SECTION III

# ADMINISTRATIVE ETHICAL ISSUES

Virtually all administrative problems that arise in managing health services organizations and programs have ethical dimensions. These ethical problems are qualitatively distinct from those encountered in the business world.

Business ethics literature burgeoned in the 1980s, and courses in business policy and ethics are now common in graduate and undergraduate business programs. For-profit enterprise has no tradition of an independent duty or obligation beyond that established by law; appropriately, emphasis is placed on profitability and caveat emptor (let the buyer beware). Business ethics literature examines concepts such as honesty, integrity, and benevolence; duties of employees to one another and the organization; and duties of organizations to employees. These aspects are similar to those that health services managers apply. Absent, however, is the concept of respect for persons, which emphasizes autonomy, fidelity, and confidentiality. Further, beneficence is not a focus in business ethics. The principle of justice is found only at the periphery of business ethics. The differences between business and health services are cited not to criticize business but to distinguish the two fields of endeavor, whose foci and purposes are, simply put, quite different.

The public's view and that of the health services field have been that health services managers have a higher calling, one that goes well beyond the financial bottom line. Codes of ethics in health services define this calling and the intrinsic duties of managers. This definition arose from the link with medical and nursing professionals and the not-for-profit status common to health services. Acute care hospitals have historical links with religious orders; Samaritan motivation created unique relationships. The totality of this higher calling emphasizes the caring and the curing aspects of health services. It reflects society's sense that the sick are a unique group, one with special status; they need protection and are not to be exploited. Despite occasional harsh criticism, especially of financial management and the quality of care, the Samaritan image of health services organizations is largely intact.

Administrative ethics issues that confront health services managers cover a gamut, from conflicts of interest to governing body and medical staff relations to an independent duty toward patients. Such problems can be subtle. They may appear in several guises but are identifiable and solvable by alert, conscientious managers. The ethical issues and concerns of managers in their relationships with the organization, staff, patients, and community are considered in Chapters 6, 7, and 8. Considered, too, are the effects of infectious diseases such as acquired immunodeficiency syndrome/human immunodeficiency virus (AIDS/HIV), hepatitis B, and hepatitis C on these relationships, and the special duties and responsibilities that they raise.

Section III identifies and examines administrative ethical issues. By and large, they are distinct from the biomedical ethical issues considered in Section IV. Differences between administrative and biomedical ethical issues are important, but the two often blur in practice.

Patient consent provides an example of these differences. Administrative ethics of consent likely affect patients as groups rather than individuals, and they affect managers' relationships with the organization, peers, profession, and community. Biomedical ethics of consent usually affect individual patients or specific types of patients. The two merge in the ethical duty of the organization to assure itself that patients have freely given informed consent to clinicians for treatment. Administrative and biomedical ethical problems actually or potentially affect one another. The primary focus of each type of ethical problem differs, however.

# CHAPTER 6

# CONFLICTS OF INTEREST AND FIDUCIARY DUTY

Conflict of interest is a common administrative ethical issue in health services organizations. A conflict of interest can arise when someone has a duality of interests or duties. This duality of interests occurs when duties are owed to two or more persons or organizations, and meeting the duty to one makes it impossible to meet the duty to the other. A classic example of a duality of interests that will lead to a conflict of interests occurs when a decision maker—such as a director (trustee) or manager—is also a decision maker on the same question for an organization with which the health services organization does business. The manager cannot meet the duties owed to both organizations—the duties conflict with each other. Conflicts of interest also arise for clinicians. Conflicting duties owed to different patients by the same physician, for example, are an important reason to separate the organ transplant team from the physician who is treating the potential donor. Other dual interests that can result in conflicts of interest arise when a duty owed to the organization by a physician are in conflict with those owed by the physician to patients or colleagues, or when patients with the same diagnosis and physician but in different payment categories receive different care in the same organization.

Conflicts of interest are insidious; one can slip into them without realizing it. Sometimes, there is a fine line between acceptable and unacceptable behavior, a pragmatic view recognizing that the relationships of normal business often create a duality of interests, which may result in actual conflicts of interest.

Relationships among staff members can cause dualities of interest that result in an actual conflict of interest, or certainly the appearance of a conflict.

### Sometimes More than Friends

Mary and John work in the medical imaging department of a large community hospital. Mary is a radiographic technologist who earned an MBA online. She was appointed the administrative head of the department 2 years ago. She supervises 14 techs, 5 clerical staff, and 4 transporters. About 2 years ago, Mary hired John to be a transporter. John had a strong recommendation from a radiologist in the department, who is a family friend. Mary and John developed a good relationship and sometimes had lunch together or took breaks at the same time. Their friendship did not seem to interfere with their jobs; they always acted professionally at the hospital.

About a year after John was hired, there were rumors that Mary and he were dating. A few months later, Mary told her staff that she and John had eloped and were married. Now, they spent even more time together. They arrived at work together, joined each other for meals and breaks, and left together. The staff began to pay close attention to how Mary treated John and if there was any favoritism. Sometimes, the other transporters grumbled that John got more attention from Mary when he had problems and that he was getting physically less demanding transport assignments.

One of the senior techs spoke to the human resources (HR) director about what she thought was a developing problem in the department. The director told her that there were no hospital guidelines on nepotism. The HR director told the tech that she could file a grievance if she felt that John was receiving preferential treatment, or if she thought their marriage was interfering with good management in the department.

The Latin root of nepotism is *nepoti*, defined as child, grandchild, or nephew. Niccolò

Machiavelli touted the value of *nepoti*—especially nephews—in government as the best means of maintaining control and wielding power effectively. He argued that great benefits resulted from keeping control and power within the family. The contemporary view of nepotism in organizations is that it should be avoided or, if allowed, minimized and controlled. Nepotism has the potential to decrease objectivity, cause behavioral problems to be ignored, result in favoritism, produce an unhealthy work environment, cause poor workplace decision making, diminish morale among non-*nepoti*, and not stand up to public scrutiny. Well-managed organizations have guidelines on nepotism. Commonly, relatives are not allowed to report to one another, or even to work in the same department. As important as the actual presence of problems is the perception of unequal or inequitable treatment. The halo effect (perceived positive qualities as to one attribute cause a perception of similar qualities in related things) and stereotyping (conceptions of an individual based on prior assumptions) are two examples of problems when there is nepotism. Generally, policies—such as those on nepotism—help managers make decisions that further the interests of the organization and its patients. In addition, they can be used by those who may not want to supervise or work in the same department with a relative as a reason to avoid doing so. HR should take the lead in developing a policy on nepotism. Managers need guidance in such matters, and the certainty of policies furthers the organization's effectiveness.

Managers' relationships with the organization and interactions with the health system and other organizations in it can cause conflicts of interest. In addition to potentially affecting managers' relationship with the organization, conflicts of interest can affect managers' relationships with the profession and their personal development.

Conflicts of interest are often subtle and can affect all managerial activities. Has the manager who uses a position of influence and authority to gain titles, stature, and income at the expense of the organization or patient care acted ethically? Is the manager who is lax in developing and implementing an effective patient-consent policy and process acting ethically? Is it ethical for a manager to review and cleanse negative information from reports to the governing body? Is it ethical for a manager who has reason to believe that quality of care problems may exist in a clinical department to do nothing to prove or disprove their presence? Is it ethical for managers who have serious concerns about their abilities to continue managing? To the complexity of such questions from an ethical perspective must be added the legal implications. Regardless, managers must first be concerned about their independent, positive duty to the patient.

There is significant evidence that many conflicts of interest are not consciously understood by persons making decisions—they honestly believe that what they are doing is in the best interest of the organization or individuals involved. Compensation program incentives may subconsciously drive decision making that leads to conflicts of interest.[1] Yet, managers must avoid any hint of wrongdoing, especially the suggestion of divided loyalties. A bad odor emanates when a hospital's chief executive officer (CEO) owns stock in a corporation that contracts for the hospital's data processing business, and in which the principal stockholder and CEO is the hospital's comptroller. The odor lingers regardless of discounted price or other advantages the hospital may gain. Outside observers will certainly think that the relationships have hidden aspects that are detrimental to the organization or its patients, and that managers

are reaping a personal advantage. Attempts to convince the public otherwise probably reinforce the perception of wrongdoing. The only course of action is to avoid arrangements or entanglements that contain any hint of duality of interests that could lead to conflicts of interests. The problem is well put by Harlan Cleveland in *The Future Executive*: "If this action is held up to public scrutiny, will I still feel that it is what I should have done, and how I should have done it?"[2] Cleveland's criterion of public scrutiny can be called the "light of day" test; its simplicity is compelling.

## FIDUCIARY DUTY

*Fiduciary* is an ethical and legal concept arising from Roman jurisprudence. A fiduciary relationship exists whenever confidence and trust on one side result in superior position and influence on the other. Superior position and influence result in duties of loyalty and responsibility. This definition suggests that numerous fiduciary relationships exist in health services. Governing body members, for example, are fiduciaries. Their duty of loyalty prevents them from using their position for personal gain, and they must act only in the organization's best interests. This definition has been interpreted to mean that no secret profits can be made in dealings with the organization and that the governing body member may not accept bribes or compete with the organization. The duty of responsibility requires governing body members to exercise reasonable care, skill, and diligence, as demanded by the circumstances.[3] Members of governing bodies have a duty to avoid both errors of omission and errors of commission. Breaching these duties could result in personal liability, whether or not the corporation is organized for profit.

Trusts are common in the health services field. Many not-for-profit health services organizations engaging in charitable activities were founded because of a gift or bequest that established a trust; trustees manage the assets of the trust. Examples are trusts to defray the costs of a patient unit or specific clinical activity in a hospital. Other uses include funding schools of nursing or providing scholarships to educate health services personnel.

The term *trustee* is commonly used to describe governing body members of not-for-profit corporations in the health services field, even though there is no trust and they are not true trustees. Technically, the legally correct term is *director* or *corporate director*. The title *trustee* is preferred in the not-for-profit sector, however, perhaps because governing body members want to be distinguished from governing body members in for-profit organizations, in which *director* is used.

The legal standard for true trustees is much more stringent than that applied to directors of corporations or to individuals responsible for monies or properties not held in trust. True trustees actually hold title to property or the corpus of the trust, and manage it for the beneficiary. True trustees must act in good faith and practice undivided loyalty in administering the trust. All situations and relations that interfere with discharging these duties must be avoided. Breaching these standards results in personal liability.

In many jurisdictions, the standard of care required of directors of not-for-profit corporations who are not true trustees is higher than that required of other corporate directors. The usual standard for directors who are not true trustees is that they are liable for ordinary negligence (e.g., errors in judgment). The minority rule is that to be legally liable, directors

must have committed an act of gross negligence, usually defined as an intentional failure to perform a manifest duty, with reckless disregard of the consequences.

## Sibley Memorial Hospital

An important court case involving governing body members of a health services organization is *Stern et al. v. Lucy Webb Hayes National Training School of Deaconesses and Missionaries et al.* (1974).[4] The members of the governing body of Sibley Memorial Hospital, a not-for-profit hospital in Washington, D.C., were called "trustees" even though they were not true trustees. David M. Stern brought a class action suit against the hospital on behalf of his minor son and other patients, alleging that patients had overpaid for care because several governing body members had engaged in mismanagement, nonmanagement, and self-dealing (succumbing to self-interest). The suit alleged that the acts of omission and commission resulted from a conspiracy between those "trustees" and various financial institutions with which several "trustees" were affiliated. The court found no evidence of a conspiracy. In considering the other allegations, however, it determined that

> The charitable corporation is a relatively new legal entity which does not fit neatly into the established common law categories of corporation and trust. . . . The modern trend is to apply corporate rather than trust principles in determining the liability of the directors of a charitable corporation, because their functions are virtually indistinguishable from those of their "pure" corporate counterparts.[5]

This ruling meant that defendant "trustees" were held to a less stringent standard of care.

The court found that the "trustees" had violated their duties as fiduciaries, even when held to the lesser, corporate standard. Mismanagement occurred because the "trustees" ignored the investment sections of yearly audits, failed to acquire enough information to vote intelligently on opening new bank accounts, and generally failed to exercise even cursory supervision over hospital funds. Nonmanagement was evidenced by the same failure to exercise supervision. In the starkest example, although certain "trustees" were repeatedly elected to the investment committee, they did not object when the committee did not meet in more than 10 years. The allegation of self-dealing was substantiated by the following: A number of "trustees" were officers of banks in which Sibley kept hundreds of thousands of dollars in noninterest-bearing checking accounts and in which interest-bearing accounts paid less than market conditions would have permitted, and one "trustee" advised approval of and voted to approve a contract for investment services with a corporation of which he was president.

The court did not find evidence of personal gain by the "trustees," although in several instances they had been associated with organizations that had benefited from transactions with the hospital. That there was no evidence of a conspiracy seems significant to the ruling.

The court did not order any "trustees" removed from the governing body, and no personal liability attached to their wrongdoing. To prevent similar problems in the future, the court ordered the governing body to adopt a written investment policy, review relevant committees to determine if hospital assets conformed to the policy, and establish a regular process of disclosure of governing body members' business affiliations. Before the case was decided, the governing body adopted the then-current guidelines on conflicts of interest published by the American Hospital Association (AHA). That action occurred long after the fact but demonstrated the governing body's good faith. The AHA's conflict of interest statement (which

is now out of print) reflected the less stringent corporate director standard.

The decision in Sibley was handed down by a federal trial court and has limited legal significance as a precedent. Nevertheless, it is one of the few cases that considers the standard of care for governing body members (directors) of not-for-profit organizations. Fiduciary duty requires that governing body members exercise reasonable care, skill, and diligence; under a negligence theory, they are liable for acts of commission or omission that violate this standard. *Reasonable care* is the care an ordinary, prudent director would exercise under the same or similar circumstances. The rule enunciated in Sibley is that governing body members (directors) of a not-for-profit corporation who are not true trustees may be liable for ordinary negligence as well as gross negligence or willful misconduct. This standard is usually imposed on the board of directors of a business enterprise.

CEOs and other managers are not fiduciaries in the same sense as directors, but they are held to a similar standard: a duty to exercise reasonable care, skill, and diligence, or the care that an ordinary, prudent manager would exercise in the same or similar circumstances. Many states' laws provide immunity from liability for governing body members of not-for-profit organizations. Often, however, the statutes contain limitations and exclusions from immunity, loopholes, and vague language, thus providing little real protection for directors and officers against liability.[6]

An infrequently discussed aspect of fiduciary duty is the politicization of healthcare. In addition to fiduciary duty, politicization may cause conflicts of interest, which were discussed earlier in this chapter. The risk of politicization is high when programs owe their existence to public funding sources; it can also occur in any organization with a defined constituency, especially if that constituency is also a major source of funding. Public health managers and their organizations and activities are at greater risk because they have a unique relationship with government and the political process. They are heavily dependent on the goodwill of government officials and politicians for their funding. This puts them at risk of adopting prevailing political viewpoints to the exclusion of objective, scientific-based decision making. Politicization arises most often in the macroallocation of resources. If public health organizations and practitioners lose, or appear to lose, their objectivity because they are too closely tied to one point of view, the public may no longer have confidence in them—they will be seen as but an extension of only that viewpoint. Once lost, trust is regained only with difficulty and over time. It will take courage and the ability to persuade through use of science and objective data to protect the public's health without diminishing its autonomy or violating the precepts of beneficence, nonmaleficence, and justice for the public. Successful managers will have a well-developed, clearly identifiable personal ethic that will help them avoid or minimize the problems of politicization.

## ETHICAL OBLIGATIONS OF TRUSTEES AND DIRECTORS

Legal standards stand as the minimum required level of performance. What are the ethical obligations of trustees and directors? Policies on conflicts of interest emphasize disclosure—putting other governing body members on notice about potential or actual conflicts. In the Sibley case, it is uncertain that disclosure would have made a difference. The "trustees"

almost certainly knew about their colleagues' outside affiliations and activities. Adopting the AHA guidelines and knowing their content might have alerted them to the ethical problems of self-dealing and mismanagement. A conflict of interest statement probably would have made no difference as to nonmanagement because the "trustees" did not take seriously their fiduciary duty to invest hospital funds prudently.

Health services managers have the characteristics of fiduciaries. They are also moral agents, and an important part of their work is assisting the organization, through the governing body, to meet its ethical and legal obligations. Concomitant with this effort, managers have a duty to help the governing body avoid conflicts of interest and problems of nonmanagement. Managers are the conscience of the organization; they recognize potential administrative and biomedical ethical problems and act to avoid them or minimize their effect.

## Hermann Hospital

A scandal uncovered in early 1985 involved activities of both administrators and trustees of the Hermann Hospital, an 800-bed facility, and the Hermann Hospital Estate, a trust established in 1914 to provide charity care to the poor of Houston, Texas. An investigation of the two entities showed evidence of theft, kickbacks, insider stock deals, lavish perquisites and expenditures, and costly trips taken by trust and hospital executives and employees at the trust's expense. Among the allegations were that the former executive director of Hermann Hospital paid money to his mistress for work that was never done and that he received kickbacks from overcharges paid by Hermann Hospital to a company of which he was president. The trust sued the former hospital executive director, asking that he repay $100,000 in kickbacks, $500,000 that he allegedly paid his pregnant mistress, and other funds he allegedly laundered. The suit also alleged that he took improper trips that, with related expenses, cost the hospital $250,000. In addition, it alleged that he used Hermann Hospital's name, credit, and money to create an interior decorating firm for his mistress, most or all of whose business came from the hospital.

The Hermann Hospital Estate's former executive director was alleged to have stolen more than $300,000. Allegations against a trust employee stated that a luxury automobile was traded in at less than 20% of its market value for a new automobile paid for by the trust. The employee then purchased the undervalued automobile at a grossly understated price. In addition, there was evidence that trustees and employees had entertained lavishly at trust expense. Newspaper accounts stated that the Hermann Hospital Estate actually spent less than 3% of its funds on financially disadvantaged patients.

As a result of the investigation, two trustees and eight high-ranking trust and hospital executives resigned. Three individuals connected with the estate, including a trustee, were indicted on criminal charges.[7]

Many of the activities at Hermann Hospital and the Hermann Hospital Estate were unethical because they violated the law. The misconduct involved in this case goes well beyond a breach of that minimum standard. By squandering funds that should have benefited patients, the trustees violated their fiduciary duty to protect trust assets. True trustees and directors alike must avoid anything that could be considered a conflict of interest and/or an

improper benefit from their association with an organization. Similarly, hospital managers must be above reproach in all that they do. They act unethically when there is self-dealing or when organization assets are diverted, whether or not these are criminal offenses.

### Cedars of Lebanon Hospital

Unlike Sibley Memorial Hospital but like Hermann Hospital, circumstances at the Cedars of Lebanon Hospital in Miami involved a hospital CEO whose behavior was both unethical and criminal. The latter resulted in a prison term for the CEO. As noted, criminal behavior is in itself unethical. In addition to conflict of interest, the case contains instances of self-dealing, bribery, and violations of federal laws:

- The CEO owned a consulting firm in the Caribbean with which the hospital contracted for architectural consulting services that were never performed.
- The CEO falsified governing body minutes to cover the fraudulent contract with his own consulting firm.
- The CEO received more than 2,500 shares of stock with a market value of $75,000 in a computer company from which the hospital had purchased a $1.8 million diagnostic computer to be used for multiphasic screening; later underutilization of the equipment caused a loss of more than $2,000 per day.
- The CEO bribed public officials to obtain approval for construction and loans for an unnecessary addition to the hospital.
- The CEO attempted to ease the hospital's desperate cash flow situation by not paying federal withholding on employees' salaries.[8]

Other violations of ethical principles occurred, but these five are illustrative. The CEO's activities forced the hospital into receivership; he was later convicted and sent to prison. Important in the Cedars of Lebanon case is that governing body members were negligent in monitoring the CEO and failed to meet their duties as fiduciaries.

### Clinical Conflicts of Interest

The preceding discussion focused on conflicts of interest involving governing bodies and administrators. Conflicts of interest arise in clinical decision making, too. For example, is an orthopedic surgeon obliged to disclose to his patients that he will use an artificial joint that he has developed and on which he receives a royalty? Similarly, should physicians who helped develop a new drug and on which they receive a royalty have to disclose that information to patients for whom the drug is prescribed? Or, is the physician who refers a patient to an imaging center in which he has an ownership interest (that meets federal guidelines) obliged to disclose this information? Each of these examples describes a duality of interests that rises to an actual conflict of interests. The facts of each situation will determine the seriousness of the conflict. To minimize the potential for a conflict of interest, the health services organization should provide guidance to clinicians about a duality of interests that could lead to a conflict of interests. Failure to provide guidance increases the likelihood that physicians will fall into the trap of conflicts of interest, with the embarrassment and negative publicity that invariably

result.[9]

## CODES OF ETHICS AND CONFLICTS OF INTEREST

As noted, conflict of interest may be only a matter of degree—certain behavior, if limited, is unlikely to cause, or is presumed not to cause, a problem. Exaggerated, the same behavior will have the appearance of a conflict of interest, though there may not be an actual conflict. Gratuities are an example in applying this criterion. Few would say that a conflict of interest arises when a sales representative treats a manager to lunch in the organization's cafeteria. A 2-week, all-expenses-paid vacation suggests something very different. Extravagant gratuities, benefits, kickbacks, and gifts that are intended to be a quid pro quo are reasonably assumed to encourage or reward certain behavior. Nevertheless, the appearance of a conflict of interest results by accepting *any* gratuity from those with whom business is done—even to the extent of a small gift or inexpensive lunch. Even gratuities of insignificant value have a cumulative effect—they bind the giver and recipient in a way that diminishes the recipient's objectivity. Keeping such relationships at arm's length is key in business transactions.

Healthcare executives are expected to conduct themselves personally and professionally so that all decisions are in the best interests of the organization and those it serves. They are expected to disclose to the appropriate authority direct or indirect personal or financial interests that pose potential or actual conflicts of interests, as well as to inform the appropriate authority of appointments or elections to governing bodies or committees inside or outside the executive's organization that result in a duality of interests that may lead to a conflict of interest. Gifts or benefits are not to be accepted if offered with the express or implied expectation of inappropriately influencing management decision making. Regardless of intention, the perception raised by the fact of the gift or benefit will suggest impropriety.

These guidelines rely on the judgment of managers. Only they possess the knowledge about personal activities and those of the organization that will permit them to determine when there are potential or actual conflicts, when a solution is required, or when certain facts should be disclosed or brought to the attention of the appropriate authority. As noted, conflicts of interest are often subtle and insidious—avoiding them or minimizing their effect once they occur requires constant vigilance.

The Code of Ethics of the American College of Health Care Administrators (ACHCA) assists managers in preventing and solving conflicts of interest. It states that the healthcare administrator shall

> Disclose to the governing body or other authority as may be appropriate, any actual or potential circumstance concerning him or her that might reasonably be thought to create a conflict of interest or have a substantial adverse impact on the facility or its residents. [Furthermore, he or she shall not] participate in activities that reasonably may be thought to create a conflict of interest or have the potential to have a substantial adverse impact on the facility or its residents.[10]

## ACCEPTING GRATUITIES AND BENEFITS

Health services organizations must help staff avoid conflicts of interest by adopting policies to guide their decision making in the acceptance (or nonacceptance) of gratuities and benefits.

Failing to receive guidance, staff and managers will act in ways that they believe are consistent with reasonable practice and the organization's culture.

### Bits and Pieces

John Henry Williams liked his new job in the radiology department of Affiliated Nursing Homes and Rehabilitation Center. He had been appointed acting head when his predecessor, Mary Beth Jacobson, asked for a 6-month maternity leave. John Henry would be responsible for two and one-half technicians, an appointments clerk, and $350,000 in equipment. He would have the authority to purchase radiographic supplies, the annual value of which was approximately $110,000. Most supplies were obtained from three vendors, companies from which the Center had bought for years.

As Mary Beth oriented John Henry, she emphasized how much she liked the meetings with sales representatives from the three vendors. Over the years, one had become a close friend. She told John Henry that most meetings were held at the nice restaurant near the Center. Some were held in her office, and, if so, the reps always brought along "a little something." When John Henry asked what she meant, Mary Beth gave some examples: perfume, a bottle of brandy, and a pen set in a leather case. John Henry remembered thinking that his wife would like the perfume, but he was more interested in the lunches. It would be a chance to get away from the dreary cafeteria as well as his boring sandwich from home. Mary Beth said the lunches were nothing fancy. She estimated the cost to the sales rep to be similar to that of the small gifts—in the $40–$50 range.

John Henry asked Mary Beth whether there was a policy about accepting gifts from vendors. Mary Beth was upset by the question, which implied something might be wrong with what she was doing. She responded curtly that the Center trusted its managers and allowed them discretion in such matters. John Henry then asked if accepting gratuities might suggest to other staff that her decisions were influenced by the pecuniary relationship with the sales reps. Mary Beth's anger flashed: "I know you think that what I'm doing doesn't look right. That's not fair! I work long hours as a manager and get paid very little extra. It takes effort and time to order and maintain proper inventory. If things go wrong, it's my neck in a noose. The lunches and small gifts make me feel better about my efforts. My work has been exemplary. I'd be happy to talk to anyone who thinks otherwise!"

This case illustrates a problem common to health services organizations. Several facts support Mary Beth's position: Taking clients to lunch and providing small gratuities is common in business relationships. The organization incurs no direct cost because everything is paid for by the sales representatives, who use their expense accounts. At least one sales representative has become a personal friend. Taken individually, it seems unlikely that Mary Beth's judgment could be influenced by the modest value of the lunches and gratuities, but a long-term pattern could result in a different interpretation. It must be asked, however, whether other potential vendors are being ignored because of what have become "cozy" relationships with vendors.

Apparently there is no organizational policy to guide John Henry. Neither the American College of Healthcare Executives (ACHE) code nor that of the ACHCA addresses the more subtle aspects of conflicts of interest. Although it is impossible to judge the giver's true intentions, vendors try to develop good relationships with buyers, and gifts are one way this is done. External evidence, including what is offered and accepted, must be used to infer that a conflict of interest exists.

Decision makers may gain from conflicts of interest in many ways. Often ignored are situations in which the parties understand that the decision maker will be considered favorably for employment or other benefits in the future. A promise or suggestion of future benefit necessarily creates a duality of interests that can lead to actual conflicts of interest and should be prohibited in professional codes of ethics. Nonhealth-sector examples of these circumstances are common. Active-duty military personnel interact with contractors and suppliers; upon retirement, they accept employment with those same organizations. Former members of Congress and staff of federal agencies find lucrative employment as lobbyists or employees of organizations they formerly affected. Federal law limits how soon such contacts

can occur, but advising those who actually make contact is permitted—a very large loophole. Former health services executives are employed by consulting firms with which their organizations have done business. Such problems in the health services field are more than theoretical, and their likelihood increases as healthcare becomes more politicized and as large aggregations of health services organizations become more common.

Anyone who takes something of value, knowing the giver intends to influence the recipient, acts unethically. Bribery is obvious: The recipient knows what is being done and what (or who) is being bought. Typically, however, the relationship of giver and recipient is subtler. What does the hospital pharmacy director do about the proffered lunch from the drug detailer? Does the CEO stop a dietitian from accepting holiday chocolates from a wholesaler? What about a modest gift from the equipment salesperson who was the successful bidder during the renovation program completed 3 years ago? Or 10 years ago? Such transactions suggest potential conflicts of interest. The gift might be given to receive special consideration in the future, or it might be payment for past decisions.

Such situations become even more complex because it is difficult to distinguish the conflict-fraught activities of managers and staff from normal interactions. People develop relationships and friendships, whether as buyer and seller or as professional colleagues. As friends or professional colleagues, however, one should expect the buyer to be equally generous in buying meals or making gifts to the seller. The street should go in both directions.

Health services organizations must establish a policy on gratuities and benefits. There are three basic options. The least complicated is to prohibit staff from accepting any gratuity or benefit offered in the course of business. Such a policy is simple—there is no need to try to judge the giver's intent. This clear, unequivocal rule can be used by staff to refuse gratuities and benefits that may make them feel uncomfortable, thus adding to its usefulness. Declining gratuities of trivial value may make some staff feel awkward, but this is not a significant negative aspect. Most important, such a policy eliminates the need to judge whether there is an expectation of influencing management decision making. The first option is the position of the Association for Healthcare Resource & Materials Management, whose code of personal ethics states, "Never enter into any transactions that would result in personal benefit or a conflict of interest."[11]

The second option is pragmatic but more complex because judgment and difficult decisions are occasionally required. A criterion of reasonableness is applied to the first option. This allows for various circumstances and recognizes that staff members have friends and relationships. What must be assiduously avoided, however, is any hint of wrongdoing or suggestion that a decision creates a conflict of interest. As noted, such balancing is achieved only with difficulty. The test should be what the reasonable person objectively viewing the situation would conclude about the intent of the giver and the effect of the gratuity or benefit on the decision maker.

A third option is a hybrid of the first two and is a compromise for organizations that prefer not to enforce an absolute prohibition, but want to minimize conflicts of interest and provide staff with a reference point. This policy considers all gratuities and benefits as coming to and belonging to the organization. They are made available for its use by sending them to the director of supply chain, either for redistribution to staff or for other corporate uses. If given to

the organization or widely shared with staff, the potential for a personal conflict of interest ceases to exist, even though a conflict between the organization and patient care may continue.

This option is similar to a health services organization that receives gratuities and benefits from businesses. Suppliers of goods and services commonly make cash or in-kind contributions to not-for-profit organizations. Accepting them is not a conflict of interest. The contribution benefits the organization directly and as a whole, just as would a price cut or a discount. This option makes it difficult to accept consumable gratuities or benefits such as meals and paid travel, but even here accommodations can be made. Free travel, for example, can be raffled to staff or used to reward someone for a significant success. The gratuity or benefit does not accrue to one person, even though the reflected glory of such contributions may enhance the reputations of those who manage the organization. In addition to enhancing management's reputation, it raises the question of future favorable treatment for vendors because of gifts made previously. The practice of accepting in-kind or cash gifts from vendors is widespread and unlikely to change even though it raises ethical concerns.

### Only a Matter of Degree

Stimson received four Super Bowl tickets in the mail. Attached was a note from the local sales representative for a major equipment manufacturing company, which read, "Thought you might be able to use these." The nursing facility of which Stimson is CEO recently decided to build an addition for a rehabilitation unit. The sales representative's company manufactures equipment that could be used in the unit. Stimson had called the manufacturer several months earlier to discuss equipment that might be available in order to make the specifications for the bidding process more precise.

Stimson is in a difficult situation. Super Bowl tickets are expensive, difficult to obtain, and highly prized in many circles. However, their intrinsic value is subjective; some recipients would place little value on them. Absent a personal relationship, such as a long-standing friendship, the proffered tickets seem intended to influence the CEO's decision. Important to discussing this conflict is whether Stimson is the sole owner of the organization. If so, Stimson's interests and the organization's are one—there is no economic conflict of interest. Nevertheless, the owner's financial interests may conflict with the interests of facility residents, which is a different type of conflict.

## APPROVAL OF SELF-DIRECTED EXPENDITURES

More subtle questions of conflict of interest can be self-induced. It seems a safe assumption that health services managers usually identify a personal obligation to put patient interests before their own. How much, then, should be spent to refurbish the CEO's office? What types of automobiles should be leased for senior management? Answers to such questions vary by type of organization and ownership.

### Patient or Self?

Anderson is the CEO of Community Hospital, a not-for-profit organization, for which he has assembled an effective administrative staff. Because Anderson's results have been good year after year, the governing body pays little attention to internal operations and focuses on fund-raising and community relations. Anderson has a large discretionary fund available. In the past, it has been used for entertainment, gifts, and staff education.

At the urging of several governing body members and managers, Anderson redecorated the administrative suite. Rosewood and leather sofas were ordered, elegant carpet and drapes were installed, a burled oak desk was delivered, and several original

oil paintings were purchased through the interior decorator. The project's cost totaled $50,000.

When the cost was criticized, even by the more financially successful members of the medical staff, Anderson reacted defensively. Anderson's primary argument to justify the expenditure was that the CEO of a multimillion-dollar enterprise needed the accouterments of his office in order to be effective. Few critics were placated.

Whether such expenditures are appropriate varies by context and setting. A big private hospital with a large endowment, in which the CEO's office is expected to reflect success and sophistication, will view this case differently from a public hospital, in which each nickel is spent reluctantly. Organizations at either extreme, however, could fund worthwhile administrative and clinical projects with $50,000. No one expects a CEO to sit on a lawn chair or use brick and board bookshelves, but the criterion should be good judgment tempered by reason. Again, it is useful to view such actions as would an informed, objective outsider. The "light of day" test enunciated by Cleveland has application here.

## CONFLICT OF INTEREST WITH NO DIRECT PERSONAL GAIN

The case of Miriam Hospital is similar to that of Hermann Hospital.[12] Both lie between Sibley Memorial Hospital and Cedars of Lebanon Hospital. This case has an element of conflict of interest, though other aspects make it unique.

### Miriam Hospital

Before 1980, routine blood tests at Miriam Hospital in Providence, Rhode Island, were performed by a 6-channel analyzer. In 1980, the hospital purchased and put into operation a 12-channel analyzer. Because of a computer programming error, patients continued to be charged for both sets of tests, even though only the 12-channel machine was used.

A year later, Blue Cross raised questions about the unusually high laboratory charges at Miriam as compared with other hospitals. The explanation was that doctors at Miriam simply ordered more laboratory tests. In 1982, a professional standards review organization audit clerk uncovered the double billing. The manager of information systems was ordered by his immediate superior to eliminate the programming error. Shortly thereafter, however, he was told by top officials at Miriam to reinstate the programming error.

Later in 1982, a Blue Cross auditor uncovered the same problem and asked for a copy of the program. The manager of data processing was told to erase any evidence in the program that showed that the original error had been reintroduced. Blue Cross received the sanitized program.

A short time later, two data processing personnel were accused of allowing an outside company to use Miriam's computer in contravention of hospital policy. Each was offered the opportunity to resign. Fearing he would be made a scapegoat, one data processor told his story to Blue Cross, who went to the state's attorney general. Six months later, a grand jury handed up indictments against the hospital and several senior managers. The charges included obtaining money under false pretenses, conspiracy, and filing false documents. The alleged overbilling totaled almost $2.8 million.

The hospital's and managers' defense was based on their interpretation of the rules under which reimbursement was made. They argued that the rules required hospitals to continue using

the same accounting methods for the entire fiscal year, even though there were errors such as those found here. An end-of-fiscal-year audit would determine what financial adjustments were needed.

Unlike Cedars of Lebanon Hospital and Hermann Hospital, there is no evidence that managers at Miriam gained personally from their decisions. Miriam Hospital was the only direct beneficiary of the double billing. This explanation does not excuse the action, ethically or legally, but does put it in a different light. Unlike Sibley, these executives did not benefit other organizations to the hospital's detriment. Regardless, to the extent that double billing improved Miriam's financial situation, the managers enhanced their positions. Thus, they benefited through continued employment, better status and reputation, and, perhaps, proffered financial rewards from the organization. Miriam's financial position was unclear; some sources stated that it could not afford to refund the overcharges, even though management stated that doing so posed no problem. If true here, saving a financially troubled organization at personal risk is altruistic, self-sacrificing, and reflects virtue ethics. Such efforts also benefit managers, however. Nevertheless, selfless or self-sacrificing activities cannot take precedence over other virtues and moral values. The end cannot be used to justify the means. These managers ignored the virtues of honesty, integrity, and trustworthiness, which are ethically more demanding.

## SYSTEMS CONFLICTS

Health services managers typically serve on governing bodies of health-related organizations. Examples of such organizations include health planning agencies, charities, insurance companies, Blue Cross plans, managed care organizations, and hospital associations. Increasingly, the duality of interests caused by such service has great potential for conflicts of interest. Conflicts of interest can be prevented by proactive disclosures to the governing body (and other parties) of service on governing bodies or committees outside the manager's organization. Such information puts the organization on notice and allows it to judge the extent of the potential conflict of interest. If an actual conflict occurs, the manager must withdraw. However, changes in the health services environment may have rendered these precautions inadequate.

The dilemma begins with the manager's civic obligation and professional responsibility based on a general duty of beneficence to assist the community in meeting its health needs. These efforts are reinforced by codes of ethics and the stimulus of governing bodies. Health services managers should be encouraged to apply their professional expertise to improving community health services, but the potential for conflicts of interest is apparent and can be present even if other health services providers are not discussed. If a health services manager is a governing body member of an insurer, for example, there are potential conflicts of interest as to rates, programs, and covered services. Furthermore, some insurers are becoming competitors of traditional health services organizations by developing service delivery capability. Even if managers abstain from debating or voting on matters directly affecting their organizations, it is impossible to avoid becoming privy to corporate thinking and strategies for other activities that in general and specific ways affect the managers' health services

organizations. Once obtained, this knowledge cannot be ignored.

Increased competitiveness in the field of health services makes all information about one's competitors important in order to meet threats to market share or to blunt unfriendly initiatives. In fact, the virtues of loyalty and conscientiousness require a manager to preserve or expand the organization's market share. If managers minimize the problem of conflict through disclosure and withdrawal when necessary, they both diminish their effectiveness as a governing body member of the external organization and potentially violate their fiduciary duty. Furthermore, they risk charges of impropriety simply by participating in outside organizations.

How is this problem solved? How does a health services organization obtain important expertise without exposing itself and manager-directors to charges of impropriety and conflicts of interest? One option is to permit service only by individuals from noncompeting organizations. This solution has the disadvantage of potentially excluding individuals with operational experience in the relevant geographic or service area. However, over time, out-of-area directors will develop expertise. This solution is complicated by the growing number of integrated delivery systems, which replace traditional, local organizations with those that are regional or national.

A second option is that health services organizations use full-time governing body members —persons who are governing body members of noncompeting organizations and who are not employed elsewhere. Full-time directors are common in business enterprise but rare in health services, especially the not-for-profit sector. These individuals are usually paid, an expenditure that should pose no problem for health services organizations, especially the larger ones. Organizations unable to bear the cost should consider the following course of action.

The third option uses professionally prepared and experienced individuals not actively managing health services organizations. Examples include retired health services managers and health services administration educators. Physicians and well-informed members of the public could also serve effectively. This option possesses most of the advantages of the second option. Here, some payment is desirable because it will produce higher levels of commitment and higher-quality involvement.

Managers working to improve community health services through cooperative efforts face an increasingly competitive environment. This challenge makes some types of cooperation difficult or impossible. Other types, such as sharing services and participating in joint ventures, are stimulated. Survival is a primary corporate goal for health services organizations, and new ethical guidelines are needed to address these problems.

## CONCLUSION

Avoiding conflicts of interest requires constant vigilance. Managers of government-owned facilities risk fines and criminal charges for conflicts of interest. The likelihood of legal penalties is less pronounced in the private sector. This does not obviate the ethical problem, however. The ACHCA stresses disclosure in order to eliminate or minimize the problem. Disclosure presumes that one recognizes duality of interests that could lead to conflicts of interest. Failure to recognize conflicts means that managers may be well into a conflict

situation before they realize it. Conflicts of interest can be subtle, and continual questioning and self-analysis are needed to identify them. Their potential and actual effect will increase as competition intensifies.

In addition to disclosure, conflicts of interest may be avoided or eliminated in other ways, including divesting a potentially conflicting outside interest, seeking guidance from the governing body, and not participating in or attempting to influence matters in which conflicts may exist. Such steps eliminate the conflict or put the governing body on notice. Both are important, but managers must remember their moral agency and must prevent conflicts of interest or work to minimize their negative effects once they are present.

Systems conflicts will cause unique problems as well as opportunities in competitive environments. To avoid conflicts of interest, managers must be alert and may need to withdraw from all governing and advising involvement with competing or potentially competing health services organizations. Nontraditional means will be required to maximize the assistance that individuals experienced in health services can offer while minimizing the potential for systems conflicts.

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CHAPTER 7

# ETHICAL ISSUES REGARDING ORGANIZATION AND STAFF

A wide variety of administrative ethical issues arise as health services managers do their jobs. Issues linked to employee performance appraisal, for example, are a function of formal relationships. Other issues, such as working with independent practitioners of the medical staff, often result from less formal organizational relationships. Managers have an ethical and legal fiduciary relationship with the organization as represented by the governing body. In an ethical sense, managers are fiduciaries for all staff in the organization, and this relationship raises special obligations. Self-dealing was examined briefly in Chapter 6 but is addressed further in this chapter.

In carrying out their duties, health services managers are privy to copious confidential and insider information. Much is sensitive; almost all is proprietary. Administrative information is distinguished from that collected, used, and maintained for patient care. Using and safeguarding both types of confidential information is a major ethical concern in health services organizations.

## ORGANIZATIONAL CONTEXT OF RELATIONSHIPS

Managers are employed to carry out the organization's mission in the context of its philosophy. As one of its most important responsibilities, the governing body selects and evaluates the chief executive officer (CEO). In turn, the CEO selects and evaluates subordinate managers, perhaps down to middle management. Regardless of organizational level, managers are moral agents who are ethically accountable for the effects of nonfeasance, misfeasance, and malfeasance affecting patients, staff, and organization. Managers' decisions are not excused because they are employees or because they were only "following orders." The law may hold individuals who are not prime actors or decision makers to a different standard, but managers remain morally accountable.

As an employee, the manager has a duty of loyalty to the organization and its staff. In terms of the organization, this duty means that the manager supports the employer's goals and activities and keeps confidential what is learned. Disagreements about policy and its implementation are neither broadcast nor otherwise shared with individuals who have no "need to know." The duty of loyalty has special importance in light of a common malady, backbiting the employer. Backbiting is not the grumbling or complaining usually considered normal, perhaps even healthy behavior. Although employees may have a legitimate reason to complain about their treatment (even the best employer does not get it right every time), rabid, negative comments are problematic. Employees who persistently speak ill of their employer act in an unacceptable fashion and should find new employment, voluntarily or involuntarily.

Managers must achieve the difficult balance between loyalty to the organization and fidelity to their personal ethic and professional integrity. Where does the manager draw the line? How far should a manager go in following the crowd or in standing alone? A clear and well-considered personal ethic is needed to answer questions such as these. Professional codes of ethics play a role but provide only general guidance and are unlikely to be useful in helping a manager decide what to do in specific cases. At the extreme, the limits of loyalty are part of whistle-blowing, which is examined in Chapter 8.

As posited previously, the manager has an independent duty and responsibility to the patient; at minimum, this means that managers protect patients from unnecessary risk and work to further their interests. What follows from that duty is the need for integrity and the courage to speak out and act to make that responsibility a reality. What happens, however, when the duty to protect the interests of patients conflicts with the duty of loyalty in achieving part of the organization's mission?

### She Only Had to Ask

Richard Weidner experienced angina during mild exercise. His internist referred him to a cardiologist at University Hospital for a cardiac catheterization. After the cardiologist examined Weidner, she explained the procedure and obtained his consent. As the cardiologist turned to leave, Weidner asked her, "You'll be taking care of me, won't you, Doc?" The doctor replied, "I'll see you in the cardiac cath room." Weidner was reassured and especially pleased that he had had such a long, friendly visit with his cardiologist.

That afternoon, Weidner was lying on the table waiting for the catheterization to begin. He had a clear view of the television monitor, and as the procedure began he saw the catheter moving from his groin toward his heart. At one point he asked a question and was startled when his cardiologist appeared near his head and described what was happening. When Weidner asked who was threading the catheter, she told him it was a resident in cardiology.

Later, Weidner was in the recovery area waiting to be discharged. He was quite agitated that a resident had performed the procedure, especially because he thought he had an understanding with his cardiologist. He described what had happened to the nurse and demanded an explanation. The nurse tried to calm him. "You know," she said, "this is a teaching hospital—we train residents so they can perform these procedures to help other people." Weidner was not placated. He said, "Had I been asked, I probably would have agreed to have the resident participate. But they didn't ask me, and I'm damned angry about it. Please tell a manager to see me immediately. I want some answers!"

Weidner was not harmed physically, but he was emotionally distraught. He believed that he was misled and that a promise was broken. Weidner was concerned about who would perform the procedure and sought reassurance from the cardiologist, whom he trusted. Her answer was, at best, evasive. She purposefully or negligently misled him and thus breached her obligation to tell the truth. In sum, Weidner was deceived and treated disrespectfully. What happened does not seem to be the result of maliciousness; all involved would likely be distressed to learn of Weidner's anger about his treatment. Weidner's understanding was unmet, however.

What should the manager of cardiology do when Weidner relates his story? Except to reassure and placate, little can be done for Weidner. Perhaps a promise to Weidner that it will not happen again (to him or to other patients) will be helpful. More important is what should be done to prevent similar problems. The manager of cardiology should be the force for staff education and necessary process changes. The personal ethic of this manager's peers and the organizational philosophy should demand this level of attention to the principle of respect for persons and the virtues of trustworthiness and integrity.

To become fully qualified, physicians in residencies need specialized training, which can only be gained by treating patients. Far less acceptable, of course, is the assumption that all

patients are willing to participate in medical education. Being used as a means to an end is a crude summary of utilitarianism and one incompatible with the principle of respect for persons; specifically, the elements of autonomy and truth telling were violated in this case.

The forms used to admit patients to teaching hospitals disclose their involvement in medical education. Few patients, however, read or understand the implications of that disclosure. Judged by legal standards of informed consent, the act of signing such a form has questionable validity. More important than the law, however, is the organization's ethical obligation to inform patients of what being a teaching institution means in terms of their care. Even if the form has been read and understood, minimum ethical conduct demands that patients are actively informed when teaching activities occur and that permission is again obtained. Medical education and consent are covered more fully in Chapter 9.

## ORGANIZATIONAL INFORMATION

In addition to some types of clinical information, the manager is privy to confidential information about the organization. As with patient information, a basic criterion for other confidential information is "need to know." Examples of confidential organizational information include decisions about capital equipment, medical staff recruitment and development, business and marketing strategies, and financial and human resources programs. Equally important, but less commonly included, is general information concerning the staff and organization and specific information such as the strengths, weaknesses, and peculiarities of individual managers or governing body members.

In a competitive environment, "loose lips" will result in significant adverse consequences. It is unethical to make confidential information available, deliberately or negligently, to unauthorized organizations or individuals. This is true regardless of whether the manager's organization is put at risk or actually experiences a loss, or whether the manager disclosing the proprietary information gains personally.

The 2007 American College of Healthcare Executives (ACHE) code directs healthcare executives to "respect professional confidences." This wording provides little guidance about use of confidential information in the organization. Managers, governing body members, and staff must ensure that confidential information, which is usually proprietary, is safeguarded. Physicians who are independent contractors—a typical arrangement in hospitals—have limited loyalty to the organization; this makes sharing proprietary information with them problematic. In a competitive environment, which likely includes competition from physicians on their own medical staff, health services organizations increasingly provide confidential information to physicians only on a "need to know" basis.

### Self-Dealing

Narrowly defined, self-dealing occurs only when a person with access to confidential information uses it for advantages such as monetary gain, unfair personal advantage, or self-aggrandizement. Misuse of confidential information that does not involve self-dealing is simply a breach of confidentiality. Examples of misusing insider information include the following: a manager, knowing that the organization will establish a surgicenter in a specific location,

purchases the property through a straw man (an agent), who then resells it to the organization at a profit that the two share; a manager discloses information about organizational decision making that gives acquaintances an advantage in doing business with it (misuse of confidential information); and a manager seeking revenge for perceived insult discloses market strategies to competitors, with no resulting personal gain. Strictly speaking, only the first scenario illustrates self-dealing. If the manager in this example is the decision maker for both the sale and the purchase, there is also a conflict of interest.

### What's a Manager to Do?

S.L. Rine joined the management staff of a large health services provider after working at a similar organization for several years. Rine is a member of ACHE and wants to build the best set of credentials in the shortest time. His goal is to become a CEO.

Rine is responsible for several support departments as well as the administrative aspects of some clinical areas. Shortly after beginning employment, Rine realized that the organization is very political. Much of what happens at the senior level is the result of personal relationships and obligations.

Maintenance is one of Rine's departments; it is responsible for all the grounds. Rine learned that grounds crews were being sent to the homes of senior members of the governing body to maintain their lawns, shrubs, and trees. Rine asked the maintenance director to explain and was told that the practice had a long history and should be left alone. When Rine asked the director for a cost estimate of the grounds work being done at the private homes, the director refused, saying that he feared the wrath of the governing body members who were benefiting. Rine pondered what to do.

Soon after talking to the maintenance director, Rine had lunch with the laboratory director. Without discussing specifics, Rine described the problem in maintenance. The laboratory director exclaimed, "That's nothing!" and went on to describe how two governing body members were selling reagents and supplies to the laboratory at higher-than-market prices. Rine asked the laboratory director why she had not done anything about the situation. She replied that her predecessor had tried to stop the practice and was fired. Again, Rine pondered what to do.

This case has two dimensions, one involving governing body members, the other involving managers. Governing body members whose yards are maintained by the organization or who sell to the laboratory at inflated prices are implicitly or explicitly using their authority for personal benefit. Selling overpriced reagents and supplies to the laboratory seems more unethical than receiving free grounds maintenance; morally, however, the two acts are indistinguishable. Both improperly divert (steal) organizational resources. Most destructive for the organization's moral health is that governing body members are setting a bad example, which, at best, makes the staff cynical; at worst, staff is encouraged to use their authority improperly as well.

The second dimension of "What's a Manager to Do?" is the role of managers. Knowing about improper (i.e., unethical or illegal) behavior, but not acting to affect it (nonfeasance), is no better than committing an unethical act (malfeasance). Codes of administrative ethics are of limited help. Rine and the laboratory manager agree that the behavior is unacceptable. Their ethical obligations are clear; they should act on them.

By confronting those involved, Rine will achieve little more than embarrassing them, and he may be fired. Managers can and should take any available steps, however. One is to question generic unethical activities at every opportunity and to encourage colleagues to speak out. If several managers agree that certain behavior is unethical, they draw strength from one another. They can implement (or at least try to implement) a policy of competitive bidding for all purchases, including those for the laboratory. They can develop and propose an organization-wide policy on self-dealing and abuse of authority. In short, they must take

whatever steps they can to end unethical practices. As moral agents, they cannot close their eyes to such problems. Nonfeasance is not an option.

### Misuse of Insider Information

Persons in an organization with access to information not available to the public are known as insiders. Ethical problems arise when managers use such information in a manner that is inconsistent with their fiduciary duty, the obligation to be trustworthy. Benefiting oneself or one's associates are examples. Some misuse of confidential information has a salutary effect and must be distinguished. An example is whistle-blowing that occurs when internal efforts at reform fail and the manager's moral agency demands external disclosure of information about practices that may affect the safety of patients or the public. The protection of such groups takes precedence over a duty of loyalty (fidelity) to the organization, even if the manager becomes subject to civil or criminal sanctions.

A common misuse of confidential (nonpublic) information occurs when employees (insiders) use it to make advantageous stock market transactions. Historically, health services organizations were largely unaffected because few were publicly traded, for-profit stock corporations. This status has changed dramatically since the late 1960s. Regulation by the Securities and Exchange Commission or state counterparts does not diminish the seriousness of the unethical conduct inherent in misusing insider information. Again, the law is a minimum that does not necessarily set an appropriate level of ethical behavior.

#### Just Part Owner

Jane Abernathy is the CEO of a large urban not-for-profit nursing facility. She is a voting member of all governing body committees. Following a retreat, the governing body's planning committee recommended that rehabilitation become a significant new initiative. For the past several months, the capital expenditures committee has considered the purchase of equipment to increase the nursing facility's capacity in rehabilitation. The part-time physician-director of rehabilitation wants to become a full-time employee.

Following an uncle's death 2 years ago, Abernathy inherited 1,000 shares of INCO, Inc., stock. She submits an annual statement of her investments and holdings as part of the governing body's conflict of interest disclosure requirement. The next report is due in 8 months. INCO's last annual report stated that 10 million shares of common stock are publicly held. INCO manufactures rehabilitation equipment similar to that which Abernathy's facility may buy.

The capital expenditures committee's draft report includes the purchase of INCO equipment. Abernathy dislikes making private information available to the governing body and is distressed about this apparent need for special disclosure.

In theory, Abernathy faces a duality of interests that could lead to a conflict of interest. Also, there is a potential to misuse confidential information to engage in self-dealing if Abernathy recommends purchasing equipment from a manufacturer in which she owns stock. Abernathy's ownership interest is remote, however—a mere .01% of the company's stock. Thus, the personal gain is so small that it is unlikely Abernathy's decision could be influenced by her stock ownership or, if it were, that she would enjoy any measurable benefit. Abernathy's objectivity becomes more suspect as her ownership interest increases. Nevertheless, Abernathy should disclose her holdings in INCO, even though it is distasteful to her.

## RELATIONSHIPS WITH THE GOVERNING BODY

The CEO is the governing body's agent in achieving the organization's mission. In turn, the CEO selects, hires, evaluates, and retains subordinate managers. The CEO and other managers and staff are moral agents, not just the organization's morally neutral arms and legs.

As previously noted, some sectarian health services organizations require that mid- and senior-level managers are adherents of the religion of the sponsoring organization. This requirement is too restrictive; coreligionists often hold different views about various doctrines and the rigor of their application. An effective corporate culture is built on managers (and other staff) who understand and accept the organization's philosophy. Nonsectarian philosophies and secular humanism commonly have values like those of organized religion. Culling for values occurs in recruiting and selecting staff, and it is here that ethical compatibility should be determined. Applicants, too, should assess their fit with the organization's culture during the interview.[1] Focusing on congruence of values widens the field from which to recruit competent managers; such diversity inevitably benefits the organization.

The governing body and the CEO and senior management (shown in Figure 6 as "Administration") must define the scope of their respective functions. Figure 6 also suggests the need to distinguish senior and middle management. Governance, administration, and management must understand their respective activities or they will interfere in one another's spheres, with resulting inefficiency and frustration of organizational goals. The diagram is not intended to depict relationships and spheres as isolated. It must include permeability of ideas and communications, but separateness as well as unity must be clear.

Early leaders in hospital administration asserted that the risk of conflicts of interest when the CEO or members of the medical staff are members of the governing body far outweighs any benefit.[2] The environment has changed dramatically, however. Current thinking is that disclosing The duality environment of interests has or potential changed dramatically, conflicts of interests however. prevents The current or minimizes think-their occurrence. the In 1989, 42% of hospital CEOs were full voting members of the governing body, an increase from 38% in 1985.[3] That study found that, on average, two physicians with medical privileges at a hospital were members of its governing body.[4] The trend toward membership of senior managers and medical staff members on the governing body has continued; as of 2011, it is considered essential that they participate in governance.

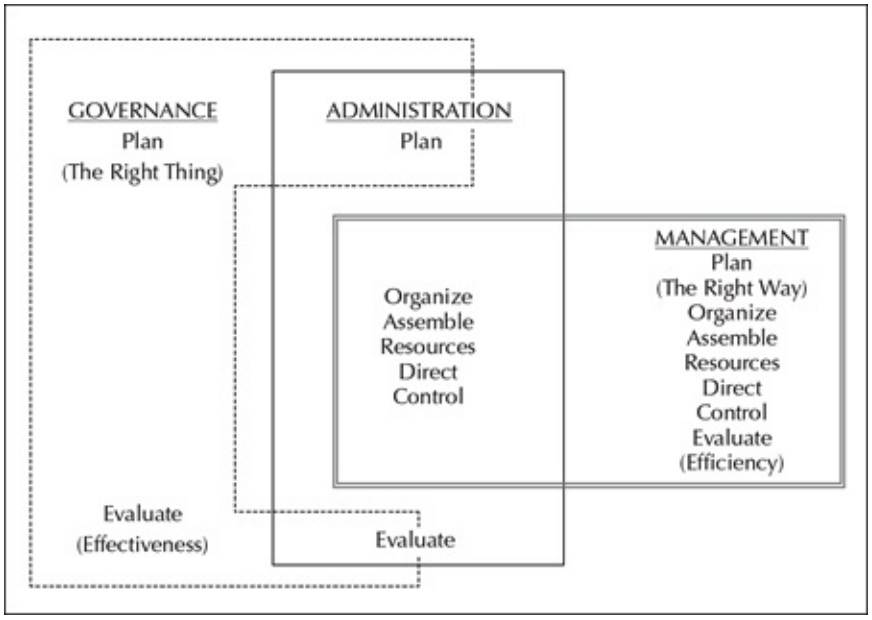


**Figure 6**. A model of hospital governance, administration, and management. (Reprinted from *Trustee*, Figure 734. , A p. model 6, by permission, of hospital governance, June 1981. administration, Copyright © 1981and , management. American Hospital (Reprinted Publishing, from *Trustee*, Inc.)

Anecdotal evidence suggests a trend toward a greater proportion of internal governing body members (senior managers employed by the organization) relative to external members. Internal members are desirable because of their general and organization-specific expertise. This duality of interests necessarily increases the potential for conflicts of interest, however. Governance has a specific and important role. The board reviews, evaluates, and directs senior management and its performance. It is a buffer, as well as a connection, between the organization and the ownership—stockholders in the case of operating corporations, or the community (service area) in the case of not-for-profit organizations. The governance and management functions are combined to the potential detriment of the organization, but especially to those served by it.

Regardless of governing body membership, the CEO and senior managers link governance to the operating components of the organization. As the governing body's agents, they provide it with the information and recommendations upon which macro-decisions are made. This enables senior managers to filter or sanitize data and make themselves look good or to mislead, as occurred in the Cedars of Lebanon case (see Chapter 6). A key issue is how much and what types of information the governing body should receive. The governing body must make this determination. The CEO and senior managers should make recommendations, but governing body members must be sufficiently informed to know which data it needs and how to interpret them. Level of involvement and expertise are special problems in organizations that have voluntary governing body members. A partial answer to improving performance of governance is to identify the qualities, skills, and education that board members of healthcare organizations should have. To stimulate such efforts, several states have adopted voluntary certification for hospital trustees; some have mandatory requirements.[5]

It is natural that managers want their performance to be viewed in a good light. Pressures in the external environment may tempt managers to engage in "creative reporting" about their performance. However, managers are obliged to be truthful in governing body interactions, an

ethical duty arising from virtues such as courage, trustworthiness, veracity, and candor. Deception is antithetical to these virtues. This does not mean staff must emphasize unfavorable information; a balanced picture is prudent and desirable. It does mean that the governing body must be informed of problems honestly and in a timely manner. Managers must be alert to understated or misrepresented problems from their subordinates as well. Truthfulness is linked to whistle-blowing, which is discussed in Chapter 8. Standardized and routinized reporting minimizes the potential to manipulate the system or the data.

### I Wonder If They Even Care?

Stu White had just returned to his office from a monthly governing body meeting. His assistant, Barbara Jones, noticed that he was agitated and asked, "How was it?" White responded by describing the governing body's chronic problem, something Jones had heard before. He said, "I think I could tell them that the moon is made of green cheese and they would believe it! They don't seem to know, or care, what happens in this nursing home!" White described how he did all the thinking for the governing body. He also described how there was no reporting system until he had established one. He emphasized that the organization had been lucky to have honest managers because, as he put it, "anybody else could have been hauling it [money] out of here by the carload."

The information-flow problem White faces results from governing body members' lack of awareness or their unwillingness to be fully involved and accountable for the organization, duties that are unquestionably theirs. White is in a powerful position. He works with a governing body that takes little interest in understanding the organization's affairs, and he determines what information it receives. This problem is not uncommon, even if not as extreme as described here. CEOs and other senior managers possess knowledge superior to the governing body's in at least two respects. They are expert about health services generally and they intimately understand the organization's activities and functions. Managers' fiduciary relationship requires them to be certain that they provide information the governing body needs. They act ethically when they present and interpret information that accurately portrays the organization. White must educate the governing body as to its responsibilities, including legal requirements. Next, he must help them identify the data and reports they need to meet those responsibilities. Failing to change the governing body's culture sets a scenario with potential for significant harm to the organization. Someone less scrupulous than White would be in a position to delay or withhold negative information, thus preventing timely action and increasing the probability of damage.[6]

## RELATIONSHIPS WITH THE MEDICAL STAFF

Relations among physicians and the organization and its managers raise several ethical issues that are present whether it is a matrix organization or one organized as a traditional functional hierarchy. Schulz and Johnson[7] suggested that the CEO's role has evolved from business manager to coordinator to corporate chief to management team leader, the predominant role at this writing. As a management team leader, the CEO is a partner with physicians in their joint efforts to efficiently provide the best possible care. This evolution causes the green-eyeshade mentality of health services managers to become no more than a historical curiosity. In collegial relationships, peers identify and solve problems of mutual concern. Regardless of the role and degree of collegiality, the CEO has duties and responsibilities that inevitably cause

disagreements with physicians.

### But He's Already Dead!

Dr. Reddy is an interventional radiologist who practices at Community Hospital. She has been an active and respected member of the medical staff for a dozen years. Dr. Reddy was on call the second weekend of March and was paged by the supervisor of the emergency department at Community.

When they spoke, Dr. Reddy was told that she would have to come to the hospital as quickly as possible. A 25-year-old gunshot-wound patient had been declared brain-dead and his family had given permission to harvest his organs. Dr. Reddy was needed to prepare the deceased for transport by beginning perfusion of his body, which would allow the organ-harvest team to obtain the highest quality organs. The organs would be harvested at University Hospital, which is one hour away by helicopter. Transport could not begin until perfusion was started.

Dr. Reddy was silent for a few moments, as though she were mulling over her options. The pause was somewhat startling to the supervisor, but not nearly as much as the response from Dr. Reddy: "It will be at least two hours before I can get there. I don't think that there's any rush—he's already dead, isn't he?"

The response stunned the supervisor. She was quick to remind Dr. Ready that the optimal time to begin perfusion is within one hour. Brusquely, she added, "As you know, the organs will suffer significant damage if perfusion is started beyond the critical one-hour window." Dr. Reddy did not reply. The next sound heard by the supervisor was the phone being disconnected. The supervisor called and paged Dr. Reddy repeatedly; there was no response. Frantically, the supervisor placed a call to the vice president for medical affairs.

Managers are ethically (and legally) expected to be aware of the quality of clinical practice and to intervene, as necessary. This expectation reflects their ethical obligations to protect and further the interests of patients. Dr. Reddy's refusal to come to the hospital has no element of clinical judgment. She simply failed to meet on-call obligations. This significant lapse should result in disciplinary action as required by the medical staff bylaws and rules and regulations. Dr. Reddy failed her duty of promise keeping and virtues such as trustworthiness. In addition, the principles of beneficence and nonmaleficence have been violated for those who might benefit from the transplantable organs.

Although not competent to judge the quality of clinical practice, managers act through experts who are. This situation is similar to that of a manager responsible for pharmacy or dietetics. Here, too, the manager relies on technical expertise to assess performance and make decisions. Some physicians react negatively to the slightest hint of such involvement, which they see as interference in clinical decision making. In fact, managerial involvement also serves the physician's best interests because it helps to ensure that high-quality medicine is practiced. Anecdotal evidence suggests that more competent physicians are less likely to object to review of their work. It must be stressed that the manager is not judging quality of care directly, but only in cooperation with those clinically competent to do so. Differing interests, perhaps even conflicts of interest, arise because managers must maintain harmonious relationships with physicians while ensuring patient safety. As moral agents, physicians are expected to meet the principles of respect for persons, beneficence, and nonmaleficence, as well as the virtues of courage, compassion, and caring. Lapses do occur, however.

The manager must be attentive to the needs and activities of physicians because they are essential to patient care. Their clinical service to and relationships with patients are the reason the organization exists. Conflicts with the medical staff result from enforcing medical staff bylaws, resource allocation decisions, and relationships between physicians and staff. Other important responsibilities of senior management are to help the medical staff keep its bylaws and rules and regulations current and to assist in enforcing their administrative provisions. A

typical example of the latter responsibility occurs when a hospital CEO or medical director applies the medical staff bylaws and its rules and regulations to suspend a physician's admitting privileges. This action occurs most often because of tardy completion of medical records. Absent dire circumstances in which summarily suspending a physician's privileges is warranted, disciplinary actions use established procedures and are not undertaken single-handedly. Because of the independent duty owed to patients, even exclusively clinical problems cannot be ignored by managers. Clinical and nonclinical managers must act as the need arises. Sometimes mistakes occur.

### Oops!

Dr. M is a graduate of a foreign medical school who has been a successful cardiologist on the staff of a large Midwestern hospital for more than 20 years. Occasionally, there have been rumors of Dr. M's alcohol abuse and disruptive behavior. Until a month ago, however, the only formal report nursing administration had received was from a registered nurse, who stated that Dr. M had been verbally abusive and had embarrassed her in front of a patient and his family. Recently, nursing administration received two incident reports: one oral, the other written. Both stated that Dr. M smelled of alcohol and seemed mentally and physically impaired. The information was forwarded to the medical director, Dr. G, a hospital employee and a member of the administration.

Dr. G called an emergency meeting of the medical staff executive committee, which the chief operating officer (COO) could not attend because of a professional meeting out of town. After discussing the information but without a formal investigation, the committee agreed to immediate termination of Dr. M's medical staff privileges. A registered letter was sent to Dr. M describing the action and the reasons for it. Another cardiologist was asked to treat Dr. M's hospitalized patients. Upon her return a week later, the COO was aghast to see the letter terminating Dr. M. She realized immediately that Dr. M's privileges should have been suspended, not terminated, pending an investigation.

Dr. M was enraged and retained legal counsel. The hospital withdrew the termination letter 2 weeks after it was sent and reinstated Dr. M's staff privileges pending a full investigation. Dr. M was not placated, however, and filed suit against the members of the executive committee and the hospital, alleging antitrust violations, defamation, and tortious interference with his business relationships.

Dr. G erred in terminating Dr. M's privileges; suspension pending an investigation was the appropriate disciplinary action. Dr. G acted to protect patients; secondarily, he wanted to protect staff. Both actions are ethically correct. However, he mistakenly chose too punitive a disciplinary action. This error was costly for the hospital in terms of public controversy and embarrassment, legal bills, medical staff disruption, and probable lingering ill will.

The hospital failed to adequately prepare Dr. G for his duties; furthermore, the medical staff bylaws and rules and regulations should require an expedited review process for such actions when patient harm is not imminent. The future holds a greater risk for this hospital, however. Managers and members of the medical staff may be reluctant to act in such cases, even when the facts are more egregious, because they fear doing the wrong thing. Had there been no action and a patient had been harmed because of Dr. M's impairment, the public outcry would have been greater. The lesson for the hospital is that all those in managerial positions must be prepared for the demands of their jobs.

Dr. M's right to due process was violated. His anger was justified, but it is not clear that he suffered significant professional or economic injuries. The termination was rescinded soon after imposition. Even if the executive committee had taken the correct disciplinary action, he would have been suspended from admitting patients pending an investigation. Regardless, Dr. M was not treated fairly. He gained sympathy (perhaps unwarranted) from physician colleagues and other staff members. This will make future disciplinary actions against him all

the more difficult, should they be needed.

## RELATIONS WITH NONPHYSICIAN STAFF

Like staff in other types of organizations, health services professionals seek various goals, objectives, and interests. Their work in the organization is a primary focus of their lives, but the congruence between personal goals and objectives and those of the organization is likely to be less than total. Chapter 3 noted that employees must understand that they and the organization possess the same core principles of working in the patient's best interests. This attitude must be reflected in action, not just in written organizational philosophy and policies. If employees and physicians perceive that the organization places greater value on performance other than that which reflects ethical interaction with patients (e.g., increasing hospital revenues), the principles of respect for persons, beneficence, and nonmaleficence cannot be satisfied. Because the organization can act only through its staff, this lapse is serious. If staff members fear that intervening on the patient's behalf jeopardizes their relationship with their colleagues and the organization, they will be discouraged from acting as they should.

### The "Uncooperative" RN

Sally Hansen, a registered nurse with 10 years experience, works nights. At the start of her shift she noted that a urinary catheter had been ordered for a post-surgical male patient with acute urinary retention. Following established procedure, she paged the resident on duty. A first-year resident appeared and told her that he would insert the catheter. Hansen accompanied him to the patient's bedside and watched him remove the catheter from its package. He looked at the package, apparently for instructions, but found none. The resident began to insert the catheter into the patient's penis, but faltered. It was clear that he did not know what he was doing and that the patient was in great pain.

The resident turned and asked for assistance, but Hansen refused, saying that inserting a catheter was the job of a properly trained resident. "Really, you shouldn't attempt something you don't know how to do," she said. She also reminded the resident of hospital policy that prohibits a female nurse from performing certain intimate procedures on male patients. The resident yelled at Hansen and stormed off. Hansen paged the chief resident, who catheterized the patient, but offered no explanation when she described the incident with the inexperienced resident.

The next day, Hansen was awakened at home by a call from the vice president for nursing. She told Hansen that the inexperienced resident had filed a formal statement accusing her of insubordination. The resident was adamant about pressing the issue with nursing administration and the chief of his service. The vice president for nursing said she could not be sure of the outcome.

What was Hansen's proper role in this matter? Where did her duties lie? Clearly, her duties lay with the patient and she acted properly. Even had she known how to insert the catheter, she was constrained by hospital policy from doing so. Stopping the resident protected the patient from pain and potential injury. A reprimand from nursing administration will greatly diminish Hansen's willingness to intervene to protect a patient in the future. The hospital must encourage appropriate action by all staff as it seeks to deliver high-quality care and protect the patient. Teaching is not an issue in this case; the resident was not competent to undertake the procedure —a failure of instruction, not of nursing—a failure that should be addressed with the hospital's director of medical education.

Other issues are present. One is the traditional subservient role of nurses, partly due to sexism. Poor relations between doctors and nurses do not result only from sexism, however. Anecdotal evidence suggests that the problem exists even where sexism is not a factor (e.g., male doctors–male nurses, female doctors–female nurses). A second issue is that a resident

attempted a procedure beyond his training. He should have asked for help from the senior resident. Here, too, bravado, ego, and the culture of medical education may have caused an unwillingness to seek help. The third issue is that the limits of residents' clinical activities are unclear. In this regard, the procedures and safeguards in the medical education program may need review. The American Nurses Association Code for Nurses requires Hansen's action: "As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system."[8] Implicit in this statement is accountability for one's actions as a nurse—a professional ethic—not merely accountability through the organizational hierarchy.

The organization must support its staff with an unequivocal commitment that encourages them to intervene when a patient is at risk. This policy should be communicated and enforced. Action in such situations may cause some individuals to accuse caregivers of spying on one another. This charge is unfounded. Spying is a negative process and has no place in health services. The focus here is on an organization-wide effort—an ethic—to protect and serve the patient. If caregivers are able to minimize their ego involvement in the care process and keep their eyes on these goals, this problem will lessen or disappear.

Ignoring problems will not solve them. This maxim is especially true if patients are at risk. As the Watergate (1970s) and Clinton-Lewinsky (1990s) political scandals showed, problems can be ignored or covered up for a time but will come to light eventually. The public reacts to such revelations by assuming that others in the organization knew, yet did nothing. The public wonders how such situations could occur or be allowed to continue. In addition to the moral guidelines of respect for persons and the virtue to be honest in all interactions, the likelihood of discovery is a utilitarian reason for recognizing and solving such problems early.

Deadly communicable diseases and other high-risk situations raise special issues in the relationship between organization and staff. Both parties are ethically bound to protect patients and further their interests. It is ethically unjustifiable for an organization, through its managers, to put clinical staff at risk by failing to properly train or equip them, for example. All potentially dangerous situations should cause managers to consider the need to protect staff from unnecessary risk; failing that, the organization cannot meet its ethical obligations to them. In turn, staff will be unable to meet their ethical obligations to patients. The paradigmatic examples of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other deadly infectious diseases are discussed below. They receive further attention in Chapter 8.

## HIV/AIDS and Other Severe Infectious Diseases

Since it was first identified in the early 1980s, HIV, which leads to AIDS, has proved an elusive foe. Its spread continues, though more slowly since the late 1980s. Both the pessimistic prediction of a major outbreak in the general population and the optimistic prediction that it would be eliminated have proved wrong. There have been scientific breakthroughs in understanding HIV and treating AIDS. Unlike the vaccines for hepatitis A (HAV) and hepatitis B (HBV), however, HIV has neither a vaccine to prevent infection nor a cure once infected. A

second strain of HIV was isolated in the late 1980s, and a new strain entered the United States from Africa in summer 1996; it is probable there will be others. Work on a vaccine is tempered by knowledge that HIV's rapid mutation makes developing a vaccine with long-term effectiveness difficult, if not impossible. Even if a successful vaccine were developed, several years of testing and clinical trials would be required before it could become generally available. Meanwhile, the attention to prevention and education is unprecedented in modern public health.

In 2008, the World Health Organization estimated that 33.4 million people worldwide were living with HIV.[9] The number of individuals living with HIV in the United States in 2006 was 1.1 million.[10] By comparison, there are approximately 3.2 million persons infected with hepatitis C (HCV), the most common chronic blood-borne infection in the United States.[11] People with AIDS are living longer as a result of more effective medical management using combinations of drugs and healthier lifestyles, including better nutrition and preventive measures that reduce risk of reinfection. The result may be that AIDS will become a chronic rather than an acute disease, a development with significant implications for health services organizations.

## Legal Aspects of HIV/AIDS

Legally, HIV/AIDS is daunting to health services organizations. Already by 1990, the number of AIDS-related lawsuits was the largest attributable to any disease in U.S. legal history.[12]

One major legal issue with HIV/AIDS is confidentiality. Dimensions include confidentiality of patient names and records, reporting HIV infection, and a duty to warn third parties. Legal protections against breaching medical confidentiality are well established. The AIDS epidemic caused states to pass laws safeguarding the confidentiality and privacy of people infected or thought to be infected with HIV.[13] Like other serious communicable diseases, all states have made AIDS a reportable disease. Contact tracing, a historically important role for health departments, is belatedly being applied to HIV infection as an effective measure to diminish its spread. The American Medical Association (AMA) supports HIV testing of physicians and healthcare workers in appropriate situations. It opposes mandatory testing for medical staff privileges but urges physicians to voluntarily determine their HIV status and/or act as if their serostatus is positive.[14]

A second legal dimension and area of litigation results from special risks present when staff members work with AIDS patients. The Occupational Safety and Health Act of 1970 (OSHA) requires employers to provide a place of employment free from recognized hazards that cause, or are likely to cause, death or serious physical harm. OSHA requires universal blood and body substance precautions.

Third are the legal concerns of the risk to staff and other patients from patients infected with HIV and the opportunistic diseases that develop as HIV progresses to frank AIDS. In protecting patients and staff, health services organizations must avoid discriminating against people with HIV/ AIDS, whom the law defines as having a disability. The ADA (Americans with Disabilities Act of 1990, PL 101-336) strengthened the right to full public accommodations for people with disabilities.[15] The ADA protects people with HIV or AIDS

from discrimination in places of public accommodation, which include professional offices. Physicians or dentists can only refuse to treat a patient with HIV or AIDS under limited circumstances, such as when needed care is beyond the provider's expertise.[16]

Risk to staff and patients from staff infected with HIV is a fourth legal dimension. Health services organizations are subject to Section 504 of the Rehabilitation Act of 1973 (PL 93-112), which prohibits discrimination against qualified employees with disabilities. Those protections were strengthened by the ADA, which requires that employers make reasonable accommodations for employees with disabilities. To establish a violation of either of these statutes (Section 504 of the Rehabilitation Act and Title II of the ADA), a plaintiff must prove: 1) that he or she has a disability; 2) that he or she is otherwise qualified for the employment or benefit in question; and 3) that he or she was excluded from the employment or benefit due to discrimination *solely* on the basis of the disability. As to the second requirement, individuals are not "otherwise qualified" if they pose a significant risk to the health or safety of others because of a disability that cannot be eliminated by reasonable accommodation.[17]

In 1987, the United States Supreme Court considered a case analogous to that of an HIV-positive employee. In *School Board of Nassau County, Florida v. Arline*,[18] a teacher with recurring tuberculosis was discharged because of the health risk to students. The Court determined that tuberculosis was a disability protected by Section 504 of the Rehabilitation Act of 1973 and developed a four-part test: 1) nature of the risk (how the disease is transmitted); 2) duration of the risk (how long the carrier is infectious); 3) severity of the risk (potential harm to third parties); and 4) probability that the disease will be transmitted. No HIV/AIDS case has been considered by the Supreme Court.

Cases litigating whether HIV-positive health services staff are "otherwise qualified" under the ADA turn on the potential risk of harm to patients, even when harm is remote. An HIV-positive cook in a nursing facility was found otherwise qualified. Medical evidence showed that HIV is not transmitted by preparing and serving food and beverages and that his HIV status did not restrict him from performing his job.[19] Conversely, a surgical technician with HIV who assisted in exposure-prone invasive procedures was not protected by the ADA and the Rehabilitation Act of 1973. The court determined that his HIV status disqualified him from working as a surgical technician and that he was not otherwise qualified to perform his job. Evidence showed that his duties occasionally required him to place his hands on and in surgical incisions and that this put him at risk for needle sticks and minor lacerations. Expert testimony showed the risk of transmitting HIV to a patient to be very small. Nonetheless, the trial court applied the four-part test enunciated by the Supreme Court in *Arline* and agreed with the defendant hospital that there was a real possibility of transmitting HIV, and that because the consequence of infection is death, the nature, duration, and severity of the risk outweighed the fact that the chance of transmission was slight.[20]

The legal theory of a duty to warn suggests the extent to which caregivers (and, likely, organizations) may be legally obligated to protect third parties in immediate danger. *Tarasoff v. Regents of the State of California*[21] held that a psychotherapist who reasonably believes that a patient poses a direct threat to a third party must warn the person in danger. The state supreme courts that have adopted *Tarasoff* limit the duty to warn to identifiable third parties at

risk of real and probable harm.[22]

## Protecting Staff from HBV, HCV, and HIV

The underlying ethical premise is that health services organizations must respond to life-threatening infectious diseases by doing all they can to protect staff. This is supported by the virtue of fidelity (faithfulness, loyalty) and by the principle of nonmaleficence. Through its managers, the organization has a duty to provide a safe work place. Rawls's difference principle (special benefits may be given to small groups if doing so is in the interests of the least advantaged) supports this duty, as does the theory of utility (the greatest good for the greatest number). An effective workforce is sustainable only if there are safe working conditions. Having identified that there is an ethical priority not to put staff at unnecessary risk, the health services organization must create and maintain an environment compatible with the obligation to provide services to the community and treat individuals with infectious diseases such as HBV, HCV, and HIV.

Although present in all body substances of those who are HIV positive, the virus apparently can be spread only by sexual intercourse or intimate contact with body substances, especially blood. Though the risk to healthcare workers is low, the consequences of severe infectious diseases such as hepatitis and AIDS make infection a major concern for them and the organization. The Centers for Disease Control and Prevention and the Occupational Safety and Health Administration guidelines for universal precautions must be used in all health services organizations.

Some physicians and staff are reluctant or unwilling to treat people with AIDS. In 1987, the AMA Council on Ethical and Judicial Affairs issued a statement that physicians behave unethically if they refuse to treat people with AIDS whose medical conditions are within their competence, and this continues to be its position.[23] In mid-1987, the American Hospital Association (AHA) issued recommendations about clinical management of AIDS patients.[24] These recommendations have not changed.[25] They are consistent with CDC guidelines and state that universal blood and body substance precautions are the best protection for caregivers. They require that all patients' blood and body substances be considered hazardous and that all patients be subject to the infection-control guidelines originally established for hepatitis and HIV. This means that isolation and biohazard precautions should be used for all patients, regardless of infectious status, and that healthcare workers should protect themselves against blood and body substances and patient contact. Under CDC guidelines in effect since 1987, hospitals should judge whether their patients' characteristics are such that all admissions should be tested for HIV.

Staff compliance with the requirements for universal precautions has been and continues to be a problem and a challenge for the health services manager.[26,27] In addition to consistent use of universal precautions, the proper disposal of contaminated materials, including needles, is a problem.[28] Enhanced education can be only a small part of the answer. No caregiver can be ignorant of the risk of HCV and HIV and the importance of universal precautions. Management must identify and correct structure and process inhibitors that reduce staff willingness or ability to comply with universal precautions.

In 1987, the CDC confirmed that three hospital staff had become HIV positive after occupational exposure to contaminated blood. The risk to healthcare workers who work with patients who are HIV positive is now well documented, and there have been 57 confirmed cases of transmission of HIV, almost all the result of percutaneous (puncture/cut injury) exposure to HIV-infected blood.[29] Three large studies in the late 1980s estimated the risk of contracting HIV after being stuck accidentally with a contaminated needle at approximately 1 in 250.[30] Recent estimates are lower, with a finding that the average risk of HIV transmission after percutaneous exposure to HIV-infected blood is approximately 0.3% (1 in 300). The risk of infection after percutaneous exposure to hepatitis B (6%–30%) and hepatitis C (1.8%) is significantly greater.[31]

CDC estimated that approximately 800,000 healthcare workers in the United States would be injured by patient needles in 1998. Combined estimates from the CDC and EPINet—a computer-based standardized injury tracking system used by approximately 1,500 U.S. hospitals—suggested that more than 2,000 of those workers would test positive for new infections of HCV. Another 400 would get HBV, and 35 would contract HIV. HIV is the most feared, but HBV, for which there is a vaccine, and HCV, for which there is no vaccine, are life threatening because they can lead to liver damage, cirrhosis, and cancer.[32] The risk of infection by HBV, HCV, or HIV after occupational injuries from sharps when the source is noninfectious or unknown appears to be relatively small.[33] Prudence in all sharps injuries is the best course, regardless.[34] Attention should be paid, as well, to the psychological aspects of blood and body fluid exposure.[35]

The CDC reports that almost 25,000 adults with AIDS have a history of employment in healthcare.[36] Of concern, too, are the opportunistic diseases that accompany progression to frank AIDS. These include tuberculosis and *Pneumocystis carinii* pneumonia (PCP). At special risk in healthcare settings are older adults and persons with compromised immune systems.

Increasing numbers of infectious diseases in health services organizations pose special problems for managers and caregivers. As they seek to comply with legal requirements, the ethical obligations owed to staff and patients cannot be put at risk. Meeting the expectations of beneficence and nonmaleficence should always be foremost in the minds of all who deliver and manage services.

## NEW RELATIONSHIPS WITH MEDICAL STAFF

Beginning in the late 1980s, significant changes occurred in relationships between physicians and health services organizations, a movement led by acute care hospitals. These arrangements are designed to add an economic dimension to relationships that emphasizes clinical activities. The *MeSH (medical staff–hospital)* concept was introduced in the 1980s but gained only limited acceptance; then, the *joint venture*, which included undertakings such as medical office buildings and the lease or purchase and operation of high-technology equipment, became the focus of economic relationships between organizations and practitioners. In the 1990s, both concepts were replaced by the *PHO (physician–hospital organization)* and integrated health

networks, both of which focus on primary care but seek to deliver a continuum of services to a defined population. The economics of clinical practice must be tied to the organization so that each may assist the other to survive.

Such arrangements are fraught with potential ethical problems. A mildly adversarial relationship between medical staff and managers is useful because it provides checks and balances in maintaining high-quality patient care. This relationship requires that each party remember that its reason for being is to serve and protect the patient. When management and clinical practice are economically bound together, patient interests may suffer. The potential for conflicts of interest increases if the physicians involved in these arrangements are also part of the governing body. Evidence of actual conflicts of interest and fear of their potential have led to the passage of federal and state laws regulating certain clinical referrals.

## APPRAISAL OF MANAGERIAL PERFORMANCE

A principal role of the governing body is appraising the CEO's performance, even as the CEO appraises subordinate managers. W. Edwards Deming rejected management by objectives (MBO) for general use in organizations. He argued that MBO pits managers against one another and leads to internal competition and suboptimization of the affected systems; ultimately, the entire organization is suboptimized. Despite Deming's concerns, MBO continues to be common in organizations.[37] In its pure form, MBO, as first conceptualized by Peter Drucker, is consistent with Deming's theory. Its use, however, has deviated from the original intent.[38]

Despite the controversy over MBO, formal appraisal of CEOs using specific criteria is appropriate. Their responsibility for the organization carries broad authority. Their interests are consistent with its optimization, and appraising them should reflect this consistency. Harvey used MBO to evaluate hospital CEOs.[39] His list of competencies necessary for managerial effectiveness included planning and organizing, achieving hospital objectives, maintaining the quality of medical services, allocating resources fairly and efficiently, resolving crises, complying with regulations, and promoting the hospital. These criteria are generalizable to any health services organization in which performance is compared against predetermined measures and standards. Current theory applies similar criteria in an MBO format.[40] One study of CEOs found that 1 in 10 had *never* had a performance appraisal, despite the Joint Commission on Accreditation of Healthcare Organizations requirement and an appraisal being an indicator of good governance.[41] Another study found that 76% of governing bodies in responding hospitals formally evaluated their CEO.[42] Ongoing informal evaluation and annual formal evaluation of CEO performance are considered essential to organizational effectiveness. Anecdotal evidence suggests, however, that relatively few CEOs are evaluated against specific criteria, especially with the specificity recommended by Harvey.

To avoid conflicts of interest when they are evaluated, CEOs must limit their role to explaining organizational performance. The CEO's performance should be reviewed without the CEO present but with feedback provided later. Like all staff, the CEO is owed fairness in the review process, especially if negative outcomes that might result in termination are possible. Problems are minimized if the governing body employs a formal process to evaluate

the CEO's performance, one based on predetermined objectives that are to be attained during the period under evaluation.

CEOs evaluate the work of subordinate managers directly or in coordination with other senior managers. This includes evaluating administrative dimensions of clinical managers' work. Personal and professional relationships may interfere with objective appraisal, or, in some cases, even day-to-day management.

### A Little Too Close

Sue Rosen has been a successful health services executive for more than 20 years. She is currently the CEO of an addiction treatment center that provides a full range of in- and outpatient services. Approximately 4 years ago, she experienced significant job-related stress. In addition, she had had emotional problems in her personal life, which became more complex after her divorce and difficulties with her only child.

She recognized her need for professional help and sought the services of Dr. Eisenbard, a clinical psychologist. In addition to his private practice, Eisenbard consulted for several addiction treatment centers. Rosen received 32 sessions of therapy over 2 years. Eisenbard was of great assistance and their final session occurred 2 years ago.

Recently, Rosen's clinical director, a clinical psychologist, resigned. Eisenbard responded to a blind advertisement and sent his resume to a post office box. The director of human resources brought the resume to Rosen, who was surprised to receive it. Rosen has high regard for Eisenbard but is concerned about the implications of his application.

A previous therapeutic relationship will make it impossible for Rosen to interact effectively with Eisenbard, either as colleagues or as superior–subordinate. Rosen will not feel at ease, and, if needed, disciplinary actions against Eisenbard will be difficult, perhaps impossible. Eisenbard may not wish to enter into a managerial relationship with Rosen, but at this point he is unaware that she is his potential employer. Regardless of Rosen's high estimate of Eisenbard's professional abilities, this employment relationship should not be undertaken, as it is fraught with problems.

Governing bodies should be evaluated, and properly applied MBO is also appropriate at this level. Objectivity and comprehensiveness will be enhanced if an external expert assists in the evaluation. Important in evaluating governing body members is input from the CEO and other managers who interact with them.

## PROFESSIONAL CREDENTIALS

The process of verifying credentials begins when a physician first applies for medical staff membership and clinical privileges. All aspects of the candidate's education and training, licensure, and clinical preparation are reviewed. Regular periodic reviews ensure that physicians continue to be qualified. Renewal of privileges depends on demonstrated current competence. All clinical staff with independent access to patients receive a similar review, whether or not they are members of the medical staff. Preventing legal actions and bad publicity are important, but the primary reasons to be concerned about competence are the principles of respect for persons, beneficence, and nonmaleficence, as well as various of the virtues.

Occasionally, there are reports of persons claiming to be physicians but whose credentials are partly or wholly false. The problem of overstated, misrepresented, or false credentials is extensive in the business world, and there is reason to believe health services management is infected with the same virus. Examples of misrepresented credentials include inflated job

titles, responsibilities, and duties; exaggerated or falsified academic preparation and credentials; and falsified or misleading information about professional achievement and activities.[43] Some ruses are elaborate and very effective at misleading others.[44] Recent studies have found significant levels of plagiarism in original essays (known as personal statements) among applicants to medical residencies.[45] Such actions are dishonest and unethical.

Even a cursory check by a potential employer will usually uncover nonexistent formal credentials, such as licenses and academic degrees. More subtle and pervasive is the problem of "creative" resume writing. One need only look at resumes produced by some employment and executive search firms to realize that it is possible to make trivial management positions appear significant. Uncovering exaggerated or overstated credentials can be difficult because specific details of employment must be verified. Even job descriptions may not adequately reflect what the incumbent actually did in a particular position. For this reason, marginal cases may slip through.

Managers who encounter a management applicant who has presented dishonest credentials have one course of action—exposure and disciplinary action through the professional society. Appropriate action is less clear when it is discovered that current employees have falsified or misrepresented their credentials. Nevertheless, action must be taken. Counseling is a first step, whether or not the employee is to be retained. Beyond counseling, the action taken should be proportionate to the seriousness of the problem. Current job performance and the reasons for the falsified credentials should be considered. Serious falsifications and misrepresentations must be reported to the professional society and to the authorities if there is criminal behavior.

What action should be taken if one has personally overstated, misrepresented, or falsified qualifications? Managers with such problems should inform their superiors and offer the strongest possible rationale for the action. This is a sound course of action even when the claimed credential does not exist but was material to the hiring decision. The employer may not take drastic action, especially if the reasons for what was done are compelling. The employer is likely to consider current job performance. The manager must be prepared for termination, however. Continued concealment is unacceptable: As one rises to a more senior level, the stakes are higher and the potential for devastating damage to one's career increases. Misrepresented or falsified credentials are a burden to the individual because they will eventually be uncovered, and because of the chronic, nagging fear of being caught. It is better that corrections be made when there is less to lose. This is a compelling utilitarian argument. The Kantian and virtue ethicist, however, would quickly add that it should be done because it is right and honest to do so.

Slovenly verification by potential employers greatly eases the use of false or exaggerated credentials. Inadequate verification is a problem for any position in the organization. Managers breach their moral obligation if they fail to perform effective credentials checks because patients are at risk, for example, if an incompetent administrative or clinical practitioner is hired. The employer is responsible for adequately checking credentials and acting when dishonesty is uncovered. Discovery of significantly misrepresented or falsified credentials should be reported. It should cause the professional association to take disciplinary action up to and including expulsion. Representation of a fictitious academic degree or position is significant to both employer and professional organization.

Employers are morally obligated to accurately and comprehensively report the performance of former employees. In the case of serious problems such as drug addiction or other criminal behavior, specific information should be reported, whether or not it was requested. The legal concept of a duty to warn reinforces managers' ethical obligation to provide information about a former staff member's significant problems. Less serious problems should be communicated as part of a balanced appraisal of strengths and weaknesses.

A Massachusetts case raised questions about ethical behavior when physicians writing references neglected to include information about the character and criminal behavior of former residents in anesthesiology.

### But Is It Relevant?

The Massachusetts Medical Society investigated three physicians at a leading Boston hospital who wrote highly laudatory letters recommending a colleague only a few days after he was sentenced to jail for raping a nurse.

The convicted physician was able to use the letters to get a new job as an anesthesiologist at the Children's Hospital in Buffalo, where officials said they were unaware of his legal troubles. He was charged later in another Boston rape case, dating back to 1978, involving patients.

Medical officials said the case, involving physicians at the Brigham and Women's Hospital, was the most striking example they have encountered of how letters of recommendation for hospital jobs have lost their value in recent years, as physicians become cautious about writing anything critical about colleagues for fear of being sued.

Other physicians on the staff of the hospital said they believed the letters were written after consulting the attorney for the Brigham and Women's Hospital. Because the rape did not occur within the hospital, they suggested that the attorney had advised the physicians that they had no basis for being critical of the physician's medical performance.

In commenting on the case, B.J. Anderson, associate general counsel for the American Medical Association, said that the association advised directors of departments in hospitals to be candid when writing letters of recommendations despite the threat of lawsuits: "Too frequently hospitals that have had a problem with a physician will write a glowing letter because it is easier to export your problems across a state line than to resolve them yourself."[46]

After an investigation by the Massachusetts Medical Society, the three physicians who wrote the letters of recommendation were censured and placed on probation for a year. The controversy over the letters prompted appointment of a panel to suggest guidelines for preparing letters of recommendation. Its report advised physicians to follow a Golden Rule of letter writing: "A letter should contain the information known to the writer that he would like to have were he to receive the letter." The report also stated that "information regarding personal character is of great importance in the case of physicians."[47]

Whether or not the physicians who wrote recommendations violated the letter of the law, they certainly failed to honor its spirit. All health services organizations hiring this physician or appointing him to its medical staff would find it relevant that he had been convicted of a felony. This is especially true of the crime of rape, which is so inimical to the intimacy of the patient–physician relationship. As with nonphysician staff and employees, the organization, through its managers, is morally obliged to report relevant information about physicians (and all staff) honestly and objectively. Reluctance to communicate information about former staff to potential new employers facilitates movement of incompetent and even dangerous clinical staff from job to job, despite spotty employment records and investigations.[48] Even state statutes that protect references if they are truthful have given limited reassurance to former employers because references tend to be subjective.[49]

## CONCLUSION

This chapter identified and analyzed the ethical problems managers experience in their relationships with the organization and staff. These relationships are analyzed within the context of the manager's ethical obligations to patients. Managers have access to patient and proprietary information, most of which is confidential. This accessibility suggests the potential for inappropriate disclosure, self-dealing, and misuse of insider information.

The unique relationships that senior managers, especially CEOs, enjoy with governing bodies and staff were examined within the context of various ethical duties. Managers must act to protect patients when questions of clinical competence arise. Taking this action includes having the policies, procedures, and resources needed to minimize the risk of inadequate practice and to eliminate it should it occur. Managers must establish a culture that emphasizes patient care and safety, and they must support all staff in their efforts to maintain this focus.

New relationships among organizations and with physicians raise ethical issues, most of which result from the potential for conflicts of interest. Emphasizing financial aspects makes it easy to forget that the patient is the primary reason for the existence of health services organizations.

The chapter concluded with an examination of falsified or overstated personal qualifications and the obligation of managers to act when these problems come to their attention. Thorough background checks and the provision of honest recommendations assist organizations in their work, protect patients, and maintain the integrity of the profession.

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CHAPTER 8

# ETHICAL ISSUES REGARDING PATIENTS AND COMMUNITY

This chapter identifies the special relationships between managers (and their organizations) and patients and the community. The personal duties and obligations of managers, as well as the responsibilities to their profession, were noted in Chapter 4 in the context of the moral philosophies and the ethical principles of respect for persons, beneficence, nonmaleficence, and justice, in addition to various of the virtues. That chapter highlighted the need for managers to have a well-defined personal ethic to guide their decision making on administrative and biomedical ethical problems within the context of the organizational philosophy.

This chapter reinforces the book's underlying premise that the manager is a moral agent with independent duties to the patient. Managers must juxtapose their relationship with and duty of loyalty to the organization with their patient relationships. The reciprocal duties of colleagues are a part of belonging to a professional group that has expectations and demands certain behavior. In many ways, organization and manager are one. Managers must keep this in mind because their actions and decisions are judged in that context—they personify the organization. However, there are ethical limits to what the organization can expect of those working for or affiliated with it. Managers must know the limits of their personal ethic and must speak out when the organization infringes on those limits.

## MAINTAINING CONFIDENTIAL INFORMATION

### Patient Records

Through their managers, health services organizations are charged with duties regarding patient information. Medical records are essential for good patient care and they must be legible, current, complete, and authenticated. The legal duty to maintain their confidentiality and security is met by providing adequate and effective personnel, systems, and procedures in medical records activities, and by ensuring that medical staff bylaws, rules, and regulations are enforced. Much can be done to prevent or minimize unauthorized access to paper medical records. The increasing use of electronic records raises significant new confidentiality issues.

The federal Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 and became effective for medical privacy in 2003. It places substantial restrictions on how health information is obtained, managed, stored, transferred, and used. Much attention is paid to the need for patients to consent for any use of their health information, including among various types of personal and institutional providers.

State legal requirements vary, but individuals working in health services organizations have an ethical duty to ensure the confidentiality and appropriate use of patient information. A

common breach of this ethic occurs when patients are discussed with or in the presence of persons with no need to know. Hospital-based research has found significant breaches of patient confidentiality and other types of inappropriate comments, such as concerns about a staff member's ability or desire to provide high-quality patient care, concerns about poor-quality care in the hospital, or derogatory remarks made about patients or their families.[1] Idle chatter or gossip may be titillating, but it is ethically unacceptable inside and outside the organization. Breaches of patient confidentiality can also occur through improper disposal of electronic patient records (e.g., those stored on computer hard drives).[2] In addition, conflicts may arise between maintaining confidential information about patients and furthering organizational interests.

## Mailing Lists

University Hospital has a very active cardiac medicine section in its department of medicine. Across several decades, it has treated thousands of people with heart problems ranging from angina to congestive heart failure. Its patients have been included in several research protocols, many of them funded by the National Institutes of Health or various national heart associations.

Periodic questionnaire surveys are conducted as part of long-term patient follow-up. To complete these surveys, an extensive database and mailing lists are maintained by the cardiac medicine section. On one occasion, the development office of University Hospital used the mailing lists to solicit general contributions. On another occasion, it undertook a special fund-raising effort to assist in converting and equipping a cardiac intensive care unit. Contributions by the cardiac program's current and former patients have been excellent, primarily because the program maintains superior rapport with its patients.

The physician-director of the program and her administrative assistant have been approached by a prominent and respected national insurance company impressed by the results of the program. It wants to use the mailing lists to market life insurance to the program's participants. The proposal is attractive because the opportunity to obtain life insurance will benefit present and former patients, many of whom are insurable only with very high premiums. The proposal is also attractive because any data obtained by the insurance company will be available to the hospital at cost if the mailing lists are provided to the insurance company.

The physician-director and administrative assistant are enthusiastic about the clinical possibilities in addition to the opportunity to help patients. The director of development views the sale of mailing lists as a way to raise money for the cardiac program's activities. Both he and the physician-director spent an hour trying to convince the chief executive officer (CEO) that it is appropriate to release the mailing lists for this worthy purpose.

As stated, the proposal violates the privacy rule of the HIPAA because medical information from a covered entity—in this case, a hospital—is being used to market a product or service without the patient's written authorization.[3] Because breaking the law is unethical per se, University Hospital must obtain consent before it can use the mailing lists as proposed.

An ethical analysis produces virtually the same result as that obtained by applying HIPAA. This case suggests the legitimate but opposing and competing considerations that are a part of patient care, research, fund-raising, and a limited duty of general beneficence to help patients solve problems indirectly linked to medical treatment. The case highlights the ethical problems of safeguarding the confidentiality of patient information. Using the information in the way requested violates the confidentiality of patient treatment and diagnosis. Some direct benefits may inure to patients (e.g., opportunity to obtain life insurance) and some indirect benefits may inure to the organization (e.g., improved data for epidemiological studies). Nevertheless, using the mailing lists as suggested serves no valid research purpose, nor does it directly further patients' medical treatment. Data that do not identify patients serve the same epidemiological purposes. The promise of mortality data on insurance purchasers is incidental to the research effort, and the money earned selling the mailing lists is likely to be modest. Regardless, these

utilitarian arguments are irrelevant because such uses are incompatible with the principle of respect for persons, which includes confidentiality. Previous use of the lists to solicit contributions was questionable and cannot be used to support making the lists available now.

A weightier ethical argument for using mailing lists could be made if all University Hospital patients were included, rather than only those identified by diagnoses. Mailing to all former patients identifies only that they were patients at University Hospital, but even this activity may raise concerns over confidentiality for some former patients. The problem of mailing lists can be minimized by determining upon admission whether patients are willing to be on mailing lists used for hospital purposes, such as fund-raising.

University Hospital's use of mailing lists must be distinguished from selling or renting them. Patients must be informed if the hospital intends to use a mailing list commercially. Chapter 9 discusses several of the issues incident to obtaining consent in similar situations. Confidentiality concerns change, and patients should know that they can ask that their names be removed from a mailing list at any time. Rental or sale of mailing lists in health services settings is fraught with ethical problems and is best avoided.

## MONITORING CLINICAL ACTIVITIES

Managers are agents of the organization, but as decision makers whose actions have moral implications and as members of a profession, they are never simply instruments of the organization. Managers have duties to patients independent of those the organization has to the patient, or those the physician has to the patient. Managers' concerns and duties are not limited to problems with the business office or the quality of food but extend to clinical activities. In terms of the patient, the manager is the organization's conscience.

Nonphysician managers do not judge clinical activities as would physicians. Just as they use technical experts to develop a new computer system or prepare a loss prevention management program, managers rely on experts in nursing and medicine to assist in understanding these activities and their outcomes. Experienced managers have considerable knowledge about clinical medicine; in a gross fashion, this knowledge enables them to determine when problems may be present. Regardless of their clinical sophistication, their purpose is not to be junior physicians but to understand what physicians do and what they need and want. The primary reason to understand clinical activities is to help the organization serve patients safely and effectively.

The health services organization benefits most when involvement is bidirectional—managers should expect and seek physician participation in administrative decision making. Hospitals in which physicians participate in management decision making achieve superior results.

An important role of managers in clinical settings is to link the formal and informal organizations. Anecdotal evidence suggests that informal communications are helpful, perhaps critical, in identifying clinical problems, and that they are an important supplement to formal systems. Nursing is especially important as an informal link. Deficient performance by physicians is often initially identified by nurses. Information from them can alert the formal system and be a starting point for further inquiry. Disciplinary actions cannot be based on

rumor, however; managers must ensure adequate follow-up and investigation in conjunction with normal monitoring of clinical outcome data. As necessary, the manager must take action to protect the patient. As a moral agent, the prudent, ethical manager cannot ignore situations that jeopardize the patient or the organization. Sometimes, however, the tables are turned.

### A Different Kind of Risk

Dr. Sagatius has just returned to his office after seeing the risk manager. He was very upset and slammed the door behind him before slumping into his chair. He would not stand for it, not again, he said to himself. This was the final straw. Administration was not going to push him around!

He thought back to the two previous incidents in the pediatrics unit and considered their similarity. Now there was a third incident, this time involving a different nurse. Another one of his patients had been medicated incorrectly—actually overdosed. Luckily, Sagatius had been able to intervene once again before serious consequences occurred. The child would have to stay in the hospital several days longer to be sure that the child was stable. He had reported the first two instances to the nurse supervisor. Now he would have to take other action.

The day following the third incident, Sagatius was asked by the risk manager to stop by her office. While there, he saw the child's medical record lying on her desk. Sagatius noticed that the risk manager had changed the medication record, which he knew had previously shown the overdose. When he asked the risk manager about it, she said that it did not matter because no apparent harm had come to the child. "Why needlessly upset the parents?," she asked. When Sagatius protested that this was dishonest, the risk manager became hostile and reminded Sagatius that a malpractice suit would hurt all those affiliated with the hospital, including the doctors, who were almost certain to be sued should the error come to light. She warned him not to discuss what happened with anyone, especially not with the parents.

Sagatius planned to tell the parents about the overdose, believing that they were owed an explanation for the extra days in the hospital. In addition, they had to watch for signs of long-term effects of the overdose and seek medical treatment for the child should they occur.

Sagatius weighed his options. He knew he had to tell the parents to watch the child closely, even if he did not discuss the overdose. He retrieved the parents' telephone number from his computer.

Dr. Sagatius faces two ethical problems. The first concerns the risk manager. Ethically, Sagatius's primary duty is to protect the interests of his patient, which means that he must provide the parents with the information they need to monitor their child; doing so meets the principles of beneficence and nonmaleficence. How can he carry out this duty given the position of the risk manager? The risk manager has violated the principle of respect for persons, specifically truth telling. In addition, by covering up clinical failures, the risk manager is enabling a system that violates the principle of nonmaleficence, as well as the virtues of honesty and trustworthiness. The dishonesty is inconsistent with the typical organizational philosophy. Furthermore, it will thwart the investigation to find the root cause of a type of problem that appears systemic.

The second ethical problem involves the nursing supervisor, who has not acted to prevent a serious, recurrent problem in the pediatrics unit. Such inaction is inconsistent with the principles of beneficence and nonmaleficence and the ethical obligations under the Code of Ethics for Nurses. Sagatius is ethically obligated to report the persistent quality problem to more senior leaders through the nursing and medical staff hierarchy or other appropriate means.

Medical record falsification is rare, even though it is human nature to want to hide problems. The manager's ethical obligations commonly become submerged in the legal dimensions of a problem, despite the fact that in this case, the risk manager's action was illegal. As a result, the patient becomes the enemy, and those in the organization move into a defensive posture. Patients and family sense this and are spurred even more to press for an

explanation, a kind word, or perhaps even an apology. Patients and their families understand that errors and mistakes can occur, and it is increasingly clear that they are less likely to take legal action if they believe that they have been treated fairly and everything was done to ease the effects of the error. What they cannot understand and often will not accept are deceit and coldness. Hiding the truth and lying to patients and families angers them; angry patients and their families are much more likely to file a lawsuit. This utilitarian argument also supports the unpleasant but ethically preferred course of forthrightness and honesty with injured patients or their families, as appropriate. Doing so has been shown to be successful in some settings.[4]

Organizations that acknowledge their mistakes and strive to make things right are better served ethically—and, apparently (with limited evidence), legally—than those who fight to the end. In this regard, it is important to note that admitting an error, accepting responsibility for an error, or even admitting negligence are not the same as admitting liability. A finding of liability requires negligence (departure from the standard of care), injury (harm to the patient), and proximate cause (the harm must have been caused by the departure from the standard of care). The plaintiff has the burden of proving *all* these elements; it is the causal relationship that remains to be proved even when negligence has been admitted.

Since the early to mid-1990s, a small number of organizations determined that their ethical duty to disclose treatment errors was greater than the potential risk of legal action against them. After acting to minimize the error's clinical consequences, they informed patients (and family, as appropriate) about what happened and why, apologized, and sought a fair solution to the medical and economic effects of the error. Money may or may not have changed hands.

Being honest with patients gained momentum in 2001 when the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) amended its patient safety and medical and healthcare error reduction standards. The changes require that patients and families, as appropriate, be informed of unanticipated outcomes, including medical error. Medical error was defined as "an unintended act, either of omission or commission, or an act that does not achieve its intended outcome." The Joint Commission addresses medical error by requiring that "patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes." The responsible licensed independent practitioner or designee provides this information.[5] Honestly admitting mistakes carries potential harms as well as benefits to patient and practitioner.[6]

All members of the organization have a shared responsibility to scrutinize the services delivered and take action as necessary. If this is seen as "ratting someone out" or being a "stool pigeon," the organization's culture is in desperate need of change. Identifying problems should be an important part of the culture and everyone should be committed to correcting them once identified.

This type of culture will make whistle-blowing unnecessary. Such a negative interpretation is possible only if one ignores the reason for being of the organization and those who work there. Both exist to further the interests of patients. When problems occur in the delivery of services, the organization and its managers must act to minimize loss and injury and do whatever is possible to make the patient whole. The manager must be involved, as necessary, to eliminate or reduce the recurrence of problems.

## WHISTLE-BLOWING

Whistle-blowing occurs when an employee reveals information about illegal, inefficient, or wasteful action that endangers the health, safety, or freedom of the public.[7] This definition is broad enough to include revelations of mismanagement, including nonfeasance, misfeasance, and malfeasance. Many contemporary discussions of whistle-blowing focus only on fraud and abuse or other illegal activities under state and federal law. Here, however, the broad definition is used.

Whistle-blowing affects the private and public sectors and includes disclosing information both internal and external to the organization. Generally, internal whistle-blowing is much more likely to be seen as positive because the organization has the opportunity to correct the problem. External whistle-blowing usually occurs after internal reporting has proved fruitless; it may have significant negative effects on the organization. Negative reaction from managers is likely to be a function of the perceived or real level of embarrassment and threat to them and the organization. Whistle-blowing results from the activities of both individuals and the organization.

An example many health services managers will recognize is an organization that harbors a clinical or management staff member whose incompetence or incapacitation is known, except, of course, to those outside the organization. Despite this knowledge, nothing is done. The organization's culture discourages acting against those "in the club," or the lack of support in remedying the problem and the fear of retribution make the price too high. Thus, the problem continues until a catastrophe occurs or the situation becomes intolerable to a critical mass of managers and staff and action is forced. Much of the stimulus is fear of public exposure and the embarrassment or disciplinary action that is likely to result. Such motivation is not the stuff of moral agents, who act because it is right to do so.

Three types of activities result in whistle-blowing: clear illegality, potential illegality or danger, and the organization's social policy.[8]

*Clear illegality* occurs when the law is knowingly violated. Examples include falsifying information reported to the government, bribing inspectors, making illegal campaign contributions, falsifying audits, deliberately violating labor laws, discriminating in employment because of race or gender, and improperly disposing of hazardous wastes.[9]

The second type of activity affected by whistle-blowing involves *potential illegality or danger*. A growing body of regulations and case law protects employee health, patient safety, public health, and the environment. In addition, managers and employees are moral agents who are obligated to take action when there is reason to believe that patients are at risk, regardless of other requirements. In most situations in which whistle-blowing occurs or should occur, the whistle-blower acts in the belief that a given practice, process, or result is either not in compliance with accepted standards or that it places the patient at risk unnecessarily. "In any well-run enterprise, management should be seriously concerned about such violations and should welcome warnings by its own employees."[10]

The third type of activity affected by whistle-blowing involves the *organization's social policy*. An employee may become concerned about the morality of a management policy and its effect on patients or society. For example, an employee may believe that the net revenue of a

not-for-profit health services organization is excessive or spent inappropriately and that too little is used for indigent care. Speaking out or refusing to participate is likely to be protected by conscience clauses in state or federal statutes or by the U.S. Constitution, if state action is involved. Assuming the policy is legal, employee protest raises two issues: the employee's right to free speech and the employee's responsibility as a moral agent. Employees are entitled to the same constitutionally protected right of free speech as are other individuals. Furthermore, as moral agents, they have an ethical duty to speak out when policies and actions could or do adversely affect patients or society. The controversy usually arises when an employee exercises the right of free speech or the duty of moral agency by speaking publicly against an organization's lawful policy, thereby harming its reputation and market advantage.[11]

Health services organizations create a paradox when they encourage managers and staff to act responsibly in all situations without causing unnecessary disruption. When the organization or individuals in it act illegally, inefficiently, or wastefully, staff is expected to be loyal and not speak out. This paradox is less easily resolved as organizations become more competitive because employees are asked to deal aggressively with external competitors but to be complacent internally.

An important dimension of whistle-blowing is found in federal law. In 1986, Congress amended the False Claims Act, which was originally passed during the Civil War to reduce fraud in federal contracting. The amendments added important protections and rewards for individuals who blow the whistle. These whistle-blowers are known as relators. The lawsuits they can bring are known as *qui tam* actions (an abbreviation of the Latin phrase *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, meaning "he who sues in this matter for the king as well as for himself"). The law protects relators against wrongful dismissal, and they are allowed reinstatement with seniority, double back pay, and compensation for discriminatory treatment.[12] After relators file suit, the case is sealed for 60 days while the U.S. Department of Justice (DOJ) decides whether it will intervene. If the DOJ does not intervene, the whistle-blower may proceed independently. Assuming a successful outcome (and a significant role on the part of the relator), the whistle-blower may receive 15%–30% of any double or triple damages and fines imposed.[13] The vast amounts spent for Medicare and Medicaid, as well as other federal healthcare and healthcarerelated programs, offer great potential for fraud; for that reason, many *qui tam* suits are brought in the health services sector. Since 1986, more than $27 billion has been recovered. In fiscal year 2010, $2.5 of $3 billion was recovered from healthcare fraud.[14] Federal false claims law is supplemented by state laws.

## Examples of Whistle-Blowing

When considering these cases, it is important to bear in mind that employees and managers are moral agents with an ethical duty to speak out when policies and actions could or do affect patients or society adversely. This is true regardless of other requirements, such as the law.

### How Sweet It Is!

Dr. A. Grace Pierce joined the research staff of Ortho Pharmaceutical Corporation in 1971. In 1975, she was part of a team developing a prescription drug known generically as loperamide. The drug was used to treat acute and chronic diarrhea in

infants, children, and older adults. Saccharin was used to make it palatable by masking its bitter taste.

The research team agreed that the formula was unsuitable because it substantially exceeded U.S. Food and Drug Administration (FDA) saccharin limits. Management was informed of this fact but decided nevertheless to file a new drug application with the FDA. Other members of the research team continued development, but Dr. Pierce refused. Although she was offered work in other projects at no decrease in pay, she resigned her position, apparently believing her refusal had irrevocably damaged her career at Ortho.

Later, she sought relief in the courts, alleging wrongful discharge. The New Jersey Supreme Court ruled that Ortho had not acted illegally and that there were no grounds for a cause of action.[15]

The court placed substantial weight on the fact that there was no imminent harm to the public. The court ruled that the ethic of the Hippocratic oath did not contain a clear mandate of public policy that would have prevented Dr. Pierce from continuing her research. Similar cases have occurred in organizations that deliver health services.

## It's Really Only an X-ray

Frances O'Sullivan was an x-ray technician employed by several radiologists and a hospital. She sued for breach of an employment contract after she was fired. She alleged she was fired for refusal to perform catheterizations, a procedure she had not been trained to perform. O'Sullivan could not legally perform catheterizations in New Jersey, where only licensed nurses and physicians may do so. The issue involved was unique because the plaintiff had been asked to perform an illegal act. The superior court denied the defendant physicians' and hospital's motion to dismiss.[16]

Denying the motion to dismiss meant that O'Sullivan was entitled to a trial on the merits of the case. No report exists that this occurred, and it may be assumed that the case was settled before trial. In light of the illegality of what O'Sullivan was asked to do, she acted properly.

## Don't Speak Now and Forever Hold Your Peace

Linda Rafferty was a psychiatric nurse at a state institution in which the conditions were appalling. The abuses Rafferty claimed to have observed included the staff failing to protect patients from sexual abuse by other patients and from sexual exploitation by outside employees, providing improper nonpsychiatric medical care, allowing patients to keep medications in their rooms, locking up fire extinguishers, leaving blank prescription forms that were signed in advance by physicians in unlocked drawers for nurses to fill out on weekends, and hospital medical staff being chronically absent from work. Rafferty repeatedly complained to her superiors but resigned when her protests brought no change.

She was hired at another institution, Community Mental Health Center, as supervisor of nurses. Before she began work, she gave an interview to a Philadelphia newspaper in which she was sharply critical of treatment at the state institution. The morning after the story appeared, she was fired from her new position because "staff members were upset about the article." No other reasons were given until trial, when the Community Mental Health Center alleged inadequate job performance in addition to the previous reason.

Rafferty brought suit alleging she had been deprived of her constitutional rights. The court ruled that she be reinstated and be awarded more than $3,000 in back pay.[17]

These whistle-blowing cases resulted in court decisions, which makes them a matter of public record. The types and number of whistle-blowing cases are legion. Senior administrators at the University of California–Irvine Medical Center were fired for allegedly retaliating against employees who had reported physician misconduct at the center's fertility clinic. Whistle-blowers said that physicians were implanting eggs and embryos into patients without donor consent. An internal investigation supported the whistle-blowers' allegations and showed that after they reported the wrongdoing, they were treated badly by medical center management and clinic physicians and were subsequently fired.[18] Another whistle-blower case alleged that 132 research center hospitals conspired to deliberately miscode procedures and manipulate patient

records so as to obtain $1 billion in federal reimbursement for the use of investigational devices, which are not covered under Medicare and Medicaid guidelines. The hospitals argued that diagnosis-related groups pay by diagnosis rather than by products used, and thus payment was due regardless of treatment. The facts suggest that this was a *qui tam* case brought under the federal False Claims Act.[19]

An example of *qui tam* occurred at a community hospital in Pineville, Kentucky, at which a new physician found that several physician colleagues were not performing some patient histories, physical examinations, and other services listed in patient records. Hospital medical records clerks wrote histories and physicals based on information in the medical records or, sometimes, by interviewing patients. The document created by the clerk was used to bill Medicare. At discharge, clerks used the medical record to prepare a discharge summary, which was stamped with the physician's signature and used by the physician's office to bill Medicare for a discharge examination and treatment plan. After repeated efforts to change the practice, the new physician brought a *qui tam* suit. The hospital settled the case for $2.3 million; each physician paid $100,000. Had they been imposed, maximum damages and penalties could have totaled $31 million. Allegedly, hospital administration hindered efforts to end the fraudulent practices. Not unexpectedly, many at the hospital and in the community saw the whistle blower as the problem.[20]

*Qui tam* cases cover a gamut: TAP Pharmaceuticals agreed to pay nearly $600 million over allegations of kickbacks to physicians and false Medicare claims regarding treatment of their patients. Beverly Medical Care paid $175 million to settle allegations that employees of its nursing homes were exaggerating claims of time spent attending Medicare patients.[21] McAllen (Texas) Hospitals agreed to pay the United States $27.5 million to settle claims that it violated the False Claims Act, the anti-kickback statute, and the Stark law (which regulates physician self-referrals for Medicare and Medicaid patients) between 1999 and 2006 by paying illegal compensation to physicians in order to induce them to refer patients to its hospitals.[22] St. Joseph Medical Center in Towson, Maryland, paid $22 million to settle federal claims that it had engaged in a decade-long kickback scheme involving cardiologists who allegedly performed unnecessary procedures.[23]

Cases such as these highlight the three significant issues relating to whistle-blowing as an ethical problem in health services organizations. The first is staff responsibility and accountability, something that applies to all employees, whether or not they are managers. The second is fair practices. To encourage responsibility and accountability, due process procedures are necessary to protect employees—whether or not these are *qui tam* cases—who consider themselves moral agents and are courageous enough to speak out. Due process regarding employee disciplinary actions (both in terms of procedure and substance) is necessary, whether the organization is one to which federal or state constitutional protections apply. Being bound by such requirements will also encourage others to act when they should. Methods must be developed to balance the individual's duty to the employer against the duty to the public. This can be difficult because "many of the rights and privileges . . . so important to a free society that they are constitutionally protected . . . are vulnerable to abuse through an employer's power."[24] The third issue is how to encourage employees to speak out in

appropriate ways in order to meet their independent duty to the patient, without causing unnecessary damage to the indispensable cooperative and trust relationships that exist within the organization as well as between them and their communities.

## Negative Aspects of Whistle-Blowing

Several negative aspects temper what is positive about whistle-blowing: Determining the accuracy of whistle-blowing charges is not always easy. Whistle-blowers may be incorrect in what they allege to be the facts of management's misconduct. The danger exists that incompetent or inadequate employees may become whistle-blowers to avoid facing justifiable disciplinary actions. Employees can blow the whistle in unacceptably disruptive ways, regardless of the merits of their protest. Some whistle-blowers are not protesting unlawful or unsafe practices, but rather social policies by management that the employee considers unwise or unethical. The legal definitions of a safe product, danger to health, or improper treatment of employees are often not clear. The efficiency and flexibility of human resources management could be threatened by the creation of legal rights to dissent and legalized review systems. Risks to the desirable autonomy of the private sector are possible because a review of allegations by whistle-blowers will expand government's role too deeply into internal business policies.[25]

## Courses of Action

Managers with the authority to remedy a problem are morally bound to do so. If persons in authority will not act, there are alternatives consistent with the duty of loyalty that managers and staff have to the organization, even if these alternatives ultimately involve public disclosure. It is ethically appropriate to act early, even at the risk of embarrassing an organization, than to await further corruption, with its attendant greater risk of harm to others as well as the organization. The alternatives involve whistle-blowing of various types. Regrettably, whistle-blowing has a bad connotation for many. It suggests disloyalty to the group, if not to the organization—the person who blows the whistle is considered an informer, a betrayer. This attitude is perverse. How, for example, could one be considered disloyal by informing senior management of illegal or incompetent actions that risk the health of patients or staff? Establishing a culture that makes whistle-blowing unnecessary is a major challenge for management. Making the environment risk-free in terms of retribution against those who are willing to speak out (i.e., internal whistle-blowers) is an essential first step.

One type of whistle-blowing involves stimulating action by approaching those in authority directly. Working with persons of like mind—finding allies and gaining strength in numbers—can reinforce and stimulate the need to act. In an environment of fear, anonymous communication with those who are able to remedy the problem may be necessary to try to produce the desired result.

It is crucial that there is a change in the atmosphere typically found in an organization—the "I win, you lose" (*zero-sum*) approach to whistle-blowing. Responsible reporting will benefit employees, employers, and, most important, patients. As Bowman, Elliston, and Lockhart[26] point out, "Directing corrective efforts to [whistle-blowers] instead of the policy or practice

they protest will not alter the conditions that make whistle-blowing necessary." As noted above, this attitude was pervasive at Pineville.

### Place of Whistle-Blowing

Leading commercial companies have created ombudsman programs in which one person receives, investigates, and responds to employee complaints. Such programs are important for employees who believe illegal or improper conduct is occurring. The problem is that the ombudsman may lack the authority to solve problems in line departments. The ombudsman may not be empowered to deal with senior managers who actively promote illegal or improper conduct as an organizational imperative.[27]

Even where employees are protected by law, as in federal employment, they fear reprisals. The U.S. Merit Systems Protection Board found that 50% of employees who said they knew firsthand of illegal acts or waste in federal government failed to report it. Only 13% of whistle-blowers were given credit by management for doing the right thing; 71% said their supervisors or upper management became unhappy with them. Of whistle-blowers, 37% said they had experienced or had been threatened with retaliation, which included poor performance appraisals, being shunned by coworkers and managers, and verbal harassment or intimidation.[28] These findings were confirmed by a later survey showing that 25% of employees believed their government agency would not protect them from retaliation for whistle-blowing.[29] Research on whistle-blowing in the private sector has similar findings. For example, half of management accountants who observed wrongdoing did not report it.[30]

#### Doorway Consultations

A consulting ethicist for a large nursing facility was asked by a nurse to discuss a problem concerning a physician, several of whose patients are residents in the facility. The nurse said she had an ethical quandary and was not sure what to do. She continued by describing how the physician routinely looked into his patients' rooms from the doorway and then made chart entries indicating he had had a professional visit with them. The nurse said that she had heard of physicians who would "survey" the dining room at mealtime and then make chart entries indicating a professional visit. She said that behavior was only slightly worse than what she had seen. In fact, she said, one of her patients asked if her doctor was coming in because she had questions for him. "What should I do?," asked the nurse.

Quality of care questions aside, the physician is acting unethically. If he bills for these "visits" he is committing fraud; this makes him subject to criminal prosecution and other sanctions. The nursing code of ethics and the expressed personal ethic of this nurse require that she report her concerns within the nursing administration hierarchy—that she become an internal whistle-blower. Failing action, the nurse should consider external whistle-blowing or a *qui tam* action if federal or state programs are involved.

### Organizational Culture

The word *whistle-blowing* is unfortunate terminology. In historical context, it suggests a police officer who used a whistle to stop criminal activity and summon assistance. It would be far better to make the concept one of highlighting the compliant culture that emphasizes quality—one in which calling attention to a problem is considered positive, not negative. An open culture that stresses honesty, integrity, quality of care, fairness, and concern for patients and

staff—an environment with shared values—will result in proper treatment of patients and staff, safe surroundings, and honest billing practices. This makes a compliance officer and compliance program largely redundant. Even if both are necessary because of legal or regulatory requirements, their roles will be to communicate information, educate staff, and assist in establishing policies and procedures that enable compliance. Assigning "ethics" to an individual or a program is foolhardy and will never create a culture of shared values. It bears repeating that meeting the law's demands (compliance) is only the base expectation for an organization. An ethical organization, through its managers, holds itself to a higher standard of performance. Larson noted this:

> Take the example of a homeless person who repeatedly comes into the ER for care. Compliance dictates only that the patient be stabilized, then released or transferred. Ethics ask us: What can we do for this patient? . . . Do we pass the buck or is it our turn? Should we do more? Compliance is the minimum, but ethics mean addressing all that is necessary.[31]

Managers must work to establish and nurture a largely risk-free culture in which problems of nonfeasance, malfeasance, or misfeasance are easily communicated and action taken. Such a culture is the ounce of prevention that is worth a pound of cure. The acculturation begins in the recruitment and selection processes and continues with new employee orientation. Later, it must be reinforced by the example of formal and informal leaders. The importance of example setting from the governing body down through the management ranks cannot be overstated.

This culture of responsibility, openness, and commitment on the part of management is essential to developing a meaningful internal policy on whistle-blowing. Also essential is drafting the principles and policy statements that apply management's intention throughout the organization and communicating these statements to employees. The importance of middle and line managers must be stressed. Not only must they be knowledgeable about the principles and policy statements, but their evaluations must encourage widespread adherence.

Identifying, communicating, and solving problems are made easier if fear and fault finding are removed from the equation, an approach consistent with the philosophy of W. Edwards Deming. Even Deming recognized that the employee causes a small percentage of problems, but that the greatest gain in quality will occur by improving the process.[32] In the case of impairment because of substance abuse or other willful acts with negative effect, however, focusing on the individual is a necessary first step.

### Summary

The concept of moral agency and the willingness to speak and act as necessary remain central, recurring themes for managers and caregivers alike. Professional dissent is critical to the field of health services administration and the delivery of health services. No morality exists without action; ethics will survive only if people speak out when it matters. Professionals are distinguished by the ability to recognize ethical problems and to act as moral custodians of the organization in which they work.

## ASSESSING AND IMPROVING QUALITY OF CARE

Through their organizations, health services managers are charged with the weighty responsibility of assessing and improving the quality of patient care. Managers cannot directly assess clinical quality, but they are ethically bound to support and encourage the efforts of experts who can. Sometimes, managers must stimulate quality assessment and corrective action. More important, managers are key in leading the organization to adopt the philosophy and concepts of quality improvement and to apply its methods.

Consistent with the manager's duties of beneficence and nonmaleficence—as well as virtues such as courage, compassion, discernment, and conscientiousness—is to discourage or actively oppose establishing or continuing clinical services that expose patients to unnecessary clinical risk. One source of risk occurs when health services organizations perform low volumes of a surgical procedure or treat few patients with a specific medical condition. Early studies suggested that successful cardiac surgery was correlated positively with the number of procedures and that hospitals performing few procedures had poorer outcomes than hospitals performing many. Explanatory factors may have included patient acuity and a willingness to accept higher risk patients, but their contributions were not examined. Absent explanation of the differences, the studies recommended closure of low-volume/high-risk programs.[33]

Data published in the mid-1990s supported these recommendations and included physician and geographic area volumes, as well as improved outcomes and lower costs.[34] Research published in 2000, 2002, and 2003 provides further support for the proposition that there is a positive relationship, albeit variable, between higher volume providers and better outcomes, including better results for high-risk patients. These studies analyzed a broad range of surgical procedures; one also showed similar benefits for high-volume site treatment of HIV.[35]

Thus, evidence of the link between volume and quality of clinical outcome continues to mount. There is a clear ethical imperative for managers whose organizations either have a low-volume service or are considering undertaking a service whose volume is likely to remain low.

## Higher-Risk Procedures

Teaching Hospital was established in 1907 with a grant from a wealthy local industrialist. The star of its long history of educating nurses and physicians is a surgical residency program, a key element of which is cardiac surgery. Two years ago, the cardiac surgery program was set back substantially by the death of the chief of cardiac surgery and the departure of a member of the team. Referrals declined markedly, and the volume of open-heart procedures dropped to five per month. This occurred despite significant efforts to build referral volume.

The quality department performs special studies for various clinical services. Recently, it reviewed mortality data from cardiac surgery and found that mortality rates were more than double the rates found in the literature. The director of quality expressed concern as she discussed the report with the CEO. She noted that the literature reported an inverse relationship between mortality rates and the number of procedures performed. It seemed that technical competence could be only gained and retained by performing a high volume of procedures.

Soon after, the CEO saw the medical director at lunch. During their conversation, the CEO asked whether he had any reason to believe that the cardiac surgery program was of lower quality than it had been in the past. The medical director replied, "As far as I know, things are fine." When she inquired as to the reason for the concern, the CEO replied that the frequency of performing cardiac procedures had declined and the literature suggested that this had implications for quality of care. In fact, the hospital's review had been confirmatory. The medical director said she would look into it. The discussion moved to other matters.

The ethical issue for Teaching Hospital and its patients is apparent. An ethical problem exists because patients undergoing cardiac surgery there are at higher risk than they would be

in a high-volume hospital, and this violates the principle of nonmaleficence. The CEO may not ignore what is happening; to do so is inconsistent with the manager's role as a moral agent, as well as that of a professional with an independent duty to protect patients. What is the next step? Discontinuing the program immediately may be politically and economically impossible, but steps must be taken now to gain the support of the medical staff and to apprize the governing body of the problem. Whether or not the medical staff lends its support, the CEO must urge the governing body to suspend the program.

What happens if working internally proves fruitless? What if the problem is acknowledged but those in authority will not act? This situation is a significant test of the manager's ethic because it poses a true ethical dilemma: The manager is confronted with conflicting moral duties. On the one hand, information about the cardiac surgery program is confidential and the manager has a duty of loyalty to the organization. On the other hand, organization inaction places patients at special risk. Weighing these conflicting moral duties should lead the manager to conclude that the higher duty is that of protecting patients. The manager must press and pursue, even to the point of releasing information outside the organization if corrective action is not taken. Going public with such damaging information (whistle-blowing) is a last resort and an act of great moral courage. External whistle-blowing will make the manager a pariah who is likely to be terminated for what will be seen an act of betrayal.

The CEO might consider two other options that are more pragmatic but ethically less desirable. One option is to ignore the short-term implications of the decline in quality of care and find ways to build on program strengths to increase volume and quality. Another option is to determine the types of procedures with better results and focus on performing them. Both approaches may place patients at unnecessary risk, although special attention could reduce the risk to acceptable levels. This option seems unconscionable in terms of the virtues of caring, trustworthiness, and integrity, and the principles of beneficence and nonmaleficence. Absent an emergency or triage situation, one cannot justify the harm to some (patients) because of benefit to others (e.g., surgeons and residents; hospital income and status). Using patients as a means to an end is morally wrong.

Other clinical quality issues go beyond reviewing and ensuring a clinician's competence. These include ensuring the adequacy of support staff and equipment, evaluating the patient's clinical appropriateness for a procedure, and acting when a clinician's abilities decline. Often, the problem is apparent only in retrospect. Some processes allow concurrent control of quality, however, and these should be used.

## Operating Beyond His Skill?

Jim Hudson picked up the form that had been delivered by the operating room (OR) scheduling clerk and began to review the procedures scheduled for 2 days hence. Hudson's job is to ensure that surgical packs, equipment, time, and personnel are adequate to meet the demands of scheduled surgery. The list included a procedure that Hudson had never seen scheduled before. Looking at the column that showed whether special equipment or supplies were needed, Hudson saw a note that the attending surgeon would provide the items. This notation puzzled him because it was the responsibility of the OR supervisor or the purchasing department to provide everything needed for a surgical procedure. Hudson called the chief of surgery, to whom OR staff reported clinically. He was unavailable, but his secretary promised he would return the call.

When the chief of surgery called, he was noncommittal. "If the procedure is scheduled," he said, "it's probably okay for it to be done." The clear implication was that the surgeon would not perform a procedure with inadequate preparation.

Hudson was unsure what to do. Not being a physician, further action by him would be seen as inappropriate meddling in clinical matters. Nevertheless, further checking seemed necessary.

This case focuses on a problem of clinical quality. Hudson must do more than ponder what the facts suggest. Hudson should query the attending surgeon, and if that does not produce satisfactory information, the problem should be taken higher up the administrative hierarchy. Additional information may clear up the questions; it may also cause the procedure to be canceled.

To obtain routine information on quality of services, health services organizations establish systems to review the content of clinical and administrative activities. The two have many parallels. It should be stressed, however, that these are primarily objective functions and measures. The judgments and conclusions of individuals reviewing the data are also required. It is these conclusions that trigger action. Table 2 shows examples of quality measures.

Table 2. Some measures of hospital quality

| Feature | Measures of patient care quality | Measures of administrative quality |
|---|---|---|
| Structure | Accreditation | Accreditation |
| | Medical staff qualifications | Administrative staff qualifications |
| | Professional staff qualifications | Employee development programs |
| | Professional staff training | Staff per occupied bed |
| | Special care unit availability/ utilization | Services provided |
| Process | Medical staff peer review | Use of management studies |
| | Average length of stay | Occupancy rate |
| | Autopsy rate Community involvement | Management planning activities Community involvement |
| Outcome | Patient outcome | Cost per unit of output |
| | Surgical procedures assessment | Staff hours per patient-day |
| | Adjusted death rate | Financial stability |
| | Hospital-acquired infections: reported/treated | Compliance |
| | Malpractice suits | |
| Attitude | Expert evaluation of patient care | Expert evaluation of administrative |
| | Patient satisfaction (dissatisfaction) | performance Employee satisfaction (dissatisfaction) |

From Grimes, R., & Moseley, S. (1976, Fall). An approach to an index of hospital performance. *Health Services Research, 2*, 289; adapted by permission.

## MAINTAINING RELATIONS WITH THE COMMUNITY

Health services organizations are considered quasi-public, regardless of ownership. They have a service orientation and a moral obligation to meet community health needs. This relationship necessitates building and retaining community confidence, and it means taking steps to act in the interests of people in the community who are as yet only potential patients. If potential patients risk acquiring an infection or are in danger because the facility is operating with safety code deficiencies, the organization has special obligations to these individuals.

## Protecting Patients and Community from Staff with Severe Infectious Diseases

Chapter 7 provided background on HIV/AIDS, hepatitis B (HBV), and hepatitis C (HBC) and issues related to protecting staff. Legal dimensions and the obligations of health services organizations to staff and physicians were discussed. Medical advances in the last two decades allow health services organizations to treat patients with AIDS more effectively and increase their longevity. The result will be more episodes of hospitalization, as well as treatment at organizations such as nursing facilities and hospice. Protecting patients and staff from infected staff and maintaining confidentiality will be a major challenge for providers.

Of the infectious disease, HIV has unique aspects in terms of its spread. A critical context for analysis is that for reasons unknown, the probability that caregivers will become infected when exposed to blood and body substances from patients who are HIV positive is several magnitudes greater than that patients will become infected from caregivers who are HIV positive. With two *possible* exceptions, there are no known cases in which a caregiver with HIV has infected a patient. There have been numerous instances of surgeons and other physicians with frank AIDS performing exposure-prone and invasive procedures. However, screening their patients found no transmission of HIV after exposure. This suggests unique aspects of HIV and the likelihood of cofactors in transmissibility as well as infectivity and progression to frank AIDS, cofactors that are not present in the general population. The Centers for Disease Control and Prevention (CDC) defines an invasive procedure as "surgical entry into tissues, cavities, or organs, or repair of major traumatic injuries," and identifies treatment locations and types of procedures.[36]

> Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the healthcare worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.[37]

These definitions should guide health services organizations in assigning staff members.

Currently, the AMA advises physicians and other healthcare workers with HIV to disclose their serostatus to a state public health official or to a local review committee to establish practice limitations. The review committee will determine which activities can be continued without risk of infecting patients. The current policy recommends that physicians *should* refrain from conducting exposure-prone invasive procedures or "perform such procedures with permission of the local review committee and the informed consent of the patient. HIV-infected physicians . . . must err on the side of protecting patients."[38] The American Dental Association's approach is similar:

> A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.[39]

Most states require patient notification for exposure-prone invasive procedures when the physician is HIV positive; many also require notification for invasive procedures that are not exposure prone.[40]

In meeting their ethical duties, clinical staff should want to know whether they pose a risk to patients and other staff. Because of the opportunistic diseases they contract as HIV

progresses to frank AIDS, infected staff may pose a risk to patients, many of whom are immunocompromised or physically weakened. Staff members with AIDS may also pose risks to other employees and to visitors. These risks should cause managers to err in favor of caution in assigning staff. As staff who are HIV positive become increasingly immunocompromised, infectious diseases common in health services organizations will pose risks to them. If the organization is to discharge its ethical obligations to staff, it must be able to consider such information in job assignment. Given how much is *not* known about transmissibility of the virus, staff who are HIV positive or who have other significant infectious disease should be encouraged to accept nonpatient care assignments. Physicians who wish to continue performing exposure-prone invasive procedures pose a special problem, but as noted in Chapter 7, the law is generally well settled. Given the unknown but possible risk to patients, it is prudent to prohibit physicians and other staff who are HIV positive from performing exposure-prone invasive procedures, as reasonably defined. Protecting confidentiality to the greatest extent possible is crucial to the success of any such effort.

Despite some legal uncertainty, health services organizations should know the significant infectious disease status of staff who engage in exposure-prone invasive procedures. It is ethically appropriate (and legally prudent) to prohibit them from performing exposure-prone invasive procedures. Such a rule meets the ethical principle of nonmaleficence, which is that the caregiver's first duty is "do no harm." That there have been only two cases of HIV transmission from caregiver to patient—one is "confirmed" but challenged and the other is "not entirely conclusive"—suggests that the risk of being infected by a healthcare worker with HIV is infinitesimally small. Notably, the risk of transmitting other significant infectious diseases is much higher.

In early 1999, a French study provided strong evidence that an infected orthopedic surgeon transmitted HIV to a patient during surgery. Of the almost 1,000 patients on whom the orthopedist had performed surgery who were tested, only one had contracted HIV. "The evidence . . . is not entirely conclusive, but provider-to-patient transmission during orthopedic surgery is the most plausible explanation for the . . . infection."[41]

The CDC has estimated that the risk that an infected surgeon will transmit HIV during an exposure-prone invasive procedure is between 1 in 40,000 and 1 in 400,000, and that the risk of transmission from an infected dentist is between 1 in 200,000 and 1 in 2,000,000.[42] By way of context, HBV is a greater threat to patients than HIV. In 1996, a thoracic surgeon was found to have transmitted HBV to 19 patients during surgery despite evidence that he used adequate infection control procedures.[43] This incident, plus that of a Spanish cardiac surgeon who infected five of his patients with HCV, supports mandatory testing for HBV, HCV, and HIV among caregivers who perform exposure-prone invasive procedures.[44]

## Something Must Be Done, But What?

Stunned, Carolyn Aubrey, the CEO of Metropolitan Hospital, sank into her chair and stared out the window for a very long time. She realized that something was afoot when Dr. Midmore's wife had angrily insisted on seeing the CEO. Even in her worst nightmare, Aubrey could have never imagined that Mrs. Midmore would tell Aubrey that she was suing her husband, an orthopedic surgeon, for divorce because he had given her AIDS. As Mrs. Midmore left Aubrey's office, she had turned back and said, "I was sure you'd want to know. Surely you'll have to do something."

Aubrey thought Mrs. Midmore's statements might be nothing more than the ravings of an angry, vindictive wife, but that

was not likely. As she considered what she had just learned, she recalled an incident several years ago involving Dr. Midmore and a male orderly. In retrospect, it suggested that Dr. Midmore might be bisexual. Aubrey also thought about the department of surgery meeting last year when there had been a long discussion about the desirability of knowing the HIV status of all surgical patients. The special risks to surgeons of torn gloves and cuts during orthopedic surgery had been described in detail.

Now it seemed that Dr. Midmore's patients might be at risk. Aubrey called operating room scheduling and learned that Dr. Midmore was maintaining a full surgical load. Aubrey asked her secretary to call the hospital attorney and the medical director and set up an emergency meeting for 7:00 the following morning. Mrs. Midmore had been right, thought Aubrey. We'll have to do something, but what?

This case suggests several ethical (and legal) issues. Protecting patients is key, and Midmore's surgical privileges must be suspended immediately. Once Midmore no longer poses a risk to patients, further action can follow in an orderly and deliberate manner. Meeting the principle of justice requires that the investigation is fair to Midmore in terms of process and substance. If Midmore is HIV positive, the hospital may choose from two courses of action: 1) allow Midmore to continue performing surgery if he follows CDC guidelines that physicians who are HIV positive notify their patients before performing exposure-prone invasive procedures; or 2) terminate Midmore's surgical privileges. The first choice maximizes patient autonomy, but the hospital must ensure that Midmore actually informs patients that he is HIV positive and that patients understand the implications of this information. As a practical matter, few patients are likely to allow him to perform their surgery after learning his HIV status. The second choice meets the principle of nonmaleficence by preventing potential harm to patients, but it is paternalistic by not allowing Midmore's patients to make their own choice. Prudence, however, demands terminating his surgical privileges. All actions must be consistent with protecting patients and meeting the requirements of the medical staff bylaws and rules and regulations, as well as state and federal law.

Confidentiality regarding Dr. Midmore's HIV status must be safeguarded. Such efforts can never compromise patient safety, however. The issue of confidentiality takes on further complexity if Midmore leaves the staff and applies for surgical privileges elsewhere. The hospital is ethically bound to communicate what it has learned in the course of its investigation. Applying the legal principles in the Tarasoff case discussed in Chapter 7, the hospital has a legal duty to warn.

Health services organizations must be alert to the special problems of confidentiality when they treat patients with HIV/AIDS or other significant infectious diseases. Within the constraints of state law, however, the first obligation must be to safeguard staff and other patients. An added benefit is that identifying these patients will be an important additional stimulus that encourages staff to comply with universal precautions.

Protecting staff confidentiality to the greatest extent possible is crucial to the success of any such effort. Consistent with the ethical principle of respect for persons, health services organizations must be alert to the special problems of confidentiality when treating patients with infectious diseases. Within legal constraints, however, the organization's first obligation is to safeguard other patients and staff.

HIV/AIDS is only one infectious disease that raises ethical (and legal) problems for health services organizations and their managers. Events at University Hospital suggest yet another.

## Protecting the Community

University Hospital plays a unique role in the community. It is a tertiary referral hospital for the region and a major source of

healthcare to the community.

In 1977, it experienced an outbreak of legionella (Legionnaires' disease). A number of patients contracted the disease; several died.

Legionella is a bacterial infection of the respiratory tract and lungs that may result in death if not diagnosed and treated early. It is especially dangerous for older adults and people with medical problems that weaken their general resistance. A factor requiring even greater caution on the part of hospital management is that at the time of the outbreaks, the process for identifying the organism in the laboratory took several days. Thus, patients were at greater risk until a confirmatory diagnosis was obtained.

Epidemiological studies showed a relationship between the fine aerosol mist that the hospital's air conditioning cooling tower gave off and the spread of the disease. Employees exposed directly to the aerosol contracted severe cases of legionella. Chlorinating the water in the cooling towers eliminates the organism. Although the cooling tower was suspected in the 1977 outbreak at University Hospital, the relationship was never confirmed. The hospital's infection control committee did not develop any standing orders or policies after the first outbreak.

In May 1982, there was evidence of another outbreak of legionella. The cooling tower water was immediately chlorinated and the number of new cases dropped dramatically. However, an undetected failure in the chlorination system brought a second outbreak in early June.

When the first cases were detected in May 1982, the hospital administrator was notified. He met with various staff members, including physicians. It was decided that information about the outbreak should be kept from the community, lest a panic and sudden drop in patient census occur, as well as loss of public confidence. A confidential letter was sent to staff physicians advising them of the problem and asking that they keep in mind the potential for infection when making admissions decisions. Admissions were not limited to emergencies, however, and there was neither a prospective review of elective admissions to determine whether patients at risk for pulmonary infections such as legionella should be sent elsewhere, nor a review of indications for and necessity of admission. The medical staff developed a protocol stating that unexplained, acute-onset pneumonias were to be treated immediately with a potent antibiotic known to be effective against legionella. However, no provision was made for effective review to determine that the protocol was actually followed.

The administrator at University Hospital faced several problems, all with ethical dimensions:

1. The medical staff wanted to continue elective admissions.
2. The community could lose confidence in the hospital if it learned that there was an epidemic of a potentially fatal disease.
3. The administrator and management staff could lose face, and even their jobs, should the infection become common knowledge.
4. There was potential legal liability.

Solving this ethical problem is difficult but not impossible. Similar situations arise in nursing facilities that are threatened with closure because their physical plants violate fire safety requirements and in hospitals in which outbreaks of meningitis or salmonella occur in the newborn nursery. How does the organization protect current as well as potential patients in such situations? More important, what is the manager's role?

One feature that distinguishes this legionella outbreak from other, similar cases is the difference in duty owed to potential rather than actual patients. The law recognizes a difference. Generally, unless there is a special relationship with potential patients, one has no duty to act on their behalf. In this case, however, there would be a duty to warn elective admissions who are at risk from legionella.

The legal distinction is useful in ethical analysis. The duty toward actual patients is immediate and more compelling than the duty owed potential patients. Potential patients should be put at risk of legionella only if their medical condition puts them at greater risk outside the hospital. Inpatients who might benefit from a continued stay but who are at greater risk by remaining in the hospital should be discharged. It is incumbent on the managerial and clinical staff to convince caregivers of their obligation to protect the patient.

The argument that the administrator must protect the reputation of the organization in the community has merit. First, healthcare has a significant psychological component and potential patients will benefit from having confidence in their providers. Second, those needing hospitalization should not fear receiving it, because deferring care may exacerbate their condition. Finally, individuals may be at greater risk by not obtaining treatment than from potentially contracting legionella.

On admission, potential risk becomes actual risk. Emergency admissions pose no ethical problem if an alternative source of care is unavailable and the risk of no care is greater than that of harm from contracting legionella.

Elective admissions are quite different, however. At the very least, the organization, led and prompted by its managers, should have developed and applied policies and procedures separating high- from low-risk elective admissions and made special provision either to send the former group elsewhere or to take special precautions regarding them. Ethically, it could not rely only on the discretion of the admitting physician. As with any quality assessment activity, management has a responsibility to review decision making about care and do so in a fashion consistent with the level of risk. Here, concurrent review is required.

Obvious potential conflicts of interest exist. It is natural for managers to protect their positions and reputations. They do so out of loyalty to the organization but also from selfish motives. A typical response is to cover up. Concealment seems an easy way to reduce the risk of personal and professional damage. Experience suggests, however, that from both an ethical and pragmatic standpoint honesty is the best policy. Rumors will be carried into the community by staff and patients, and the potential tarnish to the organization's reputation may last much longer than if the community is informed that there is a problem and that steps are being taken to protect patients. This tactic may raise questions about the cause of and responsibility for the problem, but the community will not distrust the organization. Furthermore, in terms of guiding ethical principles, the organization must treat individuals in the community with respect and dignity by being truthful, and managers must live by the virtues of trustworthiness and conscientiousness.

## CONCLUSION

Just as they rely on computer programmers or wage and salary experts for reports, advice, and counsel, health services managers rely on technical expertise and assistance to monitor, review, and maintain the quality of clinical services. Managers provide clinical staff with the systems, procedures, and resources needed to be effective in delivering and monitoring clinical care. Beneficence and nonmaleficence—as well as the virtues of compassion, caring, and courage—demand that managers are sufficiently aware of what is expected and how that expectation is measured to determine that the goal of delivering quality health services is being met. Managers are remiss in meeting their ethical (and legal) duties if they occupy themselves exclusively with nonclinical activities and claim that clinical matters lie outside their ken and range of responsibilities. The manager is accountable to the governing body for all activities, and this requires active involvement and effective partnerships between managers and clinicians.

This chapter identified and examined several generic ethical problems arising from the duties owed by managers to patients and community. The duties are not always clear and may be further obscured by accompanying problems, such as bureaucratic inertia and medical staff relations. They become clear if managers focus on the primary reasons for the organization's existence—serving and protecting the patient and community.

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