatment, and services to patients. Its standards spell out how licensed independent practitioners (typically, these are physicians) or their designees are involved when unanticipated events occur.<sup>17</sup> This requirement continues to be controversial, if not as radical as in the 1980s. Informing patients and their families, as appropriate, of problems during treatment is the ethically (morally) right course. In addition, there is increasing evidence that informing patients and their families, as appropriate, about medical misadventures makes them less likely to seek legal redress because they believe the organization is being honest and that they are being treated fairly. However, this may not make believers of governing bodies, managers, and physicians. Intellectually, they may agree with the ethics of this degree of accountability, but many will react with measured skepticism because the legal system demands an adversarial approach. Apologies are being addressed in the states. In 2010, 12 states considered bills to make expressions of regret and the like inadmissible in court.<sup>18</sup> This issue receives further attention in [Chapter 8](#).

The economic hazards of implementing such a philosophy are significant, especially in organizations with a voluntary medical staff. Regrettably, the organization that becomes supportive of patients and disregards its physicians risks alienating the physicians, who provide its economic livelihood. The organization will likely have angry physicians. One answer to this seeming dilemma is to immerse physicians in the corporate culture, thus making its organizational philosophy and value system part of their perspective. Hence, physicians will see substandard clinical treatment as endangering the corporate culture and will work with the organization—to the ultimate benefit of the patient.

The view expressed by Williams and Donnelly, and now by The Joint Commission and several states, is consistent with the high degree of trust that the public places in health services organizations, and it is an appropriate measure of the duty organizations should meet in turn. The public has every right to expect that the organization and its managers will treat them with respect and dignity and will seek to right any wrongs. For many patients, this results in a changed relationship with the organization. Sometimes employee zealotry diminishes the perception of respect.

## **Last Chance**

As she was making one of her occasional rounds to patient floors, CEO Frances Long was surprised to see the director of development for River Bend Hospital, Mark Oxley, leaving the intensive care unit (ICU). Oxley has been responsible for development, including fund-raising, for almost four years. He is very effective and has increased donations from a few hundred thousand dollars per year to well over one million. In passing, Long spoke briefly to Oxley but wondered to herself, “What could he be doing in the ICU?”

Long remarked to the ICU nurse supervisor that she had been surprised to see Oxley there. The nurse supervisor told her that she knew Oxley because he came to the ICU regularly; he spoke to patients and their family about remembering River Bend in a bequest or other means of donating money or assets to the hospital. Long asked for more details and the nurse supervisor described some positive, but also some negative, events that involved Oxley and family members. The supervisor told Long that most ICU patients are too ill to talk to Long, and this meant that most conversations were with family members. One family member likened Oxley’s conversation with her terminally ill father as that of a vulture circling over a dying animal. Other family members were more positive; they were pleased with the care at River Bend and told Oxley that they would consider making a donation.

Soliciting donations in the ICU seemed tawdry to Long. River Bend always needed donations, but she wondered if Oxley’s behavior went beyond the bounds of ethical behavior. Certainly, it exceeded the bounds of good etiquette.

Oxley's behavior is not appropriate because it treats patients (and their families) as objects, not persons worthy of respect. Long must counsel Oxley that he should review the mission and values of River Bend Hospital—which should address the expectations in the situation described—and approach his tasks of fund-raising within that context. He must do so in a way that does not negatively affect patients and their families.

***Relationships with Staff*** Like patients, employed and nonemployed (typically physicians) staff are entitled to be treated with respect and loyalty. Staff are the organization's most important asset because, ultimately, they determine the manner in which services are delivered. Like patients, staff must not be treated as a means to an end. The ethical aspects of these relations are most apparent in the organization's policies. Examples include reasonable and equitable performance appraisals and evaluation standards known in advance and fairly applied; forthright efforts to eliminate capriciousness, arbitrariness, and prejudice in human resources decision making; due process in grievances and disciplinary proceedings; and determination of the attributes and capabilities required for each position and then matching staff with them.<sup>19</sup> These considerations of ethics in employee relations also evidence good management. Employees who believe that they work in an ethical environment are six times more likely to be loyal to their employer than those who believe their employer is unethical. Employees must have the organization's values communicated to them and see that the actions of management fit with those stated values.<sup>20</sup>

Employees are in an unequal position of power with the organization and supervisors: the employment relationship limits their freedom of action. Consequently, for example, a manager who borrows money from employees is unethical. Such an action jeopardizes management's credibility, but more important, it reflects a lack of respect for employees, who are being used as a means to an end. Employees are also used in such a manner if they must undertake high-risk activities (e.g., caring for patients with highly infectious diseases) with poorly developed procedures and processes or inadequate training, supplies, and equipment. This example is a rare instance in which the duty of beneficence toward the patient is superseded by the virtues of loyalty and justice to staff, and also by the principle of nonmaleficence, a decision supported by a utilitarian calculus.

Physicians are the economic lifeblood of health services organizations. In most instances, they are there at the organization's sufferance, as either employees or independent contractors. In either relationship, the presence of these high-profile professionals complicates the organization's interactions with patients and other staff. If, for example, quality of care issues arise, the organization must meet its obligations to protect patients and further their interests by intervening, as necessary, in the physician-patient relationship. The resulting political and economic problems likely to arise for governance and management mean that intervention occurs only reluctantly and less often than it should.

Employees and medical staff should participate in developing the organization's philosophy and its vision and mission statements. Increased congruence between the philosophies of organization and staff benefits all involved; most important, it benefits patients. Rapport between the organization and its staff is essential to developing a strong, positive corporate culture.

***Relationship with the Community*** In some geographic areas, community (service area) and patients (or potential patients) are synonymous. The organization's philosophy should specify its relationship to the community: What is its obligation to provide less-than-cost or free care to Medicaid patients or to those who cannot afford to pay? What is its obligation to provide controversial services such as abortion? Prospectively answering questions such as these causes the organization to consider important issues about itself and the role it can play. This probing assists in honing an organizational philosophy and provides an opportunity for introspection and staff involvement in establishing and strengthening a corporate culture.

### **Going the Extra Mile<sup>21</sup>**

The senior managers of a home health agency (HHA) serving five rural counties were indicted (and later convicted) of Medicare fraud. The HHA served more than 1,000 patients and had more than 225 employed staff and independent contractors. During initial criminal proceedings against the senior management, their further actions caused the HHA to go into bankruptcy. The payroll was weeks behind. By the end of the next 2-week pay period, the staff had not been paid for a month. Many were home health aides earning less than \$9.00 an hour. Most of the staff were parents.

A senior supervisor met with the staff and told them of the HHA's problems. As a group, they decided to continue caring for all the patients. Some managers loaned their staff money, even though it violated company policy. Within a few weeks, the bankruptcy judge released the payroll, and a semblance of normality returned. Continuity of patient care was maintained.

What a compelling case! The HHA staff had developed a strong culture of beneficence, nonmaleficence, loyalty, and honor—principles and virtues lacking among the corrupt senior management. Their actions reflect proudly on the highest traditions of the health services field. Loaning money to staff in violation of the company policy was morally justified, given the exigencies of the situation and the honorable purposes for which it was done. The staff and supervisor should be given kudos for their shared actions.

***Relationship with Other Institutions*** Revising the organizational philosophy is difficult but necessary as the external environment changes. The organization must deal forthrightly and honestly with other entities, even actual or potential competitors. This ethic fits with effective competition—it simply means the organization competes honestly, with no hint of fraud or deception. In the past, there were few incentives for health services organizations to cooperate, but significant changes in the delivery of health services and economic pressures will force them into networks or systems. Major differences in moral philosophies inhibit cooperative efforts, a problem that may be insurmountable when sectarian and nonsectarian organizations contemplate a merger or joint efforts.

## **DEVELOPING A MISSION STATEMENT**

Vision statements are aspirational and inspirational. As such, they sketch what the organization would like to become. They set a direction for the organization and broadly state its role and activities.

The mission statement is the applied portion of the vision statement. It operationalizes the means by which the vision is accomplished. The mission statement may originate in the articles of incorporation, the documents filed to establish the health services organization as a legal entity. The statement of objectives or the purposes for which the corporation was formed are useful in developing a mission statement. The need for the mission statement to be consistent

with and reflect the organization's philosophy has been amply described. A simple mission statement is that a community hospital association will:

- Establish, operate, and maintain a hospital
- Engage in educational activities related to treating the sick and injured
- Engage in health-promotion and disease-prevention activities
- Promote and perform scientific research related to care of the sick and injured
- Engage in other activities designed to promote the general health of the community

More elaborate are the objectives (mission statement) of Sterling County Hospital,<sup>22</sup> in which elements of an organizational philosophy are included:

- To recognize man's unique composition of body and soul and man's basic right to life. Sterling County's concept of total care, therefore, embraces the physical, emotional, spiritual, social, and economic needs of each patient
- To affirm that the primary objective of our health services is to relieve suffering and to promote and restore health in a Christian manner that demands competence, mercy, and respect
- To generate and cultivate a source of allied health manpower by orienting and supporting personnel development in the areas of individual skills, knowledge, and attitudes
- To participate in the development of health services that are relevant to the total community needs by meaningful area-wide and regional planning and in a partnership for health concept

These mission statements show what the two organizations seek to accomplish. An important distinction is that the first has no values context, nor are its activities linked to a larger value system. The second statement has a more philosophical context.

Organizations state their missions differently. A pediatric medical center states that it will serve any child, regardless of ability to pay. Such a mission statement incorporates the philosophy that treating the child is primary; economics are secondary. Sectarian health services organizations cite their religious creeds; nonsectarian organizations typically link their activities to humanitarian motives. The publicly owned Sterling County Hospital is unique by having a religious reference in its mission statement. Sample organizational philosophies and vision and mission statements are shown in [Appendix A](#).

## **RECONSIDERING THE ORGANIZATION'S PHILOSOPHY**

A competitive environment will significantly affect the way many health services organizations born of eleemosynary (charitable) motives view themselves. Competition and reports of large profits will change how others, especially patients and communities, view them. Aggressive competition is at variance with the philosophy and historical mission of many organizations that serve the sick and injured and do so from a sense of duty and charity rather than from a desire to establish new product lines, increase their market share, or maximize net income over expense. The organization that does not possess the stamina, resources, or mind-set to reconsider its philosophy and mission may become uneconomic and cease to exist.

Copyright © 2011. Health Professions Press, Inc. All rights reserved.

## An Acceptable New Image?

Sebastian Hospital was founded by a Christian congregation in 1891. Its philosophy and mission statements include a strong commitment to care for the sick and injured regardless of ability to pay. This mission posed no problems during its first 90 years. Even after the community purchased the hospital in 1950, it continued to function in much the same fashion. Sebastian successfully weathered a controversy about abortion in 1973. The compromise solution limited where in the hospital abortions would be performed and how staff would be assigned.

Increasing cost pressures during the 1970s and diagnosis-related groups in the early 1980s caused substantial financial problems. A switch to all-payer prospective payment, which would prohibit cost shifting, was imminent. In addition, there was pressure for corporate reorganization. Planning consultants first recommended enterprises such as a physician office building, a parking facility, and a motel. Some of these suggestions complemented the primary mission. The trustees saw other suggestions as tangential. Another new type of enterprise was proposed: a joint venture with members of the medical staff.

The administrator was concerned that Sebastian's 100-year focus would change dramatically. It was one thing to manage a facility competently but quite another to be razzle-dazzle entrepreneurs. Would the caring reputation that Sebastian had achieved so successfully disappear in a blaze of marketing efforts and joint ventures? The administrator wondered whether Sebastian was hopelessly out of step with its environment.

This case illustrates the dilemma confronting many not-for-profit hospitals. The same or similar problems affect most health services organizations in the sense that they must rapidly adapt to what seem to be revolutionary environmental changes. Interinstitutional competition is less problematic when a community has one of each type of institutional provider. Even in these cases, however, organizations are beginning to offer competing services. It is common that hospitals compete with their medical staff members as both offer highly remunerative outpatient ancillary and diagnostic services. The loss of revenue to hospitals may mean the difference between economic life and death. Such economic tensions diminish the ability of not-for-profit organizations to carry out their historic missions.

Initially viewed with disdain by managers because it conjured up images of individuals with questionable parentage selling unneeded services of little value, marketing has become an accepted, even necessary, part of health services delivery. The preference is still to focus on health promotion and disease/accident prevention and treatment, but marketing is the buzzword; organizations that fail to heed it risk their very survival.

Competition per se is not at variance with a charitable mission. The context has changed and the stakes have increased, but managers should view such changes as a challenge—an opportunity to do what they have been doing even more effectively. Successful corporate restructuring and effective marketing allow the organization to develop revenue streams that enable it to provide charitable services.

A more insidious problem, and one fraught with conflicts of interest, occurs in certain joint ventures between health services organizations, such as hospitals, and their medical staffs. Physicians who earn income by referring patients to providers in which they have an ownership interest or a profit-sharing arrangement have an ethical conflict of interest. States began to prohibit physician referral to such facilities or mandate disclosure to patients. Organized medicine took note of such conflicts of interest in 1985.<sup>23</sup> Since then, several federal laws have set limits on physician self-referral for federal program beneficiaries.

A different philosophical dilemma faced St. Joseph Hospital, which was established in 1870 and owned over its history by various orders of Catholic sisters. In 1971, it was sold to the Creighton Regional Health Care Corporation, a not-for-profit corporation with a lay governing body. It operated St. Joseph as a Roman Catholic teaching hospital for Creighton



University. In 1984, a contract was signed with American Medical International (AMI), a for-profit hospital system, under which AMI would acquire St. Joseph Hospital and operate it as a full-service Roman Catholic teaching hospital. Based on this transfer of ownership, the Catholic Health Association (CHA) terminated St. Joseph's membership because "the Hospital is not operated, supervised, or controlled by or in conjunction with the Roman Catholic Church in the United States."<sup>24</sup> The term *full-service* is operative here. The controversy surrounding the decision suggested that other important, unstated reasons were questions about the morality of the profit motive in health services and that other AMI hospitals performed abortions. Critics of CHA's action argued that a profit motive was compatible with St. Joseph's mission and that its bondholders were paid several million dollars of interest—an action indistinguishable from paying dividends to stockholders. St. Joseph continues to be unaffiliated with CHA.<sup>25</sup>

The case of St. Joseph Hospital is important because the CHA acted when a member hospital became incompatible with its philosophy and mission. Regardless of how one judges CHA, its decision was based on a specific philosophy—a crucial underpinning for any organization. The values issues arising from the merger of faith-based and nonsectarian health services organizations can be significant. This is especially true if there are limitations on types of medical services that can be provided (e.g., certain reproductive services in hospitals affiliated with the Roman Catholic Church). Put most starkly, the issue is whether the demands of non-adherents can trump the organization's philosophy (values). It is argued that in a pluralistic society, quasi-public organizations such as hospitals do not have the luxury of limiting services needed and demanded by the public. Providing such services, however, necessarily causes the organization to violate its values or its institutional moral agency—that which personal providers, such as physicians, would call conscience. When a change in ownership eliminates certain reproductive choices, the result is commonly finessed by establishing a freestanding center that has limited, if any, connection with the faith-based organization.

## UNDERSTANDING PATIENT BILLS OF RIGHTS

Patient bills of rights (PBOR) provide guidance about the appropriate ethical relationship between the patient and the organization and its staff. Titles vary, but PBOR have been published by such organizations as the American Hospital Association (AHA), The Joint Commission, the U.S. Department of Veterans Affairs (VA), and the American Civil Liberties Union (ACLU). In addition, health services organizations have developed their own statements. PBOR developed by private organizations reflect the law on confidentiality and consent, for example, but are not legally binding. Philosophical differences among the various PBOR are significant.

The AHA first adopted a PBOR in 1973.<sup>26</sup> In 2003, the AHA PBOR was replaced by a brochure titled "The Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities." This plain-language document informs patients about their rights and responsibilities during their hospital stay. There are sections on high-quality hospital care, a clean and safe environment, involvement in one's care, protection of one's privacy, preparing



the family for when the patient leaves the hospital, and helping with bill and insurance claims. Specific statements address knowing the identity of doctors, nurses, and other involved in one's care, including their training status; informing the patient if anything unexpected happens during hospitalization; consent; and information regarding power of attorney and advance directives. This statement is patient oriented; it has little institutional bias.<sup>27</sup>

The ACLU's PBOR<sup>28</sup> was drafted as a model law for the states to enact. A much more demanding set of patients' rights distinguishes it philosophically from the AHA's bill. The ACLU bill views the patient as an autonomous individual entitled to full involvement in the care process. For example, the bill mandates that each patient must have access to a 24-hour-per-day patient rights advocate, who may act on behalf of the patient and assert or protect the rights set out in the model bill. In addition, patients have a right to all the information in their medical records and a right to examine and copy them. The ACLU bill details the information to be provided when consent for treatment is obtained. The ACLU PBOR's expectations in protecting patient rights are unconventional, but its provisions are worth considering.

The Department of Veterans Affairs' "Patient and Nursing Home Resident Rights and Responsibilities"<sup>29</sup> and The Joint Commission's "Patient Rights"<sup>30</sup> lie philosophically between the AHA's and ACLU's PBOR. The VA's PBOR recognizes that some patients may have lengthy stays in nursing facilities or hospitals, and there are provisions on the right to wear one's own clothing, keep personal items, and refuse visitors. Specifically mentioned are choosing whether to participate in research, participating in treatment decisions, and, importantly, the right to be informed of all outcomes of care, including potential injuries. Advance directives are identified only by implication. In the 1990s, The Joint Commission standards included the patient's responsibility to cooperate with caregivers. For 2011, its standards emphasize patient rights that organizations are expected to perfect, such as informed consent; providing information about caregivers; patient wishes relating to end-of-life decisions; the duty to respect, protect, and promote patient rights; and a right to gain access to protective and advocacy services. Provisions address ethical issues in research and clinical trials. The Joint Commission's view of the organization's ethical obligation to patients is moving closer to the ACLU's.

Documents such as PBOR developed by health services organizations set an ethical tone for relationships with patients and serve as a nonformal source of law in a dispute. The usefulness of such documents is limited by the organization's willingness to adopt one already available or to develop its own, and, more important, to implement the PBOR by making its contents known to patients and monitoring processes that demonstrate its application.

PBOR statutes have been enacted in 23 states. All establish a grievance policy, four protect a private right of action, and one stipulates fines for violations.<sup>31</sup> PBOR that are state mandates change the dynamics considerably; complying with the law becomes the minimum level of performance. Further, these enactments may change the psychological relationships among patient, staff, and organization. This is not to say that there will less attention paid to the ethics of patients' rights, but that the PBOR enacted by statute may not reflect the values of the organization. Nonetheless, the ethical organization obeys the law.

## STRATEGIC MANAGEMENT

The organization's philosophy also affects strategic management (planning). The philosophy must be articulated if objectives are to be consistent and set appropriately. The organization's view of its social responsibility should be reflected in its organizational philosophy and vision and mission statements. Only then should strategic management occur.

An organization's philosophy, vision, and mission state the ideal—ends thought to be unattainable in their idealized version but progress toward which is believed possible.<sup>32</sup> The mission statement must be usable to measure performance, define the organization's business, be unique to the organization, and be relevant to all stakeholders, and it should be exciting, challenging, and inspiring. In contrast, the vision is a verbal picture of what the organization's stakeholders want it to be.<sup>33</sup> In this respect, perhaps the most difficult aspect of developing an organization's strategy is determining the balance between social responsibility and economic performance.<sup>34</sup> The perspective that the health services organization is a social enterprise with an economic dimension may no longer apply; in fact, the external environment may have caused the obverse to be true. Resolving this dilemma and the resulting problems will be increasingly difficult. Although the governing body is primarily responsible for developing a philosophy as well as vision and mission statements, senior management prepares and operationalizes the strategic plan. All participants must ensure that there is consistency between the organization's philosophy and its specific policies, procedures, and rules.

## **ACHIEVING CONGRUENCE OF PHILOSOPHIES**

Several questions should be asked about the relationship between the manager's personal ethic and the organization's philosophy: To what extent must organizational philosophy and the personal ethic of a manager mesh? If the organization is to be a community of shared values, must all managers be in full agreement with the philosophy? As a class, are managers sufficiently professional to be effective in an organization when they may not agree fully with its values? What degree of congruence is needed? A literal interpretation of Deal and Kennedy's work suggests that philosophical divergence is to be discouraged; all values must be shared by all employees, including managers.

Some sectarian health services organizations require that managers at mid-level and above be adherents to the religion of the sponsoring group. Apparently, they judge their philosophy and mission so unique that only coreligionists can effectively manage their organizations. Some moral philosophies are unique, but this requirement seems largely unsupportable. If this policy also breeds conformity and diminishes innovation, it becomes counterproductive.

The organization's interview and preemployment processes should explain its philosophy and determine the applicant's personal ethic about health services and their delivery. This information permits both parties to judge their philosophical congruence, which should occur whether or not the applicant is a coreligionist, because even those of the same faith often have divergent views. Similarly, nonsectarian organizations may not want to employ individuals whose ethic constrains them from participating in services such as electroconvulsive therapy. In such cases, this information can and should be known prospectively.

It is key that persons may reach the same conclusions about an organization's activities and its relationship with patients using a moral philosophy independent of the organization's

religious doctrine. These managers would be as effective in achieving the same goals as others in the organization because they share the same values and the same philosophy. The ultimate measure is the congruence between the organization's philosophy and the results of a manager's decision making, although there are other indications. Someone claiming to be morally neutral is potentially the most inimical to an organization seeking to implement a philosophy and strengthen its corporate culture.

## CONCLUSION

This chapter examined the importance of a philosophy, or values, in determining and guiding an organization's vision and mission. From them are derived policies and procedures, the stuff from which the abstract and sometimes elusive aspects of an organization are operationalized. Developing a strong corporate culture is the result of shared values. Shared values are crucial in easing discontinuity and achieving corporate effectiveness. However, individuals who disagree must be willing to speak out, and it is problematic if the organization becomes an environment of "group think," which leads to a dangerous level of peer-enforced conformity.

A variety of sources assists in developing an organization's philosophy, including religious affiliation/orientation and humanist/humanitarian motives. Employee and patient bills of rights are also important. Whatever sources an organization uses, the principles of respect for persons, beneficence, nonmaleficence, and justice, as well as complementary virtues, are essential.

## NOTES

1. Thomas J. Peters & Robert H. Waterman, Jr. (1982, reissued 1997). *In search of excellence: Lessons from America's best-run companies* (p. 15). New York: Macmillan Library Reference.
2. Terrence E. Deal & Allan A. Kennedy. (1982, reissued in paperback 2000). *Corporate cultures: The rites and rituals of corporate life* (p. 22). New York: Perseus Books Group.
3. *Ibid.*, pp. 13–15.
4. Allan A. Kennedy. (1985, October). Corporate values/corporate culture. In *Excellence in management: Lessons learned from other industries* (pp. 5–7). Report from a special conference for the American College of Hospital Administrators Fellows.
5. Terrence E. Deal, Allan A. Kennedy, & Arthur H. Spiegel, III. (1983, January/ February). How to create an outstanding hospital culture. *Hospital Forum* 27, pp. 21–28, 33–34.
6. Amy C. Edmondson & Sandra E. Cha. (2002, November). When company values backfire. *Harvard Business Review* 80(11), pp. 18–19.
7. John P. Kotter & James L. Heskett. (1992). *Corporate culture and performance* (p. 18). New York: The Free Press.
8. Peters & Waterman, pp. 15–16.
9. Joint Commission Resources. (2011). *Ethics framework*. Retrieved January 3, 2001, from <http://www.jcrinc.com/Chapter-1-Defining-Main-Components/Developing-and-Implementing-an-Ethical-Infras/Ethics-Framework/>.
10. Sutter Health. (n.d.). *Our commitment*. Retrieved November 1, 2010, from <http://www.sutterhealth.org/about/comben/commitment/index.html>.
11. Trinity Health. (n.d.). *Mission, values, vision*. Retrieved November 1, 2010, from <http://www.trinity-health.org/AboutUs/MissionValuesVision/index.html>.
12. George Washington University Medical Center. (n.d.). *Our mission*. Retrieved January 5, 2011, from <http://www.gwumc.edu/about/ourmission>.
13. MountainView Regional Medical Center. (n.d.). *Mission and values*. Retrieved January 6, 2011, from <http://www.mountainviewregional.com/About/Pages/Mission%20and%20Vision.aspx>.
14. Mayo Clinic. (n.d.). *Mayo Clinic mission and values*. Retrieved November 1, 2010, from <http://www.mayoclinic.org/about/missionvalues.html>.
15. Sunrise Senior Living. (n.d.). *Mission, principles of service and core values*. Retrieved November 1, 2010, from <http://www.sunriseseniorliving.com/the-sunrise-difference/principles-and-values.aspx>.

16. Kenneth J. Williams & Paul R. Donnelly. (1982). *Medical care quality and the public trust*. Santa Monica, CA: Bonus Books.
17. Joint Commission on Accreditation of Healthcare Organizations. (2004). Ethics, rights, and responsibilities. In *Accreditation manual for hospitals*. Oakbrook Terrace, IL: Author.
18. National Conference of State Legislatures. (2010). *Medical professionals apologies 2010 legislation*. Retrieved January 3, 2011, from <http://www.ncsl.org/?tabid=21347>.
19. Bonnie J. Gray & Robert K. Landrum. (1983, July/September). Difficulties with being ethical. *Business* 33, pp. 28–33.
20. Study: Ethical climate closely linked to employee commitment. (2000, August 18). *ACHE-news*.
21. This case was developed from an incident related to the author by Dorothy H. Mitchell, RN, MSHA, Brunswick, Georgia, May 2003.
22. Ed D. Roach & Bobby G. Bizzell. (1990). Sterling County Hospital. In Jonathon S. Rakich, Beaufort B. Longest, Jr., & Kurt Darr (Eds.), *Cases in health services management* (2nd ed., p. 144). Baltimore: Health Professions Press.
23. Editorial. (1985, September). Dealing with conflicts of interest. *New England Journal of Medicine* 313, pp. 749–751.
24. Richard L. O'Brien & Michael J. Haller. (1985, July). Investor-owned or nonprofit? *New England Journal of Medicine* 313, pp. 198–201.
25. Information on the Catholic Hospital Association available at <http://www.chausa.org/home/>, and on the Creighton University Medical Center at <http://www.creightonhospital.com/en-us/aboutus/pages/default.aspx> (retrieved December 16, 2010).
26. American Hospital Association. (1992, October 21). *A patient's bill of rights*. Retrieved November 18, 2003, from <http://www.hospitalconnect.com/aha/about/pbillofrights.html>.
27. American Hospital Association. (n.d.). *The patient care partnership: Understanding expectations, rights, and responsibilities*. Retrieved March 12, 2011, from <http://www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html>.
28. George J. Annas. (2004). *The rights of patients: The authoritative ACLU guide to the rights of patients*, 3rd ed. New York: New York University Press, pp. 14–16.
29. U.S. Department of Veterans Affairs. (2006). *Patient and nursing home resident rights and responsibilities*. Retrieved January 5, 2011, from <http://www.patientadvocate.va.gov/rights.asp>.
30. The Joint Commission on Accreditation of Healthcare Organizations. *Patient rights*. Retrieved January 4, 2011, from <http://e-dition.jcinc.com/Browse.aspx?P=2&C=53&Seq=11>.
31. Michael K. Paasche-Orlow, Dan M. Jacob, Mark Hochhauser, & Ruth M. Parker. (2008). National survey of patients' bill of rights statues. *Journal of General Internal Medicine* 24(4), pp. 489–494. The authors note that average U.S. adults read at an 8th-grade level, yet PBOR usually require advanced college reading. This raises a crucial aspect of effectively implementing PBORs.
32. Russell L. Ackoff. (1981). *Creating the corporate future*. New York: John Wiley & Sons.
33. Russell L. Ackoff. (1999). *Re-creating the corporation: A design of organizations for the 21st century* (pp. 83–84, 87). New York: Oxford University Press.
34. James Webber. (1982, April 1). Planning. *Hospitals* 56, pp. 69–70.

## CHAPTER 4

# CODES OF ETHICS IN HEALTH SERVICES

Many factors influence human behavior and interaction. Among the most basic are those arising from the individual's legal relationships with society—those increasingly pervasive laws, ordinances, regulations, and court decisions. Other formal sources of law, such as the bylaws of a corporation, apply only to a specific entity. The link between formal sources of law and ethics was described in the Introduction. In addition, there are nonformal sources of law, such as standards of justice, public policies, moral convictions, customary laws, and notions of individual equity. Both formal and nonformal sources of law are used by health services organizations. Codes of ethics adopted by professional associations are important because they state goals and aspirations, guide members, and serve as a reference point to discipline those who deviate from the norm.

In 1978, the U.S. Congress created the Office of Government Ethics (OGE) in the executive branch to prevent conflicts of interest on the part of government employees and to resolve those that occur.<sup>1</sup> The law requires financial disclosure and restricts activities after leaving government service, accepting gifts from outside sources, and “extracurricular” earned income, honoraria, and employment. Remote or inconsequential financial interests are not thought to affect integrity and are therefore exempt. OGE's primary source of information is the employee's annual financial disclosure statement. Similarly, states provide ethical and legal guidance for their employees.<sup>2</sup>

Self-regulation is a hallmark of the learned professions, historically, law, medicine, and the clergy. Their ethics are reflected in bar discipline, principles of medical ethics, and ecclesiastic law. As law and medicine, as well as newer professions, sought regulation (economic protection) through legislation, or as regulation was forced on them, many of their ethical principles were incorporated into statutes or regulations, or, for lawyers, court-adopted rules of professional conduct.

Groups seeking professional status adopt codes of ethics. Codes are common in health services, and managerial, clinical, and technical groups have them. Their language is usually general, and performance standards are typically so vague as to make fair enforcement impossible. In the latter regard, the profession of law is a notable exception. A wag would say that this is as it should be, because lawyers seem plagued by ethics problems. The American Bar Association (ABA) is a private association that has developed Model Rules of Professional Conduct. These rules, as well as codes of conduct developed by state bar associations, reflect the profession's ethics. These statements of professional ethics take on the weight of judicial sanction because a state's highest court uses them to develop its rules of professional conduct for lawyers licensed in the state. Furthermore, these rules are used to sanction errant lawyers. For example, as officers of the court, lawyers have a duty to inform the appropriate professional authority if they know that another lawyer has violated the rules of



conduct in a way that raises a substantial question as to the lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects.<sup>3</sup> The state's highest court typically appoints a board of professional responsibility to enforce its rules and to review and investigate complaints, which are heard by a special panel of judges. Adverse action by this panel results in penalties ranging from admonition or probation to suspension or revocation of the lawyer's license to practice law.

It is clear, however, that even with reasonably stringent enforcement, a code of ethics can only guide the behavior and decisions of individuals who want to do the right thing but need help determining what that is. Individuals trying to get away with something are always on the fringes of a profession, and principles of ethical conduct (and legal requirements) only encourage them to become more devious to avoid being caught. Even in the absence of a code, some actions inevitably raise questions of character.

### **Mr. B**

Mr. B sought a job as a health services consultant. He contacted two firms and was interviewed by both. One offered him a position. Mr. B verbally accepted the offer, even though it meant moving his family. Several days later, as a courtesy, he called the second firm to tell them he had taken a position. The managing partner said, "Gee, that's really too bad. I was going to offer you a job in your area and pay you \$5,000 more than you got from the other firm."

Mr. B has an ethical problem. There is no written agreement, but he verbally accepted the first offer—he gave his word. Were Mr. B to call the first firm and explain what happened, they would likely release him. After all, who wants a disgruntled employee? This action does not affect his ethical obligation to take the job he accepted, however. Having given his word, Mr. B made a commitment that he is morally bound to keep. The virtue of promise keeping applies here. Only if Mr. B can show morally overriding considerations, such as great hardship to his family, can he avoid his commitment.

## **CODES FOR MANAGERS**

In addition to what is considered minimally acceptable, codes also state the vision of the profession. The goals stated in the vision may be unachievable. The profession must work toward them, nonetheless, because progress is possible. These aspects of codes of ethics are similar to the philosophy and vision statements developed by organizations.

In the sister field of business, the corporate scandals of the late 20th and early 21st centuries highlighted the importance of business ethics. These scandals caused educators to reconsider the place of teaching ethics in business programs and to give their graduates a better grounding in values that may prevent similar problems in the future. Accredited schools of business must provide ethics education in both the general knowledge and skills portion of the accreditation standards for undergraduates, and the management-specific portion of the standards for undergraduate and graduate students.<sup>4</sup> Like any business skill, the importance of reinforcing application of appropriate values in business has been known for decades; experts agree that ethics can be taught *and* learned, and that moral development takes place in everyone.<sup>5</sup> The implications? Classroom and continuing education in ethics for health services managers is essential, despite the skepticism of some.<sup>6</sup>



## Health Services Executives

First among health services management professional associations is the American College of Healthcare Executives (ACHE), known before mid-1985 as the American College of Hospital Administrators. In 2010, the ACHE had more than 38,000 members.<sup>7</sup> The ACHE has had a Code of Ethics since 1939, 6 years after its founding. Initially, it was linked to the code of ethics for hospitals developed by the American Hospital Association (AHA). Ensuing iterations made the ACHE code distinct; it also became more explicit than the AHA code. A major revision of the ACHE code occurred in 1987, and significant changes were again made in 2003.

The latest iteration of the code was adopted in 2007. The preamble establishes a context for the code and continues the concept introduced in 1987 that the health services manager is a moral *advocate* (*moral agent* was used in 1987) who must evaluate the possible outcomes of any decisions. It is suggested but not explicitly stated that healthcare executives are morally responsible for their decisions. Noteworthy is the executive's obligation to act in ways that will merit the trust, confidence, and respect of healthcare professionals and the public, and that, therefore, they "should lead lives that embody an exemplary system of values and ethics." This expectation melds the public and private lives of healthcare executives, and it is reinforced by a code provision that directs healthcare executives to refrain from participating in any activity that demeans the profession's credibility and dignity.

The 2007 iteration has five sections that detail the healthcare executive's responsibilities to the profession, to patients or others served, to the organization, to employees, and to the community and society. A sixth section charges affiliates who have reasonable grounds to believe that another affiliate has violated the code with a positive duty to communicate such facts to the ethics committee. A lengthy section on conflicts of interest in earlier iterations has been replaced by a modest and largely inadequate dictate to "disclose financial and other conflicts of interest."

In 2003, the section on the executive's responsibilities to the organization was substantially expanded. Added were the need to report negative information, prevent fraud and abuse and aggressive accounting that may result in disputable financial reports, act to minimize clinical and management errors and disclose them when they occur, implement an organizational code of ethics and monitor compliance, and provide ethics resources to staff to address organizational and clinical issues. These important additions were retained in the 2007 iteration.

The code pays little attention to the role of managers in resolving biomedical ethical issues. It does, however, include the need to establish a process that both resolves values conflicts among patients (and their families) and staff and ensures patient autonomy and self-determination. An important continuing lapse is attention to the independent moral duty that healthcare executives owe to patients. For example, the code has yet to define the limits of loyalty (fidelity) to the organization and the point at which it is superseded by an ethical duty to the patient. This is a vital facet of the manager as moral agent (advocate) and an essential element of the code as a living document that builds professional self-respect and esprit de corps.

Disciplinary actions under the code are highly structured and emphasize thoroughness and fairness. The ethics committee receives complaints alleging unethical conduct. The process includes initial screening of the complaint by the committee chair, informing the respondent (the affiliate) of the allegations, investigating the allegations, and the issuing of a recommendation from the committee to the board of governors. The respondent may appeal the committee's adverse findings and recommendations. The first appeal is to the board of governors. If unsuccessful, a second appeal is made to an ad hoc committee appointed by the board of governors. This committee has the authority to affirm the decision of the board of governors or to impose a lesser sanction. All information developed in the process is privileged.<sup>8</sup>

This lengthy grievance process is consistent with the expectations of procedural and substantive due process usually found in private associations. Judicial review is possible, but courts are reluctant to intervene in the actions of private associations. Expulsion is the maximum disciplinary action available to the ACHE or any private association. Because affiliation is not linked to licensure, expulsion is significant only if colleagues and potential employers consider membership in the ACHE important and identify expulsion as a measure of the individual's professional character. If they do, the former affiliate's employment and career opportunities become more limited. Enforcement makes codes of ethics vital, living documents that offer greater usefulness to members as they confront ethical issues and work to solve them.

The ACHE supplements its code by issuing policy statements that suggest a standard of behavior and offer specific guidance for members. Many address ethical issues: establishing an ethical environment for employees, decisions near the end of life, impaired healthcare executives, and health information confidentiality.<sup>9</sup> The 2007 ACHE Code of Ethics is reproduced in [Appendix B](#).

## **Nursing Facility Administrators**

The American College of Health Care Administrators (ACHCA) has approximately 2,500 members, the majority of whom are managers of longterm care facilities.<sup>10</sup> Its 2003 code is reproduced in [Appendix B](#).

Members are obliged to meet four "expectations," which are divided into prescriptions and proscriptions.<sup>11</sup> The expectations state that members shall: 1) hold paramount the welfare of persons for whom care is provided; 2) maintain high standards of professional competence; 3) strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents; and 4) honor their responsibilities to the public, their profession, and relationships with colleagues and members of related professions. The prescriptions and proscriptions are analogues. Examples of issues presented include addressing the quality of services; maintaining confidentiality of information about recipients of care; providing continuing education; handling conflicts of interest; and fostering increased knowledge, supporting research, and sharing expertise.

Like the ACHE, the ACHCA expects members to provide information to its standards and ethics committee of actual or potential code violations and to cooperate with inquiries into matters of professional conduct related to the code of ethics. The latter requirement suggests a

disciplinary dimension, but neither enforcement nor appeals processes are included. The code's preamble states that the ultimate responsibility for applying standards and ethics falls to the individual. The ACHCA code pays even less attention to biomedical ethical issues than does the ACHE code—an important lapse for both groups.

## Public Health

The American Public Health Association (APHA) is the professional association for public health practitioners. The APHA has no code of ethics, but its website links to several sources that provide ethical guidelines for practice and research in public health.

The best source of ethical guidance for public health practitioners is found in the “Principles of the Ethical Practice of Public Health,” developed by the Public Health Leadership Society and published in 2002. It reads as follows:<sup>12</sup>

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

A separate section explains each principle. It is unclear how and by whom (or what) success (or failure) is judged. There is no attention to the ethical implications of good management and the need to use resources wisely. Apparently, individual managers and/or their organizations make these judgments. No enforcement mechanisms for the principles are identified.

## CODES FOR CAREGIVERS

### Physicians

Codes of ethics in medicine date from the 18th century <sup>B.C.</sup> and the Code of Hammurabi, which established fee schedules for physicians and veterinarians. It imposed harsh punishments if a physician harmed a patient, including the loss of a physician's hands if treatment resulted in the loss of a patient's eye or life.

A very different code developed from the teaching and work of Hippocrates (circa 460–370 B.C.). A ruler imposed the Code of Hammurabi, but the Hippocratic philosophy governing relationships among physicians and between physicians and patients was developed by Greek physicians, one of whom may have been Hippocrates, for their own use. The Hippocratic oath has never received public sanction or force of law. It established standards of conduct, some of which are found in contemporary codes of medical ethics, as well as in state licensing and regulation of physicians.

The Hippocratic oath contains a largely obsolete section describing expected relationships between physicians and their teachers and students. Other provisions no longer used include restrictions on performing surgery, assisting in abortion, and only applying dietetic measures in healing. Hippocratic prohibitions on assisting in suicide and refraining from sexual misconduct with patients and others in the household, as well as broad restrictions on confidentiality of information learned during treatment, are found in contemporary codes, explicitly or implicitly.

The American Medical Association (AMA) was founded in 1847. Its first code of medical ethics was based on the work of Sir Thomas Percival, English physician, philosopher, and writer. Revisions of the AMA's code, *Principles of Medical Ethics*, occurred in 1912, 1957, 1980, and 2001.<sup>13</sup> The revision of the 1980 principles added precision to professional ethics for physicians. The changes were not as dramatic as those between the 1957 and 1980 versions, however. The 1980 version eliminated proscriptions on advertising and voluntarily associating with practitioners who have no scientific basis for treatment. In addition, the 1957 principles had a strong element of paternalism—physicians were expected to act in ways *that they considered to be in the patient's best interests*. Eliminating that provision reflected a major philosophical shift for the AMA. In commenting on the changes between the 1957 and 1980 versions of the principles, Veatch<sup>14</sup> observed, “It is the first document in the history of professional medical ethics in which a group of physicians is willing to use the language of responsibilities and rights,” rather than that of benefits and harms.

The 2001 iteration (reproduced in [Appendix B](#)) continues to emphasize providing competent medical care, honesty in all professional interactions, and safeguarding patient confidences. Changes from the 1980 version include adding *rights*, with the expectation that physicians will provide medical care with “respect for human dignity and rights,” will “maintain a commitment to medical education,” and will participate in activities contributing to “the betterment of public health.” New principles VIII and IX state that “a physician shall, while caring for a patient, regard responsibility to the patient as paramount,” and that “a physician shall support access to medical care for all people,” respectively. Principle II has been reworded to state that AMA members “shall . . . strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.”<sup>15</sup> Critics of organized medicine argue that this continuing, vital duty has been widely ignored.

The AMA's Council on Ethical and Judicial Affairs assists members in interpreting the principles by publishing opinions on issues such as experimentation, genetic engineering, abortion, and terminal illness. These opinions usefully supplement the *Principles of Medical Ethics*. The 1993 statement, “Fundamental Elements of the Patient–Physician Relationship,” complements the AMA's principles by focusing on the rights of patients (see [Appendix B](#)).

Just as it is clear that health services managers and their organizations benefit from

increased attention to ethics, there is also evidence that physicians (and their patients) can benefit from education in ethics, professionalism, and moral reasoning: “[Orthopedists] with higher moral reasoning and levels of professionalism . . . perform better clinically [and] also have fewer malpractice claims.”<sup>16</sup>

## Nurses

The American Nurses Association (ANA) code of ethics was first formally adopted in 1950, although precursors date from the “Nightingale Pledge” of 1893.<sup>17</sup> The preface to the 2001 iteration of the Code of Ethics for Nurses (reproduced in [Appendix B](#)) states that the code includes humanist, feminist, and social ethics; adherence to ethical principles; and the cultivation of virtues. It also asserts that

The ethical tradition of nursing is self-reflective, enduring, and distinctive. . . . *The Code of Ethics with Interpretive Statements* provides a framework for nurses to use in ethical analysis and decision-making. The Code of Ethics establishes the ethical standard for the profession. It is not negotiable in any setting nor is it subject to revision or amendment except by . . . the ANA.<sup>18</sup>

Noted in a description of the code’s evolution are doing no harm (nonmaleficence), benefiting others (beneficence), loyalty, honesty, social justice, and the autonomy of patient and nurse.<sup>19</sup>

Code expectations run a gamut that includes principles to guide practice, primary commitment to the patient, individual accountability, duties to self and others, improving healthcare, advancing the profession, collaboration, and obligations to the profession. Many of the code’s nine provisions are specific. An interpretive statement follows each. Like physicians, nurses are obligated to counter or expose problematic practice: “The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.” The interpretive statement discusses these obligations in the context of privacy, confidentiality, research, standards and review, and questionable and impaired practice.<sup>20</sup> Nursing has the public’s confidence.

In the recent past, nurses have been consistently perceived as the most honest and ethical professional group. In 2009, they outpolled physicians 83% to 65% and were rated highest of any group identified in the survey.<sup>21</sup>

## CODES FOR ORGANIZATIONS

### Hospitals

The AHA, the most important trade association for hospitals, last revised its guidelines for ethical conduct in 1992.<sup>22</sup> The guidelines are divided into community role, patient’s care, and organizational conduct. Members are expected to improve community health status and deliver high-quality, comprehensive services efficiently. The importance of coordinating with other health services organizations is emphasized. Some provisions are specific: the need for informed consent; confidentiality; and mechanisms to resolve conflicting values and ethical dilemmas among patients and families, medical staff, employees, the organization, and the community. Members should try to accommodate the religious and social beliefs and customs



of patients whenever possible. The guidelines identify the expectations regarding employee policies and practices and the accommodation of religious and moral values held by employees and medical staff. Conflicts of interest are defined. Neither disciplinary nor grievance proceedings are included.

## **Long-Term Care Facilities**

The American Health Care Association (AHCA) is the national association of state associations of long-term care facilities, primarily nursing facilities. Its code of ethics was developed for use by the AHCA as an organization, but it is intended to serve as a model for its state members and, in turn, their facility members. The AHCA's organizational values, as identified in the preamble, include concern for individuals in need, quality service, service to the community, integrity and honesty, fairness, accountability, respect for employees, and stewardship. Topics in the body of the code include moral responsibility, good business practices, making difficult choices, acting responsibly, the obligation to provide quality service, dealing with conflicting values, the use of information, responsible advocacy, potential conflicts of interest, respect for others, and fairness in competition.<sup>23</sup> AHCA's code is not a tool for certification and there are no sanctions for failing to meet its standards. Some states require nursing facilities receiving Medicaid funds to follow a patient bill of rights based on that of the AHCA.

The American Association of Homes and Services for the Aging (AAHSA) is the national association that represents not-for-profit or government-sponsored organizations that provide housing, health, community, and related services to meet the needs of older adults. AAHSA's ethics are reflected in its "Membership Covenant," which was first adopted in 1991. Its current covenant, adopted in 2001, includes a set of beliefs and a set of values.<sup>24</sup> The beliefs focus on quality of care and services; the value of elders in society; the special role of not-for-profit organizations; the role of legal, ethical, and professional standards in member organizations; offering programs and services based on contemporary research; and the leadership role of the AAHSA. Specific stewardship responsibilities include continuous quality improvement, public disclosure and accountability, consumer and family rights, workforce excellence, community involvement, ethical practices, and financial integrity. The membership covenant has no reporting or disciplinary process.

## **PHILOSOPHICAL BASES FOR CODES OF ETHICS**

Codes of ethics for the health professions blend various moral philosophies and ethical theories. To a varying extent, the principles of respect for persons, beneficence, nonmaleficence, and justice, as well as several of the virtues, are found in all codes.

The ACHE and ACHCA codes blend consequentialism (teleology), deontology, and virtue ethics but emphasize the latter two. Respect for persons and beneficence predominate. The statements on confidential information, for example, are grounded in deontology and virtue ethics, not in consequences. As noted, the duty to report violations was added to the ACHE code in 1987. In 2003, it required that "an affiliate of ACHE who has reasonable grounds to believe another affiliate has violated this *Code* has a duty to communicate such facts to the



Ethics Committee.”<sup>25</sup> In 2003, the ACHCA code contained a similar provision.

The preamble of the 2001 Principles of Medical Ethics of the AMA provides the context of its amended view of physician duty and respect for patients: “A physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.”<sup>26</sup> This philosophy is absent in the Hippocratic oath and the 1957 AMA principles, which emphasized paternalism. This change carries important implications for resource allocation by suggesting that physicians must consider the societal or broader effects of individual treatment. This admonition is based on justice rather than beneficence (which focuses on patients) and adds a dimension of utilitarianism—to consider the greatest good for the greatest number.

As noted, the underpinnings of the ANA’s Code of Ethics for Nurses include several moral philosophies. The code remains grounded in deontology, however, which is duty based. Within this context, respect for persons, nonmaleficence, beneficence, and justice undergird relationships with patients, and the virtues of self-improvement, collaboration, and integrity are stressed.

## APPLYING CODES OF ETHICS

### Use and Enforcement

As noted, codes of ethics should be living documents that are used and applied by an association. General education about code provisions is the first step. In addition, the professions must provide members with regular information about the code’s interpretation, application, and enforcement. However, more attention should be given to making health services administrative or institutional codes living documents that are useful in guiding decisions. Encouraging and responding to this interest remain important challenges to the professional associations. It is encouraging that the majority of managers in leadership positions have used the ACHE code to teach others about expected behaviors and to counsel colleagues.<sup>27</sup>

Educating, counseling, and propagating professionalism among members are vital uses for codes. They assume even greater importance and usefulness when they are enforced. Unenforced, they are platitudes, seemingly intended primarily for public consumption. Enforceable codes are precise and include interpretation of provisions. Absent sufficient detail to guide members, enforcement results in arbitrary decision making and a lack of fairness. As noted, private associations are unlikely to be held to constitutional requirements of due process, but it is nonetheless fair (just) that they meet such a standard. This theme should underlie an association’s relationships with members. Enforcement with feedback to members provides additional knowledge and understanding for the profession and makes the code a living document. This crucial attribute uses casuistry in building a body of cases and experience.

When health services professionals are licensed, disciplinary actions are usually a matter of public record. Reports of disciplinary actions against the licenses of physicians and other caregivers appear occasionally in the press. Among health services managers, only nursing

home administrators are licensed—the result of significant historical problems in nursing facilities. Scandals elsewhere in health services could lead to demands for licensure of managers, an approach less desirable and likely no more effective than self-regulation. This scenario highlights the importance of the profession’s voluntary efforts and the need to enforce usable, living codes of ethics.

## Separating Private and Public Actions

Health services managers are quasi-public figures; the public’s interest in them and their organizations is a function of the latter’s prominence in the community. A manager’s public role is greater in small communities, in which the organization, especially an acute care hospital, is economically, politically, and socially significant. This prominence means that health services managers are community leaders *ex officio*. They are in a fishbowl whether or not they desire it. Managers of major health services organizations in urban areas are also *de facto* community leaders. Health services managers must be prepared to accept this trust and use the public’s confidence to improve community health. Such a role demands exceptional performance.

Private citizens have a broad zone of privacy. Persons who become community leaders diminish their zone of privacy, and greater prominence diminishes privacy further. Younger, less experienced managers have difficulty understanding that persons in positions of prominence cannot escape public scrutiny. These managers jealously guard their privacy and generally consider what happens in their personal lives to be irrelevant to their performance as managers. Would that this were so. Their role in the organization and the public’s expectations deny them this luxury. New to the next generation of health services managers are the temptations of the social media. Increasingly, potential employers are reviewing social media postings by applicants to see if what is stated or shown there raises questions of competence or moral turpitude that might be disqualifying. Persons whose lives are an open book should expect the information to be used by anyone with access to those online services.

Three dimensions affect the dynamic between public and private lives: 1) the corrupt moral standard that the right or wrong of an action is unimportant—the question is whether one is caught; 2) the organization’s culture and the community standard of behavior and morality; and 3) administrative effectiveness. “It’s okay if you don’t get caught” or “It’s okay, everybody’s doing it” are unacceptable bromides for health services managers. The following simple examples highlight the effect of such views. Most employees would be embarrassed to be seen photocopying personal papers at their place of employment or to have their superiors note personal long-distance telephone calls made at the organization’s expense. Wasted time, personal use of office supplies and equipment, and personal telephone calls will not result in disciplinary action by either a professional association or the organization (except in extreme cases). Such actions must be regulated by the individual’s personal ethic. Members of the profession must consider that small infractions are governed by the principles developed in [Chapter 1](#), as well as by their personal ethic.

The organization’s philosophy and the community standard of morality are important because they affect managers’ views of what is acceptable, thus tempering the manager’s personal ethic. The micro-community that is the organization develops a culture whose mores

and standards are unique, demanding, and ignored at one's peril.

## **Organizational Culture**

### **It Just Isn't Done!**

Several university faculty were invited to have lunch with 20 middle- and senior-level managers of a data processing firm. The group was enthusiastic and highly motivated; most were younger than age 40. Lunch was a break in a long day of seminars and meetings. When the waiter asked for drink orders, no one from the firm ordered an alcoholic beverage. Instead, they ordered milk or soda. One of the faculty remarked about this unusual behavior and was told there was an unwritten company policy that no member of the staff should go back to work after having an alcoholic beverage.

This attitude may seem straitlaced, and it is certainly different from the "two-martini lunch" once described as the norm in business. Yet this "rule" reflected the group's self-view (culture), and substantial peer pressure would likely be directed at anyone who disregarded it. On both a macro- and a micro-level, this is the type of influence that health services managers can bring to bear for the good of patient and profession.

Administrative effectiveness is a question for the manager's manager, who determines whether problems have fatally flawed someone's ability to lead. Managers with badly tarnished reputations lose their effectiveness. Managers who are ridiculed, whose character deficits are blatant and widely known, or for whom respect is eroded or gone must be dismissed.

An example of private behavior considered unacceptable in a health services manager is driving while intoxicated (DWI). Regardless of the view held by professional associations, governing bodies are intolerant of managers charged with DWI, even though such behavior for a housekeeper would go unnoticed. Problems such as DWI run counter to the organization's view of the manager qua leader and its philosophy, which will be unwritten for problems such as alcohol and drug abuse, illicit sexual activity, and spouse abuse. Illegal activities are unethical per se. They are not explicitly prohibited because they run so counter to good character.

A further reason such behavior is unacceptable is that the governing body has no wish to be embarrassed by an errant manager. An organization faced with scandal will separate itself from the source. This reaction reflects the instinct for organizational survival as well as indignation and moral revulsion. Instilling an awareness of the importance of ethical behavior in others is a continuing challenge in organizations.

It may seem unfair that managers are held to a higher standard than the larger community. Employees and the public expect more of leaders than of followers. The health services management profession correctly expects its members to avoid the temptations and problems affecting those outside it.

### **This a Laughing Matter?**

One afternoon, Joan Zimmerman, the chief operating officer of a large hospital, encountered two younger members of her management staff conversing in hushed tones. As she approached unnoticed, they burst into laughter. One of the two blushed and turned his eyes downward as Zimmerman greeted them and asked lightheartedly about the source of their amusement. Neither spoke. Sensing there was something she should know, Zimmerman pressed for an answer. The awkward situation was interrupted by Zimmerman's pager, which asked her to call the operator immediately. Later, one of the two managers asked to see her. He related an amazing story about the female director of a support department with a high turnover rate. In routine exit

interviews conducted by human resources, several young male employees said they were leaving because they could no longer endure the sexual harassment by the department's director, who insisted that the young men have sex with her. Employees who refused were given the worst schedules and treated badly in other ways.

Zimmerman was told that the problem had existed for some time and was an open secret in the hospital. She was shocked and distressed that she had not been told.

This case has several dimensions. First, sexual harassment is against the law. Second, sexual harassment breaches the principle of respect for persons. Third, the unfair treatment of staff by the department head breaches the principle of justice. Finally, the department director has failed to live the virtues of self-control, temperance, and integrity.

The immediate problem is to investigate the allegations against the department director and take disciplinary action, if appropriate. Also of concern is that younger managers were amused, not offended. Their reaction may show immaturity rather than approval or true amusement; regardless, it is a problem that needs attention. Managers lead by words and actions; actions are far more important.

Two other issues must be addressed. The first is that Zimmerman was unaware of the problem. The second is the lack of action taken by staff and managers who knew of the allegations, which, if true, cast a shadow over the organization. First among staff who should have been more alert and taken action are those in human resources (HR). Turnover in a unit should be investigated by HR and appropriate action taken. Exit interviews are a common means to obtain information about matters needing such attention.

Zimmerman must make clear to all staff that such behavior is intolerable. It breaches the trust reposed in managers, breaches their fiduciary duty to the staff and the organization, and is inconsistent with any viable organizational philosophy. If true, the alleged actions of the support department director diminish the regard in which all managers in the organization are held, and, ultimately, diminish organizational effectiveness. Cynicism can become a cancer that will destroy the organization.

## CONCLUSION

Most codes of ethics provide only general guidelines. Even specific provisions require interpretation and the courage to apply them. Interpretation is crucial, because even great detail cannot address the nuances and intricacies of all circumstances. A highly detailed code would be excessively legalistic; applying it would be impractical and nightmarish.

Of the professional groups in health services management, the ACHE has the most detailed code. This detail enhances its usefulness to guide health services managers, whether or not they are ACHE members. In most respects, however, the code is too general to provide performance standards.

Codes in the health services field carry only the sanctions available to the professional association, of which expulsion is the maximum disciplinary action. This limitation is unlikely to affect the individual's legal right to engage in the profession.

In addition to the expectations of ethical codes, state law regulates most clinicians. Licensure statutes—or *practice acts*—incorporate ethical principles similar to their private associations, and licensing boards are usually composed of individuals from the profession being regulated. This tends to give the group's ethical precepts the force of law; breaching

them could lead to license suspension or revocation. It is noteworthy that the proceedings of public regulators are distinct from those of private associations or professional groups. A license is a condition of membership in the professional association, but membership in the association is not required for licensure—an appropriate distinction between private and public action.

For groups such as hospital managers, the lack of licensure increases the importance of self-regulation. The public looks to such professionals as important in safeguarding health services delivery. Unless self-regulation is effective and maintains the public's confidence, licensing or another form of governmental regulation will result.

Another pragmatic consideration is what contributes to managers' success. Historically, integrity was identified as the personality trait most important for success, more important than any other skill or factor.<sup>28</sup> Integrity's importance undoubtedly continues. This additional stimulus to be ethical and above reproach in all aspects of their lives should cause health services managers to be vigilant about themselves and their colleagues. These are significant reasons for maintaining the public's trust in health services managers and their organizations.

More important than pragmatism to encourage ethical behavior is that it is the right thing to do—it is a principle for life and the profession. The slightest hint of impropriety in personal behavior must be avoided. What a tragedy for the late Hyman G. Rickover, father of the nuclear submarine fleet and a retired U.S. Navy admiral, with an astounding 64 years on active duty, to be forced to admit that he took gifts from defense contractors. Rickover claimed that the gifts were trinkets and that taking them did not affect his judgment. The Secretary of the Navy insisted that the gifts were worth tens of thousands of dollars. Whatever the facts, these revelations badly, and sadly, tarnished a distinguished career. It is just such situations that health services managers must assiduously avoid. Failing this, managers damage the public trust, risk their careers and reputations, and violate the principles of any personal ethic worthy of the name.

## NOTES

1. U.S. Office of Government Ethics. (n.d.). *Background and mission*. Retrieved February 22, 2011, from [http://www.usoge.gov/about/background\\_mission.aspx](http://www.usoge.gov/about/background_mission.aspx).
2. Anita Cava, Jonathan West, & Evan Berman. (1995, Spring). Ethical decision-making in business and government: An analysis of formal and informal strategies. *Spectrum* 68(2), pp. 34–35.
3. American Bar Association. (n.d.). *Rule 8.3: Reporting professional misconduct*. Retrieved April 14, 2004, from [http://www.abanet.org/cpr/mrpc/rule\\_8\\_3.html](http://www.abanet.org/cpr/mrpc/rule_8_3.html).
4. Association to Advance Collegiate Schools of Business. (n.d.). *Frequently asked questions: Why won't AACSB international require a course in ethics for all business programs?* Retrieved November 12, 2010, from <http://www.aacsb.edu/resources/ethics-sustainability/faq.asp>.
5. Peter Arlow & Thomas A. Ulrich. (1983, Spring). Can ethics be taught to business students? *Collegiate Forum*, p. 17; Archie B. Carroll. (2003, February 17). Can ethics be taught? *UGA News Service*. Retrieved November 14, 2003, from <http://www.uga.edu/columns/030217/news12.html>; Ameet Sachdev. (2003, February 14). Ethics moves to head of class. *Chicago Tribune*. Retrieved February 23, 2011, from [http://articles.chicagotribune.com/2003-02-14/business/0302140374\\_1\\_ethics-and-leadership-training-advance-collegiate-schools-business-schools](http://articles.chicagotribune.com/2003-02-14/business/0302140374_1_ethics-and-leadership-training-advance-collegiate-schools-business-schools).
6. Dan Seligman. (2002, October 28). Oxymoron 101. *Forbes*, pp. 160, 162, 164.
7. American College of Healthcare Executives. (2010). *ACHE annual report, 2010*. Retrieved February 23, 2011, from [http://www.ache.org/abt\\_ACHE/annual\\_report/10\\_annual\\_report/ACHE\\_Annual\\_Report\\_10.pdf](http://www.ache.org/abt_ACHE/annual_report/10_annual_report/ACHE_Annual_Report_10.pdf).
8. American College of Healthcare Executives. (n.d.) *ACHE grievance procedure*. Retrieved October 8, 2010, from [http://www.ache.org/abt\\_ache/grievance.cfm](http://www.ache.org/abt_ache/grievance.cfm).
9. American College of Healthcare Executives. (2003). *ACHE ethical policy statements*. Retrieved March 16, 2011, from



[http://www.ache.org/policy/index\\_ethics.cfm](http://www.ache.org/policy/index_ethics.cfm).

10. Whitney O'Donnell, member services coordinator, ACHCA, personal communication, January 4, 2011.
11. American College of Health Care Administrators. (n.d.). *Advocacy: Code*. Retrieved March 1, 2011, from [http://www.ache.org/abt\\_ache/facts.cfm](http://www.ache.org/abt_ache/facts.cfm).
12. Public Health Leadership Society. (2002). *Principles of the ethical practice of public health: Version 2.2*. Retrieved March 16, 2011, from <http://www.apha.org/NR/rdonlyres/1CED3CEA-287E-4185-9CBD-BD405FC60856/0/ethicsbrochure.pdf>.
13. Tanya Albert. (2001, January 1). AMA's Principles of Medical Ethics may be infused with new "lofty ideas." *American Medical News*. Retrieved August 18, 2003, from <http://www.ama-assn.org/amednews/2001/01/01/prsa0101.html>.
14. Robert M. Veatch. (1980, June). Professional ethics: New principles for physicians? *Hastings Center Report* 10, p. 17.
15. American Medical Association. (2003). *Newly adopted principles of medical ethics, June 2001*. Retrieved March 16, 2011, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml>.
16. DeWitt C. Baldwin, Jr., & Wilton H. Bunch. (2000, September). Moral reasoning, professionalism, and the teaching of ethics to orthopaedic surgeons. *Clinical Orthopaedics and Related Research* 378, pp. 97–103.
17. American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Retrieved January 4, 2011, <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx>.
18. *Ibid.*; extract reprinted by permission.
19. *Ibid.*
20. *Ibid.*
21. Jeffrey M. Jones. (2009, December 9). U.S. clergy, bankers see new lows in honesty/ethics ratings. *Gallup*. Retrieved December 16, 2010, from <http://www.gallup.com/poll/124628/clergy-bankers-new-lows-honesty-ethics-ratings.aspx>.
22. American Hospital Association. (1992). *Hospital management advisory: Ethical conduct for health care institutions*. Chicago: Author.
23. American Health Care Association. (2003). *Code of ethics*. Retrieved March 16, 2011, from [http://www.ahcancal.org/about\\_ahca/MembersOnlyDocs/AHCA\\_code\\_of\\_ethics.pdf](http://www.ahcancal.org/about_ahca/MembersOnlyDocs/AHCA_code_of_ethics.pdf).
24. American Association of Homes and Services for the Aging. (2001). *AAHSA membership covenant*. Retrieved March 16, 2011, from <http://www.aahsa.org/WorkArea/DownloadAsset.aspx?id=9847>.
25. American College of Healthcare Executives. (2003). *Code of ethics*. Retrieved October 31, 2003, from [http://www.ache.org/abt\\_ache/code.cfm](http://www.ache.org/abt_ache/code.cfm).
26. American Medical Association. (2003, July 15). *E-principles of medical ethics*. Retrieved March 16, 2011, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml>.
27. William A. Nelson & Paula P. Schnurr. (2003, November/December). Affiliates comment on code of ethics. *Healthcare Executive* 18(6), pp. 54–55.
28. Walter J. Wentz & Terence F. Moore. (1981). Administrative success: Key ingredients (special issue). *Hospital & Health Services Administration* 2, pp. 85–93.

# ORGANIZATIONAL RESPONSES TO ETHICAL ISSUES

Thus far, little has been said about how organizations organize to solve administrative and biomedical ethical problems. The starting point is the organization's philosophy, which reflects its values and establishes moral direction and a framework for the vision and mission. The philosophy is subject to the minimum set by external constraints such as criminal and civil laws and their derivative regulations and court cases. For example, federal guidelines to protect human subjects are a starting point for the organization's relationship with patients participating in federally funded clinical research.

The personal ethic of the manager, as employee and leader, both influences and is influenced by the organizational philosophy. In addition, the manager organizes the organization and allocates resources to prevent and solve ethical problems. Such problem solving occurs in the context of the organizational philosophy but is affected by the manager's personal ethic, which should be more specific and comprehensive than the organizational philosophy. This dynamic reinforces the importance of the personal ethic, lest the manager lose an essential attribute of leadership—clear moral direction.

Since the 1970s, health services organizations have established various means to solve ethical problems; most prominent are institutional ethics committees (IECs), institutional review boards (IRBs), and infant care review committees (ICRCs). IECs can provide a broad range of assistance on administrative and biomedical ethical issues. IRBs are specialized IECs that focus on research ethics. They are more helpful in preventing and solving problems in biomedical ethics than administrative ethics. ICRCs review the care of infants with disabilities.

## INSTITUTIONAL ETHICS COMMITTEES

The progenitors to IECs were abortion selection committees (which determined, prior to *Roe v. Wade* [1973], if a pregnant woman's health or life were sufficiently at risk to justify an abortion) and medical morals committees in Roman Catholic hospitals (which assessed certain treatment decisions in light of Church teachings).<sup>1</sup> Later, in the 1960s, committees selected recipients of renal dialysis at a time when there were many more medically suitable patients than available machines.

The 1976 court decision regarding Karen Ann Quinlan directed the establishment of an "ethics" committee that was to review her prognosis. Such committees confirmed prognoses and helped determine whether to continue life-sustaining treatment. Prognosis committees were often called "God squads" because they determined when treatment would be withdrawn so the patient died from the underlying disease process(es).

The role of IECs in the 21st century is expected to be much broader. An early source of information about IECs was a national survey completed for the President's Commission for

the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which was published in 1983.<sup>2</sup> Smaller hospitals did not have an IEC, and such bodies were not ubiquitous in large hospitals. Hospitals with teaching programs were most likely to have IECs. It was estimated that there were fewer than 100 such bodies nationwide. The Quinlan case had encouraged hospitals to establish IECs.

The number of IECs grew rapidly in the early 1980s. By 1985, surveys done by the National Society of Patient Representatives found that 59% of hospitals had them. The Baby Doe controversies in the early 1980s caused many hospitals to establish specialized IECs to address the ethical problems of newborns with profound disabilities. The growth in numbers of new IECs slowed in the late 1980s, however.<sup>3</sup> This lack of growth was confirmed by 1993 estimates that nationally, almost 60% of hospitals had IECs; state and regional ethics networks put the number at 65%–85%.<sup>4</sup> By contrast, a 1993 survey by the Catholic Health Association found that 92% of members responding had an IEC.<sup>5</sup> Already by 1990, it was suggested that hospital ethics committees had matured and must reconsider their roles to determine whether they should be involved in new ways and in other aspects of organizations.<sup>6</sup> In the 1990s, IEC involvement in case consultation seemed to decline; IECs were more likely to be involved in issues of appropriateness of technology, patients' rights, relationships among healthcare providers, and conflicts of social values.<sup>7</sup> Another survey of acute care hospitals found that 86% of IECs play a role in ongoing clinical decision making through ethics consultation; all IECs among respondents to the survey were involved in developing institutional clinical policy. The survey found that 4.5% of IECs wrote policy on managed care.<sup>8</sup> In the 21st century, the emphasis on ethics case consultation has increased significantly. The source for case consultation is the IEC, which acts as the "mother ship." The specifics of case consultation are discussed later in this chapter.

Nonacute health services are moving from hospitals to other types of settings. Growth in the need for and use of IECs will be greatest in nursing facilities, health maintenance and managed care organizations, and integrated delivery networks. A survey by the American Association of Homes and Services for the Aging found that the numbers of ethics committees among its members had increased from 29% in 1990 to 45% in 1995 and that many others were in the planning stage. The committees review cases and consult, make and review policy recommendations, and educate and advise staff and administration. Of organizations with committees, 86% surveyed found them useful.<sup>9</sup>

IECs in nonacute care organizations are likely to develop differently, depending on their unique activities and roles. It has been suggested that, unlike physicians on IECs in hospitals, physicians on IECs in nursing facilities play a minor role and that administrative staff are much more important. Average staff education levels in nursing facilities tend to be lower, which may exacerbate cultural and class differences between staff and patients. Because nursing facilities are heavily regulated, it is also likely that a considerable focus will fall on legal rather than ethical issues.<sup>10</sup> An important context for ethics committees is the 1992 requirement of the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) that hospitals have a mechanism to resolve ethics issues.<sup>11</sup> This requirement is usually met by having an IEC.

## Organization

Complex health services organizations such as acute care hospitals would benefit by establishing an ethics committee with two subcommittees, one that addresses administrative ethical issues, the other biomedical issues. An alternative is to have two ethics committees, one for administrative ethical issues and one for biomedical ethical issues. Specialization is desirable because a committee prepared to address administrative ethics problems may be inadequately prepared to address biomedical ethics problems. Greater specialization is needed within the broad categories of administrative and biomedical ethics (e.g., ICRCs). Committee proliferation or overlap should be avoided, but the various types of ethical problems must be addressed effectively. Because of the need to solve both general, organization-wide problems and specific, sometimes very technical problems, the committee with subcommittees model is encouraged. Given that few hospitals follow the specialized ethics committees model, however, the IEC will be discussed here as one entity that addresses both administrative and biomedical ethical issues.

Veatch<sup>12</sup> argued that the different ethical tasks undertaken by IECs are mutually exclusive because they emphasize different ethical principles. He recommended organizing ethics using the following models:

1. *An autonomy model*—implements decisions of competent patients whose wishes are known
2. *A social justice model*—grapples with broad issues such as organizational healthcare policy, resource allocation, and cost effectiveness
3. *A patient benefit model*—makes decisions for patients unable to make decisions for themselves

Ethics committees that use autonomy models are accountable to the patient, whereas ethics committees that use a social justice model must be accountable to the organization (or the community). The first and third models emphasize biomedical ethical issues. The second model could address administrative as well as biomedical issues, if it were determined desirable to address the two types in one committee.

Before considering ethical problems, an IEC must develop a statement of its ethic, the context for which is the organizational philosophy. The IEC's ethic does not determine how to solve each type of problem. It is a statement of general principles that guide deliberations and determine its recommendations. This exercise is essential to the effectiveness of the IEC because it identifies and minimizes differences in the personal ethic of members. Only by understanding and enunciating its own ethic can the IEC appreciate how its values differ from those of a patient, for example, an essential understanding if patient autonomy is to be respected.

## Roles of IECs

Since their early, focused beginnings, IECs have broadened their activities greatly.

**General Roles** IECs have two general roles. One is to assist in developing or reconsidering the organizational philosophy (to move the organization toward a more desired

culture) and the derivative vision and mission statements. The experience and range of interdisciplinary membership will likely produce results that are better reasoned and more thorough. Education is the second role. The IEC's composition and the experience of its members make it a reservoir of knowledge and expertise; the typical case-based approach reflects casuistry, which was discussed in [Chapter 1](#). These resources should be made available to the governing body and staff. Such attributes add a level of sophistication to the organization and improve the quality of administrative and biomedical ethical decision making.

**Generic Activities** IECs undertake generic activities such as policy development, education, case review, and guidance for individuals upon request. Specific activities could include developing consent forms and policies, identifying criteria for macro-resource allocation, and providing guidance on issues related to whistle-blowing, developing do-not-resuscitate (DNR) and patient consent procedures, addressing involuntary discharge, considering patient safety issues, and advising on withholding or withdrawing life support. Another possible role is to help establish and maintain a culture of patient safety.<sup>13</sup>

**Ethics Issues** Currently, IECs focus almost exclusively on biomedical ethical problems and devote little time to administrative ethical issues, such as conflicts of interest, or to consulting on policy formulation and macroallocation decisions. Such a narrow range of activities is regrettable because it diminishes the potential value of IECs. The principal benefits of IECs in biomedical ethics include facilitating decision making by clarifying important issues, shaping consistent policies about life support, and providing opportunities for professionals to air disagreements. IECs appear not to have been effective at increasing the ability of patients' families to influence decisions or at educating professionals about issues relevant to life-support decisions.

**Ethics Consultation** Ethics consultation is an important activity for IECs that involves its members in advising and assisting to resolve patient-centered biomedical ethics problems. Ethics consultation is similar to clinical consultation. Consultation is performed by clinical and nonclinical members of the IEC with special interest and preparation in biomedical ethics. The IEC develops and recommends policy regarding ethics consultation to administration. It also serves as a sounding board for problems that develop during ethics consultation.

Clinicians who provide ethics consultation are a bridge between the ethicist and clinical staff attending the patient. These clinicians are a resource for the ethicist and vice versa. In ethics consultation, IEC members are on call and are supplemented, as needed. A variant uses a primary consultant assisted by other members of the IEC. The primary consultants and those assisting them have varying backgrounds, but all are trained in ethics and participate in case reviews, ethics instruction, and regular meetings of the staff. An early example of an ethics consultation service was developed at the University of Virginia in the late 1980s.<sup>14</sup>

In the early 1980s, the President's Commission found that IECs were involved in few cases and were dominated by medical professionals to the exclusion of patients and, frequently, family members.<sup>15</sup> After a spurt of involvement in the mid-1980s and early 1990s, case consultation declined. Yet, the problem of patient representation, control, and attendance (by family members) has continued, and this has renewed interest in the importance and need for



case consultation. Ethics consultation is commonly available at all larger hospitals. Top goals of ethics consultation include intervening to protect patient rights, resolving real or imagined conflicts, changing patient care to improve quality, and increasing patient/family satisfaction.<sup>16</sup> Attendance of patients by family members raises significant questions of patient autonomy, especially regarding resource allocation and consent. A medical center study of reasons for ethics consultation found that by far the most common involved issues related to surrogate decision makers. This category was followed by DNR/end-of-life issues, living donor transplant, patients refusing medically indicated care, and challenging or disruptive patients. Last, by a considerable margin, was consultation for medical futility of care,<sup>17</sup> which suggests that such concerns have been overstated.

**Cultural Diversity** Organizations with culturally diverse stakeholders must have staff and IEC members who are sensitive to various views about medical services. This is especially true for significant events such as dying and death.

### **Last Wishes**

A Native American was admitted to Memorial Hospital's emergency department in grave condition. His cardiac insufficiency was terminal. He was able to communicate his wishes, verified by his friend, that extreme measures not be used and that he be allowed to die naturally and peacefully. Death was expected within hours or a few days. His friend explained to nursing staff that in their religion a dying person's spirit could only enjoy eternal bliss if the person died in the open and the spirit could go to the sky, unfettered by the walls and ceilings of a building. Nursing staff wanted to meet the dying man's wishes but were uncertain what to do. They could not take the patient outdoors until he was in the final moments of the dying process. They monitored him closely. When they determined that he had died—even though a physician had not pronounced him dead—they put him on a gurney, covered him, and took him outside through the service entrance. After a few moments away from the building, they returned his body to the nursing unit. His friend came back to the hospital a short time later. He thanked the staff for letting the dead man's spirit "go to the sky."

Nursing staff was able to accommodate the patient's wishes without compromising his care or that of other patients. They acted appropriately, if outside traditional bounds of the nurse-patient relationship. Meeting patients' spiritual needs, generally, has been identified as important to faster response to treatment and reduced likelihood of depression. Failure to meet spiritual needs increases the risk of death and poor mental health and reduces quality of life. Despite this, clinicians receive little or no training in the subject.<sup>18</sup>

### **Membership**

The President's Commission found that biomedical IECs were interdisciplinary. Physicians were most common, averaging about 5 members per committee. Committees averaged one member of the clergy. Members found on fewer than half the committees were attorneys, laypersons, social workers, and physicians in graduate education programs (residents). Administrators served on only about half the committees. The commission found no strong community link, something that governing body members and individuals from the organization's service area could provide. Community members bring a vital perspective to decision making.<sup>19</sup> The commission found that managers were underrepresented, perhaps because they lacked interest in clinical matters. It was suggested in the early 1990s that nurses were also underrepresented, both in terms of their numbers in health services organizations and

in the number of biomedical ethical problems they encounter.<sup>20</sup> Current information about IECs suggests that physicians continue to be the most common members. Nurses are no longer underrepresented; 71% of hospitals have nurse members performing ethics consultation. One study found that about half of all committee members were physicians and nurses.<sup>21</sup> Social workers, chaplains, administrators, and attorneys are other professionals likely to be involved in ethics consultation. Most receive training through formal direct supervision by a more experienced committee member. About two-thirds of hospitals reported having administrators involved, which suggests appropriately greater involvement by that group as well.<sup>22</sup>

## Relationships

To a significant extent, an IEC's effectiveness will be a function of its location in the organization. The IEC could be a standing committee of the governing body, the medical staff, or administration. Concerns that physicians will dominate IECs cause some experts to suggest that they should be a governing body or administration committee. Members should be chosen for their ability to analyze ethical issues in an unbiased manner and not because they represent a constituency.

IEC relationships vary depending on its activities (role), which may be general or specific. General activities span the organization, and, as noted, include refining the organizational philosophy, ethics education, macroallocation decision making, and policy development (e.g., conflict of interest policy). Common specific-level activities are case and microallocation consultations and situational analyses. An example of a specific activity is determining whether a particular decision is consistent with the organizational philosophy.

The IEC should be proactive in developing and revising the organizational philosophy and in considering the ethical implications of macroallocation of resources. Similarly, the IEC should take the initiative in reviewing the consent process. The committee may choose a more passive role for some issues, however, and wait to be consulted in specific instances of conflicts of interest and misuse of confidential information, or in specific biomedical ethics problems.

Except as noted above, IECs are most likely to be effective when they wait to be consulted, rather than when they interpose themselves in decisions about specific ethical problems. As consulting bodies, IECs only make recommendations to decision makers. Ethics consultation recommendations may be optional or mandatory. Following the advice given by an IEC may be optional or mandatory. [Table 1](#) shows the combinations.

One study found that most physicians (72%) thought consultations yielded information that would help with future ethical issues. Many other physicians hesitate to ask for an ethics consultation. Common reasons cited were that consultations were too time-consuming, that they might make the situation worse, that consultants were unqualified or unhelpful, and that solutions were not consistent with good practice.<sup>23</sup> Physicians are unlikely to accept an ethics consultation that is mandatory—mandatory. Furthermore, mandated involvement is not desirable for situations in which the physician is willing to develop alternatives and communicate them to the patient and others concerned. Even if physicians are unwilling to involve an ethics consultation, there are benefits to making the analysis and recommendation available to

decision makers.

Table 1. Matrix of possible roles for institutional ethics committees (IECs)

| Involvement of IEC in decision making | Acceptance and use of advice provided by IEC |
|---------------------------------------|--|
| Optional                              | Optional                                     |
| Optional                              | Mandatory                                    |
| Mandatory                             | Optional                                     |
| Mandatory                             | Mandatory                                    |

## The Institutional Ethics Committee

The chief executive officer of Community Health Plan (CHP) had been approached by a group from “north of the river.” This area of the city was economically depressed and over the previous decade had lost many of its health services delivery organizations and physicians to the suburbs. It seemed to be in a downward spiral, with no end in sight. Decreasing numbers of insured patients meant that organizations were increasingly unable to serve the area. The city-owned hospital had made several ill-fated attempts to serve the area north of the river with a clinic system, but its efforts were scandal-ridden. The clinic system became a political football with little credibility in the community.

The representatives from north of the river were community leaders, none of whom appeared to have political ambitions. They seemed genuinely willing to do whatever they could to assist in securing high-quality health services for their community. They proposed that CHP establish and provide clinical staff for three storefront clinics in the area. The community leaders stated that they would find volunteers to remodel the facilities and work in clerical jobs.

The CEO presented the proposed initiative to the IEC, which included members of the governing body, managers, and physicians and other caregivers. In making the presentation, the CEO stressed the health plan’s historical role in providing services to those in need, its not-for-profit status, and its continuing modest surplus. The members listened patiently, but the minute the CEO finished, all of them seemed to speak at once. Several members opposed the proposal and made the following points about the suggested venture:

1. The area north of the river was the city’s responsibility. Providing care to the needy is not something a small, not-for-profit health plan like CHP should attempt.
2. The organization’s primary obligation was to enhance benefits for its enrollees and not to become involved in new schemes. New services had been requested by several of their physicians and many plan members.
3. The modest surplus the plan had accumulated over several years could be easily consumed by the proposed venture. The chief financial officer noted that an increase in reinsurance premiums was expected in the next quarter.
4. If the plan pulled the city’s political chestnuts out of the fire by providing even stopgap assistance, the city would never get its house in order and develop the system needed north of the river.

Several members spoke in favor of working with the community north of the river and made the following points:

1. Helping the north-of-the-river community was the right thing to do. The people living there deserved healthcare services. Someone noted that the plan’s own start came about when several physicians in the community fought the prevailing attitude among their peers about the prepaid practice of medicine.
2. Those opposing the proposal were putting dollars ahead of people’s health. They must be willing to assist those who are less fortunate.
3. Plan members would support such an initiative if it were properly explained to them.
4. The positive publicity could further the plan’s interests by increasing the number of enrollees.

It seemed to the CEO that this was a no-win situation. The organizational philosophy was not well developed and the proposal was a major step. Should something be done to help the north-of-the-river community? The IEC members had raised valid points that merited further discussion.

This case describes issues arising from decisions about macroallocation of resources. Problems here are more complex because CHP is being asked to volunteer assistance and to do so from its own modest surplus. Relevant theories of justice in allocating resources include retribution or compensatory justice (distributing resources to make up for past wrongs); just deserts (help would go to those who had not earned it and CHP’s leadership had no right to risk the plan’s solvency, which was something the membership paid to achieve); egalitarianism

in access to health services, and whether it was government's responsibility to provide it to the community north of the river; and utility as a prospectively determined element of beneficence.

A significant problem for CHP was that it did not consider this aspect of its relationship with unique subsets of the community in formulating its organizational philosophy and vision and mission statements. It would do well to develop these prospectively in a comprehensive fashion rather than address them ad hoc. Resource allocation receives further attention in [Chapter 13](#).

## Summary

IECs are useful in many ways. Overall, their effects should improve administrative and biomedical decision making. However, one cannot assume that the mere presence of an IEC preordains its success. As with all undertakings, IECs should be evaluated so that performance can be improved.<sup>24</sup>

IECs present significant potential problems. Organizational concerns, especially legal ramifications and avoiding public embarrassment, can easily overwhelm concerns about patient goals.<sup>25</sup> At the extreme, it has been suggested that because IECs represent organizations, they cannot be objective; as a result, when a dispute arises, they will take management's side to avoid risk, and thus fail in their vital role as patient advocates.<sup>26</sup> Management must ensure that IECs are not subverted in this manner.

## INSTITUTIONAL REVIEW BOARDS

Health services managers may think research and experimentation are exclusive to academic health centers, in which rigorous protection and standards of review are applied. Many health services organizations, however, engage in research, some of which may not even be known to nonclinical managers.

### Ethical Principles in Research

Contemporary codes of research ethics emphasize the subject's voluntary, informed consent. The modern emphasis on consent in research began in 1900 when a Prussian state government commission identified unambiguous consent as essential.<sup>27</sup> The research subject's mental competence receives less attention than does consent. A provision in the Nuremberg Code (1949) states that subjects should be able to halt the experiment if they no longer wish to continue. This proviso places a heavy burden on the subject, who may become incapacitated by the experiment itself or by an unrelated medical problem, or who may be intimidated by the setting or individuals involved. Subjects also usually lack the technical expertise to understand when their safety is threatened. This weakness was partially corrected in the Declaration of Helsinki (1964, revised 1975 and 1989), which recommends establishing an independent committee to review and approve the experimental protocol.

In 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research issued *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, which identified the ethical principles and guidelines for research involving human subjects. Its most influential contribution was the

enunciation of three basic precepts: 1) respect for persons (met through an informed consent process), 2) beneficence (weighing risks and benefits), and 3) justice (fair selection of subjects). The *Belmont Report* provided important guidance on the boundaries between research and clinical medicine.<sup>28</sup> In fact, its principles and guidelines are reflected in the type of committee required by the U.S. Department of Health and Human Services (DHHS).

All research codes and guidelines permit nontherapeutic research and recognize that volunteers for whom the experimental treatment offers no potential diagnostic or therapeutic benefit are needed for certain research. The utilitarian language present in all codes balances the risk to the subject (in nontherapeutic research) with the benefit to society. Conversely, emphases on voluntary and informed consent suggest a Kantian philosophy and reflect the principles of nonmaleficence and respect for persons, as well as the virtues of fairness, honesty, and trustworthiness. This perspective is embedded in the DHHS regulatory framework (“Protection of Human Subjects”; Public Welfare, 45 C.F.R., 2001).

A primary problem with research codes other than federal regulations is that they inadequately separate the physician’s roles as healer and researcher. The ethical burden on physicians is heavy because the duality of interests of physician-researchers puts them at high risk of encountering an actual conflict of interest. What is good for the research subject as patient may diminish the integrity of the experimental design. This problem is exacerbated in nontherapeutic research because the risk to the subject is not balanced by potential benefits. American Medical Association (AMA) guidelines recognize the dilemma and stress adequate safeguards for the welfare, safety, and comfort of the subject and written consent after full disclosure.<sup>29</sup>

## **Establishing Institutional Review Boards**

To protect human subjects, health services organizations conducting federally funded research should establish an IRB, which is an independent committee comprising scientific and nonscientific members that complies with federal law.<sup>30</sup> IRBs conduct initial and continued review of research involving human subjects. Committees with similar activities are considered IRBs as well.

In the health services field, the DHHS and the Food and Drug Administration (FDA) are the most important federal entities that require an IRB to review, approve, and maintain oversight of research studies. The DHHS requirements for IRBs and protection of human subjects are applicable to research funded (i.e., supported or conducted by and regulated under a specific research statute) by 17 federal agencies and departments that have adopted the “common rule” or “federal policy” for the protection of human subjects.<sup>31</sup> Examples of federal agencies that use DHHS requirements are the Department of Defense, the Department of Veterans Affairs, the Environmental Protection Agency, the National Science Foundation, and the Consumer Product Safety Commission.

Research that involves human subjects and is either wholly or partly funded by the federal government must be reviewed by an IRB with a process that meets DHHS criteria. Although technically not required, research funding applications typically include assurances that the organization will comply with DHHS IRB requirements for human subjects (and other DHHS



requirements for the protection of human subjects) for *all* its research, federally funded or not.<sup>32</sup>

The FDA regulates the interstate sale of drugs, biologicals (i.e., vaccines), and medical devices and has the same requirements as DHHS. Unlike the DHHS, however, compliance with the FDA's guidelines, including the use of IRBs, is necessary regardless of the funding source. A few states (e.g., New York) regulate medical research, but in most cases, either the DHHS or FDA regulates health-related research.

The FDA does not regulate surgical experimentation. For example, the FDA did not judge that coronary artery bypass surgery or radial keratotomy (ophthalmic surgery) were safe and efficacious or that they should be generally available. Neither does the FDA regulate innovative clinical care, which is defined as new uses of existing treatments, drugs, biologicals, and devices. *Innovative care* is distinguished from standard clinical activity, and its use requires more than the review and consent procedures for standard therapies. Absent government regulation, the organization's managers and clinical staff are essential in monitoring the activities of clinicians who develop innovative uses of drugs or treatments or who attempt new surgical procedures.

It is not easy for hospitals, most of which have no ongoing research programs, to define experimentation and innovative therapy. Nonetheless, definitions are important, not only because they determine whether there is a need to meet legal requirements or to form an IRB, but also because the organization must ensure that its own, presumably more rigorous, procedures for consent and protection of the patient are followed. The following case illustrates the problem.

### **This Is Experimenting?!**

An internal auditor conducted an audit of supplies used in biopsies. The data for kidney biopsies revealed significant discrepancies: The use of biopsy packs exceeded the number of procedures by 50%. The auditor was puzzled, but double-checking requisitions and utilization data showed them to be correct. Theft was unlikely.

The auditor made informal inquiries and spoke to technicians in the cytology laboratory. One agreed to speak confidentially about the additional kidney biopsies. The technician told the auditor that one of the nephrology fellows was using a second biopsy pack to take additional tissue during kidney biopsies. The tissue was sent to cytology for special studies ordered by the fellow. The technician said the fellow was testing a new theory about treating end-stage renal disease.

Is this research? Yes. The nephrology fellow's activities meet the definition of research as systematic investigation designed to develop or contribute to generalizable knowledge. Taking additional tissue or using part of the specimen in the manner described is experimentation, although the act of obtaining it is not experimental. By trying to prove or disprove a theory, the nephrology fellow is performing research. However, taking the additional tissue requires consent separate from that for the routine, initial biopsy. There is no evidence a second consent was obtained. Taking more tissue or performing a second biopsy puts the patient at additional risk, without any actual or potential diagnostic or therapeutic benefit. The organization and its managers have an absolute duty to prevent unauthorized research, and policies and procedures regarding such a practice are essential. Innovative treatments, too, must be closely monitored. With innovative treatment, the level of concern increases with the degree of risk. Adequate consent is essential for both experimentation and innovative therapy.

There are ethical considerations in the economics of this case, too. The second study adds to the laboratory's workload. If third parties are paying for these charges (or costs), and are told they are part of a patient's diagnosis or treatment, the organization is acting dishonestly toward the payer.

Organizational policies must distinguish standard clinical care from experimental procedures. Obtaining a few extra milliliters of amniotic fluid during amniocentesis causes moderate additional risk. Taking unused urine routinely collected for other purposes or performing analyses on the expelled placenta pose no risk to the patient but require consent nonetheless. Minor or nonexistent risks do not justify ignoring patients' rights and the duties owed to them. DHHS and FDA regulations recognize minimal research risk and permit special review procedures. Protocols for research in these categories can receive expedited review and approval from the IRB.

Defined as attempting new means, methods, and techniques, medicine has always engaged in research; without it, medical knowledge would stagnate. Protecting the rights and welfare of human subjects remains problematic, however.

### **Fever All Through the Night**

Beverly Atchison, vice president for administration, finished reading the minutes of the utilization review committee. Atchison noted that a lengthy discussion had occurred with regard to the seemingly overlong stay of a pediatric patient. In fact, the attending pediatrician had appeared before the committee to explain the length of stay and her unique treatment regimen.

The case involved a child with a fever of unknown etiology. Routine tests after hospitalization showed no pathology. The physician explained that she had read about fever therapy in the literature and was impressed with its possibilities. Therefore, she decided to determine its appropriateness in cases of fever of unknown etiology. She ordered Tylenol if the fever went above 102.5 degrees Fahrenheit. Otherwise, there was to be no intervention.

The pediatrician stated that the efficaciousness of fever therapy was proven because after 3 days the child made a full recovery. The regimen raised numerous questions among the committee members, however.

This regimen is innovative; it could even be experimental. The case raises two ethical issues: Did the child's parents receive information about the treatment adequate to give informed consent? This question bears directly on how the hospital determines that informed consent is obtained in such cases. Because the therapy was innovative, special consent and review procedures should have been used. If fever therapy is determined to be experimental rather than innovative, the second issue is whether the research was therapeutic or nontherapeutic. Experimental treatment that may benefit the subject is therapeutic—the subject is also a patient. Nontherapeutic research involves healthy subjects or patients with medical problems other than those that might benefit from the experimental treatment. Nontherapeutic research must receive closer attention because the subject will not benefit and may be at increased risk.

Had this innovative (perhaps experimental) therapy been presented to an IRB for review and approval, additional safeguards would have been required. An IRB reviewing pediatric research must be persuaded of the justification for the therapy's risks and benefits. The IRB must find that the activity falls into one of four categories: 1) research not involving greater than minimal risk; 2) research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects; 3) research involving greater than minimal risk and having no prospect of direct benefit to the individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition; or 4) research not otherwise approved

but that represents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children.<sup>33</sup>

Notable in the fever therapy case is the nursing staff's apparent lack of concern about the unusual orders. The nursing code emphasizes protecting the patient and requires the nurse to intervene if the patient is unnecessarily put at risk. Timely reporting should have occurred through the nursing hierarchy. This aspect of the case suggests a much more widespread need to protect patients and further their interests.

## Membership and Purpose

Organizations may choose the members of their IRB, but federal regulations (and perhaps state law) govern composition of the membership, the nature of the review that is conducted, and the conflicts of interest of IRB members.<sup>34</sup> IRBs review research proposals for conformity with the law, standards of professional conduct and practice, and institutional commitment and regulations. IRBs acceptable to the DHHS have a minimum of five members with varying backgrounds (at least one whose professional interests are scientific and one whose interests are nonscientific) and who are capable of reviewing research proposals and activities of the type commonly performed by the organization.<sup>35</sup>

An IRB that is acceptable to the DHHS must apply the following requirements in reviewing research activities:<sup>36</sup>

- Minimize risks to subjects.
- Determine that risks to subjects are reasonable relative to anticipated benefits, if any.
- Select research subjects equitably.
- Obtain informed consent from each prospective subject or each subject's legally authorized representative.
- Appropriately document informed consent.
- Monitor the data collected to ensure the safety of subjects.
- Protect the privacy of subjects and maintain the confidentiality of data.

There must be additional safeguards when subjects are likely to be vulnerable to coercion or undue influence. Examples include children, prisoners, pregnant women, persons with mental retardation, or those who are economically or educationally disadvantaged. Several provisions identify the information needed for informed consent.

The FDA uses the same basic elements of consent as the DHHS but applies special provisions when the subject is in a life-threatening situation that necessitates use of the test article and the subject cannot provide legally effective consent, time is insufficient to obtain consent from the subject's legal representative, or no alternative method of generally recognized therapy that provides an equal or greater likelihood of saving the subject's life is available.

## Requirements

Regulations issued in 1981 eliminated the requirement that any organization receiving DHHS funding had to use DHHS guidelines in *all* research, regardless of funding source. This marked

a shift in the role of the federal government in protecting human subjects and in research, generally. The change also magnified the responsibilities of managers and researchers and put greater reliance on the organization's policies and procedures and on managers' personal ethic in judging the research. Problems such as those in the Willowbrook case, which is discussed below, are likely to increase state regulation of research.

As a practical matter, organizations with multiple research funding sources, one of which is the federal DHHS, are likely to use the same DHHS-qualified IRB for all research protocols. It is easy to slip, however, and managers must be alert to potential ethical problems in formal research programs as well as in isolated instances of innovative therapy or surgical experimentation.

A mix of moral philosophies and values is found in the DHHS regulations. Beneficence and its subsidiary, cost-benefit analysis, determine the benefits of research. Conversely, a Kantian (deontological) perspective and the principles of nonmaleficence and respect for persons underlie the requirements for consent, privacy, and confidentiality. The virtues of honesty, trustworthiness, and integrity are appropriate here, too.

It has been argued that nondiagnostic and nontherapeutic research on children and adults who are considered legally incompetent should be prohibited.<sup>37</sup> Congress *has not* given the FDA authority to require extensive testing on children. The ethical, economic, political, legal, and scientific problems of research involving children are so daunting that researchers have been reluctant to address the issue. Despite efforts by Congress and the FDA to encourage testing of pharmaceuticals and biologicals on children, little research involving children is done, and most prescriptions for children are based on physician trial and error.<sup>38</sup> It has been estimated that 50%–75% of drugs used in pediatric medicine have not been studied adequately to provide appropriate labeling information.<sup>39</sup> As noted, nontherapeutic research on children is permitted. A risk-benefit ratio is applied, and no child can be placed in unnecessary jeopardy. Assent from both the child and parents or legally authorized representatives are required.

### **Hepatitis for Children with Mental Retardation?<sup>40</sup>**

Willowbrook State Hospital, an institution for the care of people with mental retardation in Staten Island, New York, housed more than 5,000 residents in 1971.

Dr. Saul Krugman was a consultant in pediatrics and infectious diseases. When he began work at Willowbrook in the early 1950s, he discovered that major infectious diseases, including hepatitis, measles, shigellosis, parasitic infections, and respiratory infections, were prevalent. Conditions at Willowbrook were like those found at similar facilities elsewhere in the United States. Dr. Krugman and his colleagues undertook a study of these diseases, including research on a measles vaccine and hepatitis.

In 1956, Dr. Krugman, Dr. Joan Giles, and Dr. Jack Hammond began studies on hepatitis. The final phase of the research (1965–1970) involved 68 children ages 3–10. The researchers injected an infected serum to cause hepatitis in the residents of their research unit. The objective was to gain a better understanding of hepatitis and possibly develop methods of immunizing against it. The research was approved by the Armed Forces Epidemiological Board, one of the funders of the research; the executive faculty and the Committee on Human Experimentation of New York University, where Dr. Krugman held a faculty position; and the New York State Department of Mental Hygiene.

The researchers defended their decision to expose the children to strains of hepatitis on the following grounds:

1. They were exposed to the same strains that were endemic to the facility.
2. They were admitted to a special, well-equipped, and well-staffed unit and were isolated from exposure to other infectious diseases prevalent in the institution. The health risk was thus lower for those in the experiment than for those in the hospital at large, in which multiple infections occurred.
3. They were likely to have a subclinical infection followed by immunity to the particular hepatitis virus.

The researchers emphasized that only children whose parents gave informed consent participated in the experiment.

A storm of adverse publicity arose when the experiment was made public in 1967 by a New York state senator, who charged that children were being used as human guinea pigs. Nevertheless, the research continued. In 1971, the group's work produced spectacular results, when Dr. Krugman and co-workers were able to immunize a small group of children against serum hepatitis (hepatitis B [HBV]). The preliminary results were hailed as a scientific breakthrough. In defending the research, Dr. Krugman reported that the injections that induced hepatitis in the research group were given only after employing great thought and professional discretion and only with the informed consent of the parents. He stated that the doses were small and that the inoculations usually produced the infections without making the children sick. (After 12 years of legal and regulatory controversy, Willowbrook State Hospital closed at the end of 1987, when a federal court approved a final settlement.)

Although Dr. Krugman and his colleagues made a convincing case for undertaking and continuing the research, the Willowbrook case illustrates several ethical problems. The consent obtained from parents or surrogates was given under duress—they almost certainly believed that children who were part of the group purposely infected with HBV would fare better than children living among the population at large, in which conditions were much worse. Such considerations make it difficult to apply the principles of beneficence and nonmaleficence.

The general benefit of being in the special unit is an argument that should receive some credence. The children were somewhat protected from other diseases prevalent at Willowbrook and received treatment for the sequelae of HBV. In addition, it can be argued that this research is therapeutic; even though the children did not have HBV, they were almost certain to become infected with it. Children in the unit were also likely to be less harmed in other ways than would children in Willowbrook, thereby generally meeting the principle of nonmaleficence. The real problem, however, is that the children were being used as a means to an end, despite a potential for great social benefit if the research were successful.

The research protocols had been approved by prominent and appropriate review bodies and the research continued for 16 years (1956–1971). Assuming effective consent from parents or legally authorized representatives, federal guidelines would have permitted this nontherapeutic research. At the same time, however, the organizational philosophy through its managers could have applied a more demanding standard—using the virtues of justice, compassion, and integrity—to the point of prohibiting the research. In fact, research that is not clearly therapeutic for children and others unable to give voluntary and competent consent is so fraught with ethical problems that it is rarely undertaken. Regrettably, this conundrum has resulted in a dearth of certain types of clinical knowledge, especially that of the therapeutic effects of drugs and biologicals on children—which, as noted, is ultimately to their detriment.

A question of justice in allocating state funds is raised by the horrific conditions at Willowbrook. Is it fair that human beings are treated so? In the absence of an increase in state appropriations, however, the principles of respect for persons, beneficence, and nonmaleficence must be applied within financial limits.

The research conducted on children at Willowbrook seems to be from another era—one with far less attention paid to protecting human subjects, especially children. Yet, three decades later an even more unacceptable example of research involving children occurred in



Baltimore, and involved the Kennedy Krieger Institute, an affiliate of Johns Hopkins University. The EPA-funded study, with state and city governmental sponsors and collaborators, sought to find inexpensive alternatives for reducing or eliminating the risks of lead paint in homes. A large number of families with healthy young children were placed in rental housing with various levels of lead risk abatement. Parents were not told of the full extent of the risk; upon discovering it, they sued.<sup>41</sup> Maryland's highest court faulted the Johns Hopkins Hospital IRB and ruled that "in Maryland a parent . . . cannot consent to the participation of a child or other person under legal disability in nontherapeutic research or studies in which there is any risk of injury or damage to the health of the subject."<sup>42</sup>

### **Exempt Research and Research Warranting Expedited Review**

Six categories of research are exempt from DHHS requirements. Examples are research conducted in established or normally accepted educational settings involving normal educational practices; research involving use of educational tests, survey and interview procedures, or observation of public behavior; and research involving the collection or study of existing data, documents, records, and pathological or diagnostic specimens. Limits are specified.<sup>43</sup>

DHHS regulations identify research warranting expedited review as a category to which different provisions apply. Expedited review allows special procedures for approval of certain types of research that pose no more than minimal risk to human subjects. The review is conducted by the IRB chair, or by one or more experienced reviewers designated by the chair. In reviewing the research, the reviewer exercises all of the IRB's authority. Research may be disapproved only in accordance with the nonexpedited procedure.<sup>44</sup> Subject to limitations, research categories appropriate to expedited review include clinical studies of drugs and medical devices; collection of blood samples; collection of biological specimens such as hair and nail clippings and deciduous teeth; collection of data through noninvasive procedures; research using materials collected for other purposes; collection of data from various types of recordings; research on individual or group characteristics or behavior; and continuing review of research previously approved by the IRB.<sup>45</sup> Expedited review greatly facilitates several kinds of research.

### **Falsification of Research Data**

A unique dimension to problems in research occurred in the late 1970s and early 1980s.<sup>46</sup> John Darsee, a fellow in cardiology at Emory University and Harvard University and a brilliant physician of unusual talent, perpetrated an amazing fraud. Darsee was found to have falsified large quantities of research data on the genetic and biochemical factors affecting heart disease. Some of these data had been published in leading medical journals. Other data were being used for papers in process. Many of the articles listed prominent physician-researchers as coauthors, some of whom later asserted they had no knowledge that they had been identified as such.

Darsee's champions supported him until the evidence of his deception proved overwhelming. Darsee's detractors argued that his supporters were too easily charmed by his

personality and talents. When researchers and administrators at Emory and Harvard learned of the fraud, they withdrew his papers and abstracts that had been submitted for publication. The only course for articles already published was to urge readers to disregard them. It is claimed that no patients were harmed because of Darsee's clinical work, a claim verifiable only by reviewing medical records. Much more potential harm, however, lies in the fact that Darsee's list of publications includes more than 100 articles and abstracts. Readers unaware of the fraud cannot know which publications contain false data.

The organizations involved were forthright after the fraud was discovered. What happened violated both the ethics of research and the proscriptions imposed by funding organizations (e.g., the National Institutes of Health). The most pointed questions, however, concern the adequacy of surveillance, not only of Darsee but also of all physicians in training who engage in research and collect research data. Subsequent self-assessment at Emory led to new safeguards in reviewing the work of physicians in training and in monitoring the use of names of teaching staff as coauthors. Research findings are also reviewed much more extensively since the Darsee affair. Despite the safeguards, some people argued that "[they] won't prevent the generation of fraudulent data, but under this system someone like Darsee couldn't send out articles at the rate of one a week without raising suspicions."<sup>47</sup> Healthy skepticism regarding research integrity is wise. One study of research misconduct stated

Nearly one generation after the effort to reduce misconduct in science began, the responses by NIH scientists suggests that falsified and fabricated research records, publications, dissertations, and grant applications are much more prevalent than has been suspected to date. Our study calls into question the effectiveness of self-regulation.<sup>48</sup>

Another investigation suggested that falsifications and fabrications are symptomatic of wider problems, such as plagiarism, conflicts of interest, failing to meet human subject requirements, misuse of confidential information, failing to present data that contradict one's own previous research, and failing to report others' use of flawed data or questionable interpretation of data.<sup>49</sup>

## Summary

Regulations such as those imposed by the DHHS focus responsibility on the organization and its IRB. Irrespective of legal requirements, the organization's managers are charged with independent duties under the principles of respect for persons, beneficence, nonmaleficence, and even justice (e.g., equitable selection of research subjects) in order to protect the patient. The virtues of honesty, integrity, and trustworthiness are applicable as well. Managers must establish and maintain systems and procedures to prevent unauthorized research and to provide the necessary extra protection when innovative treatment or surgical research are proposed or undertaken. The Darsee affair raises a unique set of potential problems in teaching and research institutions, the most important being staff awareness about the parameters of acceptable practice and the courage to act on those observations.

## INFANT CARE REVIEW COMMITTEES

ICRCs are another type of specialized IEC. They focus on the biomedical ethical problems of

infants with life-threatening conditions. The Child Abuse Amendments of 1984 (PL 98-457) directed the DHHS to encourage the establishment of ICRCs in health facilities, especially those with tertiary-level neonatal units. The DHHS identified the following guidelines for ICRCs:

- (1) educate hospital personnel and families of disabled infants with life-threatening conditions;
- (2) recommend institutional policies and guidelines concerning the withholding of medically indicated treatment from infants with life-threatening conditions;
- and (3) offer counsel and review in cases involving infants with life-threatening conditions.<sup>50</sup>

The guidelines make it clear that the DHHS considers it prudent to establish an ICRC but that the organization decides whether to do so. [Chapter 10](#) provides the background for the original Baby Doe regulations and the Child Abuse Amendments.

Certain aspects of the ICRC's membership and administration recommended in the guidelines are notable. Members should include individuals from varied disciplines and perspectives because a multidisciplinary approach provides the expertise to supply and evaluate pertinent information. The committee should be large enough to represent diverse viewpoints but not so large as to hinder its effectiveness. Recommended membership includes a practicing physician (e.g., pediatrician, neonatologist, pediatric surgeon), practicing nurse, hospital administrator, social worker, representative of a disability group, lay community member, and member of the facility's medical staff, who is the chairperson.<sup>51</sup> The recommendation to include a representative of a disability group on the ICRC runs counter to the principle that members of such committees should not represent specific groups.

The DHHS suggested that the ICRC have adequate staff support, including legal counsel; that the ICRC recommend procedures to ensure that both hospital personnel and patient or resident families are informed of its existence, functions, and 24-hour availability; that the ICRC self-educate about pertinent legal requirements and procedures, including state law requiring reports of known or suspected medical neglect; and that the ICRC maintain records of deliberations and summary descriptions of cases considered and their disposition.<sup>52</sup>

Many groups, including the AMA, the American Hospital Association (AHA), and various medical specialty associations, objected vociferously to the original Baby Doe regulations and sought to block implementation. The Child Abuse Amendments and regulations, however, were supported by health services trade associations, which ran the gamut from institutional and personal providers to specialized groups. In fact, the associations were instrumental in developing the law and regulations. The AHA enthusiastically backed the new law, and few hospitals will have philosophical problems complying with it.<sup>53</sup>

## **SPECIALIZED ASSISTANCE**

This section outlines assistance for organizations and their managers and clinical staffs in solving administrative and biomedical ethical problems. Analogues to IECs and specialized committees such as IRBs and ICRCs that can assist managers to identify and solve administrative ethical problems are not as well developed but should be given further nurturing and attention.

### **Ethicists**

A less formal approach than the ethics consultation provided through an IEC may be found in larger hospitals, but it should not be limited to them. This option employs ethicists on a full- or part-time basis. Ethicists are often doctorally qualified philosophers who may be faculty at a university or medical school and who consult with clinical staff on biomedical ethical issues.

Organizations needing the assistance of an ethicist can look beyond universities and medical schools and consider persons with specialized preparation in ethics and its application in health services delivery. This makes the ethicist a clinically oriented, problem-solving extension of an IEC.

## **Dispute Resolution**

Treatment options and decisions regarding them often cause disputes among stakeholders, such as patients, families, and clinicians. The various types of ethics committees (e.g., IECs, IRBs, ICRCs) may be able to resolve disputes, but being part of the organization may raise questions of objectivity. If objectivity is a problem, arbitration and mediation should be considered to resolve disputes. Arbitration involves a neutral person—the arbitrator—to whom the parties give the authority to make a decision that they agree to accept. Mediators are neutral persons who work with the parties to reach a mutually acceptable result; mediators have no authority to make or impose a decision. Competent neutrals can minimize the power imbalances present in health services settings, especially when non-clinicians are involved in the dispute.<sup>54</sup> One objective of improved dispute resolution is to weld a multidisciplinary group into a cohesive and mutually supportive team so that they can resolve their differences and maintain the quality of patient care. Formal dispute resolution could also assist the various types of ethics committees. It is overly optimistic to believe that the act of establishing an interdisciplinary ethics committee necessarily means that it will be successful.

## **CONCLUSION**

This chapter examined committees established to address ethical issues. Typically, these committees include IECs as well as IRBs and ICRCs, which are specialized ethics committees. In addition to hospitals, ethics committees can provide assistance in a wide range of health services organizations, including nursing facilities, managed care organizations (MCOs), and hospices, all of which experience ethical problems similar to those found in hospitals. The greatest growth is likely in nonhospital settings. Hospice and nursing facilities, for example, confront issues related to dying and death, and MCOs face issues of resource allocation and physician incentive plans. Ethics committees in all settings will be involved in solving complex ethics issues, some of which (e.g., organizational philosophy) may come under mandatory review.

Ethics consultations and ethicists can be involved on a more discretionary basis to assist in identifying and analyzing the moral obligations, rights, responsibilities, and considerations of justice that bear on a general issue or on the ethical issues in a specific case.<sup>55</sup> They can assist physicians and are more likely to be used than are biomedical ethics committees, which physicians may view as cost ineffective. Beyond considerations of efficiency, it may be more palatable for physicians to consult with a single ethicist than to seek guidance from a

committee. Ethicists can serve a similar function for managers by assisting them in identifying and solving administrative ethics problems and working with an administrative IEC.

Economic pressures resulting from cost cutting by third-party payers—particularly government—and new competitive pressures are affecting all health services organizations, but especially acute care hospitals. Managers may be tempted to use economic justification for decisions that implicitly, or even explicitly, affect quality of care negatively. The conflict between economic interests and quality considerations lies near the surface in most relationships with patients. The technical nature of health services and the average consumer's limited ability to judge results make it imperative that individuals associated with healthcare delivery expend every effort to further the quality of care and protect the interests of patients.

## NOTES

1. Judith Wilson Ross, John W. Glaser, Dorothy Rasinski-Gregory, Joan McIver Gibson, & Corrine Bayley. (1993). *Health care ethics committees: The next generation* (p. 1). Chicago: American Hospital Publishing.
2. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1983). *Deciding to forego life-sustaining treatment: A report on the ethical, medical, and legal issues in treatment decisions* (p. 443). Washington, DC: U.S. Government Printing Office.
3. D. Holthaus, M.T. Koska, P. Eubanks, & T. Hudson. (1989, November 20). Right to die: An executive report. *Hospitals* 66(22), p. 34.
4. Ross et al., p. ix.
5. Joanne Lappetito & Paula Thompson. (1993, November). Today's ethics committees face varied issues. *Health Progress*, p. 34.
6. Cynthia B. Cohen. (1990, March/April). Ethics committees. *Hastings Center Report* 20, pp. 29–34.
7. Lappetito & Thompson, p. 34.
8. Glenn McGee, Arthur L. Caplan, Joshua L. Spanogle, & David A. Asch. (2001, Fall). A national survey of ethics committees. *American Journal of Bioethics* 1(4), pp. 60–64.
9. American Association of Homes and Services for the Aging. (1995, July). *Summary report: Survey on ethics involvement in aging services*. Washington, DC: Author.
10. Ross et al., p. 8.
11. Francis Bernt, Peter Clark, Josita Starrs, & Patricia Talone. (2006, March/ April). Ethics committees in Catholic hospitals. *Health Progress*, pp. 18–25.
12. Robert M. Veatch. (1983, July). Ethics committees proliferation in hospitals predicted. *Hospitals* 57(13), pp. 48–49.
13. Mark E. Meaney. (2004, Summer). Error reduction, patient safety, and institutional ethics committees. *Journal of Law, Medicine, & Ethics* 32, pp. 358–364.
14. John C. Fletcher, Margo L. White, & Philip J. Foubert. (1990). Biomedical ethics and an ethics consultation service at the University of Virginia. *HEC Forum* 2(2), pp. 89–99.
15. President's Commission, p. 448.
16. Ellen Fox, Sarah Myers, & Robert A. Pearlman. (2007). Ethics consultation in United States hospitals: A national survey. *American Journal of Bioethics* 7(2), pp. 13–25.
17. David J. Ramsey, Mary Lou Schmidt, & Lisa Anderson-Shaw. (2010, January/ February). Online ethics discussion forum facilitates medical center clinical ethics case reviews. *JONA'S Healthcare Law, Ethics, and Regulation* 12(1), pp. 15–20.
18. Harold G. Koenig. (2003, July/August). Meeting the spiritual needs of patients. *Satisfaction Monitor*. Retrieved March 12, 2011, from <http://www.ourjourneyofhope.com/resources/meeting-the-spiritual-needs-of-patients.pdf>.
19. Marilyn M. Mannisto. (1985, April). Orchestrating an ethics committee: Who should be on it, where does it best fit? *Trustee* 38(4), pp. 18–19.
20. Ross et al., p. 5.
21. Bernt et al., p. 20.
22. Fox et al., p. 17.
23. Gordon DuVal, Brian Clarridge, Gary Gensler, & Marion Danis. (2004, March). A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *Journal of General Internal Medicine* 19, pp. 251–258.
24. Linda S. Scheirton. (1993). Measuring hospital ethics committee success. *Cambridge Quarterly of Healthcare Ethics* 2, pp. 495–504.
25. Mannisto, pp. 17–20.



26. Amy Haddad & George Annas. (1994, July). George Annas quoted in “Do ethics committees work?” *Trustee* 47(7), p. 17.
27. Abbey S. Meyers. (2000, January 30). A lot of rules, too many exceptions. *Washington Post*, p. B3.
28. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979, April 18). *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Retrieved March 13, 2011, from <http://ohsr.od.nih.gov/guidelines/belmont.html>.
29. American Medical Association. (Updated June 1994 and June 1998). *Opinion 2.07—Clinical investigation*. Retrieved January 3, 2011, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion207.shtml>.
30. Public Welfare, 45 C.F.R. § 46 (2001), and Food and Drugs, 21 C.F.R. § 56 (2001).
31. Mark Barnes & Sara Krauss. (2000, August 31). Conflicts of interest in human research: Risks and pitfalls of “easy money” in research funding. *BNA’s Health Law Reporter* 9(35), p. 1383.
32. *Ibid.*
33. Michelle K. Russell-Einhorn & Tom Puglisi. (2001). *The PricewaterhouseCoopers IRB reference book* (pp. 199–200). Washington, DC: PricewaterhouseCoopers.
34. Barnes & Kraus, p. 1382.
35. Public Welfare, 45 C.F.R. § 46.107 (2001).
36. Public Welfare, 45 C.F.R. § 46.111 (2001).
37. Paul Ramsey. (1970). Research involving children or incompetents. *The patient as person* (p. 252). New Haven, CT: Yale University Press.
38. Peter B. Budetti. (2003, August 20). Ensuring safe and effective medications for children. *Journal of the American Medical Association* 290(7), pp. 950–951.
39. Rosemary Roberts, William Rodriguez, Dianne Murphy, & Terie Crescenzi. (2003, August 20). Pediatric drug labeling: Improving the safety and efficacy of pediatric therapies. *Journal of the American Medical Association* 290(7), pp. 905–911.
40. Articles from several issues of the *New York Times* were used to prepare the Willowbrook case and provide background information: January 11, 12, and 13, 1967; March 24, 1971; April 18, 1971; January 11, 1972; May 25, 1981; January 8, 1984; April 19, 1985; and March 3, 1987.
41. Manuel Roig-Franzia & Rick Weiss. (2001, August 21). Md. appeals court slams researchers. *Washington Post*, p. B1; Manuel Roig-Franzia. (2001, August 25). My kids were used as guinea pigs. *Washington Post*, p. A1.
42. *Grimes v. Kennedy Krieger Institute*, 366 Md. 29, 782 A.2d 807 (2001).
43. Office for Protection from Research Risks. (1997, December 23). *Summary of basic protections for human subjects*. Retrieved August 17, 2003, from <http://ohrp.osophs.dhhs.gov/humansubjects/guidance/basics.html>.
44. Public Welfare, 45 C.F.R. § 46.110 (2001).
45. Office for Human Research Protections. (1998, November 9). *Categories of research that may be reviewed by the institutional review board (IRB) through an expedited review*. Retrieved March 13, 2011, from <http://www.hhs.gov/ohrp/policy/expedited98.html>.
46. Claudia Wallis, Sue Wymelenberg, & Renie Schapiro. (1983, February 28). Medicine: Fraud in a Harvard lab. *Time*.
47. *Ibid.*
48. Sandra L. Titus, James A. Wells, & Lawrence J. Rhoades. (2008, June). Repairing research integrity. *Nature* 453(19), pp. 980–982.
49. Brian C. Martinson, Melissa S. Anderson, & Raymond Dearies. (2005, June). Scientists behaving badly. *Nature* 435(9), pp. 737–738.
50. Final Rule, Child Abuse and Neglect Prevention and Treatment Program, 45 C.F.R. §1340 (1985).
51. Services and Treatment for Disabled Infants; Model Guidelines for Health Care Providers to Establish Infant Care Review Committees, 50 Fed. Reg. 14,893 (1985).
52. *Ibid.*
53. *Summary: Survey of infant care review committees*. (1984). Paper presented at the Annual Meeting of the American Academy of Pediatrics, Chicago.
54. Jerry P. Roscoe & Deirdre McCarthy Gallagher. (2003, Spring). Mediating bioethical disputes: Time to check the patient’s pulse? *Dispute Resolution Magazine* 9(3), pp. 21–23.
55. John C. Fletcher, Norman Quist, & Albert R. Jonsen. (1989). *Ethics consultation in health care*. Chicago: Health Administration Press.