

*Part One*

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# **The Moral Ecology of Health Care Organizations**

Why read this book? The Joint Commission on Accreditation of Health Care Organizations (JCAHO) now requires health care organizations—hospitals, nursing homes, home care agencies, hospices, and integrated delivery systems—to identify and address what it calls “organizational ethics” if they seek JCAHO accreditation (see Appendix One). One threshold problem exists: organizational ethics, sometimes referred to as institutional ethics, is an underdeveloped and underexamined topic in the literature of applied ethics. This book is one contribution meant to help fill that gap. It offers those within health care organizations who are interested in, and responsible for, addressing organizational ethics the tools to identify, analyze, and respond to its broad range of issues.

Although JCAHO accreditation motivates many health care organizations to establish ethics mechanisms (by which term we suggest, among other possibilities, an ethics committee or an ethics consultation team) to respond to patient and organizational ethics, those responsible for implementing such a mechanism may feel inadequately prepared to respond. This is not uncommon; in many areas of applied ethics those responsible for addressing ethical issues do not feel competent to “do ethics”—whatever that is. Those responsible for organizational ethics may have had experience in clinical health care ethics, but if they apply whole cloth, common methods of clinical ethics (perhaps moral reasoning based on autonomy and beneficence) to organizational problems, they quickly become dissatisfied. Clinical ethics only partially illuminate the ethical problem and resolution. Even if handy tools to

sort out moral problems in organizational ethics existed, questions would remain: What is the scope of study in organizational ethics? What do the problems look like? Which are the most pressing problems? Who is the best person, or persons, and what is the best way to address these problems?

The challenges are real, but any ambivalence about moving forward should be tempered by the potential gains to be had from wading into this problem area. One benefit is obvious: fulfilling the requirements for accreditation and taking steps to avoid liability by bolstering compliance with the Federal Sentencing Guidelines of 1991 (see Chapter Four). Other benefits to investing time in organizational ethics are less clear but no less important if an organization is to flourish. Take, for example, the ability to identify and reduce the potential for conflict of interest. Such conflict emerges where employees make judgments that challenge their professional responsibility.

An obvious and frequent example occurs when a clinician must balance business and patient care concerns in the same decision. If professionals fulfill their clinical responsibilities, they protect their patients; at first blush, this appears to contribute to fulfilling the organization's mission, since serving the patient is strongly connected to the mission of health care. It is less clear to the professional what obligation there is to meet business demands. Implementing organizational ethics in this case might mean identifying what checks and balances exist within an organization to ensure that the professional appropriately balances competing interests.

These and similar benefits that can emerge from helping the eyes to see, the consciousness to understand, and the will to respond to problems in organizational ethics become apparent in the pages that follow. Anyone who is committed to the success of a health care organization will see throughout this book clear examples of how inattention to problems and poor response to them can undercut a health care organization's mission.

## **A Snapshot: What's in This Book?**

Organizational ethics in health care is a story about the moral lives of individuals within health care institutions and about the moral life of the health care institution as an institution. In contrast, the

literature of business ethics addresses, with little controversy, the moral issues individuals face within institutions, but it rarely addresses the moral life of an institution as an institution. When it does, the discussion is far less agreed upon. Is an institution a moral agent? Is it morally accountable? If an organization is a moral agent, with which moral problems should it be concerned? How does the organization identify, analyze, and resolve moral problems? Who in the organization is responsible for this task? This book takes on the challenge of describing health care organizational ethics and offering insights about how an institution can respond to growing concerns about organizational ethics.

This first chapter paints the big picture of organizational ethics: What is the context, who are the actors, what are the generic problems found across organizational units, what method(s) can guide thinking about the complexity of issues, and which mechanisms should be established to resolve them? Chapter One also characterizes organizations, especially health care organizations, and the focus of organizational ethics. In short, it offers a view of the moral ecology of organizational ethics by mapping the forest; the trees come into view in subsequent chapters.

One can glimpse the moral ecology of health care organizational ethics by walking through any health care organization facing a range of ethical dilemmas. It may resemble yours in some important ways, but it may also differ (at least in culture). For now, suspend disbelief and enter the world of that health care organization as we explore in each chapter the case of Partnership Health Care.

Partnership Health Care, or PHC (a composite of several actual organizations), is a nonprofit, secular organization formed several years ago through the merger of five hospitals and their related institutions. Situated in a large urban area that was experiencing the first wave of managed care competition and consolidation, three faith-sponsored organizations and two community hospitals completed a full-assets merger.

The largest teaching hospital in the merger, St. Somewhere, was founded by a Catholic religious congregation to serve the inner-city poor. The dwindling religious congregation later decided to sell St. Somewhere to focus efforts on another hospital they owned in another city. Another partner in the merger, Deaconess Hospital, was located in an affluent neighborhood of the city and had solid support from its United Church sponsor. The other faith-based

partner, Jewish Health Care, had seen its original patients and health care providers migrate to the suburbs and was financially floundering. The two suburban community hospitals in the system—Suburban and Outwest—were rapidly growing.

The PHC partnership created a small integrated delivery system by consolidating two dozen physician practice groups into the PHC Physician Plan; by acquiring five nursing homes; and by launching a home health organization, a small HMO plan, and several for-profit subsidiaries. It also developed direct contracting with small and midsize local employers.

PHC faced JCAHO accreditation at all its sites. The ethics committee mechanisms across the system functioned at different levels, some well, others not well at all. The JCAHO survey bolstered the system CEO's commitment to organizational ethics; however, she had already faced a range of value conflicts (to be described later) that threatened to undermine the system's market share. She suspected that the dilemmas predated the merger and believed that a cultural transformation could address the administrative nightmares rampaging through the system at varying levels of complexity and influence. The cases that follow are not isolated incidents.

The twenty-member board comprises three representatives from each of the original sponsors and five new members. Recently, they have been in a protracted conflict over employee health benefits and benefit products. Among the benefit products to be sold directly to small employers were reproductive services the Catholic board members rejected. Additionally, the benefits offered to PHC employees needed to be standardized regarding some sensitive issues. Before the merger, Deaconess offered domestic-partner benefits; however, those benefits were now on the chopping block for financial reasons and because of potential adverse public opinion. Yet retracting the benefits was also likely to cause a public backlash (see Case Seven in Part Two of this book).

The PHC's medical director faced challenges in retaining site medical directors and physicians as well. Many of the medical group physicians were frustrated by the practice parameters that the system was introducing to reduce inpatient length-of-stay. The medical group was upset because reduced length-of-stay would be imperative if they were to receive the 10 percent of their annual compensation that was withheld until they met financial targets. They were wondering aloud who had made the decision and what was driving the decisions—patient outcomes or profits. Department heads in particular were

demoralized by internal conflict between their obligations as managers and their duty as physicians (see Case Sixteen).

Nurses at Jewish Hospital, the only ones unionized in the system, were prepared to strike. Prior to the merger, they had agreed to a pay freeze to ensure institutional solvency as well as continued access for indigent patients. After the merger, nurses at Jewish were upset that their average salary was significantly less than those at other sites, and that it would take them four years to achieve parity in compensation among nurses at all sites. If parity could not be realized in a shorter time, the nurses would strike. Board members and upper management thought that this might be an opportunity to break the union (see Case Two).

An internal audit had uncovered irregularities in coding and billing at St. Somewhere, where lax employee practices gave the appearance of misconduct. The auditors' report to the board spurred members to pressure the CEO to ensure PHC would not violate federal Medicaid reimbursement law and consequently be subjected to the 1991 Federal Sentencing Guidelines (see Chapter Four), or to risk whistle-blowing by an employee that might ultimately jeopardize federal health reimbursements, upon which PHC depended (see Case Twenty).

These concerns (and those examined throughout this book) are the source of the PHC chief executive's drive to identify, disentangle, understand, prioritize, and address the risks that can slow unification of the system and pose financial and legal threats. These and similar conflicts suffusing the organization make the CEO question her own moral responsibility and integrity and that of her organization as an organization. She wonders whether and to what extent organizational ethics assist in effecting a cultural transformation. What are the truly important questions within organizational ethics? Who should be responsible to identify and analyze the problems? What is the best way to operationalize responses to problems?

Before she can move forward, she has to understand the scope of the problem.

## **Health Care Ecology: A Moral Perspective**

In many ways PHC, like other health care organizations, can be considered an ecosystem, and its study an ecology—that is, the study of the complex relationships between living organisms and

their environment. Ecology is a helpful analogy for thinking about organizational ethics because of similar complexities in the study of the two. Ecology takes into account interactions among cells; individual organisms; and groupings of individuals, ecosystems, and the entire biosphere. Similarly, organizational ethics takes into account interaction among individuals, teams of health care workers, institutions, integrated delivery systems, and the entire health care environment. Any account of organizational ethics that focuses only on one level of the environment, such as the team or the institution, without examining and accounting for interaction among the levels of the environment, is inadequate.

Ecological thinking also contributes an emphasis on perspective; depending upon the moral vantage point within the ecosystem, certain issues come to the foreground and others recede. Viewing global warming from the biosphere perspective, for example, may not help one notice cellular mutations. Similarly, focusing on a single health care department might reveal an organizational ethics problem such as noncompliance with policies, but this perspective might not see that the practice is rooted in an organization's culture. Any mechanism that is responsible for addressing organizational ethics must be self-conscious about which perspective it is adopting. The first attempts to examine organizational ethics are likely to occur at a departmental level; however, it is important to keep clear a sense of the problems that could go unobserved and unaddressed.

Ecological analysis also brings to organizational ethics the conceptual troubles of environmental ethics. Are any levels of moral analysis most important? Which level of analysis constitutes an adequate moral analysis? Must the analysis encompass all levels, or some mix of them—individuals, teams, institutions, health care systems, and the organization of health care across the country? In ecology, if some ethicists highly value endangered species such as the spotted owl, then other parts of the ecosystem—the quality of life for the environment—take on a different, and probably lesser, weight. Alternatively, where the entire ecosystem is highly valued, the spotted owl simply becomes one value competing among other values. The same applies to health care organizational ethics; focusing on the changing values in the doctor-patient relationship means that other systemwide problems receive less critical atten-



tion. Mechanisms responsible for organizational ethics need to identify which values must be given priority and how to rank competing values.

The ecology metaphor has limits, especially if it hides important differences. In the overall ecology of organizations, it is important for moral analysis to recognize the unique features of health care organizations. The variety of professionals inhabiting health care organizations (physicians, nurses, managers), the kinds of health care organization (hospitals, nursing homes, managed care providers), and the unique range of missions and goals require that moral analysis be clear about specific social features that characterize health care organizations and distinguish them from others. Otherwise the mechanism responsible for organizational ethics could perform an inadequate moral analysis of the context and ultimately fail to meet its mission.

## Organizations

As is fully described in Chapter Two, theories of organization accentuate different characteristics. Classic studies characterize organizations by (1) noting division of labor; (2) focusing on mission, goals, or products; (3) observing how agents (employees) report to principals (managers or leaders); and (3) noting how goals are accomplished through rules and procedures. If an organization's mechanism analyzes ethics through the lens of formal characteristics of organizations, it reveals certain moral problems: mission lapse, the risks associated with unclear division of labor, the burden of too much or too little attention to policies and procedures. The business ethics literature often takes this perspective and offers a moral analysis related to agent-principal relationships—that is, to the moral problems that occur between an employee (agent) who reports to an employer (principal).

In contrast, contemporary sociological theories of organization focus on complementary issues—for example, the gap between an organization's formal policies and operations and the informal culture that animates it. Viewing ethics through the lens of an organization's informal cultural characteristics, we notice moral problems that are specific (if not unique) to that organization, such as the gap between policies and practice. Formal and informal theories of

organizations examine issues across the organizational ecosystem. Thus, both are necessary for an adequate moral analysis. Also, an ethics mechanism must be self-conscious about which theory it uses and which it omits.

## Health Care Organizations

Even though characterizing health care organizations seems nearly impossible, given the volatile, opportunistic managed care market, one can still highlight characteristics that distinguish health care organizations from others. Health care organizations possess a distinctive organizational ecology characterized by (1) their mission of health care service to alleviate pain and suffering and restore patients to health; (2) the complex, highly regulated environment—internal and external—under which they operate; (3) professional cultures (physicians, nurses, health care managers); and (4) the rapidly changing health care market.

One remarkable feature of today's health care organization is the move toward industrialization. Health care organizations in the first part of the twentieth century were physician-dominated, guildlike systems that depended upon diagnosis and treatment of the patient as an individual. In the course of that century, health care organizations almost imperceptibly moved toward an industrialized model relying on population-based, statistical evidence to organize and provide health care predictably. This shift highlights two characteristics of the ecosystem to which moral analysis must attend. One is a move from domination by a medical professional to direction by a managerial professional. Another closely associated characteristic is the ascendancy of statistical, population-focused, and evidence-based health care, used to ensure predictable health outcomes and costs.

These characteristics create the conditions for many organizational moral problems that health care institutions face. As they vest decision-making power in managerial professionals who use the industrial tool of population-based health care, multiple challenges arise. In the case of PHC and the development and execution of practice parameters, it is reasonable to ask: Did the managerial professional fully understand the consequences of her decision on patient care? Did the system offer adequate checks and balances to oversee the managerial professional's decision making? Do clear

policies articulate which decisions have been vested in the managerial professional? Has too much discretion been given the managerial professional? How do managerial professionals collaborate with health care professionals? Do their values overlap? (See Cases Fifteen and Sixteen.)

Characteristic similarities among health care organizations should not blind those pursuing moral analysis to the distinctive features of the organizations that make up the rapidly changing health care ecosystem. When people think of health care organizations, they tend to picture an individual hospital like St. Somewhere, or in the era of managed care systems a network of hospitals like PHC. It must be noted that health care organizations are at differing stages of organizational development and complexity, especially with respect to the shift from medical to managerial professionalism. Also, imagining that PHC is a representative health care organization excludes important parts of the ecosystem for which this book is also designed. Take, for example, institutional purchasers of health services, such as self-insured employers that purchase health benefit plans, and others that not only manage but also provide health services to reduce health benefit costs. To the extent self-insured employers manage and offer services, they are part of the ecosystem that organizational ethics must address.

Vendors that support larger providers such as PHC but do not engage in direct patient care are also part of the health care ecosystem. These vendors may provide one service, such as management of information systems, or they may distribute medical equipment or lend support to direct providers of care, such as PHC. Whatever they sell, they are not merely external forces playing upon health care organizations, but rather part of the community for which close attention to organizational ethics might help in moral analysis. Organizational ethics in health care applies not simply to traditional health care organizations such as PHC but to all the organizations that populate the health care ecosystem.<sup>1</sup>

## The Actors

Health care organizations are populated by a variety of professionals. Each group makes specific choices, thus confounding moral analysis. Among the potential players are trustees, stockholders of for-profit health care organizations, executive leaders,

managers, employees, institutional purchasers (employers), individual patients, the community, institutional partners, and vendors. In other areas of applied ethics, the moral analysis often focuses on one actor (for example, the virtuous manager in business ethics) or a significant relationship (such as doctor-patient in clinical ethics). Yet in health care organizational ethics, the focus on a single actor or relationship obscures identification of ethical problems. For instance, focusing on the moral lives of leaders and managers who make up only a small number of actors in any organization might overlook the moral choices and risks the greater number of employees face.

Given that numerous actors in health care come from a variety of professions, an important moral challenge for health care organizational ethics analysis is to understand the organizational psychology and behavior of each professional group (see Chapter Two). The motivation and behavior of managers within the health care organization is illustrative. Typically, managers in a hierarchical organization report to a leader or executive, and their behavior is regulated by detailed policies and procedures to accomplish a mission. One risk that managers face is not having policies and procedures spelled out sufficiently. Consequently, managers can exceed the bounds of job discretion or—for a host of reasons—pursue a mission other than the organization's. In contrast, the organizational motivation and psychology of leaders suggest they are willing to take credit (even when it is not deserved) and shift blame to managers (even when the responsibility is theirs). Chapter Two examines in depth the implications of organizational psychology for organizational ethics. Ethical analysis of the health care organization requires that the ethics mechanism (which may be an ethics committee) pay attention to generic characteristics of actors (managers, CEOs, boards) and actually account for the particular moral psychology of the actors in an individual organization.<sup>2</sup>

## **The Focus of Organizational Ethics**

If discussion of the nature of health care organizations and their moral inhabitants seems complex, the added layer of moral analysis is likely to daze even persons trained in moral theory. Before exploring how an ethics mechanism might tackle the problems occurring at PHC, it is important to be clear what this book as-

sumes about ethics—and in particular about organizational ethics. If most of us think about ethics, we can identify choices, behaviors, or actions that we consider good and worth pursuing, or not good and worth avoiding. Yet we are often uncertain why a particular action is to be preferred, or what is to be gained by acting morally (or by reflecting on acting morally). At a minimum, some people construe ethical reasoning to be conflict resolution or compliance with the law.

Although ethical reflection might serve those interests, this understanding frames the meaning and purpose of such reflection quite narrowly. Ethics as a discipline is a systematic and critical reflection on all the components of moral choices. This reflection includes framing the questions, identifying relevant facts to answer the questions, clarifying concepts (such as conflict of interest), exploring the burdens and benefits of all alternatives, giving a reason for action, and deciding on a course of action that holds competing values in balance (see Exhibit 1.3 later in this chapter).

The terms *ethics* and *morality* are used interchangeably, but some theorists distinguish the two, defining *morality* as the lived experience of making choices and *ethics* as systematic reflection on that lived experience. Sometimes ethics and morality are construed to be the difference between secular and religious ethics respectively. This book is principally concerned with secular, nonreligious reflection on the moral problems endemic to an organization.

What is to be gained by systematic reflection on moral experience? No agreement exists about there being any one goal of moral philosophy. Most people who engage in moral reflection are not conscious about what goal they hope to attain (such as happiness or compliance with the law). Yet which goal is sought determines what does and does not count as a moral problem and solution. For example, if the goal of ethical reflection is simply conflict resolution, one can find cases of a lapse in organizational truth telling or promise keeping in which employees experience no conflict; therefore these lapses are not considered moral problems. Or if the goal is legal compliance, there are health care advertising practices that violate no laws, even though the advertisement might subtly coerce patients.

Still another popular goal of ethics is seen in the slogan “ethics is good business.” This is an amalgam of goals, the views that moral organizations garner the support of customers; that organizations

resolving a moral problem before it becomes a liability are better off; and that by addressing moral conflicts among employees, workforce friction can be reduced and outcomes improved. These pragmatic views sell ethical reflection on its immediate, tangible, even monetary benefits. They also appeal to organizational leaders, especially as they consider expending resources—including employee time—in pursuit of these goals. Yet there exist some goals of ethical reflection and behavior that do not necessarily appeal to self-interest and may be worth pursuing. This book assumes a long-standing view that ethical reflection and moral living promote integral human fulfillment, of individuals and communities. Ethical reflection and action pursue values that allow humans to flourish as individuals and communities. Later chapters of this book examine the values that encourage this outcome and explore complex cases to sort out whether choices promote or undercut such flourishing.

The case of billing irregularities at St. Somewhere highlights some of these threats to thriving. There could be many explanations for the irregularities, but suppose the reason was an employee's inaccurate, even untruthful, reporting (see Case Twenty). Society cherishes truth telling because it is the glue of human community—it is difficult to live and flourish in a community where everyone is unsure about who is telling the truth. Truth telling is a prerequisite for business and organizational operation. Without it, it is impossible to make verbal agreements and contracts. In this case, the value of truth telling is easy to identify for moral analysis, and the deleterious moral consequences for community thriving are obvious. But more often, throughout this book as in life, the values that promote flourishing are difficult to identify, and it is hard to know whether our choices concerning them help or inhibit individual and community growth.

If ethics is systematic reflection on moral life that brings integral human fulfillment to persons and communities, what part does organizational ethics play in that flourishing? To understand its role, one should examine the family resemblance between business ethics and organizational ethics. Discussion of business ethics predates the recent emergence of organizational ethics; the former has been chronicled, taught, and discussed for the past half century. One theoretical puzzle in the discussion is whether orga-

nizational ethics is a subset of business ethics or a larger umbrella. If it is simply a subset, then all the theoretical questions may have been resolved by business ethics and no new unanswered questions remain.

Similarity between these two areas of applied ethics can be seen in a workable definition of business ethics (by Laura Nash) as “the study of how personal moral norms apply to the activities and goals of a commercial enterprise. It is not a separate moral standard, but the study of how the business context poses its own unique problems for the moral person who acts as agent of this system.”<sup>3</sup> This characterization makes clear what most people surely agree upon: that business ethics is not separate from other forms of ethics but rather focuses on the context of business. Similarly, organizational ethics as an area of applied ethics is not separate but focused on moral choices within organizations.

There is unlikely to be any disagreement that organizational ethics, at minimum, studies personal moral norms as they apply to the activities and goals of organizations. The most obvious family difference between business and organizational ethics is the latter’s focus on the moral life of an organization. Some have argued that it is not simply a matter of projecting the moral life of individuals on organizations, but rather of ascribing moral responsibility to organizations. They cite as evidence the legal transformation of organizations from merely legal entities to ones that have civil rights (such as freedom of speech) and are held civilly and criminally liable. In ordinary language and perception, many people talk and think about an organization as more than a sum of individuals. An organization exists after its original members die, it has power to hire and fire, and it pursues missions that override any individual employee’s desires. Moreover, the organization’s actions are not reducible to the actions of its employees.

Some people infer from this evidence that an organization, like an individual, is a moral agent that can be praised, blamed, credited, or held morally accountable.<sup>4</sup> If this were the case, then the focus and goal of organizational ethics would be defined as the study of personal and organizational moral norms and choices as they contribute to the activities and goals of an organization and to the integral human fulfillment of persons and communities. Also, if this characterization were adequate, the difference between

business and organizational ethics would be plain. Business ethics focuses on the choices of the individual *in* an organization, whereas organizational ethics focuses on the choices of the individual *and* the organization. Organizational ethics studies not only personal moral norms but also organizational moral norms as they apply to the activities and goals of an organization.

Moral norms can be glimpsed throughout the organization. Norms are manifest in an organization's formal structure, in its mission statement; policies and procedures; codes of professional conduct; strategic objectives; business plan; and contracts with employees, vendors, and purchasers. Organizational moral norms are less clearly seen, but no less palpable, in the organizational culture (which includes informal policies and procedures) and in the gap between what is formally expected and the ways things really get done. Throughout this book, we attempt to highlight organizational moral norms. Chapter Two offers a lens through which an ethics mechanism can begin to identify, study, and respond to such norms. We also argue the view that organizational ethics is not just new wine in the old wineskin of business ethics. Rather, organizational ethics proceeds on the view that organizational moral norms can be identified and morally evaluated. Although organizational moral norms may be difficult to disaggregate from personal moral norms, both sets of norms must be considered in an adequate analysis of organizational ethics.

What facets of organizational ethics are most important in this endeavor? As noted earlier, the field of health care organizationalethicsremainsunderexploredcomparedtoclinicalhealthcare ethics. Even so, the range of questions that should be considered is beginningtosolidify (Exhibit 1.1). Notallthequestions,however,are necessarily helpful in the day-to-day discussion carried out by an ethics committee or other mechanism responsible for identifying and resolving ethical dilemmas in the health care organization. One approach a mechanism might employ to identify the most important issues is to examine a laundry list of problems that have been found in most organizations (Exhibit 1.2).

After identifying the problems on the list in Exhibit 1.2 that are most prevalent and corrosive within some part of the organization, the ethics mechanism can then create a priority list to deal



### **Exhibit 1.1. The Scope and Character of Organizational Ethics.**

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1. Theories of organizational ethics
  - What is the focus of organizational ethics?
  - How does it differ from other forms of applied ethics?
  - Is the organization a moral agent?
  - If an organization is a moral agent, what are the consequences for analysis and action?
  - What, if anything, distinguishes health care organizational ethics from organizational ethics?
2. What concepts, if any, apply to most organizations?
  - Conflict of interest
  - Discretion and control
  - Allocation of resources
  - Human relations
3. Are the concepts of autonomy, justice, and beneficence, or similar ones, useful for analysis of organizational ethics?
4. How do a professional code and job descriptions contribute to organizational ethics?
  - Ethics of leaders
  - Ethics of managers and administrators (competing interests among the board, the community, clinicians, and patients)
  - Employee ethics
5. What virtues contribute to organizational ethics?
  - Integrity
  - Honesty
  - Fairness
  - Respect for others
  - Promise keeping
  - Prudence
  - Trustworthiness
6. What formal structures contribute to organizational ethics?
7. What role do mission and values statements play in organizational ethics? What role should they play?

### **Exhibit 1.1. The Scope and Character of Organizational Ethics, Cont'd.**

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8. How do policies and procedures support—or undercut—organizational ethics? Who should participate? What values should be considered? What checks and balances exist?
  9. What informal features of an organization promote or inhibit moral behavior?
  10. What parts of organizational culture should organizational ethics attend to?
  11. How does the ethics mechanism (for example, ethics committee) study the culture of the organization?
  12. Which aspects of the external environment affect moral choice for the individual and the organization?
  13. How do external forces affect organizational ethics?
  14. What role can and should external regulation play in shaping organizational ethics?
  15. What conflicts exist between personal moral and organizational norms as they apply to an organization?
  16. What are the moral issues among health care organizations and other organizations?
  17. What obligation of toleration and cooperation does the health care organization have with its partners, such as purchasers of health care, vendors, and other managed care organizations?
  18. What challenges of organizational ethics, if any, are unique to a health care organization?
  19. What part, if any, should religious values play in organizational ethics?
  20. What mechanisms exist for organizational ethics? Which are optimal?
  21. What is the scope of jurisdiction?
  22. What authority should the mechanism possess?
    - Where should it be located within the organization?
    - How should it relate to the clinical ethics mechanism?
  23. What is the relationship of the organization to corporate compliance?
  24. What systemic supports promote ethical behavior?
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Source: Adapted from Khushf, G. "Administrative and Organizational Ethics." *HEC Forum*, 1997, 9(4), 299–309.

**Exhibit 1.2. Common Problems  
Found in Organizations.**

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Greed

Cover-up and misrepresentation in procedures for reporting and control

Misleading product or service claims

Reneging or cheating on negotiated terms

Establishing policy that is likely to cause others to lie to get the job done; unarticulated, unclear, or inappropriate policy

Overconfidence in one's own judgment, with risk for the corporate entity

Disloyalty to the company as soon as times get rough

Poor quality—performance below expectation, apathy about goals

Humiliating people by stereotyping

Lockstep obedience to authority

Self-aggrandizement over corporate obligations

Favoritism; partiality, not meritocracy

Price fixing (choosing customary charges regardless of real cost)

Sacrificing the innocent and helpless to get things done (blaming subordinates)

Suppression of basic rights: freedom of speech (in other words, voice), choice, and association (in other words, union)

Failing to speak up when unethical practices occur (whistle-blowing)

Neglect of one's family or personal needs

Making a product decision that perpetuates a questionable safety decision (affecting practice parameters, resident and nursing duties, and so on)

Not putting back what one takes out of the environment or the community (for example, sale of a nonprofit to a for-profit entity)

Knowingly exaggerating the advantages of a plan in order to garner support

Failing to address probable areas of bigotry, sexism, or racism

Courting the business hierarchy, as opposed to doing a job well

Climbing the corporate ladder by stepping on others

Promoting the destructive go-getter who outruns his or her mistakes

**Exhibit 1.2. Common Problems  
Found in Organizations, Cont'd.**

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- Failing to cooperate with other areas of the company (the enemy mentality)
  - Lying by omission for the sake of business (nondisclosure by leaders)
  - Cooperation or alliance with questionable partners, albeit for a good cause
  - Not taking responsibility for injurious practices (intentional or not)
  - Abusing (or just going along with) corporate perks that waste time and money
  - Corrupting the public political process through legal means
  - Goal substitution (for example, pursuing a mission—legitimate or not—other than the organization's)
  - Dithering
  - Obstruction, stalling
  - Inefficiency
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*Source:* Adapted by permission of Harvard Business School Press. From *Good Intentions Aside: A Manager's Guide to Resolving Ethical Problems* by L. Nash. Boston, MA. 1990, pp. 8–10. Copyright 1990 by the President and Fellows of Harvard College; all rights reserved.

with them. Another method is to select issues that cut across the organization. For example, everyone within a health care organization makes choices about how to expend resources, including use of time, medical appliances, drugs, and the like (see Chapters Eight and Nine). Careful examination of resource expenditure highlights use and abuse. Another issue that cuts across the organization is each employee's use of discretion, that is, exercising judgment that is not specifically articulated in policies, procedures, and professional codes (see Chapter Seven). Still another issue that cuts across an organization is the problem of competing (and perhaps conflicting) interests on the part of employees, as between professional and home life or between managerial and clinical obligations (see Chapter Six).

A final way to estimate the importance of issues is to focus on a department or a function. Take, for example, the human resource function (see Chapter Five). Following the course of an em-

ployee's relation to an organization—being hired into it, being promoted through it, and leaving it—helps identify the range of problems and evaluate which of them are debilitating to an organization's mission and culture. In short, at this period in the emergence of health care organizational ethics, it is premature to establish once and for all which substantive moral problems are most critical. Those interested in, and responsible for, organizational ethics will want to look and listen carefully as members of the organization consider what the most potent problems are.

### **Organizational Ethics: A Method**

During the past twenty years, those in health care who have engaged in moral reasoning in clinical dilemmas have often remarked that they feel inadequately prepared. They wish they had more training in ethics and substantive moral issues associated with end-of-life care and the like. In part, they have been comforted by the prodigious study and writing done by those in clinical ethics. In contrast, there is currently nothing like the same volume of material on substantive moral issues in organizational ethics. Consequently, those interested in organizational ethics need to devise methods for identifying, analyzing, and addressing moral issues. To facilitate developing such a method, it is helpful to consider three steps: understand your moral perspective, evaluate the strengths of the moral perspectives of others, and be clear about all the things that have to be considered.

### **Understanding Your Moral Perspective**

Anyone approaching organizational value dilemmas brings, explicitly or implicitly, tools (in other words, theories) to evaluate value conflict. Some evaluate the situation with a moral tool that weighs the good and bad consequences accruing from personal or organizational moral choices. Others evaluate the situation according to whether the moral choice violates some norm (“do unto others”) stemming from human reason or revelation. Still others evaluate the situation in terms of a moral theory; for example, in the ethics of clinical health care some people proceed with a version of “principlism,” which evaluates a dilemma in light of core

concepts of autonomy, justice, and beneficence. It is not the purpose of this book to evaluate these tools or theories. But it is imperative to remember that practical, irresolvable conflicts over organizational values may be rooted in fundamental differences among those who are discussing the dilemma. Therefore, one step in the method is to understand your moral perspective. Which theoretical tools do you employ—those based on consequences, or on rules, principles, or narratives?

### Evaluate the Strengths of Other Moral Perspectives

Depending on the theory assumed for moral analysis, certain features of a case come to the foreground for discussion. With PHC, if one relies on principlism, certain features of the dispute over practice parameters come to the fore. The problem might be framed in terms of the doctor-patient relationship. The dispute is whether a patient should be given some choice in treatment even if the protocol does not allow choice, or whether physicians are morally obligated to set aside practice parameters if doing so is good for the patient. In contrast, if one relies on a theory examining the moral norms of the organization, the moral issues are framed differently, with other problems standing out.

The problem of practice parameters can be construed as the moral choice of a health care organization adopting policies that direct clinical practice. Other moral problems might surface, including what the motivation is for the rules (and whether that motivation is defensible) and what the limits are, if any, for an organization's directing health care. Each person participating in the discussion that an ethics mechanism carries out is likely to bring an individual moral perspective; each one inserts a valuable piece in the organizational ethics puzzle.

### All Things Considered: A Case Workup

The moral story of PHC, as with most of life, seems complex and irresolvable. With its refractory, almost impenetrable problems, the case illustrated by PHC is reason enough to simply avoid taking up the questions in the first place. However, when parties are pitted against each other, some benefit can be gained by teasing apart the elements to understand the locus of disagreement.

There are many variants of case workup; by and large, they are attempts to ask as many questions as possible—all things considered—along the way. We employ a step-by-step method in this book (prominently in the case studies of Part Two). It includes (1) identifying questions, (2) gathering facts, (3) clarifying concepts, (4) sizing up alternatives and consequences, (5) finding justification for action, and (6) seeking integrity-preserving compromise (Exhibit 1.3).

## **Mechanisms for Addressing Organizational Ethics**

During the rise of clinical health care ethics, health care institutions rushed to establish ethics mechanisms—most notably ethics committees—to deal with such substantive issues as decision making and termination of treatment. But in spite of all the staff goodwill and enthusiasm, the participants in the mechanism had difficulty in successfully organizing and sustaining enthusiasm. Committee members attributed the obstacles to lack of knowledge about substantive ethics issues; “If I only knew more about health care ethics, the committee would be successful” is a refrain often heard. Although an improved knowledge base could fortify ethics committee functioning, the movement has paid little attention to the fact that the *process* of addressing ethics issues might be as great an obstacle as the lack of substantive knowledge. What is the best process for addressing ethical issues? Who can best address them? What resistance does this process, and do these people, face? What is the scope of authority for this process? What are the expected outcomes of the process and the best ways to accomplish them?

In developing an ethics mechanism for organizational ethics, one encounters a formidable obstacle: identifying and addressing the unwieldy range of issues found throughout the organization. In contrast, clinical health care ethics faces a simpler process insofar as it focuses on the patient, and clinicians have familiar structures (such as clinical case conferences) that they can imitate and use to discuss clinical ethical problems. It is too early in the discussion of health care organizational ethics to know if the clinical model of an ethics committee is adequate to the task of organizational ethics. (More about this later.)

One frequently hears “Why do we even need a mechanism for organizational ethics?” If the clinical health care movement is any

**Exhibit 1.3. All Things Considered:  
A Method of Moral Analysis.**

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1. Question identification
  - What questions need to be answered?
  - Are there any priorities among the questions? For example, do some questions need to be asked and settled before others can be asked? Or are some questions necessary for the current problem while others can wait? Or are some questions so complex that they have historically resisted answers?
2. Fact gathering and assessing
  - Depending on the question to be explored, what facts are important for that question?
  - What facts are missing?
  - If certain facts are clear, will they sway the case one way or another?
  - Do you have enough factual understanding of the organization's mission, policies, procedures, and culture? Do you understand the context? Do you understand the moral psychology of the actors—for example, the professional motivation of leaders or managers?
3. Concept clarification
  - Suppose that when a question is framed, someone alleges that the problem involves a conflict of interest, or an abuse of discretion, and insubordination. What do those concepts mean? Is there any agreement about the characteristics of the concepts?
  - What facts are needed for the concept to be applicable in this case?
  - Is there a priority among concepts in this case? Sometimes a case raises several concepts. (For example, in health care advertising, it is alleged that the concepts of coercion and truth telling are relevant.)
4. Alternatives and consequences
  - Have you considered the case from the perspectives of all those who might have an interest in resolving it? Have you imagined the resolution of this case from the perspectives of all who have an interest?
  - What are the burdens and benefits of pursuing each alternative? Whose interests will suffer if a course of action is taken?
  - Have you examined short- and long-range consequences?



**Exhibit 1.3. All Things Considered:  
A Method of Moral Analysis, Cont'd.**

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- Which consequences are important? The economic ones? Health-related? Survival?
5. Justification
- What are the reasons to prefer one alternative over another?
  - Does any rule of thumb apply? For example, would you do X in all cases—in a sense, universalize your actions? Would you apply the decision to yourself? Are equals treated equally? Has the decision-making process been fair and open to inspection? Would there be a moral hazard if the community knew about the decision?
6. Integrity-preserving compromise
- If a course of action is decided upon, is there a means to protect the values important to others in the dispute?
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indication, those within an organization might see no need for a mechanism. The objection stems from several sources of resistance. One is “We don’t have any moral problems around here—everything is just fine.” The common notion that if it ain’t broken, don’t fix it is plausible, since health care organizational ethics is not front and center in the media or on the docket of trustees or administration. However, accrediting agencies and some clinical ethics committee members understand that adverse patient outcomes can be caused by problems on the organization’s business side.

Another reason some see no need for an ethics mechanism is duplication. The corporate compliance committee, the ethics officers, internal audit, an ethics hotline, and the human resource department are identified as adequate mechanisms to deal with organizational ethics problems. The managerial rule of thumb to favor existing, functioning mechanisms demonstrates not only good stewardship but also the wisdom of avoiding turf conflicts. When a mechanism is established, therefore, it must be clear what it does and does not address if one is to ensure there is no overlap with other mechanisms. Even if other mechanisms (such as a corporate compliance program) exist, their membership, scope of authority, and focus tend to be restricted. Any mechanisms adequate to the task of identifying and addressing organizational ethics

require having all things considered, as we have said, which includes multidisciplinary input.

Still another reason some think an ethics mechanism is unnecessary is the cost involved. In the competitive health care environment, time—that is, staff time—is money. If the clear concern is cost and not actual need for addressing organizational ethics, then creativity is in order. An organization may consider fortifying existing mechanisms, integrating them into the fabric of each department's operations, or collaborating with another health care organization. This book consciously avoids recommending that an organization establish one more committee or task force; instead, we simply recommend—as do the JCAHO requirements—that an organization have some mechanism in place to address organizational ethics.

As health care ethics committees developed, a common obstacle in the way of efficient functioning was turf warfare. A committee would encounter a roadblock when some people perceived that it had overstepped its bounds by interfering with the role and responsibility of existing authority. Part of the expressed concern was that the ethics committee would get out of control—stirring up all kinds of trouble that could be managed differently. What was overlooked was that the mechanism needed to be managed; it needed a clear scope of authority and accountability, which was often missing in a clinical ethics committee. Whatever mechanism an organization relies upon, there must be explicit discussion of who gives the authority to the mechanism, to whom the members of the mechanism report, what its functions are, and what goals it is held accountable for meeting. Too often, a clinical ethics committee was established with little thought to these issues, which can make or break a mechanism. Turf wars can be avoided with advanced planning of a mechanism's authority and accountability.

Misperceptions about the mission of the mechanism are also likely to cause it to falter. A common, lethal misconception about a mechanism is that it should have a police function within the organization. As we address several times in this book (see, for instance, Chapter Three), any connection between an ethics mechanism and guarding, patrolling, watching, reprimanding, and punishing undercuts its broader mission.

As noted earlier, organizations pursue ethical identification, analysis, and action for a variety of reasons. Even if the members

of the mechanism pursue this activity only for legal liability, that pursuit will be stymied. Problems are likely to go unnoticed and unaddressed if the mere thought of them brings sanction. Issues that are identified as “organizational ethics dilemmas” might be moral problems with greater ambiguity than is first seen. Consequently, ambiguous problems rooted in numerous factors might be difficult to resolve through disciplinary measures. Equally important, if an organization is using the ethics mechanism to meet its mission or to improve employee and patient satisfaction, then using sanctions might undercut promoting the virtues the organization desires. Whatever mechanism is adopted to address organizational ethics, it should present a safe, confidential place to address potentially troubling issues. Creating a safe place for unsafe ideas encourages discussion of problems that might find no other place to be voiced.

Some misperceptions about the mechanism can be traced to confusion about its functions and its workload. Whatever form the ethics mechanism takes, an organization is likely to expect it to permit education, consultation, and policy conferral. If those in the mechanism group are unclear about its scope of authority and accountability, problems arise and conflicts can occur in providing such education and consultation. Consider the potential confusion related to consultation: Is it a true consulting function, or a mandating one? If an employee seeks information about an issue that is clear in the law (for example, accurate coding and billing), consultation on this matter might be perceived by the employee as mandating compliance. This in turn suggests a policing function, which the mechanism must avoid. Mandating compliance also usurps the power and authority of existing structures and occasions turf battles. Mandating sends the message that the mechanism is not a fair, confidential, safe venue for exploring moral issues. If clear lines of authority and accountability are established, however, the mechanism—should it identify a clear-cut moral and legal liability—is responsible to report the matter to the organizational structure that commissioned it. Appropriate reporting sends the message that the mechanism is not acting on its own, nor overstepping its bounds by duplicating existing organizational functions.

Given the number of pitfalls awaiting the organizational ethics mechanism, four pragmatic guideposts are worth highlighting. First, any hope of launching a mechanism requires support from

the top down. A mechanism that starts at the grass roots is likely to flounder without the support of leaders who might perceive the movement as a threat. Influential leadership participation in the design and function of the mechanism contributes to its acceptance and successful operation.

Second, whoever commissions the mechanism should be realistic about its workload. Many clinical ethics committees have become disillusioned when unrealistic outcomes were placed on them. Realistic priorities and time lines should be set once a mechanism has mapped the moralecology of an organization. Third, the mechanism can succeed with as little effort as appropriately advertising its existence. Take, for example, the use of the term *ethics*, which immediately connotes wrongdoing for some employees. Instead, using the word *values* might be less threatening, because it avoids association with policing or with flagrant problems that need little in the way of subtle moral consideration.

Fourth, adopting the committee structure that is found in a clinical ethics committee might obstruct the productivity of the mechanism. If the moral problems in health care organizational ethics are broader than doctor-patient relations, for example, it is ill-advised to create a committee that simply mimics the clinical ethics committee in its membership and moral analytical abilities.

Throughout this book, we make the case that the problems of health care organizational ethics require innovation and departure from doing things as usual. The discussion in the next chapter suggests that those interested in organizational ethics need a new way of seeing problems—and a new way of responding.

## Notes

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