Ethics in HEALTH ADMINISTRATION

A Practical Approach for Decision Makers
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This book is dedicated to my son Grant, who has always believed I could do anything.
Gratitudes xi
Contributors xiii

Section I Foundations for Ethics ...........................................1
Introduction .................................................................1
Reference ...............................................................4

Chapter 1 Practical Theory ................................................5
Points to Ponder ..........................................................5
Words to Remember .....................................................5
Introduction ...............................................................5
Why Study Ethics Theory? ............................................6
St. Thomas Aquinas (1225–1274) ......................................7
Immanuel Kant (1724–1804) ............................................8
John Stuart Mill (1806–1873) ..........................................10
John Rawls (1921–2002) ................................................12
Personal Ethics Theorists ................................................14
Martin Buber (1878–1965) .............................................14
Lawrence Kohlberg (1927–1987) ....................................16
Viktor Frankl (1905–1997) .............................................19
What Is Ethics? ...........................................................20
Summary .................................................................22
Web Resources ..........................................................22
References ...............................................................22

Chapter 2 Autonomy ..........................................................25
Points to Ponder ..........................................................25
Words to Remember .....................................................25
Introductions and Definitions .......................................25
CONTENTS

Autonomy as Informed Consent .................. 26
Autonomy as Confidentiality .................. 29
Autonomy as Truth-Telling .................. 31
Autonomy as Fidelity .................. 33
Summary .................................. 35
Cases for Your Consideration .................. 36
Web Resources .................................. 43
References .................................. 43

Chapter 3 Nonmaleficence and Beneficence .................. 45
Points to Ponder .................................. 45
Words to Remember .................................. 45
Introduction and Definitions .................. 45
Nonmaleficence in Health Care Settings ........ 46
Beneficence in Health Care Settings ........ 50
Summary .................................. 53
Cases for Your Consideration .................. 53
Web Resources .................................. 62
References .................................. 62

Chapter 4 Justice .................. 63
Points to Ponder .................................. 63
Words to Remember .................................. 63
Introduction and Definitions .................. 63
Justice for Patients .................. 64
Distributive Justice .................. 65
Staff Justice .................. 69
Summary .................................. 72
Cases for Your Consideration .................. 73
Web Resource .................................. 77
References .................................. 77

Section II External Influences on Ethics .................. 79
Introduction .................................. 79

Chapter 5 Quis Custodiet Ispos Custodes? Who Will Guard the Guardians? .................. 83
Points to Ponder .................................. 83
Words to Remember .................................. 83
CONTENTS

The Age of Accountability ..................84
The Ethics of Advocacy ......................91
The Ethics of Staff Competency ............93
Summary ..................................101
Cases for Your Consideration ............101
Web Resources ...........................108
References ..............................108

Chapter 6 Market Forces and Ethics ........111
Points to Ponder .........................111
Words to Remember ......................111
Introduction and Definitions of Market Forces .112
General Market Forces ...................112
Managed Care and Ethics ................114
Where Is the Ethics? .....................118
Integrated Medicine (IM) and Ethics ....122
Summary ................................126
Cases for Your Consideration ............127
Web Resources ...........................132
References ..............................132

Chapter 7 Social Responsibility and Ethics ....133
Points to Ponder .........................133
Words to Remember ......................133
Prevention as Social Responsibility ........136
Quality Assurance as Social Responsibility ....140
Summary ................................142
Cases for Your Consideration ............142
Web Resources ...........................149
References ..............................149

Chapter 8 Technology and Ethics ..........151
Points to Ponder .........................151
Words to Remember ......................151
Technology and Its Impact on Health Care ....152
Emergent Technologies and Future Issues ....156
Technology and Ethics ..................159
I owe a great debt to my friends, family, and colleagues who served as sources of inspiration, guidance, and wonderful stories. I also want to honor all of my students who have taught me in more ways than they will ever know. Special gratitude goes to my editor, Mike Brown, who has given me encouragement and exceeded all expectations.
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“It was the best of times, it was the worst of times. It was the age of wisdom, it was the age of foolishness. It was the epoch of belief, it was the epoch of incredulity. It was the season of Light, it was the season of Darkness. It was the Spring of hope, it was the winter of despair. We had everything before us, we had nothing before us….”

This quote from *A Tale of Two Cities* by Charles Dickens (p. 1) could have been written about the health care system of today. It is truly the best of times and the worst of times. The American health care system is one of the most technologically advanced in the world. The potential to conquer diseases and extend life to almost biblical proportions seems possible. A system exists that once was just part of the imaginations of science fiction writers and dreamers. In many ways, this is the best of times in health care.

Yet, these same advances in the system pose enormous challenges in the human dimension. Members of the system and society at large are faced with decisions that would test the wisdom of Solomon. For example, because we have the technology to create the new forms of human life, does this mean we should use it? From an organizational standpoint, how do we decide who benefits from technology and life-extending procedures, and who does not? Who will pay for optimal health care for all Americans? The tremendous progress in medical knowledge and technology makes it a difficult time for ethics and ethical decision making.

What is the role of health care administration in all of this? Health care administrators certainly do not provide the care, conduct the research, or design the technology. Yet, they are critical to the success of these system functions. They provide an environment where the important work of health care can take place; they are the creators of structure and support. Health care administrators have the ethical obligation to provide a safe environment for patients and employees. They are also the connection to the community and the stewards of the
SECTION II INTRODUCTION

resources society invests in health care. Certainly, this is a grave responsibility.

How are you supposed to meet this level of responsibility? Certainly, this task requires a foundation in knowledge of system functions, human relations, finance, and leadership that you are gaining through your formal education. It also mandates a deeper understanding of the principles of ethics and appropriate ethical behavior from the individual, organizational, and societal view. Your actions must be based in practicality that incorporates theory. Ethics must be a way that you conduct the business of health care on a day-to-day basis.

A Word about the Text

Just like a health care organization, this book has a mission and a vision. Its mission is to give you solid preparation in both the theory of ethics and, more important, in its practice in the real world of health care. Scholarly textbooks exist on bioethics and ethics in organizations and the knowledge they provide guided by the creation of this text. Hopefully, this wisdom will lead to your understanding of the principles and issues of ethics. However, theory alone is not enough. If its mission is to be fulfilled, the book must also give you practical examples of how ethics can be used in your daily decisions as a health care administrator.

This text is designed to combine theory and practice in a palatable format. Each chapter contains a feature called “points to ponder” that should help you to focus on the most important concepts. It is a good idea to think about these questions as you read through the chapter content. There is also a “words to remember” section that features important words and phrases. You will find these words in bold print in the content section of the text.

In addition to information about the topic under study, each chapter contains case studies in the form of stories. These are fictionalized versions of stories that were contributed by health care providers from many different health care settings. They are designed to show you how the chapter information relates to the real world of health care. References are also included at the end of each chapter so that you can do additional reading if you choose.

The model seen in Figure 1 guides the vision for this text. Ethics decisions are not made in a vacuum; there are many areas that influence how they are made. The circles in this model represent the impact of influences on your ability to make ethics decisions. The circles start with theory and principles and move to community areas that are external to the organization. Then it considers forces within the organization that can also influence your decisions and practices. Finally, the inner circle shows how your own personal ethics influences what you do. Each circle needs to be understood and considered as part of ethics-based administration.
The chapters are organized in sections that illustrate key issues within these circles. Section I, represented by the outermost circle, begins to establish your foundation in ethics theory and principles. Chapter 1 explores founding theories of ethics that guide most of Western ethical thinking. Using this theoretical foundation, Chapter 2 explores autonomy, which is one of the four key principles of health care ethics. In Chapter 3 and Chapter 4, you will continue to establish your knowledge of the principles of ethics. These chapters will deal with nonmaleficence, beneficence, and justice. Chapters 2 through Chapter 4 will also include cases or stories that will allow you to apply these principles to real-world events.

Section II, the next circle, presents some of the external influences on ethics for the health care administrator. Chapter 5 provides information about how the community protects itself from the power of the health care system. Chapter 6 deals with the powerful influence of market forces, including managed care and alternative medicine. Chapter 7 also deals with external influences through a discussion of social responsibility and ethics. Finally, Chapter 8 presents an in-depth view of technology’s impact on ethics. Each of these chapters also includes cases or stories that will help you apply what you are reading to practical ethical decisions.
The health care organization’s influence on your ethical decisions is the focus of Section III. Chapter 9 presents the challenging area of fiscal responsibility and how it influences our ethical decisions. Chapter 10 examines the impact of organizational culture on ethics and features information on ethics committees and models for decision making. Chapter 11 presents the organization’s view of health care regulation and the challenges it faces in achieving compliance. It shows how both regulatory bodies and individual organizations are moving beyond compliance to true quality assurance. Finally, Chapter 12 addresses how the organization views patients and how it acts to meet their needs.

Section IV (innermost circle) is designed to present a more personal look at your ethical foundation. Chapter 13 discusses the concept of moral integrity and what it means to you as a health care administrator. Chapter 14 presents information about codes of ethics and the impact they can have on administrative practice. Chapter 15 discusses issues related to your day-to-day practice as ethical health care administrators. Finally, because ethics is a dynamic area of health administration, Chapter 16 addresses issues that are in the immediate future and their ethical implications. It also provides an overall summary of the learning in the text.

Why bother reading this book? While it will not make you an ethics scholar, this book will assist you to become someone who is of great value in today’s health care system. You can be the administrator who can see the world through “ethics eyes” as well as through financial ones. On the surface, this ability can make things more difficult for you because your decisions will not be simple ones. However, by being able to look at any situation holistically and make appropriate, ethics-based decisions, you can actually enhance the overall effectiveness of your organization. Because health care is a trust-based industry, you will be able to maintain the community’s trust by helping your organization avoid actions that can be perceived as unethical or immoral. In addition, you can enhance your own career by being known as an administrator who understands that ethics makes a difference.

**Reference**

Practical Theory

“A theory must be tempered with reality.”
—Jawaharlal Nehru

Points to Ponder

1. Why does a health care administrator need a foundation in ethics theory to be effective?
2. Who were the Big 7 and what did they contribute to modern-day ethics?
3. What is my working definition of ethics?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

categorical imperative  consequentialism
conventional  deontology
I-THOU  moral development
natural law  original position
pre-conventional  pre-moral
principled moral reasoning  self-interest
sense of meaning  social justice
utilitarianism

INTRODUCTION

Practicing as an ethics-based administrator begins with a foundation in the theory and practice of ethics. You will need this foundation because you will face decisions that will challenge you to balance the financial
and human aspects of the health care business. These decisions will not be black or white. In fact, their shades of gray might cause you some sleepless nights. Having a foundation in ethical theory and using it in practice should help you sleep better and be able to defend your choices.

Ethics has been a subject of study for many thousands of years and brilliant scholars have spent their lives exploring it. In this chapter, you will explore seven of the key theorists who were instrumental in creating the foundation of ethics for the health care setting. Sometimes, when students read these theorists’ works in their original forms, they find them obtuse and uninteresting. Some have even complained that they found it hard to understand what these “old dead guys” were trying to say.

First, so you need to see them as people and not just “old dead guys,” the chapter will include a brief biography. This thumbnail bio includes lesser known, but interesting facts, about each of the theorists. A concept summary with the essence of each scholar’s key points is included to help you avoid being overwhelmed or bored. Finally, as Nehru suggests, their theories will also be “tempered with reality” through the inclusion of a section on application to health care.

This exploration should lead you to the final section in the chapter that is designed to examine various definitions of ethics. After this review, you should be able to develop your own working definition. Your personal definition, based on the thoughts of experts, should serve as a solid foundation for your role as an ethics-based health care administrator. The goal of this chapter is to give you a personal theoretical foundation and working definition of ethics.

**WHY STUDY ETHICS THEORY?**

Can you imagine being a surgeon and not knowing the anatomy of the human body? What about being an accountant and not knowing how to use a calculator? You might do the job, but the results would be a complete disaster. It is not any different for a health care administrator. You must have the basic knowledge, skills, and attitudes to do your work effectively and efficiently.

Why include a foundation in ethics as part of these basics? Health care is a dynamic environment where one area affects the other. Because of this, the answers to problems you will encounter cannot always be found in a textbook or on a balance sheet. They involve qualitative intangibles like organizational mission and values, trust, human dignity, and service to community. Your decisions have to be made based on an accurate assessment of your financials and resources (quantitative information), simultaneous with the qualitative issues that
must be considered as well. In addition, your patients, staff, organization leaders, and the community expect your decisions to be ethical. How can you make ethics-based decisions without a foundation in ethics? This chapter is the beginning of that foundation.

The writers represented here in this chapter are known as the Big 7: Aquinas, Kant, Mill, Rawls, Buber, Kohlberg, and Frankl. These philosophers created the ideas that led to the major principles of ethics found in Chapters 2, 3, and 4. The first group of philosophers—Aquinas, Kant, Mill, and Rawls—examined the global issues surrounding ethics and ethical decisions. The second group—Buber, Kohlberg, and Frankl—studied personal ethics and moral development. This section gives a summary of their work and provides an understanding of their contribution to ethics.

### ST. THOMAS AQUINAS (1225–1274)

#### Biographical Influences on His Theory

Although Aquinas was called to the church early in his life, his family did not support this vocation. They considered his choice to join the Dominican Order inappropriate because it was too radical. In an effort to change his mind, his family actually held him prisoner for two years. They even tried to make him renounce his calling by tempting him with worldly pleasures (including women). Finally, they relented and allowed him to go to Cologne, join the Dominican Order, and study with the major scholars of his day. Aquinas became a prolific writer; the greatest of his writings was the *Summa Theologica*. Part Two of this work was devoted entirely to ethics and combined Aristotelian and Christian thinking. This work helped to establish what has been called natural law.

#### Concept Summary

Aquinas believed that God is perfectly rational and that He created the world in a rational manner (Kuhse & Singer, 1998). His design for the world included giving humans the ability to reason and to wonder about the cause of all things. Because humans are given this gift of rationality, they are capable of choosing good and avoiding evil. Notice the word “capable”; it does not mean that people always do this. If people are true to their rational nature, they will listen to their conscience (i.e., the voice of God) and choose good over evil.

So what is goodness as defined by Aquinas? He believed that goodness preserves life and the human race. Something is good if it advances knowledge and truth, helps people live in community, and respects all
persons. He also believed that to find happiness people must not look to pleasures, honors, wealth, or worldly power because these are not the true source of goodness. True happiness can only be found in the wisdom of seeking to know God. Truly understanding God is the ultimate good that is sought by all rational human beings.

Theory Applications
First, you must remember that knowledge of ethics builds on the work of previous scholars. Aquinas was heavily influenced by those he studied, including Aristotle, Dionysius, and Christian doctrine. How does his thinking apply to today’s world? If people act against their “rational nature” (as defined by Aquinas), they can do things that are evil for themselves and others. Think of a modern day example. It is not rational to drink to excess and then get behind the wheel of a car. Yet, if people make this irrational decision, their actions can cause them harm or even death. This harm can also extend to others who have the misfortune of coming into contact with them.

In addition, Aquinas’s idea of “basic good” seems on the surface to be simple. All you have to do is respect people and help them live in community. But, when you translate this into the health care system and its policies, it becomes much more complex. What does this system do about people who do not make rational choices for good—such as those who abuse alcohol or drugs? Do they deserve the same level of care as those who make rational choices? How can the business of health care engage in practices that preserve the human race and still have enough money to keep its doors open? These questions relate to the difficult choices (gray areas) that must be made in today’s health care system, where demand for care often exceeds finances.

■ IMMANUEL KANT (1724–1804)

Biographical Influences on His Theory
Although Kant became a dominant force in ethics theory, he did not begin his career in this field. Rather, he studied math and physics and earned his doctorate in 1755. After many years of dedicated study and expansion of his knowledge, he became a well-known professor of logic and metaphysics. His writings even came to the attention of King Fredrick William II—who did not support them. In fact, in 1792, he decreed that Kant could not teach or write about anything related to religion or ethics. Kant honored this edict until after the king’s death, when he continued to publish his works on ethics and morality.

Concept Summary
Kant’s work in metaphysics had a major impact on his work in ethics. His two most important works in this area were Foundations of the
Immanuel Kant (1724–1804)

Metaphysics of Morals (1785) and Critique of Practical Reason (1787). He was a foundational theorist for an entire area of ethics called deontology or duty-based ethics (Kuhse & Singer, 1998).

For Kant, everything in a society had worth based on its relative value. Therefore, nothing was good in and of itself. All things could be used for good or evil. This was true because attributes (such as intelligence, physical beauty, or bravery) are gifts of your genetics or from your environment. They also have their source in your mind or perception, so you decide who is smart and who is not. All gifts can be used for good or evil. Likewise, personal attributes that are valued by a society, such as influence, money, or even happiness, can be used for good or evil. For example, if you are highly intelligent or extremely wealthy, you might discover a cure for a terrible disease or create a heavenly symphony. You might also use that same intelligence and wealth to become a serial killer.

For Kant, the only good that can exist without clarification is something called good will. Good will meant that there was no ultimate end for the person who chooses it. In other words, acting with good will does not give you benefit. You just do it and it is valuable all by itself. So good will is not a means to an end; it just is.

In the Kantian view, all humans have absolute worth simply by the fact of their existence. People are not a means to accomplish an end or societal good. They are an end in themselves. What does this mean? It means that you cannot use people as a way to get what you want and remain ethical. You should honor them because they exist. For Kant, humans are subject to universal laws that are always in place. How does this translate today? It means that, when dealing with humans, you have a duty to choose to act as a moral mediator and base your actions on good will. Anticipated consequences or the end product of your decisions should not be a part of the decision-making process.

How do we know what is good? In Kant's work, there exists something called the categorical imperative, which is a test of your actions and can help you make moral decisions. Decisions should be based on the idea that what is right for one person is right for all persons. You can ask yourself the question, “Would I want everyone to act as I just did?” If the answer is “yes,” then it passes your categorical imperative and is a moral duty for you. A shortened version of this concept can be illustrated by the Golden Rule: Do unto others as you would have them do unto you. In Kantian ethics, all humans have worth, so you are obligated to apply your decisions to all individuals in similar circumstances.

Theory Applications

First, Kantian or duty-based ethics acknowledges the value of all human beings and gives you a rule to guide decision making regarding actions toward all. It tells you that, for moral decision making, all persons in similar circumstances deserve the same treatment. Kant also
CHAPTER 1  PRACTICAL THEORY

presents the idea of a moral duty, which means that you have obligations to other people as fellow humans. All people you come into contact with in your daily work-life—employees, patients, community members, among others—have absolute value simply by the fact that they exist. Just because they can accomplish more or less in society’s eyes does not change their value as human beings.

The categorical imperative can be useful for decision making when you are developing policy and procedures. For example, if you have to develop personnel policy, you can ask yourself, “Why am I really doing this? What is the reason behind it?” You can also try to discern if it can apply to everyone in the same way, or if the policy will treat some employees better than others. Finally, you can ask, “How would I feel if this were done to me?”

Despite its base in good will, you can see that being a strict Kantian might be a problem for the health care administrator. To follow Kant, you should make all your decisions based on good will and not on things like profit, legal mandate, or pleasing your stakeholders. This is not practical or even possible in the political world of health care. Kantian moral theory also tends to deal in absolutes and does not provide answers to all of the complex issues in today’s health care system. How about just one example? If a researcher uses human subjects in a study to help find the cure for cancer, is he or she not using them as a means to an end? Does this negate the worth of human beings and fail the categorical imperative test? You could say that it does, and yet there is potential benefit to a larger group from the knowledge gained.

JOHN STUART MILL (1806–1873)

Biographical Influences on His Theory

John Stuart Mill had an interesting childhood. In today’s view, it might be seen as abusive. He was an extremely intelligent child who was heavily influenced by his father’s insistence on strict discipline in learning. At 15, John Mill was already disagreeing with current moral theorists and began to write his own theory, which was influenced by Bentham’s utility concepts. When he was 21, Mill suffered what was then called a mental crisis, believed to be caused by the physical and cerebral strain of his strict, self-imposed education. Later in life, he married Harriet Taylor, a feminist and intellectual, who came from a Unitarian background. She was an author in her own right and published articles advocating women’s rights. They shared philosophies and collaborated on many articles. His major works on ethics include Utilitarianism and The Subjection of Women. Mill was ahead of his time in his activism in support of his beliefs. For example, he became a Member of Parliament to use his political power to help improve the status of women.
Concept Summary
Mill is one of the most influential theorists in the American view of applied ethics, especially in the area of health care. Based on the idea of Telos, or ends, his theory of **utilitarianism** has been used in the formulation of many health care policies that have an impact on the American public today. Utilitarianism or **consequentialism** was founded on the idea that ethical choices should be based on their consequences and not just on duty. In this view, you weigh the consequences of your actions and how they affect others before you make a decision.

Something is good if it produces utility. Just what is that? Mill meant that it gives the greatest benefit (or pleasure) to the greatest number. It is wrong if it produces the greatest harm for the greatest number. The focus of an ethical decision is not on the individual person, but on the best outcomes for all persons. Mill discussed Christian theology as the best example of utility because the Bible asked people to live by the Golden Rule and to love their neighbors as they love themselves. In health care, you could say that the opportunity for the highest quality of life should be provided to the highest number of people in a community. Monagle and Thomasma (1988) provide an example of utility in health care and suggest that it should include restoring health, relieving symptoms, saving life, providing education, and avoiding harm.

Mill divided ethical decisions based on utility into two main groups. The first is to act from utility, which means that each decision is made based on its own merit. The consequences for that specific case are analyzed and a decision is made. However, to act from utility or make each decision independently cannot always be practical in health care because your decisions are numerous, complex, and often interrelated.

The second is to rule by utility. In contrast to the first group, this ethic uses the consequences of decisions to determine rules for action. These rules help guide decisions so that, on average, they produce the greatest good for the greatest number or cause the least amount of harm to the least amount of people. Rule by utilitarian decision making appeals to health care administrators because it allows for decisions that will be the best in most cases. It also is part of using the process of cost benefit or gain/loss analysis to justify a decision.

Theory Applications
Many health care administrators perceive Mill’s utilitarian principles of ethics as a practical way to tackle difficult health care decisions. Because there is always a scarcity of resources, there has to be a way to make decisions based on universal benefit. Using the balance sheet approach of identifying consequences, determining the merit of each, and making a decision that will benefit the most people makes ethical
CHAPTER 1  PRACTICAL THEORY

decisions easier to make. You will see evidence of this approach in later chapters where you will examine some ethics decision-making models.

One limitation of this theory is that it might be possible to ignore the needs and desires of the minority to provide the greatest good for the majority. The individual is not the focus of moral decision; the consequences of the action are the most important element. For example, what if you funded a screening program that served all the members of a community, but thereby eliminated funding for a program that served a small group of uninsured patients who needed liver transplants? Your program might provide the greatest good for the greatest number, but those who were left untreated might have good reason to disagree.

■ JOHN RAWLS (1921–2002)

Biographical Influences on His Theory
As you can see by the dates, Rawls was a modern ethics theorist. He began his studies at Princeton and went on to serve in World War II. While in the service, he witnessed the aftermath of the bombing of Hiroshima. It had such an impact on him that he declined a commission as an officer and left the Army. When he returned home, he finished a doctorate in moral philosophy at Princeton.

Rawls taught at Princeton, Oxford (Fulbright Scholar), and Massachusetts Institute of Technology. In his final academic appointment, he served as a professor at Harvard for 40 years. He is known for his work in defining social justice and what a moral society should be. Because of this work, he had a great influence on modern political and ethical thinking. He continued his work and study right up to his death in 2002.

Concept Summary
John Rawls was interested in defining what makes a moral and just society. He studied all of the philosophers who came before him and found that he both agreed and disagreed with them. For example, some of Kant’s arguments appealed to him, but he was opposed to the position of utilitarianism. He formulated his own theory of justice that was based on the concept of self-interest. What did he mean? First, he set up a scenario where all persons are equal (like you are at the moment of your birth) to each other. He called this the original position. In this state of equality, people are all rational human beings and act in their own best interests. What would be in their best interests?

Because humans generally live in social groups, they must set up rules that protect their personal interests and those of the society in which they live. To live in society with any kind of peace and justice, people must agree to these rules and practice them. He defined some-
thing he called the liberty principle (Cahn & Markie, 1998), which means that all people should have the same basic rights as all others in a society. For example, if the rich have a right to basic education, then so should everyone else.

In his view of social justice, people must make choices in order to protect those who are in a lesser position in society. This includes children, those in poverty, and those who have medical problems that affect their quality of life. This idea has been called the Maximin Rule (Cahn & Markie, 1998). Why would anyone choose to do this as part of their self-interest even when he or she is not in a lesser position in society? In Rawls’s view, everyone has the potential to be in a lesser position, so acting to protect the rights of those who are less well off is actually based on self-interest. Further, the problems in a society tend to be suffered more by those who are in disadvantaged positions. For example, those in poverty are also more likely to be victims of crime or have more severe health problems. Finally, societies are often judged by how they treat those who are not well off or in optimal health. Again, using the Maximin Rule would be favorable for those who are in power, because they will be known as just leaders in a just society.

Does this mean that everyone in a society has to make the same amount of money and have the same circumstances? Rawls postulated that differences and advantages could exist in economic and social position in a society if they were used for the benefit of that society. For example, a physician could be paid more than others and have greater status if he or she served the community in which he or she lived. However, such positions of advantage had to be available to all persons in the society. So technically, in Rawls’s view, anyone who has the ability should be able to attend a university or college and become a person of privilege.

Rawls also dealt with the idea of providing services or benefits for everyone. He felt that it was morally right to limit services when there is a greater need among certain groups. This can mean that not everything is available to everyone in every instance. For example, if you go to the emergency department with a sprained ankle, there are many services available to diagnose and treat you. But you might not get immediate treatment or even all of the available treatments if there are people in life-threatening situations present. It is in the self-interest of all if those in greater need are treated first.

Theory Applications

Rawls has had a great influence on how leaders think about social justice in America. His ideas also influenced how America is judged by other nations. For example, how does America treat its poor or imprisoned citizens? This can be seen as a greater indicator of the nation’s
quality than its wealth. Rawls's thinking about social justice also influenced the introduction of such programs as Head Start and Medicaid/Medicare. His theory has ramifications for institutions such as education, public health, and health care.

Rawls presents a great challenge to the American market-based health care system. His theory asks that you consider more than the greatest good for the greatest number or the greatest profitability for the greatest bottom line. Instead, it asks that you address how you treat those in your community who have the least amount of financial resources to invest in health care. You are expected to provide for their needs and still maintain a bottom line that allows you to stay in the business. This certainly poses a great challenge for the health care system.

■ PERSONAL ETHICS THEORISTS

A few words of introduction are needed before you read about the next three theorists. Rather than look at the macro picture of the ethics, these philosophers addressed how people acquire their morality, ethical thinking, and decision making. Martin Buber presented ethics in terms of moral relationships, while Kohlberg investigated stages of moral development. Finally, Frankl addressed personal ethics and its relationship to the ultimate meaning of life. This section continues the previous format. You will learn something about the biography of these writers, their basic concepts, and how they influenced health care ethics.

■ MARTIN BUBER (1878–1965)

Biographical Influences on His Theory

Martin Buber was born in Germany and was part of a family of scholars. He became a social activist and tried to help Eastern European Jews during World War I. In 1933, he served as the Director of the Central Office for Jewish Education during a time when Hitler would not allow Jews to go to school. In 1938, he immigrated to Palestine and continued his writing. One of his most important works on ethics is called *I and Thou* (1996).

Concept Summary

Buber examined how people relate to each other and behave in moral or immoral ways. He organized a hierarchy of these relationships and showed how they move from what he considered to be the lowest to the highest ethical levels. At the very bottom of his hierarchy is the “I-I” relationship. In this level, a person is seen as merely an extension
of another person. An example of this might be a child who is expected to become a physician because his father is a physician. The child is seen not as person, but as an extension of the father’s ambitions. In severe cases such as a psychopathic personality, a person cannot see anyone except him- or herself. The needs of others simply do not exist and neither does the responsibility of ethical behavior toward them.

Buber’s next level is the “I-IT” relationship. In this case, people are merely tools to be used for a person’s own benefit or for the benefit of the organization. People are not individuals; they are the vehicles for accomplishing some goal. Names are not important or even known; people are just “Its” or convenient labels.

For Buber, I-IT relationships are morally wrong because they fail to accept people as having individuality and value. People serve only as a means to an end for the person or the organization. Some examples of I-IT relationships occur when an administrator uses the term “my people” to refer to the health care professionals. Another example could be when Mrs. Smith is referred to as “the colon in 405” instead of by her name. Still another example of I-IT occurs when an administrator uses the expression “FTEs” in planning without any regard for the fact that a “full-time equivalent” is a person.

Next in Buber’s hierarchy are the “I-YOU” relationships. In this case, people are recognized as individuals with value; they each have unique talents, gifts, and ideas. These differences are not only recognized, but they are also accepted and respected. An example of this type of relationship can be found in a well-functioning health care team when each member respects the contributions of the others. In health care, patients expect I-YOU relationships as a minimum level of performance from all employees. Employees also expect and appreciate this level of ethical relationship with their supervisors and with each other. When such an environment exists, staff are more productive and exhibits higher morale.

The highest moral relationship that you can have is called “I-THOU.” It is based on the Greek concept of agape (meaning love for others), which Buber viewed as the most mature human relationship. In an I-THOU relationship, each person is recognized as being different and having value. In addition, a choice is made to consider that person as beloved or special. Notice that the word “choice” is used in that last sentence. Making a choice requires many things from people who make the decision to consider someone beloved. These requirements include increased tolerance of differences, patience, and efforts to make that person’s needs equal to their own. A person who is beloved is held in high esteem or unconditional regard.

I-THOU relationships do not exist with each person that you meet. However, in health care, patients assume that they are in an I-THOU relationship when you are providing for their health needs. They
assume that you value their needs equally with your own because you chose to have a career in a service-based industry. Likewise, the community assumes that, as an administrator, you are acting with the highest regard for their needs and serve as a good steward of their resources.

**Theory Applications**

In this short summary, you have only looked at the basics of Buber’s complex thinking about ethics and ethical behavior. However, his definitions of ethical relationships can be useful to you as an administrator. For example, when you are planning a new venture or evaluating a current program, do you think of employees as tools to get the job done or as people who can make contributions through their talents? When you are in conference with a fellow employee, do you try to have at least an I-YOU relationship? Finally, when you choose to be in an I-THOU relationship, do you really put that person’s needs and wants on equal footing with your own? Are you aware of how the community sees your relationship to them? These questions can be helpful in examining your personal ethical behaviors and relationships.

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**LAWRENCE KOHLBERG (1927–1987)**

**Biographical Influences on His Theory**

Lawrence Kohlberg joined the Merchant Marines during World War II. At the end of the war, he was actively engaged in smuggling Jews through the British blockade for settlement in Palestine. As a result of this experience, he began to think about moral reasoning and how ethical thinking is learned.

Kohlberg finished his doctorate at the University of Chicago and became a professor at Harvard University. He began to theorize that moral development happened in stages and researched this theory using children and adults. He used a qualitative research model based on categorizing responses to stories featuring moral dilemmas, such as the now famous Heinz’s Dilemma. This story was used to evaluate a person’s level of moral development based on his or her answers and the reasoning behind those answers. The responses to these stories and the reasoning behind them helped to formulate a hierarchy of moral development. His theory of moral development has been subsequently verified by studies in America and throughout the world. Kohlberg became an international name in the study of morality and ethics, but his death is still a mystery. He disappeared in January of 1987, and his body was later found in a marsh. The exact cause of his death is unknown.

**Concept Summary**

How do you become an ethical person? To understand Kohlberg’s answer to this question, you need some information about developmen-
Lawrence Kohlberg (1927–1987) proposed his moral stage theory (Kohlberg, 1984). In this theory, people must go through one stage before they can achieve the next highest stage of development. The movement through stages is not always chronological, but happens as you are challenged by life and attempt to find solutions for those challenges. Finding solutions helps you to advance in your moral development and reasoning. In addition, Kohlberg believed that you cannot understand the moral reasoning that is too far beyond your own level. It is also possible to be grown-up physically, but not be morally mature. Kohlberg believed that only about 25 percent of people ever get to the highest level of moral development and that most people remain on what he called Level 4.

What are Kohlberg’s stages and what do they mean? There are two stages (Level I and II) that Kohlberg calls pre-moral or pre-conventional. These stages exist before you have a true sense of moral decision making. In Level I, you make decisions purely to avoid getting punished or because a person in higher authority tells you to do it. Your decision is centered on what might happen to you and nothing else.

Level II is also pre-moral but is centered on the personal outcome of the action. In this case, decisions are made based on selfish concerns and the ability to gain personal reward. This is sometimes called the “What’s in it for me?” orientation to ethical behavior or decision making. In this stage, people are valued for their usefulness to the individual and not for any other reason. Generally, Level I and II stage behaviors are common in young children, but they are also present in adults. An example of this behavior is if you choose to act ethically only when it benefits your own agenda.

Kohlberg’s Levels III and IV are what he calls conventional or external-controlled moral development stages. In Level III, people make moral decisions based on the need to please people and to be seen as “good.” The motivation for making ethical decisions is in trying to avoid guilt or shame. People who do what is perceived as good should be rewarded and those who do not should be punished in this view. Ethical decisions for people in this stage are made so that they can be viewed as good employees, good parents, or good friends. They also want to avoid the stigma of being labeled as a “bad employee.”

In Level IV, moral reasoning is governed by the need to respect rules and laws and maintain a certain order. In this stage, justice is being punished for disobeying the law. Ethics is seen as obeying the law and keeping order in society. Authority is usually not questioned; the idea is that if it is the law, then it must be right. This stage explains how Nazi soldiers could actively participate in the holocaust and consider themselves to be moral people. They simply claimed that they were being good soldiers, obeying a higher authority, and “carrying out orders.”
Levels V and VI of the Kohlberg theory are designated as **principled moral reasoning** because decisions are based on applying universal moral ideas or principles. In Level V, ethical decisions are based on a set of rights and responsibilities that are common to all members of a group or community. These rights encompass the law but go beyond it. Moral decisions are based on respect for yourself and for the rights of others. Level V requires complex thinking about the social contract you have with others and not just about laws. When society-based decisions are made about health care resources, an element of Level V reasoning should be present.

Kohlberg’s Level VI moral reasoning is based on ideas or principles that are universal. These principles are higher than the authority of law and include ideas of justice and respect for persons and their rights. Ethical decisions are made based on higher level principles and not just for legal compliance. In addition, those who are functioning at Level VI assume that all humans have worth and value regardless of their societal status. Level VI ethical thinking occurred when Martin Luther King, Jr. and others said that segregation, while legal, was unethical. Segregation violated a higher law than that which was created by the courts. They were willing to disobey the law to bring attention to this issue and to bring about change.

**Theory Applications**

Kohlberg’s Theory of Moral Reasoning helps to provide an understanding of why people make the decisions that they do. As an administrator, it might be helpful to understand that not all persons have the same ethical reasoning as you. In addition, if there is too great a difference in the levels of reasoning, they might not even understand why you see your decision as ethical. Understanding Kohlberg’s ideas can also help you analyze your own decisions and determine your moral reasoning behind them. This ability should prove useful when you are required to defend your decisions. Why did you decide to act as you did? What was your reasoning?

There is another implication for knowing and understanding Kohlberg’s Theory. The implication occurs in patient/system relations. Think about your role as an HCA in society’s view. Society has granted that health care is a system of a high level of authority. Along with this authority comes an assumption of trust in the system. Patients must have faith that you are functioning at high levels (at least on Level IV) of moral reasoning when making decisions about their care and treatment. In other words, they expect you to have the ability to put their needs first and profit second. When evidence of actions that do not meet this standard is uncovered, the public can lose trust in the system itself. They can view the health care system, and you as its representative, of being unethical and untrustworthy. Once trust is lost, it is diffi-
Viktor Frankl (1905–1997)

Biographical Influences on His Theory

As a young man, Frankl demonstrated wisdom beyond his chronological age. While still in high school, he began a correspondence with Freud, who published his work. He had the courage to draft a book on his own view of psychology early in his career. But in 1942, Frankl, along with his new bride, brother, and parents, was arrested and taken to a concentration camp in Theresienstadt. His wife, parents, and brother later died in the camps.

Frankl survived the brutality of five different camps before his release. Instead of losing hope, he actually used this experience to test his theories of human motivation and conscience. His observations confirmed that those who had a sense of meaning and purpose kept their humanity even in this unbelievable suffering. His experience led to his lifelong work in what has come to be called meaning theory (logotherapy). He is author of many books, but the most well known is *Man’s Search for Meaning*, which has sold over nine million copies and has been translated into dozens of languages.

Concept Summary

First, Frankl believed that you are not just a body or a brain. You are a total person who has mind, body, and spirit. You are also unique in the entire universe and entitled to dignity. Your life has meaning no matter what your personal circumstances. As a thinking person, you are able to question and wonder about your purpose in life and what life means to you. Only humans can ask, “Why am I here and what am I supposed to do?” For Frankl, morality is also related to your sense of meaning. You make decisions to behave in moral ways for the sake of something in which you believe, are committed to, or love, or because of your relationship to God (the ultimate meaning).

When you do not feel a sense of purpose in your life, you will have emptiness, or an existential vacuum. You will tend to fill that void with, in some cases, alcohol or drugs; for others it is work, food, or power. For Frankl, “A lively and vivid conscience is the only thing that enables man to resist the effects of the existential vacuum” (1971, p. 65). What is a conscience? It is your ability to go beyond a situation and find meaning in it. You can then make choices that are ethical and affect more than your selfish needs. Your conscience is not infinite; it
CHAPTER 1  PRACTICAL THEORY

does not have absolute knowledge. It tries to find the best action to take in a situation. Because your conscience is a part of you, you can choose to make decisions that honor those things you value and avoid those things that bring harm.

Theory Applications

Can you see a connection here? It almost feels like you have closed a circle that goes back to the writing of Thomas Aquinas. Conscience is again part of your consideration of ethics. In the case of Frankl’s interpretation, you can use it to help you understand the meaning of your actions and choose the best action possible. Think about the word “choose.” By using this word, Frankl implies that because you choose your actions, you are responsible for them. In health care, the statement has profound implications. Each day you make decisions that can affect the health and quality of life of both patients and employees. You should make these choices based on as much data as you can obtain and after serious consideration. Basing your decisions on the best data available is a choice that might take more effort on your part, but it also demonstrates your willingness to be responsible for what you do.

WHAT IS ETHICS?

Now that you have reviewed summaries of the basic concepts of the Big 7, you are ready to define ethics in a professional and personal sense. Again, there are many authors who have attempted to define this word. If you refer to Figure 1 in the Introduction, you can see that ethics can be theoretical, community-based, organizational, or personal. As an administrator, you must be knowledgeable about all of these forms of ethics. For example, from a theoretical base, you can define ethics in terms of a theory such as deontology or utilitarianism. You can also clarify your understanding of the basic principles of ethics (see Chapters 2 through 4) and use them to guide your decision making.

Ethics can be defined as a way to examine or study moral behaviors. Of course, that definition is too general for your purposes and needs some clarification. Darr (2004) uses a complex definition that stresses ethics is more than just obeying the law. Law is the minimum standard that society approves for actions or behaviors; ethics is much broader and often much more difficult to codify. So, you could behave legally, but not ethically. You can probably think of many examples where a law has not been broken, but the lack of ethics has caused problems for a person or an organization.

The community establishes its sense of what is appropriate ethical behavior, and it can even vary within communities. Often, administrators
What Is Ethics?

are not aware of community standards and suffer career setbacks because of this ignorance. For example, if you are a hospital administrator in a large city, it might be acceptable for you to go to a bar after work and have a drink. In a small community, that same behavior might be seen as unethical, and even be reported to the Board of Trustees.

Monagle and Thomasma (1988) discuss ethics as patterns of behavior and values that are assumed. You can immediately see the problem with this definition based on the word “assumption.” Because you hold certain values, you might mistakenly think that others hold them too. This could lead to problems with expectations, communications, and actions.

Normative ethics are concerned with a general ethics code or decision-making pattern for a group or organization (Beauchamp & Childress, 2001). Other authors call this organizational ethics or “the way we do things here.” This form of ethics helps people understand the standards for acceptable behaviors within an organization. Taking the time to establish basic ethical standards for a health care organization is of great importance because of its power and influence. However, health care organizations are made up of people who have differing ideas about ethics. Can you see why establishing normative ethics for an organization is so important?

These authors also talk about professional ethics, which is part of the innermost circle of Figure 1. Guidelines have been developed by your profession to assist you in identifying expected ethical behaviors. For example, there are codes of ethics that have been developed for nurses, physicians, physical therapists, occupational therapists, and even massage therapists. In addition, as a health care administrator, you have guidance from the American College of Healthcare Executives on ethical behavior and policy development. There is even a self-assessment test to help you keep your ethics on track. You will be studying these codes later in this text.

Of course, ethics really comes down to you (the innermost circle in Figure 1). You must be aware of theoretical, community, and organizational ethics as you make daily decisions. You also have to be in tune with what your profession or professions require of you. However, in your daily operations as an administrator, you are ultimately the one who must choose the actions that you take. You might ask, “Isn’t ethics just doing what is right at the right time?” The answer is “yes, but ...” In health care organizations, what is right is not a simple matter. This is why you must develop your “ethical bottom line.”

First, think about the community in which you live and what it expects from you as a person in the health care system. You must also become more aware of the mission and values of your organization and explore the code of the profession or professions with which you are
CHAPTER 1  PRACTICAL THEORY

affiliated. Finally, you must think about your own values and ask yourself, “What is my true ethics bottom line? On what issues would I be willing to act even if it meant quitting my job?” This thought process should lead you to design a personal ethics statement that can assist in making the difficult decisions. The chapters in this book will help you to do this and to apply your ethics to your daily decision making. Your ethics actions must match your ethics words or you face being seen as a hypocrite.

Summary

This chapter should help you better understand the theory behind ethical decisions. You will see how these theories translate into principles in Chapter 2 through Chapter 4. In addition, you should be able to recognize the influence of these theorists in other chapters of the book as you explore how the community and organization view the practice of health care ethics. It is hoped that you will also integrate some of their thinking into your own ethics decision making as a practicing health care administrator.

Web Resources

The following are Web sites that provide additional information about the theorists in this text.

St. Thomas Aquinas
http://www.utm.edu/research/iep/a/aquinas.htm

Immanuel Kant
http://www.utm.edu/research/iep/k/kantmeta.htm

John Stuart Mill
http://www.utm.edu/research/iep/m/milljs.htm

John Rawls

Martin Buber
http://www.emanuelnyc.org/bulletin/archive/34.html

Lawrence Kohlberg
http://www.psy.pdx.edu/PsiCafe/KeyTheorists/Kohlberg.htm

Viktor Frankl
http://logotherapy.univie.ac.at/

References

Autonomy

“He alone is free who lives with free consent under the guidance of reason.”

—Spinoza

Points to Ponder

1. What are the key issues for the health care administrator with respect to informed consent?
2. How does HIPAA change the way you view confidentiality?
3. Is it ever appropriate to withhold the truth from a patient?
4. What is the significance of fidelity to the success of health care administrators?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- authorization
- competence
- disclosure
- ethicist
- fidelity
- informed consent
- reasonable person standard
- veracity
- voluntariness

INTRODUCTIONS AND DEFINITIONS

Autonomy is a major principle of health care ethics that is derived from the theories you studied in Chapter 1. In this chapter, you will explore the meaning of this principle and its application to health care practice.
Current concepts of autonomy stem from its Greek definition as self-rule and self-determination (Beauchamp & Childress, 2001). The health care system’s position on this principle is supported by Kant, Frankl, and others who believe that because people have unconditional worth and should be given respect, they also deserve self-determination.

To be applied, the principle of autonomy must assume that you are free from the control of others and have the capacity to make your own life choices. You also must have the right to hold views that are incongruent with those of the health care establishment. For example, if you are a Jehovah’s Witness and do not believe in blood transfusions, you have the right to refuse such treatment even when your physician recommends it. The word “choice” is a key element in this principle. How does this relate to your position in health care? As administrators, you must understand that people should be free to choose whether to be compliant with their physician’s instructions or not. They must also be able to make informed decisions about signing consent forms for surgery or other procedures without undue influence or punitive repercussions from medical staff. You will learn more about the complexities of autonomy as informed consent later in the chapter.

Autonomy is more than just making informed choices. It also is concerned with how individuals are viewed and treated within the health care system. If autonomy is an ethical principle for your organization, then certain standards should prevail. In this chapter, you will explore some of these standards including autonomy as confidentiality. You will also examine how the new Health Insurance Portability and Accountability Act of 1996 (Title II) (HIPAA) rules have increased the awareness of the need to protect this area. Autonomy as truth-telling is also included in this chapter; you will learn what telling the truth means in health care situations. Finally, you will explore autonomy as fidelity and what it means to keep your word to patients and employees. A summary will be included to reinforce the key concepts of the chapter. You will then be able to apply your knowledge of this principle to two cases that are based on real-world health care incidents.

**AUTONOMY AS INFORMED CONSENT**

Legal and ethical considerations come together when applied in the area of informed consent for treatment. Through case law and legislation, informed consent has come to be seen as the duty of physicians or their designees to obtain the patient’s permission for treatment. This permission should be given only after the patient understands the treatment and supports its implementation. Failure to obtain permission can constitute negligence or even lead to medical malpractice actions. From a larger view, informed consent is an ethical issue because it requires
respect for the autonomy of the individuals and their right to choose what is done to their bodies.

Autonomous consent is implied through a person’s actions. For example, if you make an appointment with your dentist and keep that appointment, it is implied that you consent to treatment. However, if a procedure must be used that is not routine, then there is an ethical (and often legal) duty to obtain specific written consent.

What is meant by informed consent? Beauchamp and Childress (2001) present a model that clarifies this term and serves as a basis for discussion. This type of permission to treat contains the preconditions of competence on the part of the patient to understand the treatment, and voluntariness in his or her decision making. It also requires disclosure on the part of the physician of material information including the recommended treatment plan. Finally, consent means that the patient is in favor of the plan and gives his or her authorization to proceed.

The idea of competence is not a simple one in health care. In general, it is assumed that adults are competent to make decisions about their health but children are not. However, adults can be in situations where they are not deemed to be competent. This includes incidents when they are unconscious, mentally ill, or under the influence of drugs. There are exceptions to the child rule, too. Children can be deemed to be competent when they are legally emancipated from their parents. In these non-routine circumstances, health care professionals can need additional guidance about informed consent, and the physician’s responsibilities through policies, procedures, and training programs that are provided by the institution in which they practice.

Voluntariness means that the person is not under the influence or control of another person when making a decision. This means that he or she is not threatened or forced into treatment. While this sounds bizarre, there are occasions when patients can think they are being forced into treatment by health care professionals or other parties. In even more rare occurrences, the patients are actually threatened to undergo treatment. Whether the situation is actual or perceived, these patients do not freely choose to participate in the treatment. The use of threats or the perception of a threat means that an autonomous decision by the patient is not possible.

Similarly, if a health care professional tries to manipulate a person into consenting to treatment, this negates autonomy. For example, suppose a researcher needs a certain number of subjects in order to maintain funding for his study. This researcher finds a suitable subject and promises him or her that there are benefits for participation in the study. The subject then signs a consent form, without knowledge of the researcher’s true agenda. This manipulation of study information is unethical and removes the voluntary element from the process of informed decision making.

Disclosure is a major element in both legal and ethical aspects of informed consent. It can appear to be a very simple thing to disclose
information about a patient’s condition, the methods of treatment, and alternatives for that treatment. However this does not always happen. Many states now require what is called a reasonable person standard with respect to what should be disclosed in order to obtain consent. This means that there is an obligation to present enough information so that a “reasonable person” would be able to make an informed decision about the procedure. Adhering to this guideline poses some ethical issues, particularly in sophisticated and often expensive research studies. If a researcher is too zealous in making statements about the anticipated benefits versus the risks of the study, the subjects might choose not to participate. This could lead to expensive searches for subjects or even a loss of funding for the research.

In order for patients to make an informed decision about their health care options, a recommendation must be made by the health professional. Recommendations must include all of the options available for the patient and the practitioner’s best assessment of the best choice. Even this part of informed consent is not without difficulty. For example, there are alternative treatments such as the use of herbs or holistic medicine that have proven to be effective but are not approved by the Food and Drug Administration or fully recognized by the medical community. If the physician does not support the use of such forms of treatment, he or she might not present these options to the patient. Another complexity of disclosure occurs in the case of managed care. The physician’s recommendation cannot be based solely on the covered treatments in the plan. The patient should be informed of the costs of other existing treatments so he or she can decide if he or she is able to pay for them if the treatments are not covered by his or her health maintenance organization.

Making efforts to ensure the patient’s understanding of the disclosures and the treatment plan is an ethics obligation if you are seeking informed consent. News about a medical condition and required treatment can evoke an emotional response on the part of the patient that affects his or her ability to make sound decisions. Therefore, requiring a signed consent too soon after such news might not be appropriate action. But, this delay can add time to scheduling of the treatment and cause a negative outcome.

Achieving understanding also requires comprehension of what is being presented. This is a challenge because consent forms are often full of legal and medical jargon and are written at a college reading level. Because the average reading level of Americans is between sixth and eighth grade, a true understanding of such forms might not be possible. Again, health care administrators have the responsibility to put policies, procedures, and forms in place that encourage understanding as a way to meet the competence aspect of autonomous consent. Checking the readability of such forms and having qualified personnel available to answer any questions is both good business and good ethics.
Finally, you must consider the patient’s decision to implement the plan and the appropriate authorization. This final step can require the use of additional personnel to verify that the patient fully understands the form and the procedures described therein when he or she gives consent to proceed. Even though nonphysician personnel are used during the process of obtaining informed consent, ultimately, the responsibility for this consent lies with the physician. So he or she must be willing to verify informed consent with the patient.

As you can see from the discussion, the issue of autonomy as informed consent is a complex one for the health care system. As an administrator, it is important for you to know your level of responsibility for ensuring that forms used to gain consent are understood, questions are addressed, and procedures are followed during this process. You also might be required to maintain proof of consent in various formats and to ensure that this proof is kept confidential and secure. This is part of your responsibility under the HIPAA laws.

### AUTONOMY AS CONFIDENTIALITY

Autonomy is also practiced when information about a person’s identity, family, health status, and treatment procedures is kept private. This aspect of autonomy also extends to information that you know about employees and their families. As a health care administrator, you have many duties when it comes to confidentiality, some of which extend into the legal realm because of the new HIPAA laws.

When patients enter the health care system, what is their expectation of confidentiality? Most believe that they have a right to privacy or to have control over access to their physical bodies, their health information, and their decisions. When patients choose to surrender some of their privacy and allow others access, they have an expectation that what is said or done will be kept confidential (Beauchamp & Childress, 2001). This expectation goes all the way back to the time of Hippocrates when physicians were cautioned not to disclose what was said to them in confidence.

Is there really absolute confidentiality in health care settings? The truth is that it can often be necessary to share private information about patients in order to effectively treat their conditions. Nurses, physical therapists, radiation technicians, and many others might need access to a patient’s information in order to treat him or her appropriately. Worthley (1999) suggests that this access should be granted only after some standards are in place for the use of the private information. For example, only those who have a legitimate need to know the information should have access to it. Safeguards need to be in place to ensure that medical information is protected from access by those who do not need to know it.
On the surface this sounds straightforward, but safeguarding confidentiality in today’s health care system is not as simple as a locked file cabinet. With the advent of the electronic record, the risk of inappropriate access to confidential information has greatly increased. This is part of the reason for the enactment of certain provisions of HIPAA that standardize the electronic record and provide safeguards for confidentiality. While none of these policies are foolproof, they demonstrate that efforts are being made to protect confidentiality.

There are additional problems involved in safeguarding confidentiality beyond those surrounding electronic records. Within the structural procedures at a hospital or clinic (Worthley, 1999), there are practices that can automatically threaten the patient’s confidentiality. For example, before HIPAA, it was customary to post patients’ names and procedures on a white board outside of outpatient surgery. While this might have been standard procedure and convenient for the staff, it could be devastating for patients when they realized that anyone who saw that board knew their impending procedures. This action is also a violation of the provisions of the HIPAA that deal with confidentiality. What about discussing the patient’s medical condition when he or she is in a semiprivate room? Only a curtain separates the patient from the other occupant of the room, so confidentiality is not protected. Every effort needs to be made to ensure that confidentiality is respected, but it can be difficult to accomplish.

Actions in the informal organization that can threaten confidentiality can be even more subtle. If your staff are not trained on how to effectively manage patient information, discussions about interesting cases can occur in the hallways, elevators, break room, or the cafeteria. Such conversations, while not intended to do harm, can be overheard by the patient’s family. It is your responsibility as an administrator to reduce the likelihood of such staff actions through appropriate policies, procedures, and training. In addition, you can conduct informal observations to evaluate how such training is being utilized; this has often been called “management by walking around.”

Patient confidentiality is not an absolute even with appropriate practices and procedures in place. There are occasions when the law or ethical practice makes such action necessary. Legally mandated exceptions to confidentiality include such things as reporting certain diseases, traumatic events such as gunshot wounds, and incidents of child abuse. In the case of mental health providers, there is a duty to warn others if a client threatens to be violent. This position is supported by the utilitarian theory that you have studied; it is based on the consequences of keeping that confidence versus the benefits of breaching it.

Other issues of confidentiality pose even more complex ethical challenges. For example, should employers have a right to your medical records? If so, can they use what they find in them to avoid hiring you if
you have an expensive pre-existing condition that will drive up their insurance costs? If you have a test for human immunodeficiency virus (HIV) and are found to be positive, should the physician or other health professionals tell your family even if you do not consent to have them informed? What if you are diagnosed with a genetic condition that could affect the health of family members? Should the physician tell your relatives even if you do not want it discussed with them? These questions are just a few examples of how complicated confidentiality can be when considered in its full ethical context. The decision of a patient to withhold information from his or her family can create some true dilemmas in the organization. As an administrator, you have to understand that such decisions are not always black and white. An ethics committee (to be discussed in a later chapter) can assist you with determining appropriate action in these cases.

There is another area to consider in respect to confidentiality. This concept goes beyond the realm of patient care. Depending on your position in the health care facility, perhaps you have access to very private information about your employees and their families. It is imperative that you recognize the need to maintain confidentiality with this information and not to share it with those who have no need to know. Because you are in a position of authority, violation of employee confidentiality might not only be a breach of trust, but might also cause you to lose your job. Therefore, it is important for you to be aware of the need to keep private information private.

### AUTONOMY AS TRUTH-TELLING

Should you always tell the truth? Kant includes truth-telling as an area that meets the categorical imperative and should be an absolute. Beauchamp and Childress (2001) consider it to be one of the obligations of health care. “Society cherishes truth telling because it is the glue of human community…” (Boyle, Dubose, Ellingson, Guinn, & McCurdy, 2001, p. 14). Can you imagine trying to do your work as a health care administrator if you could not assume that people were telling the truth? You would drown in “proof paperwork.” Contracts and verbal agreements would be all but impossible to negotiate.

So truth-telling or veracity is a key part of the business of health care. When patients interact with a person in the health care system, they have an assumption that they are being told the truth. Likewise, the practitioners must assume that truthful information is being given to them by their patients. This is the basis of trust that provides accurate information and underlies effective treatment decisions.

Given this right to truthfulness, you could assume that it is always ethically correct to tell the truth. However, health care presents situations where an absolute position on truth-telling might not be the best position. The utilitarian position on truth-telling is that you should always...
weigh the benefit against harm before disclosing the truth. Once this assessment is done, it might be more ethical to be cautious about disclosure or to tell the truth in pieces over time. What exactly does this mean?

Professionals in health care often have to give bad news and even news of impending fatality to patients. The full information about this news and the timing of full, truthful disclosure can be influenced by the age and emotional state of the patient and the family’s desires for such disclosure. For example, if a 90-year-old patient has been diagnosed with end-stage cancer, the family might not want her to know the full truth. They might feel that it is more ethical to deceive this patient and have her enjoy what time she has left. If the physician is aware of the family’s request, it can pose an ethical dilemma. Does the physician tell the family and not the patient? What does this mean to the patient’s right to know and to choose? Will the family feel that their trust has been violated if the physician tells the patient the truth?

There can be different standards about the scope of truth-telling when dealing with the diagnosis and the subsequent prognosis of a condition. Perhaps a patient can be given the full truth about his or her condition and treatment options. However, when it comes to what happens under treatment, practitioners can choose to give information in pieces over time so that the patient is not overwhelmed by too much truth (Beauchamp & Childress, 2001). This decision is justified as ethical because no one ultimately knows how well a person can do under treatment; or results are based on statistical data and not on human determination. In dealing with the truth in stages, providers do not erode the patient’s hope—which in and of itself can be a great motivator for treatment compliance and even healing. This type of truth-telling has the potential to challenge the trust between practitioner and patient, but it is sometimes practiced in the name of compassion.

Truth-telling is not limited to the clinical aspects of health care. Whether you realize it or not, as a health care administrator, you are in a position of power. This power can have an impact on those with whom you work, the patients whom you serve, and the larger community in which you live. Power carries with it the ethical responsibilities of truth-telling. In fact, the American College of Healthcare Executives Code of Ethics (Hoffman & Nelson, 2001) specifically addresses this issue and makes it part of your responsibility to your organization. This code will be described in greater detail in future chapters.

On the surface, this seems like an easy thing to do. However, there can be times when it is extremely difficult. For example, when there is a possible need to downsize the staff at your organization, do you tell the whole truth? If you do, there is a possibility that your best staff will seek employment elsewhere rather than go through the stress of this process. It is also possible that senior executives do not want anything
disclosed to protect their fiscal interests. So you might also find yourself engaged in stages of truth-telling, just like the clinical staff.

Even in daily interaction with staff, you must remember how powerful your words are and be careful in how you use them. Truth can destroy or enhance performance depending on how it is delivered. Consider your words carefully. This applies to both spoken and written communication. Both spoken and written words can have great emotional impact on others, but written words can come back to haunt you. Be sure to consider the text in your e-mails when considering truthful communication. In the business world, e-mail is not just a friendly exchange; it can be evidence of your truthfulness on any given issue.

Your silence can also provide a certain truth because it implies your consent. You must have the courage to speak your thoughts about an action or a decision even when it might challenge your career status. Finally, you must be aware that lying, while expeditious at the moment, might cause the end of your career. You have to keep track of lies and tell others the same lies to cover them up. Eventually, a lie can lead to a loss of integrity and even to the loss of your position (Dosick, 1993).

While truth-telling seems, on the surface, to be a straightforward aspect of autonomy, you can see that, with regard to health care, it is much more complex. There is power in the truth and you will be tempted to use that power in both positive and negative ways. It is wise to remember that the way in which truth is delivered (the message) is often as important as the facts (the content). Think carefully about the methods of telling the truth before you deliver the truth.

**AUTONOMY AS FIDELITY**

**Fidelity** means keeping your word to others, or promise keeping. In ethics it fits the Kantian view of the categorical imperative because it is universal. People want to have promises kept to them, so they should, likewise, keep their promises to others. Buber agrees with promise-keeping as part of autonomy because it respects the I-You relationship. Because you respect the individuality of each person, it is ethical to honor them by keeping your promises. Even the utilitarians agree with this aspect of ethics because it can provide the greatest good for the greatest number or avoid the greatest harm.

In business the idea of fidelity has long been an ethics standard. It used to be said that a man was as good as his word. Business deals could be accomplished with a handshake and only scoundrels failed to uphold them. Even in today’s business settings, fidelity is important because there is an assumption that contracts, both oral and written, will be honored. This assumption permits services to be rendered and
payment to be made without undue concern about fraud and abuse. The vendors with whom you do business count on your fidelity as part of their business.

You are acting in a trust-based business. This means that fidelity is expected by the community as well as your business contacts. The community considers it a norm that you will keep your word to treat patients with dignity and fairness, and provide care that is appropriate and effective. This promise is reflected in Patient Bill of Rights documents that have been created by the American Hospital Association and other organizations. These documents assert that, not only is fidelity an ethics duty, but it is also a right for all patients and that you will honor those rights.

This ethical imperative is also part of your mission statement that can be used by the community as an indicator of your business position. For example, if you use your mission to advertise your services, you have an obligation to honor those promises. For example, suppose a hospital uses the mission statement “Grant Hospital: Demand Excellence” in its television, print, and radio campaign. The employees at Grant could conceivably be inundated with patients “demanding” all kinds of services and special treatment based on these ads. Perceived promises would not be kept and employees and patients would feel deceived.

This obligation of fidelity means that you must create a mission statement that is specific enough that you can actually meet it but not so crass as to offend your community. For example, you would not want to have a mission statement that says “Profit Is Number One” because the community thinks that they, the patients, should be your number one concern. Likewise, your mission statement should not be something vague like, “Optimum Health for All People” because it is a promise that cannot be met. Remember to review your mission statement frequently so that it truly reflects your commitment to service and ethical behavior. In addition, you are obligated to make sure all employees understand what fidelity toward this mission means in their daily work behaviors.

Fidelity is also an ethics obligation to your employees. If you make promises about any aspect of the employment relationship, you must honor those promises. Be careful about perceptions versus actualities. Your words are powerful and can easily be viewed as a promise by employees. This is why you need to be aware of what you say and when you say it. For example, if you are discussing benefit changes with employees, you must have correct information on what those benefits will be, what they will cost, and when they will be in effect. Misinformation can lead to situations where trust can be broken. This is especially true when major changes are occurring, such as during a merger or buyout. You must be able to act on any promise that is made, so use your words appropriately.
As you have seen in earlier sections, maintaining autonomy through fidelity is not a simple matter in health care. Violations of promise-keeping occur for many reasons. Perhaps the most obvious is the potential conflict of keeping your word to the patient while also being loyal to third-party payers’ demands. Are you loyal to those you serve or to those who pay for services? In health care, these are often two different groups. Payers might require gate-keeping and other functions to provide appropriate levels of care at the least amount of expense. However, when managed care organizations pay bonuses to physicians for controlling this access, an ethical problem can occur. Would the physician be tempted to cut corners on treatment when 10% to 20% of his or her salary is at stake? Should the physician disclose the bonus arrangement to the patient? Gate-keeping and other fiscal arrangements are appropriate for the bottom line but could present real ethics problems for patient fidelity.

There are other incidents where fidelity to patients can be challenged. For example, when a health care professional works in a prison setting, there can be conflict of fidelity between the interests of the patient and those of the institution. Certainly, when the legal system is involved, there might be a need to violate patient fidelity because of a subpoena or other action. In areas of public health such as in the prevention of epidemics, fidelity to the overall community can take precedence over fidelity to the individual. This is also true in the military where different rules exist for physicians and other health care professionals. Using knowledge and skills to keep soldiers “combat ready” and regarding them as “government property” can appear to be an issue of fidelity to the organization over that of the individual.

What is your responsibility for fidelity as an administrator? Certainly, you need to be aware of the impact of mission on fidelity and do what you can to see that the promises of your mission are fulfilled. This can entail periodic reviews of the mission statement, training efforts, and observation to see if the mission is being met. You also have an obligation for fidelity where any contract is concerned. This means that you should understand the word and the intent of the contract before you sign it. You must also be able to communicate the features of the contract to those that the contract will affect. In the case of third-party payers, this communication effort includes patients as well as employees. Finally, using the Kantian question of, “If I were the patient or the employee, would I want this promise kept to me?” can guide you in making appropriate decisions about the fidelity aspect of autonomy.

Summary

Autonomy as a principle of ethics assumes a certain level of respect for persons and their ability to take actions that affect their health.
includes issues of informed consent, confidentiality of information, truth-telling, and promise-keeping. On the surface, autonomy seems to be a basic principle that should remain inviolate but, in health care, it is never this easy. There are situations and relationships that challenge the principle of autonomy and make it difficult to follow on a consistent basis. As an administrator, your challenge is to be aware of these challenges within your organization and to do whatever you can to maintain the right of autonomy. The community and your employees expect this of you.

**Cases for Your Consideration**

**The Case of the Misguided Relative**

As you read this case, consider the following questions. Responses and commentary will follow the case.

1. What aspects of autonomy were violated in this case?
2. Why did Ms. Jamie Jenson make the telephone call?
3. What was the impact of this action on the family?
4. What action could the family take?
5. If you were the administrator of this clinic, what action would you take?

**Case Information**

*The Scene:* The office of Dr. Randy Williams, internist, in Smalltown, USA.

*The Situation:* Mr. Basil Carpenter has been suffering from problems with urinary insufficiency and frequent urination so he went to his physician, Dr. Williams, for evaluation. Dr. Williams performed an ultrasound in the office and saw a shadow in the kidney area. He explained to Mr. Carpenter that this might be a tumor and that a consultation with a urologist was needed. An appointment with Dr. Samuels would be made as soon as possible.

While Mr. Carpenter was not thrilled to hear this news, he knew that further tests were needed before he should be worried about his situation. He accompanied Dr. Williams to the front office where instructions were given to Ms. Jamie Jenson, the receptionist. She was asked to make an appointment with Dr. Samuels so that he could evaluate the shadow on the kidney. She also needed to make a follow-up appointment for Mr. Carpenter. After reviewing the chart, she made the call to Dr. Samuels, scheduled the follow-up, and gave Mr. Carpenter his appointment cards.

However, Ms. Jenson was the cousin of Mr. Carpenter’s ex-wife and this news was just too good to keep. As soon as Mr. Carpenter left the office, she called her cousin and told her that Basil had a kidney tumor.
and it might be cancerous. On hearing this news, Basil’s ex-wife called their son, Hamilton, and told him that there was a problem with his father; he had cancer of the kidney and might not live.

Hamilton decided to get further information about his father’s status and called Basil’s current wife, Sandra. His first question to her was, “Does Dad have his will and finances in order?” Sandra responded, “Why are you asking this?” and was told that Ms. Jenson from Dr. Williams’s office said that Basil had kidney cancer and was terminal. Sobbing, Sandra hung up the phone just as Basil walked in the door. It had only been 30 minutes from the time he left Dr. Williams’s office when he walked into hysteria of unknown origin.

Responses and Commentary on Questions

1. What aspects of autonomy were violated in this case?

   It should be noted that this case occurred before the HIPAA rules were in effect. However, it clearly is a case of breach of confidentiality by a nonmedical staff member. Because Ms. Jenson needed to provide referral information, she had the right to access the chart. However, information that she found, no matter what the relationship with the patient, should have been kept confidential. Kant would be very upset by this situation because it violated the categorical imperative for confidentiality. Imagine if this same incident happened to Ms. Jenson instead of Mr. Carpenter. How would she feel? Yet, she did not even consider this question before she called her cousin. The utilitarians would also find this action inappropriate because it had the potential to cause the greatest harm to the greatest number, and should have been avoided.

   Comment: Access to confidential records and the temptation to violate confidentiality can be enhanced by the self-profit motive. Suppose the patient was a major celebrity and the condition was erectile dysfunction. The temptation to leak this information to the press for profit might sway a person’s sense of ethical obligation. This might sound like an exaggeration, but similar incidents occur frequently. For example, think about the release of the medical records of diet guru Dr. Atkins’s medical records to the press and the controversy it caused.

2. Why did Ms. Jenson make the telephone call?

   Ms. Jenson could have had several motivations here. Perhaps she saw herself as altruistic by giving the family important information that might not be shared by the new wife. Perhaps, she saw it as an issue of family loyalty and a duty to honor the family’s right to know. She might not have even realized that she was violating Basil’s right to confidentiality because no one ever told her not to
do this. Of course, the motive could have been more purulent and she could have succumbed to the need to share gossip that was truly juicy.

Comment: As an administrator it is important to consider that everyone who has access to the medical record is important to the chain of confidentiality protection. Often persons who are not on the clinical side of patient treatment are forgotten in this important area. Receptionists, office managers, and even custodians might have access to sensitive materials more than you realize. Training and monitoring of policies and procedures is a must.

3. What was the impact of this action on the family?

In this case the family includes an extended network of individuals. First, you need to consider Ms. Jenson—who just put her job in jeopardy to inform her cousin of some family news. We will deal with her consequences in later responses. You must also consider Basil’s ex-wife, who was upset enough to contact their son, Hamilton. How do you think she was feeling? Basil is her son’s father and his loss could be very painful. Of course, you might also wonder why she called Hamilton when she did not have the whole story about Basil. Perhaps less than altruistic motives were in place.

How about Hamilton? He received this shocking news from his mother. Perhaps he was upset and concerned about his financial future. Of course, he too had the option of waiting for the full story before he called Sandra. You might wonder about his motivation and his response to the news, but you cannot deny that he was affected by this misinformation and added to the chain of grief that it caused.

Poor Sandra. She had waited for Basil’s return from Dr. Williams’s office with concerns about his health. Then she got the telephone call from Hamilton. The news shocked her but also made her furious. How did Basil’s ex-wife know about his condition before she did? What right did Ms. Jenson have to share this information with Basil’s ex-wife before she even knew it? Just how bad is the situation? Will she lose her husband and the father of her children? It is no wonder she is crying.

How about Basil? Can you imagine walking into this situation? He had been given potentially frightening news but decided to put it in its proper perspective until more information was known. He knew that he would have to tell his family but did not want to upset them too soon. Despite his sensible nature, he must have had some fears in the back of his mind. He wondered, “What will happen to my family if I am not around?” He walked in the door to chaos. Sandra was crying and he did not have a clue why. Imagine how angry and upset he was.
**Cases for Your Consideration**

*Comment:* Sometimes it is difficult for health care personnel to understand how much of an impact their actions have on others. This case is an example where an entire family was affected by the actions of one health care team member, but there are many incidences where whole communities can be affected. Health care professionals must always be aware of their power and use it ethically.

4. **What action could the family take in this situation?**

Minimally, Basil should contact Dr. Williams personally and inform him of what took place. This would allow the physician to take appropriate action in his practice and deal with Ms. Jenson. Dr. Williams could also apologize to Basil for what happened and assure him that it would never happen again. If Basil was so inclined, he could contact his attorney to see if there were grounds for suit.

What actually occurred in this case was very interesting. Sandra accompanied Basil to his appointment with the urologist. She told the specialist that she did not want the records released back to Dr. Williams. She also asked that they be stamped, Confidential. When she was asked the reason for her request, she informed the urologist of the events. He was upset for the family and promised to honor Sandra’s request. He also spoke to Dr. Williams about the situation. Shortly after this Basil received a telephone call of apology and numerous statements in the mail about new protection of confidentiality policies in Dr. Williams’s office.

5. **If you were the administrator of this clinic, what action would you take?**

First, the minute you received the information about what transpired, you would have the obligation to investigate. You would document what the family told you about the situation. It would be important to remain calm, listen attentively, and provide assurance that action would be taken. Next, you would need to speak with Ms. Jenson privately to hear her account of what happened. You might also want to contact your legal counsel to get his or her advice on the best course of action. Once all of the information has been obtained, you would have to confer with Dr. Williams about the situation. He could decide on immediate termination or some other form of action with regard to Ms. Jenson.

This action would deal only with the immediate situation, however. To prevent future incidents of this nature, you would have to review your current policies and procedures to make sure they are clear about confidentiality and what it entails. You would also need to review all HIPAA rules and regulations to be sure that you are in compliance with those standards. New policies or clarifications would have to be written if they are needed.
CHAPTER 2  AUTONOMY

In addition, you would have to determine that the current staff understand the policies and how they are to be implemented. You might want to have an in-service education meeting to review confidentiality procedures with staff. In addition, you might consider doing some nonintrusive observations to see if procedures are being implemented. These actions would help you to prevent any future legal actions regarding the violations of confidentiality.

The Case of the Self-Serving Surgeon

As you read this case, consider the following questions. Responses and commentary will follow the case.

1. What aspects of autonomy were violated in this case?
2. Why did Dr. Schwartz make these decisions?
3. What was the impact of this action on Mr. Johnson?
4. If you were the administrator of St. Dismas Hospital, what action would you take?

Case Information

The Scene: St. Dismas Hospital is a 150-bed facility located in Bigtown, USA.

The Situation: St. Dismas is known for its surgery services and Dr. Schwartz, a thoracic surgeon, is one of its highest producers. In fact, one member of the financial team called him a “one-man revenue stream.” He has several pre-surgical procedures that he feels are necessary to ensure the success of his surgery.

Questions were asked about HIV and hepatitis as routine items on all surgical consent forms at St. Dismas. In addition, a battery of tests was conducted to assist in treatment, but a test for HIV or hepatitis is not included in the battery. All patients must sign a written consent for this battery, which is then reviewed by Dr. Schwartz. All of this is appropriate action. However, once the consent was given, Dr. Schwartz ordered additional tests including one for HIV and hepatitis. Based on the results of these tests, he altered his gowning and gloving procedures. In other words, if he found a positive result in the tests, he gowned differently. The positive result was also a clue to Dr. Schwartz’s surgical team that they had a “hot one” and should take appropriate action. After surgery, he informed his patient of any positive results that they needed to seek treatment for HIV or hepatitis.

This practice did not seem harmful to anyone, and the staff appreciated Dr. Schwartz’s action. However, when Mr. Johnson was informed of his positive HIV status after his surgery, he begged Dr. Schwartz not to tell his pregnant wife. He was afraid that she would leave him because of his behavior and his illness. Dr. Schwartz agreed to keep this information to himself. His decision to withhold this information brought
gratitude from Mr. Johnson, but in doing so the surgeon prevented the pregnant wife from obtaining the necessary testing and potential treatment for her unborn child.

**Responses and Commentary on Questions**

1. What aspects of autonomy were violated in this case?

   First, you can see that this case violated the intent of informed consent when the surgeon ordered tests that were not on the consent form. The patient had no knowledge that additional tests were performed or the reason why they were done. The real need for the tests was not to benefit the patient but to protect the surgeon and his staff. For future purposes, Dr. Schwartz amended the consent form but did not spell out the reasoning for the additional tests.

   In addition, there was a potential violation of the truth-telling aspect of autonomy when the surgeon informed his patients of their HIV or hepatitis status after their surgery. Because they learned the truth after the fact, they did not have the whole picture of their status when they made their decisions about surgery. In addition, Dr. Schwartz caused an additional ethical problem when he promised not to tell Mr. Johnson’s wife about her husband’s HIV status. Dr. Schwartz was caught between his fidelity to the patient and the need to tell the truth. By failing to share the truth with the wife, or encourage the husband to do so, he actually put two lives in unnecessary jeopardy.

   From a Kantian view, the surgeon failed to treat patients as he himself would have liked to be treated. While his intention might have been to protect his staff and himself from risk, he neglected the right of patients to have full information before their procedures. Buber would say that the patient was considered to be an “it” and not given the minimal “I-You” status. This makes the decision inherently unethical. Finally, the utilitarians would suggest that the surgeon did not weigh all of the benefits versus consequences in this situation. The benefit was clearly for the staff and not for the patient.

   **Comment:** Some would say that if no harm is done, then an act is ethical. This situation shows you what happens when the letter of the law and ethical judgment is stretched, albeit with good intention. While the surgeon protected his staff, he caused potential harm to others. In the long run, he might have actually harmed himself if his actions ever became known.

   Of course, correct action in the first place would have avoided these ethics violations. Failing that action, Dr. Schwartz should have insisted that Mr. Johnson inform his spouse so that appropriate treatment could be given. His powers of persuasion could have
been used to influence Mr. Johnson to do what was best for his wife and child.

2. Why did Dr. Schwartz make these decisions?

Dr. Schwartz might have had his own version of altruistic motivation in adding the blood tests to the lab reports, so that he and his staff could gown accordingly. He might have seen this as a way to protect his ability to support his family and produce income for the hospital. He also might have seen himself as an ethical practitioner because he disclosed the patient’s status to him after the procedures. After all, what did it hurt if the patient was told in the end?

3. What was the impact of this action on Mr. Johnson?

Obviously, Mr. Johnson is devastated by the news. He had just completed major surgery only to be told that he also had a terminal disease. He certainly is in a state of high anxiety and fear. Perhaps this is why he asked Dr. Schwartz not to tell his wife about the situation. However, if he does not tell her himself, then his wife will not be tested. The result could be the potential loss of two additional lives.

4. If you were the administrator of St. Dismas Hospital, what action would you take?

If you are the administrator of St. Dismas, you now face some major problems caused by this situation. First, the altering of a medical order is not only an ethical issue, but it is also illegal. You are also going to be in trouble with your HIPAA standards on several counts. To make matters worse, if Dr. Schwartz also failed to report any of these cases to the proper public health authorities, you have even more worries.

How would you handle this? Obviously, you are going to have to conduct a careful and thorough investigation. This will require consultation with the Medical Chief of Staff, the Chief of Surgery, the Chairperson of your Board, and your attorney, among others. Your investigation might lead to the dismissal of not only Dr. Schwartz, but others who knew about the practice and did not report it. While necessary, this action could not only impact your revenue streams, but it could also tarnish the trust that has been built in the community.

You also have an ethics issue regarding Mr. Johnson and his family. You will need to consult with your attorney, your hospital ethics committee, and perhaps an ethicist (expert on ethics) to assist you by making a recommendation for action. You might want to consider contacting Mr. Johnson and discussing the need to inform his wife about his condition. You could offer to have appropriate staff assist him in telling her about his medical status and her treatment options.
However, your attorney will be concerned that your action, while protecting the patients, does not cause undue damage to the image of St. Dismas. Finally, to avoid this problem in the future, you might consider adding HIV and hepatitis testing as part of the routine tests for all surgical candidates. While this might add to your overall costs, it can serve to protect patients and staff. In addition, it will provide a complete picture of a patient’s health status before surgery. As you can see, this is a tall order, indeed.

Comment: From this discussion, you can see that the actions of one health care professional, no matter what the motivation, can have grave implications for the entire organization. To prevent such actions, you must be aware of the current policies and procedures with respect to informed consent, truth-telling, and fidelity. Those policies must also be evaluated against those mandated by HIPAA and revised so that they meet or exceed the standards. Further, it is not enough to have paper standards. You must take the necessary action to ensure that staff know the standards and act on them. This might include more than just an annual in-service program for review.

In this case, it is worth wondering how many people knew what was happening and failed to report it. Fear of taking action against such a high revenue generator might have been a motivation. Your organizational climate needs to be such that “knowing but not telling” is not the informal policy when ethical and even illegal actions occur. You will find more information to guide your thinking about organizational culture, how it influences ethics practice, and your responsibility as an administrator in later chapters.

Web Resources

The following are Web sites that provide additional information about areas in this chapter.

General Information on Informed Consent and Truth-Telling
http://sprojects.mmi.mcgill.ca/ethics/X/topics/truthtelling/truthtelling_main.htm

HIPAA Information
http://www.hrsa.gov/website.htm

Patient’s Bill of Rights (AHA)
http://www.hospitalconnect.com/aha/about/pbillofrights.html

References

CHAPTER 2  AUTONOMY


CHAPTER 3

Nonmaleficence and Beneficence

“Love and kindness are never wasted. They always make a difference.”

—Barbara De Angelis

Points to Ponder

1. How does the principle of nonmaleficence affect the health care administrator’s role in the organization?
2. How can you avoid causing harm to employees?
3. What does the principle of beneficence have to do with operating a health care organization?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

beneficence  nonmaleficence

INTRODUCTION AND DEFINITIONS

This chapter presents two parallel principles of ethics: nonmaleficence and beneficence. Some ethics writers view these principles as inseparable cousins. Others argue that nonmaleficence is the strongest obligation of the two. Whatever the relationship, these two areas are central to a trust-based health care system because they are assumed by society
CHAPTER 3  NONMALEFICENCE AND BENEFICENCE

to be its pillars of practice. This has been the case as far back as Hippocrates, who recognized these duties in his oath of practice.

Just what do these words mean? Nonmaleficence involves an ethical and legal duty to avoid harming others (Beauchamp & Childress, 2001). It is based on the Latin maxim *Primum non nocere* or “First, do no harm.” This principle involves areas of health care practice including treatment procedures and the rights of patients. In addition, it has an impact on how you treat employees in your practice as a health care administrator. You will read more about these applications in this chapter’s section on nonmaleficence.

In health care, you go beyond avoiding harm to people. Your obligation is to create benefit and contribute to optimum health for individuals and the community at large. This obligation is called beneficence. Beneficence includes the obligation to help those in trouble, protect patients’ rights, and provide treatment for people who need it. Kantians agree that these obligations exist because you are dealing with the basic needs of humanity and because all people have value. However, in day-to-day health care decisions the utilitarian view of beneficence is often used. This involves balancing benefits of a health care decision against its harms. Avoiding the absolutes of Kantian logic, practice or policy decisions are made on this reciprocity. You will read more about beneficence and its implications for you as a health care administrator later in this chapter.

■ NONMALEFICENCE IN HEALTH CARE SETTINGS

First, do no harm. How can this be part of the principles of ethics in today’s technology-centered health care system? Do you not have to cause patients pain and suffering to cure them? Should you not use invasive diagnostic tests and blood work to provide optimal care? What about the emotional pain of receiving a diagnosis? Certainly this First, do not harm does not mean that you cannot ever cause harm to patients in order to treat them. Sometimes harmful action is necessary, but it should never be automatic. The benefits that you provide through your procedure should outweigh the suffering that you cause.

This principle has been upheld in both the ethical and legal practices of health care. Using utilitarian logic, the benefit of procedures is balanced against the harm. If there is greater benefit, the act is viewed as an ethical one. In fact, you have a duty to provide appropriate care to avoid further harm to the patient under what some legal texts call a due care standard. This basically means that you have taken all necessary action to use the most appropriate treatment for the condition and have provided that treatment with the least amount of pain and suffering possible. From an administrative standpoint, the care has been pro-
vided by professionals with appropriate levels of education and training. Policies for safety and protection of the patient’s physical health and dignity are applied. Infection control and other environmental practices are also part of the process of providing care and avoiding harm. Therefore, your patients receive care with a trust that it will not cause them harm even if some pain and suffering is involved.

Like many other areas of health care, nonmaleficence is complicated when advanced technology is part of the regimen. Issues around withholding or withdrawing life support, extraordinary measures, and death with dignity involve decisions about avoiding further harm to the individual. For example, health care professionals and family members seem to be more comfortable with withholding (i.e., not starting treatment) than withdrawing it. Somehow what has come to be called “pulling the plug” seems more harmful to the patient than not starting the technology to support life. The line between extraordinary and ordinary care has become murkier with the advent of advanced life-sustaining technology. The recent Terri Schiavo case is an excellent example of this level of complexity. It used to be that care when there was no hope of benefit was avoided. However, family members, educated in the marvels of modern medicine, changed their view. They might see what used to be called extraordinary measures as ordinary and appropriate for their loved one. Even some physicians who see death as a failure might advocate for care that prolongs some form of life but increases the suffering of the individual.

How does your work affect nonmaleficence for patients? Of course, you are not actually treating the patient, but you create an environment where this principle can be applied. For example, if advance directive policies are not in place and are not clearly written, you will probably be involved in policy development or refinement. If they are in place, you certainly will be involved in making sure that they are implemented appropriately. This responsibility will include periodic staff education so that staff members are clear about their responsibilities and actions. In addition, you might be working closely with an ethics committee who can advise you when challenging situations occur.

**Nonmaleficence and Staff**

The application of the principle of nonmaleficence is not restricted to patient treatment. It also must be considered when dealing with any member of the health care staff. You have an ethical obligation to provide a working environment that is safe and does not harm your employees. Such an environment allows for discussion of concerns without fear of reprisal. It should also be a positive environment where values are respected and employees can do their best work on behalf of the patients they serve (this is the I-You relationship). This environment should be free of harassment, imposition, and discrimination for all employees regardless of their status in the organization.
CHAPTER 3  NONMALEFICENCE AND BENEFICENCE

Creation of a positive environment can go a long way to ensure the implementation of the principle of nonmaleficence for employees. However, situations can occur that are potentially a violation of this principle. Certainly downsizing has the potential to cause the staff great personal and professional harm. How can you implement a layoff plan and cause the least amount of harm to employees? The American College of Healthcare Executives (ACHE) gives you some assistance through its Policy Statement—Ethical Issues Related to a Reduction in Force (Hoffman & Nelson, 2001). This statement urges you to consider both the long- and short-term impact of this decision, not only on those who will lose their jobs, but also on those who will remain in the organization. Survivor guilt can often be destructive to a positive workplace and productivity.

The ACHE also stresses the need for frequent and accurate communication with all those involved in the layoffs and the provision of as much support as possible for those who lose their jobs. Often administrators try to avoid communication about layoffs because they fear disruption and loss of productivity. In keeping information from affected employees, they are trying to balance their view of benefits versus harm. Knowledge of what is to happen is kept to a chosen few. Inevitably, the rumor mill will take over for the void in accurate communication and make the situation worse. Even though it might seem to make your burden easier in a difficult situation, silence is truly not golden and can cause unnecessary harm.

It is equally important to remember those who remain after a layoff. There can be an administrative attitude of “You should think yourself lucky to have a job” and a lack of empathy for the feelings of survivors. This attitude causes unnecessary harm because it fails to acknowledge the human reaction of “Why them and not me?” Care should be taken to acknowledge what has occurred and allow time for processing the feelings associated with it. This can be done through several channels of communication including meetings, newsletters, and e-mails. In addition, communication needs to be ongoing regarding workload expectations and the potential for any future reductions in force.

As an administrator, you will be dealing with diversity on many levels. Your staff are educationally diverse in that they represent a range of credentials from a GED to an MD/DO. They are also professionally diverse because they come from many different professional backgrounds, each with its own culture. They can also be ethnically diverse because they represent different cultural traditions and experiences.

Your ability to recognize this diversity, honor its differing values, and still administer a cost-effective organization will certainly pose a challenge. You must review your policies and procedures with respect to diversity and make sure that they are designed to protect differences and decrease the potential for harm. For example, you need to make it
very clear that discrimination, harassment in all forms, and sexual imposition are not tolerated. Appropriate steps need to be in place and enforced when violations occur. Looking the other way when violations occur, while seeming easier in the immediate present, has a great impact in the long run. Staff will come to believe that you condone behaviors that cause harm by your silence and lack of action.

Another staff issue related to nonmaleficence that you must consider is what has been called workplace bullying. Workplace bullying is a form of psychological violence that can cause great harm to staff and their families. Bullying involves aggressive behaviors toward employees including spreading untruths, social isolation, constantly changing work expectations, assigning unreasonable workloads, publicly belittling the opinions of others, and intimidation. Bullying manifests itself when there is a pattern of such behaviors.

American employees do not have any legal protection against this form of aggression as they do with racial and age discrimination or sexual harassment. In fact, they might even see this as “business as usual,” because over 80% of bullies are bosses. Bosses might see this as good management and a way to get rid of those who do not agree with their management style. This lack of understanding of effective management behavior is part of the reason why bullying is so prevalent. Some experts believe that one in five employees will experience it in the workplace.

The impact of bullying on staff can be profound. First, individual employees sometimes actually take responsibility for the bully’s behavior. They work harder, put in longer hours, and try to prove that they are valuable. This leads to increased stress levels and can take its toll on overall family life. However, these efforts usually fail to stop the aggression and can actually make the bully feel more powerful.

Next, the work force might begin to experience psychological symptoms such as loss of confidence, depression, and helplessness. Physical symptoms might also occur including headaches, panic attacks, and hypertension. If they question the treatment they are given or take action of any kind, they can be accused of insubordination. Fellow employees try to avoid being associated with the victim, so that they do not become the bully’s next target. They can even join in the aggression to stay on the bully’s best side.

As you might imagine, the workplace soon becomes unhealthy and productivity is decreased. Victims of bullying can become absent from work more frequently because of physical problems or the need to avoid the bully. They can lose their motivation to provide high quality service and just go through the motions. These actions contribute to a loss of productivity. Morale is decreased as others see the bully’s actions and wonder if they are next. Finally, turnover rates can increase as the victims choose to resign and move to another job to avoid the situation. A stereotype of the phenomenon of workplace bullying is that it
occurs only in male-dominated professions or corporate settings. However, research has shown that the top three professions for this behavior are the female-dominated fields: nursing, education, and social work.

What should your role be in preventing workplace bullying and the harm that it causes? First, assess your own actions and communications with staff. How do you treat people whose personalities do not agree with yours? What do you do about any needed disciplinary action? Do you keep information confidential or are you part of the gossip mill? These questions and others need to be answered to be sure that you are not a bully boss.

You should also be committed to a safe and healthy workplace for all employees. This means that you need to have established policies that make it clear that all types of aggressive behavior are inappropriate in your workplace. This includes the range of behaviors from bullying to sexual harassment to physical violence. Education is critical here so that administration and staff can identify these behaviors and know what to do if they occur. Providing examples through case studies or even role plays helps to clarify. There should also be a confidential way to make a complaint about bullying without fear of reprisal. All complaints should be taken seriously and investigated as promptly as possible to avoid re-victimizing the victim.

■ BENEFICENCE IN HEALTH CARE SETTINGS

Beneficence is another principle of ethics that is expected to be a given in a health care setting. Patients assume that you will act with charity and kindness and have their best interest at heart. Without this element of trust, it would be very difficult for them to be treated by practitioners, especially when such treatment often requires embarrassing, painful, or even life-threatening procedures. However, practicing beneficence means that health care personnel must make an active decision to act with compassion. This decision requires that they go beyond the minimum standards of care and consider the patients’ needs and feelings. It also requires that they communicate compassionately with the patient about what is going to happen and why the treatment is necessary.

Delivering bad news is never easy, but it does not have to be brutal. An example of active beneficence can be as simple as holding a patient’s hand during a painful procedure. It can also be more complex such as taking the time and effort to go beyond what is necessary to assure that a patient can receive appropriate care post-discharge. It can also involve the entire organization through community service projects that have nothing to do with profit, but everything to do with compassion for the community.
Making the decision to be actively beneficent fits well with Buber’s I-You and, even in some cases, I-THOU relationship. It acknowledges each patient as a unique individual who has worth. From a business standpoint, it increases the organization’s positive image and level of trust in the community. However, it is not without a price. It is not easy to practice this principle on a daily basis because it requires a spirit of giving that is not always rewarded. Think about the real business of health care. You often see people at their worst, when they are in pain or deep grief. You also see things happen to people that others in the community never see and do not understand. Suffering and dying are part of your professional life.

The real beneficence challenge is to consistently treat patients with compassion even under these stressful circumstances. It takes a good deal of effort and training to be able to accomplish this goal on a daily basis. Often personnel are emotionally exhausted at the end of the day and experience what has been called compassion exhaustion or burnout. They feel like they simply cannot give any more. Yet, the next patient still expects the same level of caring received in the previous encounter.

It is important to remember the effort required to provide active beneficence and do what can be done to foster it among staff. It can be as simple as telling staff members how much you appreciate their efforts. It might include publishing in the newsletter (with the patient’s permission, of course) a thank-you note from a patient or the family written to the staff. It can mean watching the amount of overtime hours worked and allowing staff enough flexibility to actually use their vacation time for vacation. Some institutions even use rewards programs with various titles like “Caught You Caring.” They provide cash rewards to staff who have done something that demonstrates active beneficence. Their photographs can be placed in the lobby. (A word of caution: While some of these ideas sound like great ways to boost staff morale, they are not always well received by patients. Some patients feel that staff should not have to be “caught caring.” They assume the staff will be caring at all times.)

Beneficence also includes the planning function of an organization when using cost/benefit analysis for decision making. In this model, there is an attempt to balance community or business benefit against potential harms. It seems to be useful for many types of health care organizations with differing financial structures and can also be found in public health organizations. This system would certainly be supported by utilitarians, who see ethics as the greatest good for the greatest number. However, cost/benefit analysis as a decision-making model is sometimes difficult to implement effectively. It requires time for accurate data collection, openness to discussion, and the application of the
principles of ethics to final decisions. Generally, this extra effort is well worth it because the organization can justify its actions to its board and community at large. You will learn more about beneficence in decision making in a later chapter in this text.

Beneficence and Staff

As an administrator, you should strive to have a climate of caring in both your formal and informal organization. While you cannot guarantee that your employees will always practice active beneficence, you can work to create a culture where this behavior is reinforced. The way in which employees are treated in the organization can do much to create this culture of compassion.

A compassion deficit can occur when patients are provided active beneficence, but employees are not. The message taken by employees is that they do not matter in the organization. They can be replaced at any minute. It is easy to see that this impression does not foster the motivation to go beyond the minimum requirements in caring for patients or for each other. The organization becomes a place to do one’s time and hang on until retirement.

Your behavior and attitude as an administrator can help you prevent such attitudes from having a negative impact on your organization. You can use your power to increase the dignity and growth of staff (Worthley, 1997). For example, you can choose to praise your employees in public for the work that they do, rather than just assume that it is their job to do well. If corrections need to be made, you can choose to do this in private and in a constructive manner. By practicing respect and honoring an individual’s work, you help to foster a climate of caring (Dye, 2000).

Being an administrator in a culture of compassion requires more than knowledge of budgets and strategic planning. You must practice “stewarding with respect” (Dye, 2000, p. 33). This means that you use your influence as an administrator to ensure completion of the necessary work, but you do it in a manner that promotes self-esteem and demonstrates respect. There are several ways to do this but they require some degree of effort. For example, you can choose to seek out information and ideas from staff before you make decisions. While you do not have to use every idea that is offered, asking and considering others’ ideas is part of respect. Offering guidance to employees when tasks need to be done rather than “barking orders” also shows respect. This can also be cost effective because the time spent in clarification can prevent costly errors or resentful, passive aggressive behavior. Not only should you show appreciation for your employees and their work, but you should be appropriately enthusiastic about the work that you do. Certainly, you can demonstrate enthusiasm for the mission of your organization and department. If you cannot, perhaps it is time for a job search.
Last, but not least, you need to think about being a good steward to yourself. You need to practice frequent self-assessment so that you can build on your strengths and work on your weaknesses. You need to be willing to own your mistakes and apologize when necessary. As an administrator, you need to consider yourself a lifelong learner and be open to new knowledge and practices. Because all of these ideas will take effort on your part, you need to practice self-protection through whatever means works best for you. This can mean planning quiet time in your day, taking time out for exercise, remembering that family counts too, and planning real vacations for self-renewal. These actions are not only a benefit to you, but actually assist the organization. You will have greater energy to provide the kind of leadership that encourages a culture where active beneficence is the norm, rather than the exception.

Summary

Nonmaleficence and beneficence are often viewed as paired principles because they seem to be linked together. Actually, nonmaleficence requires only that you prevent individuals from being harmed. This act of prevention can involve creating an environment where treatment can be practiced in a safe manner and where employees can be free from harassment in its many forms.

Beneficence requires that you go beyond prevention to ethical action. You work to respect the individuality (I-You relationship) of all employees and find ways to nurture them. Making the effort to be a steward of resources and talent is, in itself, a virtue but it can also have a positive impact on your bottom line. It is much more cost-effective to do the small things that are necessary to build employee morale and retention than to pay the price for constant recruitment and rehiring.

Cases for Your Consideration

The Case of the Academic Bully

As you read this case, consider the following questions. Responses and comments will follow the case.

1. Why did Ms. Nodons treat Dr. Xenia differently than Dr. Kado?
2. What was the impact of her actions on the overall morale of the department?
3. Why did Dr. Xenia resign and what was the impact of this action?
4. What could have prevented this situation?

Case Information

This case occurred in an academic health care setting, but the behaviors seen here are typical of bullying in hospitals, clinics, and other environments. After 20 years in nursing and hospital administration, Ms.
Nodons was appointed the director of the health studies program at St. Dismas University. With her leadership, this program had grown to over 200 undergraduate students. She received approval to begin a master of health studies (MHS) program. With this approval came authorization to hire two doctoral-prepared faculty, and Ms. Nodons was excited about the prospect. After conducting a national search, Dr. Kado was hired. Dr. Kado had just completed his doctoral studies and was given a position as an associate professor. Ms. Nodons also hired Dr. Xenia as an associate professor.

Ms. Nodons immediately charged Dr. Xenia with the task of designing the curriculum for the new MHS program. Dr. Xenia clarified her responsibilities and formulated plans for data collection, objective writing, and curriculum design. She then presented a draft of these ideas at a faculty meeting for consideration. However, Ms. Nodons’s reaction to Dr. Xenia’s work came as a total surprise. She began to verbally attack Dr. Xenia, asking her, “Just who do you think you are?” She followed this up with the abrupt statement, “I am the boss here and I make the decisions, not you.” The other faculty members just sat in silence. Dr. Xenia was shocked and tried to explain that she was only trying to come up with a plan for the project. She also apologized for any misunderstanding that she might have caused.

From that time on, Ms. Nodons’s negativity toward Dr. Xenia became even more evident. Dr. Kado was granted special travel money to attend meetings, allowed to have flexible work hours, and given high visibility committee assignments. Dr. Xenia was chastised if she was not at work at 8:30 A.M. or used sick leave. She was denied travel funds for meetings and had to use her own money to finance these trips. Faculty meetings became excruciating for Dr. Xenia because any comment she made was immediately attacked. In contrast, all of Dr. Kado’s ideas were applauded as brilliant.

When she made an appointment with Ms. Nodons to discuss the situation, she was accused of being paranoid and insubordinate, and was called a failure as a team player. The meeting also brought on Ms. Nodons’s retaliation in the form of increasingly personal comments about Dr. Xenia at faculty meetings. Ms. Nodons also began to complain about Dr. Xenia to her fellow faculty members, accusing the associate professor of “not knowing her place.” These faculty members reported the comments back to Dr. Xenia to “help her” but did nothing to defend her, either publicly or privately.

Dr. Xenia tried to maintain high standards of teaching despite all the strain of preparing her courses, the lack of collegial support, and the increasing intensity of bullying behaviors by her boss. While she had been an award-winning teacher in the past, she began to doubt her ability to teach. She also experienced physical symptoms including
Cases for Your Consideration

headaches, acid reflux disease, and panic attacks while driving to work. Her blood pressure increased dramatically and she was placed on medication to control it.

Trying to be a problem solver, Dr. Xenia considered making an appointment with the Dean to discuss the situation. However, the Dean was a personal friend of Ms. Nodons. In fact, they had been friends for 20 years and regularly played tennis and golf together. She also considered discussing her situation with Human Resources, but was told that there were no grounds for any inquiry. The advice she was given was just to live with the misery until Ms. Nodons retired or quit. Her administrative assistant promised to warn her when Nodons was having a “bad day” so that she could stay clear. Dr. Xenia assessed the situation, began a job search, and resigned.

Responses and Commentary on Questions

1. Why did Ms. Nodons treat Dr. Xenia differently from Dr. Kado?

   There could be any number of explanations for difference in treatment between the two faculty members. First, it is possible that Ms. Nodons simply did not like Dr. Xenia’s personality. There could have been something about Dr. Xenia that “rubbed her the wrong way.” Of course, she did not acknowledge this even to herself. Second, the difference in treatment could have been because Dr. Kado was male and Dr. Xenia was female. Ms. Nodons could have, through her life experience and education as a nurse, been taught to defer to males. Dr. Kado was also a brand new doctorate, so perhaps he posed less of a threat to Ms. Nodons than Dr. Xenia.

   Whatever the reasons behind the behavior, Ms. Nodons’s actions certainly fit many of the signs of bullying described earlier in this chapter. However, she probably did not see herself as a bully. She was used to unquestioned obedience in her former nursing and administrative positions. She ran a tight department with large class sizes and low faculty-to-student ratios. Although she had never had a female faculty member, she felt competent to handle women in general. She wanted to teach Dr. Xenia to know her place and not cause any problems.

   Comment: Remember that bullying behavior is sometimes perceived as good management, especially when it has been reinforced in the past. In Ms. Nodons’s previous work experience, she was probably rewarded for “keeping her nurses in line” so that the work of the hospital was accomplished with minimal interference. In her academic career she was the sole source of power, so any form of questioning was not even in her experience. She also viewed any questioning of her actions as a lack of obedience and insubordination. A collegial model is usually found in an academic
setting but it was not part of her administrative background. Ms. Nodons’s administrative style should certainly not be emulated but should make you stop and think about your own interactions with staff and how they are perceived.

2. What was the impact of her actions on the overall morale of the department?

When you think about this question, try to view the big picture. Was Dr. Xenia really the only one affected here? How about Dr. Kado? Initially, it must have been great to be the “golden one” and have all of your ideas praised. It also must have been nice to have special benefits that others did not have. However, a golden status can be fleeting. What happens if he does something that has a negative impact on Ms. Nodons? Will he face the same treatment that was afforded to Dr. Xenia? Of course, if he was functioning at the Buber I-You level of ethical relationship, he might not be happy with the treatment he sees Dr. Xenia getting. He might also consider a job change to avoid her fate.

What about the rest of the faculty and staff? You can well imagine that this is not a healthy workplace when the administrative staff has to figure out if each day is a bad one or a good one. Can you imagine how unpleasant faculty meetings are for everyone? The lesson taught, through the treatment of Dr. Xenia, was to keep your mouth shut unless you want the same treatment. Obviously, a flow of creative ideas did not occur, and the potential was great for stagnation and high turnover.

There was also no discussion about teaching assignments in this department. Faculty taught what they were told to teach even when they did not have sufficient expertise in the area, or time to develop that expertise. Maybe Ms. Nodon purposely made class sizes extremely large to boost her to high productivity statistics within the institution. The result was either a high potential for faculty burnout, or the provision of low quality instruction, or both. Overall, this was an unhealthy environment, with some of the faculty just biding their time until they retired—or until Ms. Nodons did.

3. Why did Dr. Xenia resign and what was the impact of this action?

Dr. Xenia resigned because she had no power to counteract the environment in which she found herself. After attempting to address her concerns with Ms. Nodons without success, her next step should have been to make an appointment with her Dean. However, the close personal relationship between the Dean and Ms. Nodons made this seem futile. The Human Resources department was not even aware that bullying in the workplace was an issue, so they were not of any assistance. Faced with an unfixable
situations and increasing health concerns, Dr. Xenia made a decision that was appropriate for her. This decision had impact on many aspects of the program. Immediately, Ms. Nodons sent out an e-mail to all faculty stating that Dr. Xenia had resigned because she was a poor team member and did not fit well in the department. However, faculty who knew Xenia well questioned this and began to wonder who would be next in the “pecking order.” Fearing that the work environment would only get worse, Dr. Kado also began a search for a new position, even though he had been afforded special treatment.

Adjunct faculty had to be hired to take over Dr. Xenia’s heavy course load. This required a total of four different adjuncts a semester and added additional expense to an already tight department budget. A national search, with all of its expenses, had to be conducted to find a replacement. This took over a year and was not successful.

Students in the graduate program were particularly affected by this resignation and began to question the stability of the new MHS program. Several of them chose to transfer to a competitor institution that was perceived to be more stable. The loss of student base threatened the future of the program and its expansion.

Comments: The important thing to remember here is that keeping a healthy workplace that is free from bullying and other forms of aggressive behavior is much more cost-effective than losing staff. Think about all of the unnecessary harm that happened to the survivor faculty, students, staff, and—yes—even to Ms. Nodons. Certainly her days are now more stressful because of the additional burden of making sure classes are taught and searching for replacement faculty. Much of her stress could have been avoided by exercising a different administrative style.

4. What could have prevented this situation?

How could St. Dismas University have addressed or prevented harm caused by bullying? The first action that should have been taken was to increase awareness of this issue. No one at St. Dismas University had even considered bullying to be an issue for academe. Awareness might need to start at the University level, rather than the School or Department, by having significant and influential personnel receive training in the recognition of bullying and its effects. Information on appropriate policy development should also be a part of this training opportunity.

Once trained, the group could work with Human Resources to develop policy and procedures to inform all faculty and staff about
acceptable and unacceptable behaviors. Procedures about complaints and investigations would be delineated. Of course, once this policy is developed, additional training would be required, starting with the administrative level. In addition, the organization must be willing to enforce the policy even if it means the dismissal of department heads or deans. Failure to take action when a proved case of bullying exists means that such behavior is acceptable, if not encouraged.

The Case of the Beneficent Boss

As you read this case, consider the following questions. Responses and comments will follow the case.

1. Why did Ms. Dee choose to take the actions that she did in Cindy’s case?
2. What was the impact of her actions on the staff?
3. What was the impact of her actions on Cindy?
4. What was the impact of Ms. Dee’s actions on the bottom line of the New Hope Community Program?

Case Information

Ms. Teresa Dee was a human resources director for a small nonprofit organization called the New Hope Community Program (NHCP) that was funded through United Way and other community sponsors. Its mission was to decrease the relapse rate of substance abusers by providing the knowledge and skills needed to obtain and keep jobs. Using effective prevention methods to reduce treatment costs for these individuals was also part of the NHCP mission.

Once a client was employed after completing her program, Ms. Dee had the responsibility of serving as liaison between the employer and the client. This required frequent follow-up contacts with both parties. Follow-up duties could be delegated to appropriate staff, but she tried to do her fair share so that they were not overwhelmed.

One Monday morning Ms. Dee walked out of her office and saw a thin, young, blond, unkempt woman waiting in the reception area. A review of the referral form from St. Dismas Drug Rehabilitation Center revealed that the client’s name was Cindy Rumford and that she had only six months’ sobriety. She was only 17 years old but had already had six arrests for prostitution. Ms. Dee’s experience told her that Cindy had an uphill struggle ahead at best.

The initial interview was not a positive one. Cindy’s appearance and demeanor showed almost no self-confidence and her responses were barely audible. Ms. Dee was able to determine that she had not finished high school, had no discernible job skills, and did not know what she
wanted to do with the rest of her life. When asked if she was serious about staying sober, she quietly replied, “Well, I guess I can. I want you to help me make it.” Such a response was not a good omen for a positive result for this client. Yet, Ms. Dee sensed something in Cindy that warranted further attention. After all, helping people like Cindy was the mission of NHCP.

From that initial intake visit, she took particular interest in Cindy. She held a staff meeting to design a plan to meet Cindy’s immediate needs for safe housing, clothing, food, and transportation to the program office. After settling on a plan, the staff worked with Cindy so that these basics could be met. Next, she explained NHCP’s Work for Recovery Program to Cindy. She could sign a contract with the Program to attend classes to complete her GED and learn basic work habits like applying for jobs, maintaining a good business appearance including dress and makeup, and learning skills to interview and communicate appropriately. Once she completed her classes, Cindy was required to work at the Program Office for three months.

During Cindy’s training period, Ms. Dee took special interest in her progress. At first, she seemed to be a passive learner who barely made eye contact with the staff. She did show some interest when an employer came to talk to the class about what he expected from his employees. The day she passed her GED seemed to begin a real turnaround for Cindy. It was the first time Ms. Dee saw her smile.

Cindy’s three-month trial employment at the program began with housekeeping activities. Ms. Dee made a point to tell her how well she was doing with her attendance and attention to detail. Gradually, she increased Cindy’s responsibilities to include reception and office work. Cindy’s confidence seemed to grow with each new responsibility. By the end of her contract training period, she had become a more confident person with a professional appearance and a ready smile.

Ms. Dee contacted those employers whom she knew would be open to giving Cindy an opportunity to continue to build her work skills. After only one interview, she was hired by a small company as an office assistant. Ms. Dee decided to personally follow up on her placement rather than to delegate it to the staff. Although there were a few rough times, Cindy maintained her sobriety and her position. Ms. Dee still gets Christmas cards from Cindy thanking her for caring and the difference she made in her life.

1. Why did Ms. Dee choose to take the actions that she did in Cindy’s case?

Ms. Dee had seen many “Cindys” in her position as human resources director. Some of them completed the program and went on to become sober and productive citizens. However, many of them chose to drop out when it became too difficult. Still others
completed it but relapsed when faced with the pressures of the real world. Experience should have made Ms. Dee cynical about Cindy’s chances. Yet, she chose to act with beneficence. Perhaps she saw something in her demeanor that others did not see. Perhaps it was just her nature to refrain from generalizing from previous experiences to the current one. Whatever the reason, Ms. Dee decided to act with kindness in this case and remain hopeful.

Ms. Dee was also being true to the mission of her organization and her position as an administrator. If you consider its purpose, all of NHCP’s activities were rooted in the principle of beneficence. As an administrator, she had the obligation to demonstrate its mission in action. Her decision to live the mission rather than just post it on the walls might have added to her already busy workload, but the time she spent with Cindy seemed to make the sacrifice worthwhile. In addition, Ms. Dee had the personal satisfaction of knowing that her actions made a difference.

2. What was the impact of her actions on the staff?

As an administrator in a small organization, Ms. Dee was highly visible to the staff. In addition, her multiple roles ensured that she was not “office bound” but had the opportunity to interact with them on many occasions. Because of this situation, she served as a role model, not just for Cindy, but for the staff as well. When she took extra time to praise Cindy for her efforts, it was noticed. When she followed up on her status when she was not mandated to do so, it was noticed. When she remained positive about Cindy’s future in spite of her odds, it was noticed. She did not have to preach about the mission of NHCP and what it meant; she just exhibited it through her interactions.

Her behavior toward staff compared well to her actions toward clients. She listened to their concerns, acted on suggestions that were appropriate and feasible, and gave credit to the staff members who suggested them. She always made a point to acknowledge the work of her team. When there was a staff issue, she held a frank and documented discussion with the individual including the development of an action plan for improving the situation. She lived the mission with her staff and her clients.

Because actions really do speak louder than words, Ms. Dee set the norm for the organization. Staff members tried to emulate her behaviors and in turn used active beneficence in their dealings with their clients. While the relapse rates for all of their clients did not change dramatically, there was a shift to the positive in their yearly statistics. In addition, overall morale seemed to be much more positive and clients seemed more appreciative. The end result was that, on most days, the staff were happy to do their meaningful work,
Cases for Your Consideration

and the clients reaped the benefits of their attitudes and actions. Turnover was very low, which saved the organization thousands of dollars in lost productivity, recruitment, and re-staffing funds.

**Comment:** You should remember that as an administrator what you do is noticed. This should not make you paranoid, but should help you to motivate your staff. A variation of The Golden Rule works here. Do unto your staff well, and by your example, it is more likely that the staff will do their jobs well. So, this means that you must at least understand the jobs that your staff do and be willing to “pitch in” when necessary. On a daily basis, if you want an environment where beneficence is the norm, then you must choose to practice it in your actions toward others.

You also should remember that when you treat a client with beneficence but deny it to your staff, you are creating an environment of inconsistency. The morale of your department can quickly deteriorate when you see the staff’s efforts as “just doing their jobs.” They will get the message that they can be replaced at any minute with anybody. This lack of active beneficence will reinforce an I-It relationship with you. Because no one really wants to be replaceable, morale will decrease even among your most dedicated staff. Your potential for high turnover and its associated costs will grow, as will your negative reputation with the higher echelon.

4. **What was the impact of her actions on Cindy?**

Certainly, this decision to practice the principle of beneficence made a difference to Cindy. Maybe, this was the first person who took a special interest in her well-being. Cindy responded to even the smallest positive comment from Ms. Dee. The encouragement bolstered her own determination to stop her cycle of addiction and its consequences.

In addition, Ms. Dee made a point to have Cindy’s first real world work experience be with a person who practiced active beneficence. Her new employer continued to foster Cindy’s confidence and self-esteem. She was not treated as a charity case but as a true employee of the firm and offered the same level of respect. While there were times when she made errors, she was given assistance to correct any problems. Because of the training and affirmation she received from Ms. Dee and the staff, Cindy was able to become a valued employee in her new position. Having a job and the income it provided gave her the opportunity to live a different and healthier lifestyle.

5. **What was the impact of Ms. Dee’s actions on the bottom line of the New Hope Community Program?**

Certainly, one person cannot make or break an organization, but he or she can have a positive impact. In the case of Cindy, Ms. Dee
and her staff were able to see that practicing beneficence brought both personal and organizational rewards. While NHCP’s success rates were not perfect, the overall environment of beneficence toward clients and staff did produce less staff turnover and better client results. It is true that this decision took more effort and time than “business as usual,” but the reward of a positive work environment offset the investment, making it a positive return on investment.

Comment: Sometimes it really is the small stuff that makes a difference or makes a statement. For example, a chief executive officer (CEO) of a major hospital makes a point to pick up any trash seen each morning on the way in from the parking lot. This is a small action indeed, but it carries a large message about pride in an organization. When employees observe or hear about this behavior, they think “If the CEO can pick up trash, then maybe I should care about this place, too.”

Beneficence is really cost-effective because actions of charity and kindness well outweigh the costs of time and effort. It seems so easy to do on the surface, yet you will all get busy with your daily efforts and crises and forget that there are humans behind those FTEs. So the practice of active beneficence requires a daily decision to act within Kant, Frankl, and Buber principles. The organization, your employees, and your career will gain the benefits of this decision.

Web Resources

Classic version of the Hippocratic Oath
http://www.pbs.org/wgbh/nova/doctors/oath_classical.html

Bullying in the Workplace
http://www.safety-council.org/info/OSH/bullies.html
http://www.ccohs.ca/oshanswers/psychosocial/bullying.html

References


Justice

“I know, up on top you are seeing great sights,
But down at the bottom we, too, should have rights.”
—Dr. Seuss

Points to Ponder

1. What is patient justice? Why is it not difficult to practice?
2. What are the different positions on distributive justice?
3. How does distributive justice impact a health care organization?
4. What does it mean to be a just administrator for staff?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- distributive justice
- ethicist
- justice
- patient justice
- staff justice

INTRODUCTION AND DEFINITIONS

Before you deal with the application of the principle of justice, it is important to understand what it means in health care settings. When dealing with people, whether they are patients or staff, justice is concerned with doing what is fair or what is deserved. This implies an active ethical response in each situation. But justice does not apply just to individuals. The term distributive justice is used when considering what is fair and appropriate to protect the rights of a community or
society. Since groups in American society view distributive justice very differently, this is an area of great controversy for both society and the health care system. As an administrator, you will struggle with different societal and organizational views and will have to come to a viable compromise for your organization. In this chapter, you will learn more about this form of justice. In addition, you will explore aspects of patient justice and staff justice.

## JUSTICE FOR PATIENTS

When people enter the health care system at any level, they believe that they will be treated with fairness and that their needs will be met expeditiously. They believe that they will be treated with respect regardless of their lifestyle or financial circumstances. Patients believe that you will do everything you can to heal them. Their primary view is that health care organizations are places where healing is the mission. Television and advertisements can reinforce this view. Health care is often presented as a place where restoring or protecting health is the primary mission. Seldom is there any mention of the business aspects of health care or what is needed to stay in business.

The American health care system might not be able to live up to this idealized view. From a treatment standpoint, there can be times when a patient does not get the full attention of the system no matter what his or her financial circumstances. For example, in a busy emergency department (ED), a screaming child with an earache might have to wait far longer than his parents view as fair. This “unfairness” happens when people with more severe emergencies enter the ED at the same time as the child. While this system of prioritizing is necessary, unless it is explained to the parents, it can be viewed as unjust.

While patient justice seems to indicate that all patients who have the same health care issues should be treated the same way, it is not an easy principle to consistently maintain. First, health care truly is a business and not all patients have the ability to pay for its services. Depending on whom you read, there are 48 million uninsured people in the United States. Who will pay for their care when it is needed? Because insurance is linked to access, these individuals might not receive the same level of care as those who are well insured (Shi & Singh, 2004). You will learn more about this issue in the section about distributive justice.

Even if they can pay for services, some patients stretch the professional’s ability to apply the principle of patient justice. The personality or life choices of a patient might offend the professional’s personal values and sense of professionalism. Yet, health professionals are expected to act with justice even when patients demonstrate unpleasant behav-
iors, are filthy, or verbally abusive. They also must be just when patients are arrogant and demanding.

Such behaviors should not affect patient justice, but they do. The daily exposure to demanding, unpleasant, or challenging patients puts a definite strain on the ability to act with justice. Some professionals react to the strain by using labeling and dark humor as a protection. For example, you can find the term GOMER (get out of my emergency room) used instead of a patient’s name. People become “Its” instead of humans when justice is strained.

Active patient justice requires positive consistency. This means that you strive to treat each patient with dignity and justice, as Kant and others would advocate. It also requires careful observation to determine the best way to act with justice for each person. For example, one patient might find a simple touch on the shoulder reassuring, while another might find it offensive. Your goal should be an I-THOU relationship while you are in the patient’s presence. In other words, he or she should be the most important thing to you at that moment.

However, the ability to use careful observation and positive consistency in behavior is not innate. It must be taught in schools by focusing on the human elements of care and not just clinical skills. It has to be reinforced in the workplace through role modeling, in-service education, and frequent reminders. Work practices such as shift scheduling and taking meal breaks can decrease “compassion fatigue” and increase the likelihood that patient justice will be the norm in your facility.

DISTRIBUTIVE JUSTICE

Definitions

The principle of distributive justice involves the appropriate and fair distribution of the benefits offered by a society. It also includes the distribution of the burdens for these benefits (Beauchamp & Childress, 2001). Just what does this mean? In health care, the available benefits are not limitless. Distributive justice must deal with how society decides who gets the benefits of health treatment, how much they get, and who pays for them.

Distributive justice in health care seems simple on the surface. People who need medical services should get them, and those with the same diagnosis should be treated equally. However, the United States is a market-driven economy; how it defines who needs assistance and the mechanisms for providing such assistance are not that simple. For example, if people have risky lifestyles and do not take good care of their health, should they be given free health care? In a market driven economy, this simply does not make good business sense. On the other
hand, is it just to allow people to suffer and die prematurely because they did not follow all of the rules for good health? The answers to these questions are even more confounded by the knowledge that determinants of illness are complex and not always linked to personal lifestyle choices.

In the United States, access to health care is linked to the insurance coverage. While government is becoming increasingly more involved in the financing of health care, the backbone of the system is still the employer-provided insurance system (Shi & Singh, 2004). Approximately 60% of the American population has this coverage, but it varies in its benefits. Another 25% of the population has private or publicly supported insurance. However, there are people who have no coverage for a variety of reasons, including those who have a high risk status or conditions that are excluded from policies; who work for companies that do not offer plans; or who are unable to pay for private coverage. This group of over 41 million Americans includes over 10 million children. While access to health care alone does not guarantee health, some would argue that the problem of the uninsured constitutes a failure of distributive justice.

Theories of Distributive Justice

Why is health care for all Americans not provided through the government as it is in many other industrialized countries in the world? Would that not be distributive justice? A discussion of the differing views of distributive justice prevalent in American thinking might help you better understand this quandary. Each of the views on this topic is founded in principles based on societal and ethical arguments and traditions. In this section, you will examine the basic concepts of the views that commonly apply to health care. This should assist you in understanding why “just pay for it” might not be the best answer for the U.S. health care system.

First, think about the utilitarian position. Utilitarians tend to view justice in health care as taking actions that can provide the greatest amount of benefit to people or prevent the greatest amount of harm. They favor public health activities such as sanitation, air pollution control, and protection against epidemics, which would improve the health for the entire population. They also find the provision of basic services to all as a form of distributive justice.

However, in the purest form, the utilitarian position might support denying access and treatment to the frail elderly, or the most gravely ill. In this view, these population groups use a disproportionate amount of scarce health care resources and tend to have poor treatment outcomes. The money spent on them might be better used to benefit society at large through prevention programs and prevent the greatest harm to the greatest number of people. However, this analysis certainly does
not appeal to the families of individuals in vulnerable situations or to those who are forced to deny them care.

The free market or strict business approach to distributive justice takes the position that health care is a business and not a right. In a business, providers of goods and services should be able to provide them and make a profit. In addition, those who work and earn income should be able to purchase goods and services in accordance with their wealth. So when this is translated into health care, those who have the funds have the right and the freedom to purchase the health care that they choose. Physicians and other health care providers also have the right to provide such care or to refuse it based on the individual's ability to pay. There is no moral obligation to provide health care any more than there is a moral obligation to provide any other commodity (such as a home, a coat, or a hamburger).

The market position on distributive justice makes sense when you consider the bottom line in running any business. Payroll and expenses must be met and stockholders or the community must receive a fair return on their investment. To survive in a competitive environment, there must also be a sound fiscal foundation. While you might feel compassion for people and their situations, you still have to keep the doors of your facility open. This concept is where the phrase “no margin, no mission” has its origin.

Because American culture is based on its capitalist success, on the surface, this approach makes a good deal of sense. However, in the court of public opinion, a health care institution would not fare well if it used this form of distributive justice as its operational definition. If your mission statement reads “Profit Is Number One,” the media would certainly portray your facility as “Scrooge Hospital.” Certainly, the government would not look favorably on your denying access to patients and might try to deny you payment or close you down. So, the market view of distributive justice, while it has some merit, cannot be the only principle for decision making about distributive justice.

Rawls would argue that distributive justice means that people need to have fair access to health care when they need it. However, all persons do not have the same ability to access health care services because of economic or other barriers. Society has an obligation to do what it can to eliminate or reduce those barriers. By meeting this ethical obligation, it would allow people to increase access to care. Restoring and maintaining health also allows each person to be a full member of society (Beauchamp & Childress, 2001).

However, this position does not mean that all people should be given everything that the health care system has available. It does not mean that, just because you want a “tummy tuck,” you should get one free of charge. What it does mean is that, regardless of your social or insurance status, you should have access to adequate basic health care. Those
who have insurance or the financial means should be able to purchase services beyond this basic level.

Already you can see a problem with this position. The term “adequate basic health care” is incredibly vague. Just what does this mean? People of high ethical thinking and an understanding of the American economic system have argued this for years. Often this argument leads to a discussion about what basic health care is not, rather than what it is. The state of Oregon attempted to identify basic health care for its Medicaid patients by using an elaborate system that included citizen input. While this attempt was laudable, it caused some real public relations nightmares for the state. However, even if it is not popular, this issue will not disappear. If anything, the need to grapple with it will increase as the boomers come of retirement age and use more of the nation’s health care resources. Who will be entitled to services and how will Americans finance it?

**Issues for Health Care Organizations**

The application of distributive justice can bring many concerns at the organizational level. There is the need for each organization to create its definition of justice or fair treatment for patients. This definition should consider the positions that you have just examined. What is the organization’s obligation to its community for just care? How will it balance its fiduciary obligation to its stockholders, payers, and others with this obligation? How does your organization define basic health care for those it serves? Should care be different based solely on the ability to pay or will other criteria determine this? These questions should not be taken lightly and can even require the investment of a retreat for the administration to discuss them. You might even need to use an ethicist or specialist on ethics on a consultant basis to assist in defining your position on these issues. If you serve in a religious-based facility, the answers to these questions can form a major part of your mission statement.

Distributive justice on an organizational level is more than theory, discussion, and mission statements. For example, your facility might have invested a good deal of capital and staffing on its oncology services. It might pride itself on this effort and even advertise them on radio and television. However, your advertisement campaign can backfire if too many of these high-risk patients use your services. What if their needs are not fully covered by insurance or, even worse, what if they have no insurance at all? The community expects that you will provide the just and compassionate treatment that you have advertised. But, you still must maintain your bottom line (Pearson, Sabin, & Emanuel, 2003).

When you must serve both high-risk and high-profit patients, what does this mean for the practicing health care administrator? First, the organization must construct its definition of just treatment in this case. For some organizations, each service is a business entity, so it must
make a profit like all other entities. In this case, you would have to balance the number of Medicare, Medicaid, and charity care patients against those who are well insured so that you do not have a profit drain. You might have to limit the number of these cases to preserve your profit status.

Another way for the organization to deal with this issue is to limit its service area so that only those high-risk patients in this defined area are served. While this can mean turning some people away, it could allow you to concentrate on providing quality care to those who are in your service area. The disadvantage of this approach is that it limits you from expanding your service area into more lucrative markets.

For some facilities, the service of high-risk patients is the mission. This is typically found in faith-based facilities. Their mission emphasis means that they must concentrate more on the ethics side of the equation rather than just the business side. However, they must still find the funds to treat these individuals. Care for high-risk patients becomes part of their business and fundraising strategies in the community.

Whatever approach is taken in planning for high-risk patients, Pearson, Sabin, and Emanuel’s (2003) research provides some solid information to guide you. First, it is important to assess your community and its high-risk patient potential. You must use whatever data are available through state and local sources to get a snapshot of your community’s health status, its resources, and its culture. This assessment of both medical and social health will give you the ability to plan your programs with more realistic detail. In thinking about this population and its needs, provide ways for easy access to your system to address questions and concerns and to educate. Time spent on this effort can potentially save you from costly treatments later.

They also stress the need for timely access to your services in the broadest definition of that word. High-risk patients can face many barriers to using your services including transportation, language difficulties, and a lack of insurance coverage or inadequate understanding of coverage. You might need to be very creative to be able to provide true access for these patients, including coordinating or even providing transportation, helping with insurance coverage, and providing adequate patient education. If your mission includes services to this population, this extra effort can benefit both the patients and the organization by making sure services are used and funded appropriately.

**STAFF JUSTICE**

The concept of justice is also about fairness and equity for employees. You should begin your understanding of staff justice by realizing that, as an administrator, you have both title power and subtle power. First you have a title and all of the responsibilities and accountabilities that
CHAPTER 4  JUSTICE

go with it. This alone gives you a certain amount of authority or you could not do your job. But, perhaps even more important, you have subtle power. How you present yourself, what you say, and how you say it can be perceived as fair and just—or just the opposite.

Of course, your title alone does not make you a model for ethics in your department or area. How you treat staff sets the climate for what is expected and how people will treat each other. You need to be concerned that your behaviors enhance fairness and decrease the likelihood of inequity. For example, even though you like some staff more than others, you should not have lunch with them every day to the exclusion of the others. Exclusionary lunches with you are more than burgers and fries; they provide a connotation of favored status. Whether this is true or not does not matter. The image is set and inequity is perceived.

Think about when perceived injustice has happened to you in a job. How did it make you feel? Certainly, you saw this taking place in The Case of the Academic Bully from Chapter 3. For no easily discernible reason, Ms. Nodons (the boss/bully) gave Dr. Kado preferential treatment, and Dr. Xenia was victimized. It seemed that Ms. Nodons liked Dr. Kado’s personality, style, and even his gender better than Dr. Xenia’s. Ms. Nodons also mistreated her support staff. It was fine to abuse them verbally, she thought; they were not faculty. However, Ms. Nodons never saw herself as an unjust administrator. She believed that she was top-notch, ran a tight ship, and kept her people in line. However, contrary to her belief, she was the administrator of a hostile work environment, with a department of low productivity, and the potential for a serious employee retention problem.

What can you do to be a just administrator? Can you use your subtle power as well as your position power to create a just work environment? First you must read. Policies and procedures are not just pieces of paper; they can be used to form an agreement about how business gets done in your department. So, you will need to review them to refresh your understanding. Are they clear? Are they fair? Do they function to make things work more smoothly? Do your staff members know what the policies are?

How can you know the answers to these questions? You could do something radical (or sometimes radical in a health care setting) and ask the staff. If you have a climate of trust, they will tell you what is working and what is not. You can also do some “management by walking around” and observe work processes. Some health care facilities even have the administrators spend one day doing their employees’ jobs (nonclinical, of course) so that they truly understand policy in action.

If the answers to these questions do not turn out to be positive, then you must re-word or even discard those policies and procedures that do not meet the criteria. Again, staff input can be used to assist you in reviewing drafts for clarity and practicality. You can schedule a policy
review meeting so that everyone is up-to-date and understands how they are supposed to work.

Next, you must plan. While you often have to make “right now” decisions, they should really not be your entire administrative style. Immediacy is necessary but it does not afford you the time to think about the justice of what you have ordered. You want to consider the big picture when making your decisions. This is quite a challenge, but you are prepared for it.

How about a practical and quick planning example? When you hold a meeting, think about more than the agenda. Consider what you are going to say and what impact it will have on others. Consider how you can give bad news or even good news in a way that is fair to all. Remember that you are sending a message that goes beyond your words. While you do not want to look like you are making a speech during your meetings, having “talking points” to remember to emphasize certain words is a good idea. You can even do a mental rehearsal of what you will say so that you appear confident and prepared. As you saw earlier, your image is part of your message.

Next, you must write well. When you communicate in writing, how will it be interpreted? Do your written decisions convey just treatment? If there is a need for some people to be treated differently, is there an explanation? Providing a reason, rather than just issuing an order, is more likely to be viewed as just by your employees. Your written words should be tools for efficiency and not creators of problems in staff relations.

Is your writing unambiguous without being terse? Remember that any document is a permanent record of your decisions and applications of policy. While you do not want to be paranoid, you also do not want to write words that could be interpreted as being unjust to your staff. In times of crisis, such as a downsizing, your written words become even more important. The environment can be emotionally charged, so you need to be aware of what you are writing and how it can be interpreted under those circumstances.

When you consider your writing and how it can be just or unjust, do not forget e-mails. This is becoming a society of “right now” communication. While that has its advantages, it also has some real drawbacks and can lead to unjust behavior. Suppose you arrive at the office late after a really bad start to your morning and an even worse commute. You open your e-mail and find a message that “irritates your last nerve.” One temptation is to fire off an immediate response that reflects what you think of this person or his or her message. Be careful.

First, because e-mails can be read and interpreted in so many ways, the e-mail that bothered you might not have been intended to be negative. Even if it was, you are supposed to be able to avoid getting to the level of pettiness and retribution. Maybe the best executive decision is to “take ten” and get a cup of coffee before you respond. Maybe you
could telephone this person and get clarification before you “jump to administrative conclusions.” Because your e-mails can be kept as a record (i.e., a paper trail) of just or unjust communication with your employee, you always want to use care in responding.

Even the time of the distribution of your words can be just or unjust. For example, if you are the one who is being laid off, when would you want to receive your written notice? At 8:00 A.M. in front of all your peers or just before leaving work on a Friday? If this had to happen, would you want it to be on the day before Christmas Eve or after the holidays? Better yet, would you rather receive it after a discussion with your administrator so that it is not an unpleasant public surprise? While deciding when to give bad news might not always be in your hands, you should try to do it in the most just way possible through your timing and verbiage.

Finally, you must become a keen observer. Management by walking around is not just a catch phrase for the health care administrator; you must know what is really happening in your department. It is also helpful to identify someone who is already a just administrator. Observe how he or she deals with difficult situations when they occur. In addition, you might ask this person to serve as an informal mentor for you. Having a person who will serve as a sounding board to help you think out loud can assist you in making just staff decisions.

Reading, planning, writing, and observing are not the only skills that you need to exhibit as a just administrator, but they form a solid foundation for the application of this principle. They can be coupled with periodic self-assessment to assist you with staff justice. When decisions must be made that have an impact on your staff, ask yourself, “Do I have the facts?” and “Am I being fair to those involved?” You also have to be willing to give an explanation for your decisions, rather than using “Because I say so” as a justification. Certainly, the role of a just administrator is not an easy one but it does make for a more positive and productive workplace.

Summary

As you can see, justice is not an easy concept to implement in a health care setting. While it is certainly laudable, there are many societal and business factors that make its consistent practice difficult. As a health care administrator, you face the challenge of balancing mission and margin in an era of increasingly complex and costly technology coupled with changing patient and family expectations. Certainly, practicing justice will require more than just having a policy on the books.

You should not forget the import of your position and role on staff justice. Even small things when done carelessly can be seen as unfair. Staff should receive the same level of fairness that you afford to
patients. Otherwise, the inconsistency can lead to costly issues of retention and lowered productivity.

**Cases for Your Consideration**

**The Case of the Dipsomaniac Veteran**

As you read this case, consider the following questions. Responses and comments will follow the case.

1. Why did Dr. Smythe include an NFR notation for Mr. Dipsoma?
2. What should the staff have done about this notation and why did they fail to act?
3. How does this case demonstrate the failure of patient justice?
4. If you were the administrator, what would you have done in this situation?

**Case Information**

The actual story on which this case is based occurred outside of the United States, but it could have easily happened in any U.S. hospital, especially before the advent of DNR orders. Sam Dipsoma, a 44-year-old veteran, was a frequent re-admission to the Clarion County Hospital (CCH) for treatment of cirrhosis and other complications. During his most recent re-admission, he exhibited the symptoms of alcohol withdrawal delirium and liver problems. His medical history contained many incidents of alcohol abuse.

After Dr. Alistair Smythe reviewed Mr. Dipsoma’s chart, the staff noticed that the medical notes had been appended with the abbreviation NFR (Not For Resuscitation). This meant that if he “crashed,” had a heart attack, or went into respiratory arrest, he should not be resuscitated. The staff knew that Mr. Dipsoma had not been told about this medical note, nor had any of his relatives. But none of the staff questioned it or said anything to the patient or his family. Fortunately, he did not have a medical crisis during this admission but that did not take away the seriousness of his situation. If he or any of his relatives had known about the note, they could have had a serious case for legal action. The irony of this situation was that this same hospital had just been in the news for its treatment of a major celebrity who suffered severe injuries when he wrecked his Mercedes while driving under the influence of alcohol and marijuana. Dr. Smythe had been part of a news conference to update the press on the quality treatment that the person received at CCH. Maybe wealth really does have its privileges.

**Responses and Commentary on Questions**

1. Why did Dr. Smythe include an NFR notation for Mr. Dipsoma?
   Perhaps Dr. Smythe had treated Mr. Dipsoma on several previous occasions and was disgusted with his repeated bouts of alcohol abuse. Maybe he felt that Mr. Dipsoma was putting an unfair
burden on the resources that could be used better for other patients whose lifestyle was more socially acceptable. After all, he was accumulating bills that, given his lifestyle, would probably go unpaid. This could negatively impact the bottom line of CCH. So, it made sense in the physician’s mind to include an NFR note in the patient’s chart. As for informing Mr. Dipsoma about this fact, what good would that do, the physician thought. He probably could not understand what it meant anyway.

Of course, when it came to the celebrity, Dr. Smythe had a different view. While his alcohol and drug abuse was unfortunate, he was able to pay his account in full. In addition, the care this “celeb” received was generating positive press for CCH. There might even be a major donation made to the hospital when this person recovers. Dr. Smythe saw no connection between this case and that of Mr. Dipsoma.

2. What should the staff have done about this notation and why did they fail to act?

First, the supervisory nurse should have politely questioned Dr. Smythe to see if the note had been placed in the chart in error. This would have afforded him the benefit of the doubt and allowed him to amend it without penalty. If this were not the case, the nurse could have asked Dr. Smythe if Mr. Dipsoma and his family should be apprised of this note. If this second step did not resolve the issue, the supervisor should report this situation to the Director of Nursing. The director would then alert the Chief of Staff or other appropriate authorities. Failure to address this issue of patient justice could place CCH in legal jeopardy.

Perhaps the staff failed to take action because they felt they had no power to contradict Dr. Smythe. After all, he was almost a celebrity himself, especially after participating in the news conference where he stressed the quality of care provided at CCH. Fortunately, there was no true medical emergency during this admission of Mr. Dipsoma. But the staff’s lack of attention could have placed the hospital in the middle of a legal action. This example makes a case for having a clear policy about the just treatment of patients.

3. How does this case demonstrate the failure of patient justice?

This case illustrates the need for a clear understanding about policy related to patient justice. Sometimes people become frustrated with the cost and care needed when an individual’s lifestyle contributes to his or her condition. The burden of providing such care often strains the financial resources of the hospital. Nevertheless, there is no policy for differential treatment when someone’s disease or condition is a result of lifestyle behaviors. You are expected to treat people to the best of your ability regardless of their economic circumstances or life
Cases for Your Consideration

choices. Certainly, in this case, you can see that having economic resources made a great difference in the attitude and treatment of the two patients. This is the opposite of patient justice.

4. If you were the administrator, what would you have done in this situation?

Clearly, this case illustrates the need for policies and procedures related to NFR orders and the treatment of individual patients. You should have policies in place that define just patient treatment. Policies can be reviewed with all staff so that they are clear. They can also be part of the admission patient information packet so that individuals and their families are informed. A patient bill of rights is often included in this packet.

In this case, you can assume that such policies were not in place or that they were violated. Once you are aware of the situation, even if it occurred after Mr. Dipsoma’s discharge, you should confer with your Chief of Staff. He or she would then have a discussion with Dr. Smythe about staff attitudes and actions. Such a discussion might lead to a suspension of privileges or some other action. In any case, as the “informant” you should be careful to document your actions and even consider a telephone conference with your hospital attorney as a precautionary measure.

The Case of the Just Downsize

As you read this case, consider the following questions. Responses and comments will follow the case.

1. How did Mr. Muggs prepare to handle the situation with justice?
2. If you were a staff member, how would you feel about Mr. Muggs’s actions?

Case Information

Jerry Muggs, director of a public health program called the Youth Anti-Smoking Project, had a staff of five extremely dedicated people. They were so dedicated to the prevention of smoking behaviors in young people that they often worked long hours without even a thought of overtime. Even the administrative assistant did extra duty by traveling to program sites to provide support to the three health educators. Unfortunately, the state health department office had just decided that a reduction in force was required for all programs. Mr. Muggs was scheduled to be transferred to another position, but his whole department was to be eliminated. The work being done in his program was to be added to existing staff in other departments. How could he deliver this news and keep his sense of justice? How could he prevent any unpleasant or even violent reactions from the staff?
CHAPTER 4  JUSTICE

First, Mr. Muggs was somewhat relieved by the fact that this decision would not be a total surprise for his staff. He kept them informed of the communications from the state and their deliberations about downsizing. Still, he knew that hearing that they were the ones to be downsized would be painful. So he immediately contacted the state offices to get up-to-date information on their elimination plans. He asked about the timetable, benefits, and salary packages to be given. He received information on the possibility for staff to transfer to other departments. Mr. Muggs wanted to be fully informed so that he could provide current and accurate information to the staff.

Knowing that not all of the members of his staff were not financially independent, Mr. Muggs wanted to see what else he could do before he broke the bad news. He researched community agencies that might be of help and even contacted the local university to see if their career center could provide a consultant for outplacement services. Because he could anticipate that everyone would be upset by the news, he created information packets so that they could have reference materials to use after the meeting. After several sleepless nights, Mr. Muggs scheduled a staff meeting.

During the meeting, Mr. Muggs remained calm as he told the entire staff the news and expressed his sadness about it. He allowed some time for reaction before he gave them information about their options. Because he was prepared, he was able to answer their questions and give ideas for additional resources.

During the weeks that followed, he worked with each staff member to assist in any way that he could. The staff, while upset at their change in circumstances, told him how much they appreciated his efforts. Even though this was one of the most difficult times of his administrative career, Mr. Muggs felt that he did everything he could to handle the situation with justice.

Responses and Commentary on Questions

1. How did Mr. Muggs prepare to handle the situation with justice?

First, Mr. Muggs provided information to his staff before the elimination decision was even made. They were kept informed about downsizing discussions to keep the secrecy issue to a minimum. While this was somewhat risky on his part, Mr. Muggs knew his staff's level of dedication and trusted them. The decision to create a flow of communication in this important area actually made Mr. Muggs's job easier when he had to break the bad news. While it was unwelcome, it was not a total shock.

Mr. Muggs also went beyond what he had to do to comply with the wishes of the state. He actually planned his words and actions to anticipate the needs of his staff. Certainly, he was not required
to try to get outplacement assistance for them, but he did. As a result of Mr. Muggs’s altruism, the staff were better able to adjust to what they had to do and appreciated his efforts on their behalf. They did not blame him or the state for their fate, but understood that they were part of a larger situation. His preparation made a difficult situation much more palatable.

2. If you were a staff member, how would you feel about Mr. Muggs’s actions?

First, it must be remembered that losing your job is one of life’s most stressful events. Even though you were kept informed of the state’s plans, you really did not believe that downsizing would happen to you. You might wonder if there was something wrong with your performance in the department that influenced the state to choose your department from all of the others. Your reaction might mirror the stages of grief identified by Kubler-Ross (1997) and others. So you might experience denial, bargaining, anger, sadness, and finally, acceptance. For the short term, you would be pretty miserable.

Yet, you would have to respect Mr. Muggs’s efforts on your behalf. Because he had earned your trust in the past and formed a strong working relationship with the team, you believed him when he explained the circumstances of the elimination. You wanted to be angry at him, but somehow you just couldn’t blame him for the decision. You would then be able to try to make the best of a bad situation and move on to the next stage of your career and your life.

Web Resource

Information on the Oregon Health Plan
http://www.dhs.state.or.us/healthplan/overview.html

References

INTRODUCTION

To paraphrase John Donne, no health care facility is an island. It is part of the larger entity known as a community. This community can include people representing a myriad of health issues and cultures. If the health care facility exists in an urban area where social issues of overcrowding, crime, and poverty exist, they add to its treatment burden. If it also exists in a remote rural area, maldistribution of professionals and distance add to its treatment challenges. Yet, each of these facilities markets its mission as serving the community’s health care needs and creates expectations that its mission will be accomplished.

Because health care institutions exist in a community, they are subject to the values and standards of acceptable behavior defined by that community. Their ethics are judged partially by their ability to meet or exceed these standards. Standards influencing the practice of health care are articulated by local and state governments and by various branches of the federal system. They are also formulated by external agencies such as the Joint Commission on Accreditation of Healthcare Organizations or the National Committee for Quality Assurance. Standards also come from other businesses such as managed care organizations or business cooperatives. These standards are concerned with, among other things, the provision of care, patient rights, acceptable business practices, credentialing of health care professionals, payment for services, and ethical and legal issues. They are often copious, conflicting, and arcane.

Like all businesses, health care entities are also expected to be self-regulating. Therefore, they are assumed to have their own internal standards that serve to articulate appropriate behavior within the organization. These standards are often developed to comply with those defined by external evaluators, but should not be limited to these
sources. So, health care business must be profitable amid a sea of external regulations and internal policies and guidelines.

Already, you can see that the business of health care is like no other. In this section, you will study how these external forces have an impact on ethics policy and behaviors of health care entities. You will also see how the community affects your day-to-day practice as a health care administrator. In Chapter 5, you will address the Latin question: *Quis custodiet ispos custodes?* “Who will guard the guardians?” You will examine the rationale for external controls in health care and some examples of how those controls influence ethical practices. In addition, you will study the issue of advocacy as a part of the guardianship role of health care. Finally, you will explore the ethical issues of maintaining the competencies of your staff and your own competency as a part of your ethics obligations to the community.

In Chapter 6, you will explore how market forces influence the ethics of health care administration. This chapter includes a major section on managed care, which is now a key influence on all of health care practice. In addition, you will be introduced to issues related to the consumer-led movement toward integrated medicine (IM). IM, or as it is also termed, complementary/alternative medicine, holds great potential, but presents unique ethical issues for the system.

In Chapter 7, you will study the need for social responsibility in the health care system. While health care is a business, the community expects it to have a greater emphasis on social justice than other businesses. In this chapter the difficult issues of resource allocation and efforts to address access to health care are also explored. You will also look at prevention services as a social responsibility. Public health and its emphasis on social justice and prevention will be discussed. The chapter will help you decide what your relationship with public health should be and just how much you should be part of the prevention of disease. Social responsibility will also be examined in relation to issues of patient safety and quality of service. This chapter includes a discussion on the ethics of implementing the Institute of Medicine report called *Crossing the Quality Chasm*. In the end, you will be able to develop your own answer to the question: “Are we our brother’s (or sister’s) keeper?”

Chapter 8 presents the most challenging issues in the External Influences Section. It gives a brief overview of some of the current and anticipated advances in technology. A discussion of ethical implications for each of these modern miracles follows. You will come to understand that technology brings great promise to health care. But you will also see that health care is not always able to match its ethics with its technical achievements.

This section addresses many external forces that affect the practice of health care. These forces are complex and can even conflict with
each other. Because you are working in a business in which trust is the main commodity, you cannot ignore or de-emphasize the influence of your community. Yet, you are expected to run a business that provides a high quality product to meet community needs. How do you do that? While this section does not provide all of the answers, it will increase your understanding of these forces and challenge your thinking.
Quis Custodiet Ispos Custodes?
Who Will Guard the Guardians?

“Everybody’s for democracy in principle. It’s only in practice that the thing gives rise to stiff objections.”
—Meg Greenfield

Points to Ponder

1. Why is health care subjected to so many rules and regulations?
2. What do health care regulators say about ethical practices?
3. What can you do to practice ethics-based administration in light of multiple regulations?
4. How can you be an ethics-based advocate for health care?
5. What is your responsibility to ensure staff competence?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

ACHE AHA BFOQs
dogma HIPAA JCAHO
MGMA NCQA Poka-yoke
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

THE AGE OF ACCOUNTABILITY

JCAHO, CMS, NCQA, HEDIS, FDA, EEOC, AHA, AMA, HIPAA, IOM; these are just a few of the agencies that want to know how you conduct the business of health care. You can add numerous state and local agencies to this list. Add also the various managed care organizations (MCOs) with which you have contracts. Do not forget consumer groups such as the American Association of Retired Persons. When you consider the enormity of the burden of accountability, it becomes almost overwhelming. As a health care administrator (HCA), you are expected to meet the requirements and standards of this plethora of agencies and still maintain a profitable enterprise. This section of the chapter will assist you in understanding why the burden of accountability is so great and provide some examples of these multiple accountabilities. In Chapter 11, you will read about this issue from the viewpoint of the organization in terms of compliance that conforms both to the letter and spirit of the law. You will also see how organizations go beyond compliance to excellence, and how those decisions are influenced by organizational ethics.

The reality of health care organizations is that they work under the microscope and magnifying glass of both macro and micro accountability (Worthley, 1997). On the macro level, you are accountable to external regulators such as federal, state, and local governments. You are also responsible to your accreditation body or bodies. On the micro level, you are accountable to your patients, their families, and certainly, your superiors. Worthley (1997, p. 147) provides a set of questions to guide your assessment of your responsibility. He asks: "As health care professionals to whom are we accountable? For what are we accountable? How are we held accountable? Why are we held accountable? And what results from all of this?"

To answer his questions, you must understand the public’s view of the health care industry. To paraphrase an old song, “There’s no business like the health care business.” No other business has the amount and type of power over its clientele. It can literally kill its customers or heal them. It can cause them unnecessary suffering or relieve their pain. In addition, many of the practitioners in this business hold a monopoly on the ability to provide their services through certification and state licensure. This means that not only is the business of health care the most powerful one in the United States, but individuals within this business hold power over others.

American society has learned to have a certain level of mistrust for anyone or anything that wields such absolute power. History shows how such power can be abused by those who have less than altruistic motives to the detriment of the population. Therefore, society must protect itself from the professional power held by health care by taking certain actions. First, society must try to limit such power by limiting its boundaries. You can see this action evi
denced in external controls such as accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation (more on this later), Medicare/Medicaid regulations, and state laws that govern various medical practices. In addition, lawsuits and adverse publicity through the media can sometimes limit the power of organizations. The impact on an organization’s reputation and marketplace confidence should cause an organization to re-think its position. In the worst case scenario, such external forces can cause the organization to fail.

Society can also protect itself from the power of health care by trying to structure it. It establishes certain regulations regarding payment for services that control demand and supply. In turn, these regulations influence the structure of the system itself. For example, because certain areas are covered by insurance, they are more likely to be provided by the health care system and are included in its design. This puts some limits on what the system can do and serves to control its power. Some would maintain that without such controls, the health care system could become even more expensive and demand even more of the U.S. gross national product. Another example of control is the need for clinical trials and proof of effectiveness before drugs are released to the public. While this is not a foolproof system, it does try to curtail the absolute power of the drug industry.

Society also attempts to limit health care by checking the power of individual practitioners. You will learn more about this in this chapter’s section on staff competency. However, it should be noted that legislation on practice; continuing education requirements; accreditation of undergraduate and graduate programs; and to some extent, enrollment requirements all assist in limiting professional power. On the micro (i.e., organization) level, strict standards on employment practices including background checks; verification of credentials; formal policies on employee ethics; and serious investigation of employee actions that appear to violate the organization’s policies all serve to protect the public.

Shortell and colleagues (2000) provide additional reasons for the demand for accountability. The United States has a long history of valuing individual rights and the ability of professionals to make decisions about health care. However, the changes that have occurred in the health care industry have caused a greater demand for more community accountability. These changes include managed care, knowledge about the quality of health care and its problems, and information technology including the Internet. In addition, there is much more public awareness of how health care works because of news coverage and television programs. Today, consumers can actually be “in” the operating room and watch what is happening through entertainment programming. They see the hospital in action through “reality” and fictional programs. This up-close view of health care, whether accurate or not,
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

influences the demand for accountability for both the outcomes and the costs of health care practice.

The demand for accountability in health care has been increased by public attention to ethics violations in other industries. When you turn on the television or read any print news source, you cannot help but wonder what has happened to corporate ethics in general. You see chief executive officers (CEOs) being taken off in handcuffs and domestic divas facing time in prison. People have lost life savings through corporate scandals involving creative accounting and other practices. While these cases have ended up in the legal system, they began with the lack of ethical standards and practices in large corporations. The public is beginning to wonder if anyone in business has any ethics. Are the business ethics courses provided in MBA programs totally useless? The overall climate of trust for business in general is eroding.

Large health care systems are not exempt from this situation and have had their share of executives in disgrace. It is not surprising then, that the public wants more information about what is happening in health care. The potential erosion of trust is particularly bothersome for you as an administrator because, as Annison and Wilford (1998) have stressed, you are involved in a trust-based business. Without a high level of trust from the community, your bottom line can erode or even disappear. Imagine the level of accountability you would face if that trust is lost.

Given this concern from the public, whether it is a government agency, business contractor, or private citizen group, it is not surprising that you live in an environment of high accountability and constant scrutiny. You must be prepared to operate a profitable business entity despite this sometimes cumbersome environment. The first step in this challenging process is to know your organization. You will learn more about establishing a mission, vision, and values statement in Section III. But, you should keep in mind that knowing who you are as an organization assists you in meeting the compliance challenge. You will establish both formal and informal structures and practices that will keep you accountable to the values you espouse as an organization.

Next, you must know your confronter. In other words, you must understand the standards that govern your business practices and what they mean to your particular organization. This can entail many hours of tedious reading, telephone calls for clarification, and meetings with staff for interpretation and practice applications. However, because knowledge is truly power in this case, the payoff is worth the effort. Some examples of the standards you will need to know and how they specifically pertain to ethics will be discussed in this section. Standards relating to staff competence will be featured in that subsection of the chapter. While it is not possible to detail all of the articulated ethics
standards, you will learn about some of the major external influences including JCAHO, AHA, HIPAA, and NCQA.

The Dogma of JCAHO

Worthley (1999) points out that health care ethics is governed by dogma (or strongly held standards) that has its source in laws and regulations. One of the most prominent sources of such standards is JCAHO. This organization began in 1951 and was originally focused on hospital accreditation. Currently, in addition to hospitals, it accredits long-term care facilities including assisted-living centers. It is also involved in the accreditation of ambulatory care facilities, clinical laboratories, and behavioral medicine organizations including residential treatment centers and foster care. JCAHO provides accreditation for home health agencies and health care networks. Recently, it has added disease-specific programs to its list of accreditation functions. Although participation in the JCAHO process is voluntary for facilities, it is often viewed as essential. In addition, Medicare recognizes its inspections as a substitute for its own process. Accreditation in this case is tied to funding. In addition, many state agencies contract with JCAHO to review MCOs. JCAHO also publishes performance reports that the public can access through its Quality Check™ program. Because of its scope and depth of involvement in health care accreditation, this organization has great influence on both the practices and ethical standards for the industry.

There are sets of standards, which can number into the hundreds, for all of the facilities that are accredited by JCAHO. There is also an attempt to standardize indicators for these standards through the ORYX® initiative. Guidelines assist you in understanding and providing documentation of compliance. In addition, there is an onsite visit of JCAHO-appointed evaluators to verify your compliance.

This visit is expensive and requires many months of preparation. There used to be a time when a site visit meant that you made sure the carpets were cleaned, the walls were painted, and your documentation was complete. JCAHO accreditation used to be viewed as just meeting the minimum written standards. Now, the emphasis of a site visit has shifted to be more about the delivery of care and continued quality improvement. There are interviews with your staff, patients or clients, and their families. In addition, you might be selected for unannounced visits. This feature of the accreditation process is supposed to keep you vigilant in maintaining the standards.

JCAHO has specific standards that relate to your ethics. For hospitals this standard set is called Patient Rights and Organization Ethics (RI). There are separate standards dealing with ethics in patient care in
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

general; respect for the rights of patients in treatment; and patients’ involvement in their own care. Informed consent is stressed including separate standards dealing with participation in research. Standards are presented that stress the family and their right to be informed about care decisions and potential outcomes, and to be involved in decision making. Advance directives, withholding resuscitation, withdrawing life support, and end-of-life treatment are all included in the standard set. The patient’s right to pain management has also been assigned a separate standard. Organ donation and procurement have a standard.

In addition, JCAHO addresses respect for confidentiality, privacy, and security in separate standards. Pastoral care and spiritual needs are included. The hospital itself must demonstrate that it works under a code of ethics and that its code deals with its marketing, admission, transfer, and billing practices. Clinical decision making must be protected regardless of the financial compensation system used by the facility.

These are just some of the standards presented in section RI. You might think that RI includes all of the facility’s ethics requirements and your work is done if you comply. After all, they seem to comply with your previous reading about the principles of ethics including respect for autonomy, beneficence, and nonmaleficence. However, your thinking would not be correct. First, the standards themselves can be vague. For example, Standard RI.1.3 states that “The hospital demonstrates respect for the following patient needs: RI. 3.1 Confidentiality; RI.1.3.2 Privacy; RI.1.3.3. Security. . .” (U.S. Army, 2004, ¶ 18). This standard is open for many interpretations. Developing or implementing indicators that can be used to prove consistent compliance can be difficult. Second, even though these standards are helpful in ensuring some level of ethics for patients in hospital settings, they certainly do not encompass all ethics concerns. No specific mention is made of the ethical treatment of employees or of the employers’ treatment of vendors and contractors. Third, just meeting the standard does not constitute ethical behavior; you must go beyond the letter of the law. You will read more about this issue in Chapter 11. JCAHO recognizes that recent business scandals have created a need for more information about organizational ethics. The Commission has even published an e-Book on organizational ethics, which is available through its Web site.

The Dogma of AHA

Another agency that has influence on the hospital and its ethics practice is the American Hospital Association (AHA). This organization represents the interests of hospitals and other organizations in national policy development. It has been an organization since 1917 and still addresses health care issues today. For example, its current president is involved in grassroots reform of the health care system to better serve the needs of this nation in the future.
With respect to ethics, the AHA has published the *A Patient’s Bill of Rights* since 1973. This document has gone through many revisions and is now available on the AHA Web site in multiple languages. The current iteration contains 12 points including the right to considerate care; accurate information about their condition and treatment; and the ability to make informed decisions. It also addresses issues of personal privacy and confidentiality of records, advance directives, and continuity of care. In addition to patient rights, the document addresses patient responsibilities including providing information on symptoms, prior illnesses, and prior treatments including medications. They also must provide a copy of an advance directive if one exists. Hospitals commonly provide the AHA *A Patient’s Bill of Rights* to all patients on admission.

This document tries to help patients understand their rights in the often alien environment of the hospital. The document addresses many of the principles that you have studied such as autonomy, beneficence, and nonmaleficence. However, it can also pose problems because it can be misinterpreted by the patient. First, he or she might not even read the document and just assume that certain procedures will be done. Because the language is not concrete, even if he or she does read it, there is no guarantee that it will be fully understood or correctly interpreted. So it is imperative that you make sure that your staff knows what *A Patient’s Bill of Rights* means for your institution and can correctly interpret its meaning to your patients.

Just having a document about patients’ rights does not mean that these rights will be ensured. Continuing education, monitoring, and other administrative actions will still be needed to ensure the practice of patient-centered ethics. Just as you saw with JCAHO, AHA does not address all of the ethical issues you face as an HCA. You still must work to ensure the ethical treatment of staff, vendors, contractors, and the community at large.

**The Dogma of HIPAA**

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) as an attempt to engage in health care reform and to deal with new issues facing the industry. The act had several objectives including assurance of health insurance coverage when there was a job change and or when pre-existing conditions existed, reduction of fraud and abuse, standardizing health information, and ensuring security and privacy of health information. The legislation had several titles to address all of these objectives. The Administration Simplification provisions dealt with rules for compliance with this act and addressed electronic claims submission, including standards of privacy, confidentiality, and maintenance of health information.

This legislation has an impact on almost all health care institutions and vendors who serve those institutions. Even educational institutions
that have any contact with those institutions were affected by HIPAA. You can imagine how confusing the initial communications about the law and its mandates were. There are now numerous documents that serve to advise you on HIPAA compliance, and whole industries have surfaced that work to assist you to maintain compliance. All staff have to be educated on both the provisions of the fraud and abuse and privacy aspects of the law; this training must be documented. The costs for coming into compliance are estimated to be in the billions, and the law offers no mechanism for recouping these costs.

The positive features of the law are that electronic transfers should become much easier and more cost effective. Security upgrades should improve the confidentiality of patient data. Patients do have the right to know who has seen their medical records, and to protect the use of their personal information within a health care organization. In addition, staff have become much more aware of the potential for violating confidentiality. There are procedures for taking health histories; actions to take when staff talk about patients in elevators; and methods to prevent marketing firms to access patient names and addresses. Ethics aspects of autonomy and respect for patients can certainly be seen in the provisions of HIPAA.

What does this mean to you? Of course, you will be responsible for making sure that your organization does whatever is needed to be in HIPAA compliance. You may be spending long hours reading the many publications that relate to this law and keeping up with its revisions. You also have to ensure that training and its documentation are correctly done either through in-house programs or contracts with vendors.

As with any area that deals with ethics, mere compliance with regulations will not ensure that health information is protected. You will be engaged in various monitoring, evaluation, and education efforts. You will read more about this in Chapter 11, which deals with going beyond the letter of the law in compliance situations. HIPAA will certainly be a part of your life as an HCA now and in the immediate future. While it can cause you stress and additional expense, you should be better able to cope if you understand that its intent is to provide more ethical practices when dealing with health information and electronic records.

The Dogma of NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that monitors and accredits the managed care industry. Accreditation at this point is voluntary but, according to its Web site, almost one half of all health maintenance organizations are accredited, with many other types of MCOs participating in the process. In addition to its accreditation duties, NCQA maintains an
informational Web site called Health Choices where employers and employees can access specific information about quality in MCOs. It also publishes a report (which can be found on its Web site) called The State of Health Care Quality. The report provides information based on data derived from its Health Plan Employer Data and Information Set performance standards.

Recently, this organization has become even more specifically concerned with ethics through its new Partnership for Human Research Protection, Inc. Accreditation Program. This program is a collaboration with JCAHO to ensure protection of human subjects in organizations that conduct research. Protection standards include a self-evaluation, an off-site review of the self-evaluation findings, and an on-site visit to evaluate compliance on standards. Areas such as institutional review board operations, informed consent, and patient communication are considered in the evaluation.

How Does All This Affect You?
We have examined just a few of the agencies that have standards of conduct to try to limit the power and influence the ethical practices of the guardians of health. Sometimes these standards seem overwhelming and they can be contradictory. They can make you feel that you are operating your business in a fishbowl. You are examined by so many external sources and so busy with such long paper trails that you can feel more like a paper pusher than a professional administrator. So on a visceral level, this multiple accountability can be almost painful. However, you must consider it part of the overall cost of doing business.

In the immediate, you must be able to juggle these responsibilities and still maintain your positive staff relations and attention to the bottom line. You also must take an active role as a continuous learner to keep up with any changes in current standards or the addition of new ones. In the next section of this chapter, you will learn how to have a greater impact on what laws are passed and how they influence you and your organization. In Chapter 11, you will learn how to go beyond the letter of the law to capture its best impact on organizational ethics.

THE ETHICS OF ADVOCACY
How can you run your business in spite of all of this external control? How can you be proactive rather than reactive? Certainly, no one would argue that regulations, standards, and indicators are costly in both time and in the fiscal resources required to address them. However, none of this will change if you remain passive or just react to every new obligation.
First, you must understand that the larger community might not have a good understanding of the business of health care. You have already learned that individuals and law makers have differing views of what it is and what it should be. Therefore, if you expect positive change in the future, you must be willing to assist in increasing understanding of the true nature of the health care business. You must become an ethics-based advocate for your particular organization, your part of the industry, and for your profession. The advocate role will require you to be aware and informed; be actively involved in the community and in legislation; and model the behavior that you expect of others (“walk the walk, not just talk the talk”).

Being aware and informed first requires that you research the current state of legislation in your area. This includes not only pending federal legislation but also state and even local laws. You also need to maintain currency in the main health care issues facing your community. Numerous databases are available that capture findings about the prevalence of health care issues. It is also smart to maintain a connection with your local public health department because it has information about state and local issues that are current or that might surface in the near future. Of course, journals abound with information about national trends in health including health problems, ideas for dealing with these problems, and pending legislation about these problems. For example, the media has publicized the rapid increase in childhood obesity and diabetes. A prudent HCA might consider that, when the awareness of this issue reaches sufficient strength, there will need to be programs to address it. If appropriate, a treatment program for this problem can be something that an organization should consider as a new revenue stream.

Being an advocate also means getting involved. You already saw the need to have contact with public health to maintain your knowledge. It is also proactive to examine the idea of joint initiatives to increase the likelihood of preventing expensive health problems. These might include community health assessment projects, health fairs, school programs, and other prevention-centered activities. You also might consider becoming an active member of the various groups and associations that represent your particular part of health care such as the local, state, or national chapters of the hospital or long-term care associations. Being an active member means more than just going to meetings. It would involve being on committees, giving presentations, or even holding office to support your part of health care. Finally, you should also consider being an active member of your professional association. For many who are administrators in the clinical side of health care, this includes tie-ins with organizations devoted to nursing, respiratory therapy, dentistry, mental health, or medical education, among others. A great many opportunities are available for advocacy in the
local, state, and national chapters of the American College of Healthcare Executives (ACHE) and the Medical Group Management Association (MGMA). Their Web sites have been included in this chapter for your information.

You may be saying, “How can I afford the time to do all of this and still have a life?” This question is very appropriate. But consider the cost of non-involvement. It can mean that you and your organization are left behind when trends occur that can either be beneficial or detrimental to your health care business. You also might consider that, as an HCA, you are expected to be on top of things. If you maintain currency, you will become the go-to person for information and ideas about new initiatives. If you are prepared, this could be a true career builder. Finally, in order to “have a life” you should choose your advocacy opportunities wisely. You do not have to do everything, but making a contribution, reading your literature, scanning the Internet, and maintaining liaisons with public health offices can go a long way to keeping you “in the know” about current problems, pending legislation, and future business initiatives. Certainly, there will always be paperwork and long hours. But by participating in legislation, community activism, or associations of professional interest to you personally, you will find that you do, in fact, have a life.

THE ETHICS OF STAFF COMPETENCY

When patients or clients enter the health care system at any level, they make at least one assumption—that those who are treating them know what they are doing. This assumption of competence is essential to the foundation of trust on which health care is built. Because healing is not just based on drugs or surgery, but also on faith in the healers, it can be said that this assumption is crucial to healing itself.

As members of a business that is charged with guarding the community’s health, you must take the ethical responsibility to ensure the competence of all staff who provide or influence patient care. Obviously, this includes those who provide direct patient care such as physicians, dentists, nurses, and counselors. However, it also includes anyone who supports the facility such as engineers, information services technicians, and housekeeping staff. In short, anyone who works in the health care setting should be competent to perform the tasks of his or her position. In this section, you will learn about practices and issues related to the ethics of ensuring staff competence.

Practices for Competency Assurance

Fottler, Hernandez, and Joiner (1994) devote several chapters of their text to ensuring staff competence through human resources functions.
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

The ethical responsibilities related to staff competency assurance actually begin with the analysis of the job itself. You need to be accurate and honest in determining just what is needed in each position and in assessing the level of required education and credentials. Your initial analysis will form the basis for the other human resources tasks of recruitment, selection, training, and performance appraisal.

Each of the stages of staff acquisition and retention has its own ethical responsibilities and challenges. For example, in the recruitment stage, you should have a thorough understanding of the type of professional you want to recruit. This should include the job analysis mentioned earlier but should go beyond the basic job description. Be aware of any specific requirements for the position, also called Bona Fide Occupational Qualifications (BFOQs) so that you can be accurate and honest in your recruiting efforts. When hiring health care professionals, regardless of their job title, you must also consider more than just their knowledge and skills. Attitudes, professional ethics, and ability to work with team members are equally important. Determine what kind of person you want to hire, because being professional includes knowing “who one is and one’s way of being” (Kuczewski & Pinkus, 1999, p. 167). Be sure to have a plan for recruitment and check all advertising and application materials ahead of time for concurrence with the Equal Employment Opportunity Commission rules, the organization’s mission statements, and ethical practices.

During the selection process, many ethics issues can arise. First, you must be very careful to treat all applicants fairly and with respect. Even if the applicant in no way meets the position criteria, he or she should be treated with courtesy. You might have to discuss telephone protocols and review correspondence for ethics assurance. You are the organization to this person, so you want to be seen as friendly but professional.

You can choose to conduct telephone or in-person interviews on an individual or group basis. Be very careful about the way that you ask questions. Try to link your queries to the job analysis, allow time for responses, and remember to let the applicant ask questions. Be sure to provide honest answers about your organization, but do not stress the negatives unnecessarily. Remember that interviews have many sources for bias including the first impression of the interviewee, responses from candidates who preceded him or her, and physical appearance. Also remember that the interviewee is trying to be on his or her best behavior, but can also be very nervous. Obviously, you are not getting a complete picture of the candidate.

Checking references and credentials has become a key ethics responsibility in ensuring staff competence. In the past, people have engaged in such fraudulent practices as writing their own reference letters, altering transcripts, and forging licenses. Reference and credential verification, while expensive and time consuming, is essential for preventing
such irregularities. Remember that a reference letter can be politely, but not entirely honestly, written. If you choose to follow up a reference letter with a telephone call, be prepared in advance with your questions so that you do not waste the person’s time. Allow time for response and listen to both the words and the tone of the response. You can learn a great deal from the conversation. Be sure to make careful notes so that you can provide an accurate account of the conversation. This will help in later decision making about choosing the best fit for the position.

With respect to credentials, be sure to inform the applicant about what documentation is necessary. You should stress that he or she must be able to document a current licensure, educational background and training, and certifications if needed for the position. The applicant must also be informed that these proofs will be checked. In large organizations, the human resources department will assist you in the verification process, but in smaller organizations, you might be responsible for it. Be sure to ask that official copies of transcripts be sent directly from the colleges or universities involved. You will also need to verify current licensure and check for any suspension, modification, or termination of license. Be sure to get copies or verification of all licenses because the individual can be licensed in several states. This becomes an issue because the license in your state might be current but the person perhaps has a suspended license in another state.

You definitely need to check for citizenship and authorization to work in the United States, and for any felony convictions. If appropriate, liability coverage should be verified. You can see that this is a time-consuming process but one that is absolutely necessary to ensure staff competency in the hiring stage. Be sure to be current on all policies and procedures relating to employee selection so that you do not overlook important information. For example, some organizations require a physical exam, testing on Occupational Safety and Health Administration or HIPAA requirements, and drug testing before an offer for a position can be given.

After the employee is hired, your responsibility for ensuring staff competence has not ended. First, you must provide an orientation to introduce your new staff to the values and standards expected in the organization. This process can be somewhat lengthy depending on the complexity of the job responsibilities and the level of the new hire. For instance, a novice employee might require much more time for orientation and supervision than will an expert one. Some organizations function on a mentor system where the new employee is matched with an appropriate mentor. Usually the mentor is two or more levels higher than the protégé. If this system is used, care must be taken in matching up the two people, because the mentor will most definitely serve as a role model and have a great influence on both the practices and attitudes of the protégé.

The organization also has an obligation to provide job-related in-service education that goes beyond orientation. During these in-service
sessions, specific training can be provided, such as the use of new equipment. Providing onsite training is also helpful to ensure consistency in the level of professional competence. Be sure to document competence achievements in the required skills and maintain those records. In addition, in-service time can be required to keep staff informed about specific policies and procedures, and defend attitudes that are required for the positions. For example, if the mission of the organization has been revised or a new program has been introduced, a staff in-service program might be required. It is your responsibility to ensure that staff are kept informed regarding job requirements and responsibilities. The process you use to deliver this information will vary depending on the size of your organization. If you have a human resources department, it can help you make information delivery decisions.

There are differences of opinion regarding the organization’s role in maintaining professional currency and continuing education requirements for licensure. Some organizations believe that it is the professional’s responsibility to maintain his or her own license and do not offer any assistance with this process. Other organizations feel an ethical responsibility to cover the cost of continuing education units (CEUs), because they require a current license for employment. Many organizations use some combination of the two and provide released time for continuing education, some coverage for fees, or assistance with travel expenses.

If you choose to support continuing education for your employees, you must practice the principles of fairness in your policies. Be wary of “meeting hogs” who want more than their share of the travel budget, while less aggressive employees seldom get support. You will need to have clear policies about what kind of meetings and continuing education events will be covered, the amount and type of support that is offered, and who is eligible for this benefit. Some departments have chosen to award a flat amount per employee per year for CEU efforts. Your message should be that all employees are equally valued and that you are interested in keeping them current in their field. You might even have to encourage some employees to take advantage of the CEU benefits. However, positive and fair policies in this area can go a long way toward maintaining department morale. Remember to keep accurate records of who is attending CEU programs and what they have attended so that you can demonstrate your stewardship of scarce CEU funding. Be sure to consider all staff in your plans for employee development support and not just the clinical professionals.

Experts in business encourage investment in training and employee development as ways to reduce turnover, increase morale, and stay competitive in hiring the best staff (Fottler et al., 1994). However, there is a risk in being too generous with staff development and CEU benefits. Less than ethical employees might choose to gain advanced degrees
and credentials through your facility’s generosity and then resign for a higher paying position. To avoid this ethics-based problem, many organizations require a signed contract from those who avail themselves of this benefit. The contract might stipulate that they will serve a certain amount of time after achieving their goals, or reimburse the facility for the costs of their education if they leave early. Of course, any such contract would have to be evaluated by the legal and human resources staff before it is even discussed with employees.

**Ethics and Incompetence**

What happens when a staff member demonstrates a lack of competence? This is one of the most difficult and emotionally draining problems for the HCA. First, you must understand that incompetence can be due to several reasons, including impairment from psychoactive drugs and health and personal issues. While many people in the United States take psychoactive drugs such as alcohol, caffeine, or tobacco, sometimes their use can interfere with professional judgment or patient safety. If there are signs of this, action must be taken. In the early stages of impairment, the symptoms might not be recognized by individuals or their coworkers. In addition, well-meaning coworkers sometimes enable the behaviors by making excuses, covering up mistakes, and privately complaining but taking no public action. They might choose to remain silent because they have engaged in the same behavior themselves, do not want to be a snitch, or be responsible for another’s loss of livelihood. Some even fear retribution if the impaired person is seen as having power in the organization.

What should the ethical HCA do about such problems? First, you should remember that it is always better to be proactive than reactive. Policies should be in place that spell out acceptable and unacceptable behaviors. For example, it used to be acceptable to have an open bar at organization functions. While it was not a solid career move to overindulge at such affairs, many did so without repercussions. In today’s health care environment, a policy to look the other way would be highly unusual. It is best to avoid serving alcohol at functions or, at the very least, to limit its potential for misuse.

Education is always a good idea as a proactive strategy. You can educate staff on the policy, and on the signs and symptoms of impairment. Be sure to include information about resources that are available to assist the impaired person. For example, many states have special programs for impaired physicians and nurses. Your human resources (HR) department can be a great source of information on this topic. In addition, if your organization is large enough to have an Employee Assistance Program (EAP), be sure to consult with them regarding available services.

Check to see that you have appropriate policies in place for reporting suspected impairment with protection for the person doing the
reporting. Remember that failure to report can be viewed as negligence, especially if a patient is harmed. However, do not jump to conclusions if a report is made. Not all reports are true, so spend time investigating and obtain the assistance of the HR department in this effort. When you do confront an impaired employee, be prepared for denial and hostility. It is wise to have an expert from HR or your EAP to assist you and serve as a witness. Always remember your principles of ethics and duty to the patient when dealing with any impairment situation. Using appropriate counseling and interventions can prevent future problems and save someone’s career.

Finally, you should be aware that a lack of competence is not always caused by substance abuse. Sometimes the aging process, early symptoms of Alzheimer’s disease, or other health issues will cause impairment in the ability to effectively treat patients. Emotional problems such as going through a divorce or the death of a loved one can temporarily impede the ability to make sound judgments. If you have created a working environment of respect and trust, individuals can self-report such problems. If this happens, you should take time to counsel the employee and refer him or her to the appropriate source of assistance such as compassion leave, EAP services, or HR. If the change in behavior is reported by staff, you should investigate, while doing what you can to preserve the individual’s self-respect and dignity. Again, be prepared for a strong reaction when you confront behaviors. This part of your work as an HCA is not easy. However, doing it well, with regard for both the staff member and the employee, you will increase your value to the organization and honor your role as guardian of patient safety.

What about Your Competence?
Steven Covey (1989) in his now classic work, *The Seven Habits of Highly Effective People*, stresses it. Carson Dye (2000) devotes a whole chapter to it in *Leadership in Health Care: Values at the Top*. What is it? It is the necessity for self-evaluation and assurance of your own competency. If you are an ethics-based HCA, you do not wait until your annual evaluation to appraise your level of competency. You should choose to engage in consistent self-assessment and in the process of lifelong learning.

How does this translate into your daily routine as an administrator? First, in keeping with what you learned from Frankl’s work, you would take time to think about the meaning of your work. This might mean taking some time in your busy schedule for contemplation and determining the answers to the difficult questions that really matter in your career. You should ask yourself questions like: “Why am I here? And what do I want to do with my life?” You examine the meaning in your work by asking: “Where can I make a difference? And what do I see
myself doing in five years?” Finally, you should think about the global question of: “For what do I want to be known?”

Many HCAs find it helpful to write a personal mission statement based on this process of contemplation. They review this statement at least annually (often on their birthdays) to see if it is still true or needs revision. It also serves as a compass for making career decisions. For example, comparing your personal mission statement with that of your organization can be very insightful. Do you respect its mission? Is it reasonably compatible with your own? This assessment gives some guidance when considering a new position or thinking about a job change, because it would be difficult to support an organization that you do not respect or whose practices directly oppose your core values. You will learn more about personal mission statements and ethics in Section IV of this text.

Conducting an ethics self-assessment is also helpful to identify your true “ethics bottom line.” You need to think about your own definition of integrity and not just the textbook definition. For example, you could ask yourself, “What principles or events would cause me to resign?” Or, “What principles am I willing to state publicly and act upon?” The ACHE has a self-assessment tool that many have found helpful in this process. It helps you to examine your ethics in an organizational context. You will read more about this when you examine codes of ethics in a later chapter.

You then need to take the time to write these statements down for your personal ethics code. You can put them in a place where you can easily refer to them, such as the middle drawer of your desk. The really brave HCAs state their personal ethics in a document suitable for framing and post them in their offices. This means that, not only are they willing to articulate their “ethics bottom line” but they are willing to have staff know what it is. This lessens the temptation for hypocrisy.

After self-assessment comes the process of building and maintaining your professional competency as an HCA. When you graduate from school, you will possess certain knowledge, attitudes, and skills that make you competent to practice health care administration in certain settings. While you should have a positive feeling about your accomplishment, it is only the beginning. You will add many more levels of competence as you progress through your career. Much of this will come through actions and self-assessment of those actions that builds to experience. You might want to seek out a mentor to assist you in building your experience-based competence. Be careful to find a person you can trust and who is at least one or two levels above you in the organization. This should also be a person who is willing to take time to help you assess your strengths and areas for improvement in an honest, but not ego-crushing, manner. Mentors can also provide insight into the arcane organizational culture and its unwritten rules so that you do not step on someone’s toes because of your ignorance.
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

Once you have identified your strengths, do not be too complacent. You cannot rely just on these areas or always assume that they will be there. Just like a muscle, if your strengths are not used and reinforced, they will diminish. You must continue to use and build those areas. You also need the humility to work on areas of improvement. When you are a new graduate or in a new position, you have a honeymoon period where you are not expected to know everything. Take advantage of that time to ask questions and listen to the answers to those questions. You will be forgiven for not knowing everything, and you can learn much during this period.

You also need to consider your own continuing education opportunities. These can be met on a formal or informal basis. For example, consider taking continuing education courses through your local ACHE, MGMA, or community resources. If you are strong in a certain area, you might consider becoming a part-time teacher or workshop leader. Nothing helps to reinforce what you know or to make you learn new areas like teaching them to others. Some organizations have programs for administrators where they do the job of one of their staff (nonclinical, of course) for one day or one-half of a day. Participants in these programs report a great increase in their understanding of staff’s contribution to the organization. Staff also appreciate an administrator’s willingness to understand their role in the organization, so it is a win-win situation. Finally, if you are in a position to do so, become a mentor to a new HCA or an experienced one who has recently joined your organization. Your efforts will help to reinforce your own learning and assist in the career building of another.

Competent HCAs do not isolate themselves from their communities. You need to take advantage of opportunities to be involved in appropriate organizations as either a member or an officer. These organizations can include the local Rotary Club, the Kiwanis, or the Boy Scouts or Girl Scouts. You might also consider being on advisory boards for HCA programs at local colleges, public health programs, and other health-related organizations. Remember that you are always representing your organization when you do anything in the community, so you will have to pay attention to your words and actions. However, putting yourself “out there” to have a better understanding of the real issues facing your community is worth the extra effort. It also improves your image and that of your organization.

In light of your busy schedule, just how are you supposed to find time for all of this competence assurance? First, you cannot afford not to find some time for it. You are the role model and cannot expect something from staff that you are not willing to do yourself. Second, making the time investment discussed here can have a substantial return on investment. Not only can you build up your career, but you can have a greater understanding of what you want in life. Third, you
Cases for Your Consideration

will have a better understanding of your organization, your staff, and your community. This will help you to be more effective in your daily operations as an HCA. Finally, you will be a more complete person who has a good level of self-understanding and desire to grow and adapt to the ever-changing environment that is today’s health care administration.

Summary

In this chapter, you can see that health care exists in an age of multiple accountability. You are expected to comply with regulations from a great many external organizations that serve to protect the public’s interests. You learned that you need to be an advocate for your organization and profession through maintaining current knowledge and getting involved. The chapter also presented your responsibility for ensuring your own competency and that of the staff. Because you are part of a trust-based industry, competency assurance is vital to ethical organizational behavior.

Cases for Your Consideration

The Case of the Novice Nurse

As you read this case, consider the following questions. Responses and comments will follow the case.

1. How effective was the orientation process for intensive care unit (ICU) nurses at St. Dismas Hospital?

2. What could have been done to prevent this situation from occurring?

3. How do you think Lawanda’s family feels? What about the client’s family?

4. What action needs to be taken to address this situation and decrease the damage to St. Dismas?

Case Information

Lawanda Person was a recent graduate of a BSN program. She had only one year of experience in Medical/Surgical units when she was hired by St. Dismas Hospital to be a staff nurse in the ICU. The situation for this case occurred during the fourth week of her six-week orientation. On that particular day, she was assigned two clients who suffered an anterior myocardial infarction (MI) and were both 48 hours post event. One of the clients was still on a ventilator. Lawanda had been assigned to be the medication nurse, should a code happen during her shift. This meant that if a code was called, she would be the team member to give physician-ordered medications to the clients.
Just before her shift was to end, Lawanda’s ventilated client went into code. The code team arrived and CPR was begun. The code had lasted over 20 minutes when the nurse behind her handed Lawanda a syringe. Without any further action, she injected into the IV line. Immediately, the client reacted to the medicine and his heart stopped. The client was pronounced dead at 10:30 P.M. Lawanda felt sad that the client died, but knew that she had done everything she could to save him.

After the code, the nurse supervisor completed the documentation and checked the procedures used. She discovered that the wrong medication had been injected into the client. Apparently, there was a mixup in the medication drawer, and the syringe was drawn from the wrong bottle. The nurse manager and the physician were immediately notified, and an investigation was begun.

The next day at the beginning of her shift, Lawanda was called to the nurse supervisor’s office. She was told about the medication error that was made on the code. The nurse supervisor said, “You killed that client last night. You were the one who was in charge of the meds and you did not check them. You are going to lose your license over this.” She told Lawanda that she must call and report herself to the state board of nursing. In addition, she might be subject to fines and jail time for the medical error she had made. The nurse supervisor also threatened to put her on suspension. Even though Lawanda was visibly upset by this news, the supervisor told her to “get some backbone” and finish her shift.

Lawanda went back to the ICU and, at the first chance she could, called her parents to tell them what had happened. They told her that they would do whatever they could to help. However, this did not make her feel better. She could feel the cold stares of the staff who would not speak to her during the shift. She tried to be attentive to her patients, but the supervisor’s words echoed in her head. She was a murderer! She might go to jail! She began to imagine what was going to happen to her during a full investigation of the event and how her mistake was going to cost her everything she had. She thought about the humiliation of being taken before board and losing her license.

Somehow she made it to the end of her shift and then she made her decision. She went to the medication drawer and took a bottle of potassium and a syringe and put them in her pocket. On her way out of the lobby, she entered the restroom, locked the door, and gave herself a fatal dose of potassium. Her body was found by the housekeeper later that evening and an emergency call was made, but it was too late. The CEO was called and he made the necessary notifications including the hospital’s attorney. He also called Lawanda’s parents. Understandably, they were shocked and angered by the news and accused St. Dismas of...
“killing our daughter.” Soon after this conversation, they contacted their attorney and alerted the press.

**Responses and Commentary on Questions**

1. How effective was the orientation process for ICU nurses at St. Dismas Hospital?

On the surface, it seems that this is not an effective orientation program at all. After all, a client died as the result of a medication error that could have been prevented. However, the program itself perhaps was not totally responsible.

First, you need to consider the hiring practices that preceded the orientation process. It could be argued that St. Dismas, like many other hospitals, was facing a nursing shortage and, therefore, had to take a chance on a nurse with limited experience, and none of it in the ICU. However, the overall costs of this decision were great. A client and a nurse lost their lives, and the hospital faced the potential for tremendous negative publicity. In fact, it took several years before it regained public trust completely. In addition, Lawanda was assigned full care for two clients even though she had not finished the entire orientation program. Perhaps, this was just too much responsibility for her at this stage of her orientation process.

*Comment:* This case makes a good argument for having a well-designed orientation program to be completed by your staff. You need to consider not just an orientation to the routine practices for your institution, but also prevention strategies. It is a good idea to have your organization’s legal support personnel evaluate your program to see if it contains the most significant information. In terms of prevention of medication errors, some organizations have begun using *poka-yoke* or error prevention practices, including bar coding for medications. If such practices are active in your organization, they certainly need to be featured in your orientation program. You also need to evaluate the program frequently and actually review these data and use them to make appropriate updates. An out-of-date or inaccurate orientation program will not help the staff or the organization.

2. What could have been done to prevent this situation from occurring, other than instructions given in the orientation program?

You must begin at the beginning. During a code, there is a great deal of stress, even though protocols have been clearly defined. However, in the haste to save a life, sometimes these procedures are overlooked or omitted. Clearly, Lawanda was not the only person to make an error here. The nurse who was responsible for obtaining the drug failed to check and re-check to make sure she had the
correct medication as ordered by the physician. When Lawanda received the medication, she should have verified that it was the correct one before injecting it. Failure to follow the protocols was the cause for making and not catching the medication error.

What about the actions after the code? The correct procedure for documentation and verification of the process was done by the nurse supervisor. When she did find a problem, she followed the correct procedure for notifications. It was also correct that an investigation needed to be conducted and the individuals involved needed to be made aware of the seriousness of what occurred.

However, the way she dealt with Lawanda was totally inappropriate. First, the supervisor assumed a tone of accusation and blame even before the full investigation was completed. She also threatened Lawanda with jail and loss of license rather than getting to the bottom of the situation. In her anger over what happened, she failed to consider the effects her words would have on this novice nurse. Rather than deal with the situation fairly and apprise Lawanda of what could happen and why, she chose to present the worst case scenario without complete knowledge of the situation. Then, to add to the problem, she told Lawanda to complete her shift, thereby potentially endangering clients.

The nurse manager should have been given proper instruction on how to handle situations where bad news must be given. Lawanda had a right to know what had occurred and what was being done about it. She also had a right to be told in a professional manner. In addition, there should have been a policy concerning her status while things were being investigated. Minimally, she should not have been working with clients on the day that she learned of the incident and the investigation. The potential for causing unintended harm to clients was too great.

You should also look at the behavior of Lawanda’s coworkers. By ignoring her and, even worse, talking about her when her back was turned, they demonstrated a presumption of guilt. Perhaps some compassion or support was too much to expect, but they should have treated her in a professional manner. In addition, no one seemed to be watching the medication drawers, which made it very easy for Lawanda to obtain her fatal dose. Do her coworkers have any ethical burden here? Perhaps they should have been educated about appropriate behavior in such circumstances.

3. How do you think Lawanda’s family feels? What about the client’s family?

Can you even imagine how Lawanda’s parents felt? They were only aware of the situation at St. Dismas on a surface level. They had one quick phone call from their daughter, who seemed terri-
bly upset by what the supervisor had said. However, she was going to finish her shift, so they had no real indication of how severe those feelings were. Perhaps, they were feeling some guilt for not going to the hospital and insisting that Lawanda come home. However, she was an adult and they did not want to interfere. They were also angry at the facility staff for their treatment of their daughter and felt that the way Lawanda was told about her situation caused her suicide.

As for the client's family, they certainly were upset. While an MI is a serious problem where death can occur, they lost their loved one through an error made by people that they trusted. Besides the grief from the loss, they are probably feeling confused and angry. It would not be at all surprising if St. Dismas received a telephone call from their attorney.

4. What action needs to be taken to address this situation and decrease the damage to St. Dismas?

Because this situation now involved the law and the media, there was a need to be in contact with whoever provides legal counsel for the hospital. This person would have provided St. Dismas administrators with information on how to deal with any action that is taken against them and how best to handle the press to protect the hospital's interests. In addition, an internal investigation needs to be conducted so that all of the facts are known. Any appropriate actions would need to be taken and documented.

In dealing with the press, the hospital would be best served to have a designated spokesperson, who would be forthcoming with the appropriate level of information. The spokesperson should be cautioned to avoid the use of “no comment” (it only makes the person appear to be guilty) and instead to direct the inquiry to the appropriate contact person. Staff members who were involved should be instructed not to speculate in the press so that the situation does not become even worse. Regaining the public’s trust in St. Dismas Hospital after such a situation would take much additional effort and time.

**The Case of Patient Safety and BFOQs**

As you read this case, consider the following questions. Responses and comments will follow the case.

1. What motivated Sara and Emma to report their supervisor?
2. What should Stan do in this case?
3. What needs to be done to prevent future situations of impairment?
CHAPTER 5  WHO WILL GUARD THE GUARDIANS?

Case Information
Stan Delouse was the assistant director of HR at Seraphina Compassionate Care Center (SCCC), a specialty hospital for the treatment of cancer. On Monday morning, he was greeted at his door by two of the RNs from the Evergreen Floor. After introducing themselves as Sara Katz and Emma Smith, they informed him of the reason for their visit. It seemed that Linda Chard, their nurse supervisor, was no longer able to do her duties. She was, they said, “so fat that she does not even leave the desk anymore unless it is to take a smoke break.” They described her as being only five feet four inches tall but weighing at least 250 pounds. While her weight was not a new issue, her latest incident caused them to be concerned enough to report it to HR.

On Sunday night one of the patients on Evergreen had a code. Ms. Chard was the first one in the room but she could not even begin to provide basic CPR. She was too heavy to reach across the bed and assist the patient. Further, she appeared to be having symptoms of shortness of breath herself. Fortunately, Sara and Emma were there almost immediately and began the correct procedures. The two nurses did not want to be seen as “tattletales” but they were very concerned that Ms. Chard’s health condition was putting patients in jeopardy. In addition, they felt it was unfair that they had to cover the supervisor’s duties because her weight and shortness of breath interfered with her ability and desire to do them. They both wanted Stan to address this issue, but they also had some fears of retaliation.

Responses and Commentary on Questions
1. What motivated Sara and Emma to report their supervisor?
   First, you can consider an ethics-based motivation for their actions. They work in a facility that is dedicated to meeting the needs of patients who are in varying stages of pain and suffering. Consider what it took to report on someone who has power and authority over them. They might genuinely be concerned that Linda’s health could compromise that care and jeopardize the healing of patients. They also might be somewhat concerned with the injustice, as they view it, of having to do Linda’s work as well as their own. They are asking for an investigation into the matter.

   On the other hand, they might be angry at Linda for something totally unrelated to the situation. Their motivation might be less than ethical and include a desire to cause difficulty for their supervisor. Perhaps, they are prejudiced against people who are overweight or obese and or who are health professionals who smoke. Stan needs to investigate this information about Linda without making a prejudgment of fault.
2. What should Stan do in this case?

First, Stan should review the job description related to Linda’s current position. Were there specific BFOQs that related to the physical ability to do the job? If yes, it makes his job a little easier because Linda would have been hired under these conditions. If physical abilities were not spelled out, he might have to contact the legal team to get advice before taking any direct action.

Next, he needs to consider the source of his information and its motivation. He should be sure that other issues are not present here and that the information presented is accurate. He might contact the director of nursing (DON) and ask her to stop by his office. Then, he could have a confidential conversation about the situation that was just presented to him. He could verify the information given and ask for further information. Do Linda’s health issues truly have an impact on her ability to successfully meet the needs of SCCC’s patients?

Assuming the answer is yes, Stan needs to handle the situation with a concern for the ethical treatment of staff. First, he needs to prepare himself for a meeting with Linda. Remembering the cost of termination, recruiting, and rehiring, he must develop a plan to solve the problem without having to fire Linda. The DON should be consulted about this plan and invited to come to the meeting. Asking Linda to come to the HR office could create anxiety, but he cannot afford to ignore the problem. So he starts by holding the meeting in his office. He begins by telling her the reason for the meeting and stating the facts as he knows them, including the BFOQs for her position. Then, he should take time for compassionate listening.

Because this situation potentially threatens her livelihood, Linda might be angry and defensive. Stan should allow her to react and to give her version of the case. After she completes her comments, Stan should make note of them and ask for her ideas about how to resolve the situation. This will help her be a part of the solution and not the victim of it. Perhaps she really has the answers to her own problems. Stan should also introduce his plan for solving the problem, which might include support for Linda to enter smoking cessation programs and referrals to weight management services. There should be a reasonable time line with checkpoints so progress can be monitored. If the DON is present, she can assure Linda that she supports the plan. Before Linda leaves the office, she should sign off on the plan and receive a copy. Another copy should be placed in her HR file.

This meeting might have been stressful for all concerned, but it does not solve the problem. Stan still has the responsibility to follow up on the actions and time lines. He should be in frequent contact with the DON to verify that Linda has taken the agreed-upon
actions and is making progress toward solving her health problems. He should inquire about her job performance and check to see if it is now meeting standards. It is hoped that there will be progress at each of the checkpoints and the problem will be solved. However, if there is no resolution, Stan must be willing to take appropriate action up to and including dismissal. The patient must always come first in any health care organization.

3. What needs to be done to prevent future situations of impairment?

As you read earlier in the chapter, employment of competent personnel begins with the job analysis stage. Therefore, this incident might trigger a re-evaluation of the nurse manager position and its job requirements. If additional requirements are needed, the job description and BFOQs should be changed appropriately. Stan should also review the policies and procedures for handling situations where impairment occurs, regardless of its source, to be sure that they support appropriate action. Of course, staff education might be needed in the future on the subject of impairment and how to handle it. Stan should always keep in mind that he needs to balance safety and quality care for the patients with compassion and respect for the humanity of the staff. This is no easy task, but one that is essential to an ethics-based health care facility.

Web Resources

American College of Healthcare Executives (ACHE)
http://www.ache.org/hap.cfm

American Hospital Association (AHA)
http://www.hospitalconnect.com/Deskt0opServlet

Health Insurance Portability and Accountability Act (HIPAA)
http://www.hrsa.gov/website.htm#overview

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
http://www.jcaho.org/

Medical Group Management Association (MGMA)
http://www.mgma.com/

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/index.asp

References


Market Forces and Ethics

“Markets change, tastes change, so the companies and the individuals who choose to compete in those markets must change.”

—An Wang

Points to Ponder

1. What is the relationship between market forces and ethics?
2. What were the ethical roots of managed care?
3. Why should an HCA be concerned about ethics and managed care?
4. What ethical issues have been introduced since the advent of alternative/complementary medicine?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- case management
- disease management
- HEDIS
- integrated medicine (IM)
- managed care
- practice profiling
- utilization review
- consumer-driven health plans
- gatekeeper
- health reimbursement arrangement (HRA)
- National Committee for Quality Assurance
CHAPTER 6  MARKET FORCES AND ETHICS

■ INTRODUCTION AND DEFINITIONS OF MARKET FORCES

What forces in the marketplace affect the business of health care? To answer this question, first consider who is a potential user of the health care market. The most encompassing answer is that everyone is a potential customer for health care. As this is the case, then almost all events or market forces in the community can have an impact on your business. For example, think about what happens to your market when a new research discovery hits the news. Even if the results are not definitive, there is often an almost immediate public response. Physicians’ offices are inundated with telephone calls for the procedure or product. On a more serious scale, think about what happens when there is a major scandal in a health care facility somewhere in the United States. When it is reported on the national news, the public’s mindset can paintbrush the entire industry with the sins of the few. Trust is questioned and your telephone begins to ring with questions.

In this chapter, you will explore examples of general market forces and how they affect the business of health care. Because managed care is such a powerful market force, a separate section is devoted to it. You will learn about its foundation in ethics, current status, and future direction. All of this information will assist you in thinking about your ethics and how to apply it in decision making when dealing with managed care. Because the increased role of the consumer is also a major market force, you will explore an example of a consumer-driven phenomenon—the rise in integrated medicine (IM). There will be a summary to suggest some key concepts to remember in dealing with market forces in an ethics-based way.

■ GENERAL MARKET FORCES

In addition to managed care and the increased role of consumers, several market forces influence the business of health care. You have only to enter a health care facility to experience a major one of them—technology. The strides that have been made in this arena and its potential for the future pose serious business and ethics issues. In fact, technology has had such a profound effect on your business that an entire chapter is devoted to it (Chapter 8).

Another market influence that cannot be ignored is the aging of the American population and the role of baby boomers in that phenomenon. Shi and Singh (2004) state that in 2030, when most of the boomers are in retirement, they will represent 20% of the U.S. population. Even today, they make up over 12%. What is the impact of the aging of this “bolus of boomers”? History gives you a clue. When
the boomers hit first grade, the schools changed to accommodate their large numbers. When they hit college age, the colleges expanded. When they began to buy homes, the real estate market changed. Now, they are aging. What do you think will happen to the health care market?

Because chronic disease is more prevalent with the onset of aging, you have to anticipate a different kind of health care service. This will require a major change in thinking and system design, as health care today is still in the acute care model. However, you can also see this as a stellar business opportunity to increase your revenue stream by providing services that this population wants and needs.

Remember that aging boomers tend to be educated, affluent, and demanding. They are willing to spend their resources to prevent the onset of chronic disease or to lessen its severity if it already exists. They want high quality of life right up until the end of life—and are willing to pay for it. What does this mean for your business? Prevention, once thought to be the purview of “health nuts,” will be a business opportunity. Goods and service related to the quality of life among the elderly will increase. The boomers will expect their health care system to provide geriatric services at a reasonable price (Coddington, Fischer, Moore, & Clark, 2000). Community and institution-based care will have to be evaluated and expanded to meet this new market demand.

Not only will this market force bring change to the type and delivery of health care; it will also bring its own ethics issues. For example, how will the health care business maintain its profit margin if demand for care exceeds its resources? The boomers represent a powerful voter block. Will their power allow them to take more than their fair share of the health resources at the expense of younger generations? What about the human resources issues here? Will your business experience a “wisdom drain” as boomers retire and positions need to be filled? Is there a way for you to use this new “leisure class” of boomer retirees to benefit your organization and its efforts for community health? These are just a few of the ethics issues that this market force will generate in the immediate future. You might not have the answers now, but you will need to seek them in the future.

You can see by these examples of market forces that prudent health care administrators (HCAs) need to maintain a current knowledge of cultural and community trends in order to stay ahead of them and keep their organizations’ competitive edge. Tunnel vision will only cause you to miss market opportunities for your business or face unnecessary ethical challenges. In light of these challenges, there is a need for each facility to carefully define or refine its mission and make it address market force concerns.
Managed care has been part of health care delivery in one form or another for over 50 years (Morrison, 2000) and has become a major influence on how you do business. It changed the emphasis of health care from philanthropy to economics. As a response to the limitations of fee-for-service and health care inflation, it increased pressure to control costs and access. Managed care covered services now drive the provision of care, because facilities are reluctant to offer what they do not fund. The result has been a corporate system that might not meet the needs of the individual consumer or the community at large. Health care is now a highly competitive business where profit margins are tight and a struggle to meet your mission can exist. Multiple regulations imposed by government and managed care contracts to control costs, prevent abuse, and regulate practice patterns have led to a highly charged and stressful environment for many HCAs.

The response to managed care from the greater community is not always favorable. The public, while generally liking their individual practitioners, tends to have negative feelings about managed care in general. It finds the limitations of choice and coverage, gatekeeper referrals, and other features to be annoying at best. In addition, this system of delivery has been the target of the media that looks for prime time issues to cover. Entertainment venues also reinforce a negative image for managed care. For example, think of the portrayal of insurance coverage—or lack thereof—in such films as *As Good as It Gets* and *John Q*. Politicians also find it a convenient target and strive to protect voters from its abuses through an increasing amount of regulation (Pearson, Sabin, & Emanuel, 2003).

A market force with this much impact also brings significant ethical issues. For example, what happens when managed care no longer can control costs and access? If you fail to negotiate contracts to cover your expenses and profit, how do you still provide services when you cannot make enough money to keep your doors open? What happens to patient autonomy when third-party payment directs available care? How will you provide care for those not under a contract? And what is your role as an ethics-based HCA in negotiating contracts and maintaining standards? These are just a few of the potential ethics questions that managed care raises.

The first step in answering them is knowledge. In the case of managed care and ethics, the idea that knowledge is power is not a cliché. The more you are informed about these organizations, their missions, and their past and future, the more you can be successful forming business relationships and making sound ethical decisions. The next few sections of this text will provide you with an overview of history, current status, and future concerns in managed care. You must remember that there are whole courses and textbooks on managed care, so these sections will not make you an expert on the subject. In order to keep up
with current trends in this business, you must, to paraphrase Dori in *Finding Nemo*, “Keep reading, reading, reading.”

**Historical Foundations**

Why begin with history? Organizations do not exist in a vacuum; they have a foundation and a philosophy. Understanding their history will help you to understand the traditions that govern their thinking and actions. So, history does matter in your ability to make educated business and ethical decisions. Even though some think that ethical managed care is an oxymoron, this delivery system was actually founded because of an ethics concern. The health maintenance organization (HMO) (earliest form of managed care) movement actually began in 1938 when the Kaiser Company was trying to find a way to provide health care to its workers. The company made an agreement with its partners to contract with local facilities to prepay for worker health care coverage. Kaiser Company paid for any expenses associated with accidents, and employees paid seven cents per day for other health care needs. By addressing both preventive and acute care, Kaiser was better able to maintain a healthy work force and gained a reputation as a benevolent and ethical company.

However, managed care did not remain a social movement for long. In 1971, President Nixon, in reaction to rising health care costs, pushed for the creation of HMOs. He hoped that this delivery system would correct the abuses of fee-for-service and eventually provide health care for all Americans. His interests led to the HMO Act of 1973 with its certification program. From that point, despite protests from the American Medical Association and others, managed care began to grow with promises of decreased health care costs, increased health care benefits, quality control, and patient satisfaction.

**Current Situation**

Managed care evolved from its roots as a social experiment to its present state through a series of incremental changes in coverage and delivery options. Managed care has penetrated the health care market in ways that could never have been imagined by the Kaisers in 1938. Almost all employer-financed health care options include a managed care plan. In fact, many people think of managed care as a synonym for health insurance. Even federal and state governments have used this model for delivery to dependents either through contracting or through their own versions. So managed care has evolved into a complex system with many options. Today, you might be dealing with an HMO, IPA, PPO, POS, EPO, TriCare—or all of these options at once. This alphabet soup of delivery systems came into being when managed care was opened to the for-profit sector (Morrison, 2000).

The managed care industry has been successful in using business practices to control access to services and cost of delivery. For example,
the use of the primary physician as a \textit{gatekeeper} for access to hospitals and specialists has reduced unnecessary hospital stays and treatments. Consumers do not have unlimited choices in treatment or physicians unless they are willing to pay more for this option. Case \textit{management} and \textit{utilization review} were instituted to coordinate patient care and oversee the appropriateness of that care. While this has not met with great favor from practitioner or patient, it has helped to control health care costs. Finally, \textit{practice profiling}, the bane of many physicians, allows managed care organizations to compare practice patterns between physicians, in similar practices, for evidence of practice excesses or even fraud and abuse (Shi & Singh, 2004).

Through these and other business practices, managed care has been able to control the rate of growth of health care expenses. They have also given those who use these services access to primary care and increased the use of preventive services. However, the overall impact of managed care on health care access has not been defined. For example, managed care’s coverage of low income persons through Medicaid can have a negative impact on the safety net providers (public health departments, and state and county hospitals). They no longer have the funds to meet their mission to provide care even to those who cannot pay. Even though lower health care insurance premiums have allowed small employers to provide health coverage, it has not had a substantial impact on the growing number of uninsured Americans.

Managed care organizations have attempted to influence the quality of patient care through various utilization reviews and practice profiles. In addition, the \textbf{National Committee for Quality Assurance} accredits managed care organizations through a detailed process involving self-study and site visits. This organization has worked to monitor quality through a set of standardized measurements called \textbf{Health Plan Employer Data and Information Set (HEDIS)}. At present, there are no studies that show the introduction of managed care has had a negative impact on the overall quality of U.S. health care. In fact, it may have increased the use of preventive services, which in turn has lowered the need for more expensive hospital care.

Despite all of this good news, managed care may have done all it can to control costs and produce quality care. Even with its evolution to adapt to consumer demands, medical costs continue to rise and premiums do not cover these costs. Physician groups, hospitals, and other providers cannot do business based on the lowered premiums. They simply lose too much money. In addition, with the increased access and use of the Internet, consumers are becoming much more savvy with respect to their benefits. They are demanding even more choice about how their health care dollar is used. Information technology (IT), fraud, abuse, and other concerns have led to more regulation including the Health Insurance Portability and Accountability Act.
Managed Care and Ethics

Future Concerns

The Institute for the Future (2003) predicts that managed care must reinvent itself if it is to be profitable in the future. Key to these changes is addressing the issues of choice, disease management, and IT. The system will need to create tiered options that offer a choice of benefits and costs so that consumers can be directly more involved in their health care options. This system is already in its infancy in several major insurance companies through their consumer-driven health plans. These plans shift the decision emphasis from pre-designed benefits to choices based on costs. Each of the plans has its own array of covered costs, deductibles, and co-pays that the consumer can choose based on his or her needs. Consumers are assisted in their choices by Web-based information systems and can compare prices for office visits, drugs, and even hospital procedures. It can be hoped that they choose wisely and meet their health care needs; there is a cost savings; and managed care retains its profit margin.

Companies are offering this version of managed care, which is now called a health reimbursement arrangement (HRA). Although these funds vary in their arrangements, the following example can clarify how they work. A company offers a fund where the employee receives $1,000 a year to cover health care expenses and an additional fund amount for drug costs. The employee then chooses his or her provider based on published rates that are available online or in other formats (i.e., comparison shops). If there is a surplus in this fund, it can be rolled over to the next year.

If there are additional expenses, the next $1,000 is out of pocket expense for the employee. Once the maximum is spent and documented, the employee becomes part of a major medical-type plan and is responsible for 20% of the costs for his or her care. The HRA allows for more flexibility of coverage that can be tailored to the consumer’s needs and stresses prevention and wellness. Education of the consumer is considered critical to the success of the plan. If the consumer has greater choice and greater financial burden, then it is hoped that he or she will use the system wisely. Although this option is far from universal, it is becoming more popular with consumers and employers. Other experiments for consumer choice include an increase in focused care centers (women’s health, heart health, pain management, and so on); coverage for electronic visits; and increased emphasis on preferred provider networks.

To remain viable and profitable, managed care will have to determine how best to care for chronically ill patients who need high-cost

(HIPAA) and the Balanced Budget Act of 1997. These and other factors mean that managed care must decide to make serious changes for its future survival.
CHAPTER 6  MARKET FORCES AND ETHICS

treatment. This can be accomplished through better use of disease management practices. It is hoped that as knowledge of this area expands, best practices will be identified and adopted. These approaches should provide appropriate care and reduce overall costs.

IT is already a force in the managed care industry, but it is predicted to become even greater. It can be hoped that its use will help to control health care cost inflation (Institute for the Future, 2003). Managed care should be better able to identify practice patterns that yield cost-effective care and adopt them more systematically. Through use of IT systems, improved data collection, and effective indicators, it should be able to improve quality throughout the industry. In addition, it is predicted that the use of IT will improve the accuracy of diagnosis and help consumers make better prevention and treatment decisions.

The future for managed care looks to be one of change and more change. Certainly, its demise is not imminent. Rather, it appears that it will, through mergers and acquisitions, become dominated by a few, highly successful companies. However, its path will be filled with the business and financial challenges mentioned here and perhaps many others to be identified. As you can imagine, ethics concerns will also be a part of the future of managed care.

Where Is the Ethics?
The interaction between managed care and the health care system introduces ethics issues that stem from conflicts between patient autonomy; the overall benefit for managed care members; and profit margins. For example, a conflict occurs between the patient’s need for expensive services that are not covered by the contract, and the patient’s recent loss of income. Denying such care could cause unnecessary suffering or even premature death, but providing uncovered services to everyone could have a negative impact on the facility’s profit margin and viability. Incentive programs, gatekeeping, inclusions or exclusions in plans, marketing, and disclosure of information are also examples of potential ethical problems related to managed care.

Perry (2002), Darr (2004), and Anderlik (2001) discuss incentive programs and the ethics issues surrounding them. Typically, incentives are incremental or lump sum payments designed to reward desirable practice patterns. An ethics concern is that these incentives unduly influence physician practices to the detriment of the patient. For example, a primary care physician might choose to treat the patient rather than refer that patient to a specialist, in order for the physician to meet an end-of-year bonus. However, if a patient’s needs are beyond the scope of this physician’s practice, the patient might not receive appropriate care. The decision also leaves the physician open to possible malpractice litigation.
As an HCA, there are several actions you can take to address the ethics of incentive programs. First, consider the scope of the program. If incentives are too broad, they can prove too tempting and produce a negative long-term effect on patient care. If they are too narrow, patient variability can make them impossible to meet. You also need to consider the incentive’s effect on overall income. If the percentage is too high (for example, 25%), it might inappropriately influence patient care decisions. If it is too low (for example, 5%), it can fail to control costs. Remember that when incentives are linked to improvements in quality and effective practice innovation, they can be used for positive change. Maintaining patient trust and benefit should always be considered when deciding on accepting or implementing an incentive plan.

The gatekeeping function used in managed care can also bring ethical concerns. On the one hand, it serves to coordinate care and provide the best possible outcomes for the patient. It fosters cooperation between providers so the best practices can be identified and customized for the individual patient with consideration of level of acuity and co-morbidity. On the negative side, the gatekeeper can function as a barrier to care. The physician is put in the middle between the patient and the payer. He or she becomes the agent for rationing care based on cost-effectiveness. In some cases, the physician’s background does not prepare him or her to make decisions about providing or denying access to specialty care. For example, physicians are not well educated in the areas of mental health, yet they can deny these referrals. Some ethicists see the gatekeeper role as inappropriate for physicians because they should be an advocate for patient care. Others feel that this role is highly ethical because it serves to hold down health care costs for the whole community.

What should you do about the ethics of gatekeeping? Anderlik (2001) suggests that there is no solid research evidence to support strict rationing principles and stringent adherence to clinical protocols. Physicians’ clinical judgment is also a viable part of patient care and should be considered. To support their judgment, physicians should be given information about costs and benefits of treatments. They should be encouraged not to recommend treatments that can only minimally benefit the patient. In addition, they should make greater efforts to educate patients about treatment decisions. Of course, policies that clearly define covered and noncovered treatment and the rationale for the exclusion need to be in place. Such policies will assist physicians to make more appropriate gatekeeper decisions.

Several community-level ethics issues have been associated with managed care including its impact on the least advantaged in society. Managed care works as a business and not a force for social justice. Therefore, its policies are designed to improve its profit margin and not necessarily the overall health of the community. Providing care for
those who cannot afford co-pays, who require numerous visits, or who have complex physical and social health problems, is simply not good for business.

Despite this business position, competition has led managed care to expand to the Medicare and Medicaid market. Some studies show that HMOs have been effective in caring for elderly patients and kept them from expensive nursing home care. However, these results are not universal. Because healthy seniors need fewer services, there is an ethics concern that managed care will market to and attract these individuals (this is called “creaming”). While this makes sense in the short term, it does not make good long-term business sense. As they age, even these healthy seniors will need more and more services that will affect profitability. What happens to those seniors who have chronic diseases and require frequent visits? Some managed care companies have tried to serve this population and have discontinued their service because of the negative impact on their profits. For an even bigger picture, think about what happens when the bolus of boomers becomes part of the Medicare system. Their numbers and increasing chronic disease experience will be a challenge for the entire managed care system.

The Medicaid population has also become more attractive to the managed care market. However, this population tends to have greater health care issues and poorer overall outcomes. Yet, some success has been reported by managed care in reducing inappropriate use of the emergency department and providing increased access. However, issues such as lower reimbursement rates, providing too little service, and patient skimming have also been reported. Practitioners might not want to contract for these patients because the lower rates and service restrictions prevent them from covering the cost of their service. In addition, as you saw in Medicare, if managed care begins to lose too much money on the Medicaid venture, it may discontinue service, which increases the ranks of the uninsured (Anderlik, 2001).

What is the impact of managed care on the already uninsured? First, when managed care organizations treat the healthiest of the poor, it means that the others must rely on community hospitals and public health facilities for their care. This means an additional strain on an already taxed public health budget. In addition, for-profit and not-for-profit health care organizations are faced with the financial impact of providing uncompensated care when managed care discontinues services or physicians will not serve this population. This whole issue of managed care’s impact on social justice is an issue that may become large enough for the nation to take action. In the meantime, it continues to cause concern at many levels.

In your role as an HCA, you can be faced with the ethics issues posed by marketing managed care. Darr (2004) points out that if you
are too successful in marketing the quality of your specialty care, you can adversely affect your bottom line. Too many high-risk patients could choose plans that access your services, causing you to lose money. Does this mean that you should have high standards of quality for your services, meet those standards, but keep it quiet? Darr advocates just stressing the quality of your general services. Again, you are seeing the conflict between the individual patient’s needs and right to information and the collective good of members and the organization in general.

Anderlik (2001) also suggests that marketing can be an ethics problem when promises are made that cannot be delivered. In the highly competitive managed care business, salespeople might be tempted to inflate benefits and choice options to close the sale. This can also occur when contracts are discussed and negotiated. In negotiations, your role includes doing your homework, questioning all claims and presentations, and asking about the sources for information. You should negotiate in good faith, but not give away too much information. Remember the managed care company is there to close the deal, but you are trying to get the best possible contract to benefit your organization.

If you are in a position to work for a managed care organization in marketing and advertising, be sure that you do not give “dis-information” (Anderlik, 2001, p. 163). Check the accuracy of all materials (print, media, or Internet) before they become public so that they present a positive but accurate picture. Make sure that your sales representatives are well trained on your existing products. One training session might not be enough. Certainly, when you introduce a new product or service, you must make sure that your staff are sufficiently trained and provide accurate information. While such extensive training can seem like a high cost decision, it is easily justified if you consider the cost of legal action or negative press about your managed care organization.

You will also want to evaluate how your sales force presents your organization and its products. This can be accomplished through follow-up telephone interviews with employers or other data collection methods. Should you find a problem, be sure to counsel appropriately so that actions are not repeated.

Finally, the issue of informed consent and disclosure of information in managed care should be considered. When a person enrolls in a managed care plan, he or she consents to having his or her care rationed. Therefore, no ethics issues should arise when information about options that are not covered are withheld. However, this assumes that the decision to enroll was an informed one, which might not be the case. Another argument on this issue is that the patient/physician relationship should be the best source of what to disclose and to whom.

What you have been learning about ethics should offer some assistance with the issue of consent and disclosure. The patient should come
first. While the plan may offer a certain range of services, the patient has the right to know if other effective options are available. However, such information must include a balanced view of options including cost (to be borne by the patient), benefits, and success rates, among other things. You should also make every attempt to provide user-friendly information about treatment options. For some patients, this can mean updated information on your Web site. Others might not have computer access or the desire to use this communication tool. For them, you will need well-designed, accurate, and understandable booklets or pamphlets. Remember that the patient might be receiving news that evokes an emotional reaction. Whenever possible, allow time for information processing before asking for consent.

So far in this chapter, you have seen how managed care grew from its roots in social justice to its current state as business. This growth has brought with it many ethical issues that must be considered by both the managed care organization and its business partners. Perry (2002) gives you some general guidelines that should prove useful in dealing in managed care situations.

1. Be careful to use accurate marketing and advertising so the choice is truly informed.
2. Protect patients’ rights to confidentiality. HIPAA rules go a long way here but they do not address everything.
3. Remember your responsibility to hire competent health care staff and ensure their competence.
4. Establish practice guidelines based on evidence and supported by your physicians.
5. Have appropriate appeal policies in place that do not punish the person who asks for the appeal.
6. Remember your community and maintain a commitment to education, research, and uncompensated care.

In addition, you will need to rely on the organization’s mission and values for your decisions. Asking the question “Does this fit with our mission and values?” frequently should help you discern the correct decisions. As you will see in later chapters, the use of organizational ethics committees is also helpful in dealing with difficult managed care–related ethics issues. The latter half of the chapter discusses the ethics attached to IM, also known as complementary/alternative medicine (CAM).

**INTEGRATED MEDICINE (IM) AND ETHICS**

*Why IM and Why Now?*

In 1993, David Eisenberg and his group at Harvard Medical School stunned the medical community with a report in *The New England*
Journal of Medicine. He estimated that there were over 425 million visits to CAM providers in the United States every year, which exceeded the number of primary care provider visits. The cost was 13.6 billion dollars, most of which was paid directly by the consumers. Although this study was criticized for its methods, it became one of the most widely cited research efforts of its type and demonstrated a much wider use of these practices than suspected (Eisenberg et al., 1993). It began a major re-examination of what was once thought to be only quackery or fad.

Eisenberg and colleagues (1998) repeated this study in 1997 with even more startling results. The increase in users of CAM services was found to be 629 million, which was an increase of 47% from the previous study. CAM has become a multi-billion dollar business in the United States. In addition, most of the subjects combined CAM practices with conventional medical care. However, they did not often inform their physicians about their CAM use.

Just what is this consumer-driven movement that is now called IM? It is actually an eclectic collection of philosophies and practices that are centered on a holistic view of the client, the healing properties of the body, and prevention as well as treatment of disease. They do not see humans as being reduced to cells and diseases to be treated, but rather as unique individuals who are part of the environment in which they live. IM in the United States encompasses well over 200 different types of practices, many of which have their roots in healing systems that are thousands of years old (Micozzi, 2001).

The consumers who have directed this movement tend to be educated, affluent, and female. They desire to be partners in their health care and seek information on their own. These consumers also seem to be aware of the need for prevention and view IM as a way to decrease the likelihood of serious illness or to prolong the quality of their lives. Evidence of their belief in this system of health care is demonstrated by their willingness to pay billions of dollars in out-of-pocket expense to use IM services.

A major market for IM services seems to exist among people suffering from chronic disease. They seek relief and/or control over their symptoms and are often disappointed by what traditional medicine has to offer. They have a need to have control over their problems and find that IM offers a greater sense of control. They need to be a partner in their care. Traditional medicine’s lack of definitive treatments for chronic diseases helps to explain the growing appeal of IM.

Most IM users also include traditional medicine in their treatment. Even though consumers use both systems, they are not entirely pleased with the traditional system. They often find it too impersonal, expensive, and rushed. They actually find its high tech approach to be demeaning and miss the high touch of earlier years. In addition, they find the side effects of the medicines provided by traditional medicine
to be undesirable. IM, in contrast, spends far more time with each client, includes him or her in treatment plans, and uses high touch modalities. In addition, practitioners stress preventive practices and areas that complement traditional medicine’s approach. The most commonly used IM practices include chiropractic care, massage, herbal medicine, and acupuncture. Clients seek relief from back and neck problems, chronic pain, depression and anxiety, fatigue, and digestive disorders. This list is not surprising when you consider that 60% to 90% of all traditional medicine visits are for stress-related problems.

Traditional medicine’s reaction to this consumer-driven movement has been mixed at best. Some have declared it to be total quackery and even ridicule patients who use it. Criticisms include that it is not grounded in scientific theory, does not have demonstrated long-term studies on safety and efficacy, and that practitioners are not qualified to treat. Initially, physicians who used these practices received severe treatment from State Boards or the American Medical Association. Even practices with thousands of years of documented effectiveness, such as acupuncture, were branded as fads or just the result of the placebo effect. Herbal medicine, despite extensive research in Germany and other countries, was branded as a waste of money or as unsafe (Humber & Almeder, 1998).

However, traditional medicine’s response is not all negative. Since the National Institutes of Health began supporting serious research in IM, physicians have slowly begun to be more interested in the area. Over 126 of U.S. medical schools now offer courses in this area. There is even a Physicians’ Desk Reference for Herbal Medicine available to provide updates for busy practitioners. Pharmacy and nursing schools are expanding their coverage to include herbal medicine and other areas. The National Institutes of Health has expanded its involvement with the creation of a Center for Complementary and Alternative Medicine that now has millions of dollars invested in research on these modalities.

Recent studies find acceptance of physicians increasing, with some actually referring patients to IM practitioners such as chiropractors, massage therapists, and acupuncturists. Hospitals and specialty centers have capitalized on the holistic care concept by adding IM practices to their existing offerings. It is not unusual to see music therapy, massage, guided imagery, and acupuncture featured in some of these facilities. In addition, long-term care facilities have added IM to their services to improve the quality of life for their residents. Examples of this service expansion include music therapy and pet therapy.

Insurance companies are becoming more willing to include IM as a covered benefit because it has the potential for preventing more costly treatments. Managed care organizations are particularly interested and provide supplements that cover services of IM providers in their networks. These providers are credentialed to
Integrated Medicine (IM) and Ethics

offer the best possible service to the consumer. In addition, credentialing for IM practitioners has become more standardized and includes some of the major professional groups such as acupuncturists, massage therapists, registered dietitians, and naturopathic physicians. It is predicted that IM will continue to grow over the next 10 years and that traditional medicine will become more accepting of this consumer-driven movement (Institute for the Future, 2003).

Where Is the Ethics?

The integration of two systems of health care with very different views of patients and their needs has the potential for many ethical problems. If future predictions are correct, IM will be a part of your health care business on some level. It will be important to consider these potential ethics issues and do what you can to prevent them. First, you must have an informed practice in order to correctly diagnose and treat patients who also use IM. While you might not agree with what your patients do, they will still expect you to honor their autonomy and to make accurate diagnosis of their condition.

Failure to have a basic knowledge of IM practices will prevent you from providing the most informed care and can have drastic results. For example, there are some herbs that affect the blood’s ability to clot. If they are taken with prescribed blood thinning agents, the results can even be fatal. A well-informed practice is able to prevent such problems by gaining patient information about herb use and by knowing the action and drug interactions of what the patients are using. Physicians and nurses could also answer questions about IM practices in a fair and evidence-based way. Continuing education programs and resource materials might be needed to do this, but the expenditure of money and time will be worth it.

Informed consent is another ethics issue related to IM. Some have argued that health care practitioners should discuss IM options as well as traditional medicine with their patients. This is supported by the American Medical Association’s Patients’ Bill of Rights, which stresses the need for patients to be given information on benefits and risks of health care decisions. This means that physicians and other practitioners should be aware of all treatment options and be able to answer questions about them. You will also be expected to provide objective and accurate advice about these modalities so that consent is truly informed. As more and more evidence surfaces about which IM practices are effective and which are not, practitioners will feel more comfortable discussing these options with patients. The policy of “don’t ask; don’t tell” with respect to IM will not work for the future. In fact, many practices have already added questions about IM uses and herbs to their medical history forms.
If you are considering adding IM modalities as a revenue stream, there are some areas for you to consider. First, you will want to analyze what services are readily available in your area and which of them are frequently used. You will also want to investigate which of these services are covered by insurance. This information can be obtained through Web searches and telephone surveys. Because patient safety is an ethics concern, you will always want to consider the efficacy and quality of any services. You could research Web sites such as the National Center for Complementary and Alternative Medicine, which will give you information about modalities, what they are supposed to do, and what they actually do. You would then have to take all of the appropriate steps, including gaining all the appropriate approvals, for adding IM services. Do not forget to consult the physicians and have a champion or two on your side. It is wise to start small and build. For example, add a massage therapist or music therapist, after evaluating patient satisfaction and profitability of such an addition. Fortunately, Faass (2001) has written a detailed book on how best to integrate IM services into traditional practices.

As part of your ethical duty to protect patient safety, you must contract with or hire IM practitioners who are prepared in their area of service. Several of the over 200 areas of IM are now certified or licensed. For example, the American Massage Therapy Association has accredited programs throughout the United States and also has established certification standards. Many states also require a license to practice massage therapy. Likewise, there is a program for school accreditation and individual certification/licensure for acupuncture and naturopathy practice. To make this even easier, firms have been created to verify practitioner certification and to make the selection of who to hire much easier. Remember though that, while certification and licensure is increasing for many of these areas, not all practitioners have formal credentialing or are even required to have it to practice. You will have to use discernment based on your mission, research, and consumer information in those cases.

**Summary**

In this chapter, you have begun to explore the impact of market forces on health care systems and the potential ethical problems that they can create. It concentrated on two major trends, managed care and IM, but this is not the whole picture. As a practicing HCA, you will have to keep your finger on the pulse of what is happening in your health care market. Additional issues can arise that must be addressed. Your responsibility will be to address them in an ethics-based manner. Remember that you are trusted to provide safe, quality care for patients. In addition, your image in the community is critical to your success as a health care business. In dealing appropriately with market forces, organizational and personal ethics matter.
Cases for Your Consideration

The Case of the Concerned Managed Care Administrator

1. What ethical principles did this administrator use in dealing with Mr. Michigan?

2. What was the cost of her practicing ethical behavior and what were the benefits?

Case Information

Mary Ledfedder was one of the claims managers for St. Dismas Health Plan (SDHP). On Monday, she received a case from one of her assistants for review. The case involved a man named Shamus Michigan. He had visited his acupuncturist, who found a problem in the kidney meridian. He then had a full body scan at a local clinic. This scan picked up a mass in the kidney area and a follow-up was suggested. Mr. Michigan had another scan and a follow-up MRI. He was diagnosed with cancer of the kidney. Fortunately, the tumor was encapsulated and he was treated by a laparoscopic nephrectomy. He filed a claim for reimbursement for the three scans and was denied.

Mr. Michigan became quite upset when he received this news. He told the claims representative that he thought SDHP discriminated against people who used alternative medicine practitioners. After all, if it weren’t for his acupuncturist, he might be dead instead of just losing one kidney. He could not understand why coverage was denied and after consulting with an attorney, he asked for an appeal.

Usually, Ms. Ledfedder would do a quick review of such cases and issue a form letter to the appellant. However, she felt that this case might be different and wanted more information. She contacted Mr. Michigan and asked for more details. At first, he was upset about the denial of his claim, but he listened to Ms. Ledfedder as she explained their policy. They could only pay for procedures that were ordered by a physician, not ones that were chosen just by the patient. She asked Mr. Michigan if he had a physician order for any of the tests. As it turned out, he did. The second and third tests were done based on a referral from his physician and he had a copy of his letter.

Ms. Ledfedder put Mr. Michigan on hold and checked her policy book. While such a referral was not specifically mentioned, it certainly seemed appropriate. She told Mr. Michigan to send her a copy of the information that he had so she could review it. When it arrived by fax, she found that Mr. Michigan was correct; he did have proof of a physician order. When she called him back, she was able to give him good news. SDHP would pay for the last two tests, which would lessen his financial burden considerably.

Mr. Michigan was not pleased that all of the tests could not be covered but, after talking with Ms. Ledfedder, he understood why. He thanked
her for putting in the effort to help him with his situation and said he looked forward to receiving his check in a reasonable time frame. After their conversation, he called his lawyer and told him not to go forward with the lawsuit.

Responses and Commentary on Questions

1. What ethical principles did this administrator use in dealing with Mr. Michigan?

At this point in your study, you should be able to identify many ethics principles for this case. Ms. Ledfedder acted with beneficence when she chose to take the extra time to truly review the case instead of just issuing a form letter. Her follow-up phone call and decision to assist Mr. Michigan were also acts of beneficence. In addition, she supported the principle of nonmaleficence by making sure that his claim was handled fairly and he was paid what was appropriate.

Certainly, Ms. Ledfedder acted to respect Mr. Michigan’s autonomy by giving him complete information about why his claim was denied. She even went further to inquire if he had proof of a physician’s order. This inquiry helped her to arrive at a successful resolution of the problem because additional information could be provided. In addition, she treated Mr. Michigan with respect even though he was angry at the Plan. She was not condescending or rude in her conversation, and that kept things on a more rational basis. Finally, she practiced justice because, while she did not order payment for a claim she could not support with a policy, she did make sure that Mr. Michigan received the reimbursement for which he was entitled.

2. What was the cost of her practicing ethical behavior and what were the benefits?

Basically, the cost of Ms. Ledfedder’s use of ethical behavior was minimal compared with the cost of having to deal with a lawsuit. Even if such a suit did not reach the courts, the negative publicity potential would be great. In addition, she kept an SDHP member satisfied, so he did not wish to change health plans. If asked, he could attest to the fairness of his treatment. This was worth a great deal in positive word-of-mouth publicity for the Plan. In all, practicing ethical behavior was good business practice in this case.

The Case of the Confused Abuela (Grandmother)

As you read this case, consider the following questions. Responses and comments will follow the case.

1. What principles of ethics are involved in this case?
2. What were the ethics issues for Porter Sanders?

3. How important was knowledge of IM practices to the successful resolution of this case?

Case Information

Porter Sanders was the assistant administrator of St. Dismas Home Health (SDHH) program. On Monday morning, one of his best home health nurses, Emma Ray, stopped by his office to discuss a concern. Here was the case she presented.

Ms. Ray received a physician order for a home visit assessment of Mrs. Viola Romero, an 80-year-old woman with hypertension, who was also on thyroid medication. Mrs. Romero was living independently in her own home, but the family was concerned. Her behavior seemed to be deteriorating. She often appeared confused, exhibited some unusual aggressive behavior, and cried without provocation. They were worried that she had Alzheimer’s disease and contacted her physician who then ordered the visit.

During her assessment, Ms. Ray questioned Mrs. Romero about her health history and activities of daily living. She was supposed to be taking medication for her hypertension. Because she had a thyroidectomy, she was also supposed to be taking daily thyroid pills. However, Mrs. Romero also consulted with the local curandero who conducted several rituals including sahumerio (incensing) and prayer. This healer advised Mrs. Romero to stop taking all of her medicines because they were poisoning her system. Instead, she suggested drinking an herb tea made from mint and to include olive oil in the tea. She also sold Mrs. Romero a magnetic bracelet to wear every day to balance her energies.

Mrs. Romero believed in the powers of this healer, who had a good reputation in the community and wanted to follow her advice. Ms. Ray tried to talk to her about the problems associated with not taking her medications, which could explain her change in behavior and other symptoms. She tried to explain that Mrs. Romero was endangering her safety and her life by not taking these medications. Mrs. Romero accused Ms. Ray of not respecting her beliefs and being on the side of the physician and her family. At the end of the visit, she remained adamant that she did not want to visit the physician or get back on her medications.

After she filed her report to the physician, Ms. Ray asked for Mr. Sanders’s advice on the next steps to take. While she wished to respect Mrs. Romero’s autonomy and right to choose or refuse treatment, she was concerned that Mrs. Romero was threatening her life. Mr. Sanders agreed and also expressed concern about the effect on SDHH if no
CHAPTER 6  MARKET FORCES AND ETHICS

action is taken. After a lengthy discussion, Ms. Ray decided to discuss her findings with the physician and the family.

Once the physician had a full picture of the situation, he told Ms. Ray to advise the family to bring Mrs. Romero in immediately. In his opinion, this curandero was jeopardizing her life. He needed to evaluate her status and get her on the appropriate medication immediately. Ms. Ray then visited the family and explained what happened. They were shocked and greatly concerned. The family said that they would get Mrs. Romero to the physician “if they have to drag her there.”

Two weeks later, Ms. Ray received a call from the family. Mrs. Romero consented to be taken to the physician’s office but cried the whole way there. Fortunately, her physician was aware of the practices of curanderos and was able to convince her that her medications were not poisons. She could still use prayer and the bracelet for balance as long as she continued to take her pills. Mrs. Romero did not want to make the physician angry, so she decided to take the pills. Her symptoms disappeared.

Responses and Commentary on Questions

1. What principles of ethics are involved in this case?

From your study of ethics, you can see that many principles are involved in this case. One of the most obvious is the conflict between patient autonomy and paternalism. Who knew what was best for this patient? Ms. Ray wanted to honor Mrs. Romero’s autonomy and treat her with respect. Mrs. Romero had the right to control her own body and accept or reject treatment, but her actions put her life at risk. However, these actions also compromised her ability to make informed decisions. Therefore, her family had to intervene in this situation. Additionally, as part of autonomy, she also had the right to truth-telling. Ms. Ray carefully provided truthful information to convince Mrs. Romero that the curandero’s practices were not in her best interests. Because the belief in the power of curanderos is a part of Mrs. Romero’s core culture, this was difficult.

You can also see the dual principles of beneficence and nonmaleficence in this case. First, Ms. Ray had a moral obligation to respect Mrs. Romero’s beliefs and not demean them. Even though she disagreed with these practices, she had to treat Mrs. Romero with respect and kindness. However, she also had a moral duty to do no harm. Allowing Mrs. Romero to continue this practice without any intervention could cause her great harm and contribute to her premature death. Mrs. Romero’s physician told Ms. Ray to contact the family immediately, and she supported this decision.

The principle of autonomy was also an issue for the family. They dearly loved their Abuela Viola and wanted to respect her rights.
However, they were concerned that her latest actions made her too confused to make appropriate health decisions. On the advice of Ms. Ray and the physician, they took action on the situation and coerced Mrs. Romero into visiting her physician.

2. What were the ethics issues for Porter Sanders?

Porter Sanders had a different view of the ethics in this situation. While the mission of SDHH stressed that he must respect the cultural practices of his clients, he also needed to consider the impact of Mrs. Romero’s actions on his business. If Mrs. Romero was not convinced to see her physician and died as a result, it could pose real problems for SDHH. The family could choose to blame Ms. Ray and SDHH for her death and contact an attorney, the press, or both. Certainly, the publicity of such actions, even though unfounded, could be harmful to the organization.

Mr. Sanders was also concerned with providing the best advice to Ms. Ray. He needed to listen to and consider her viewpoint in this situation. Of course, since the organization functions under physician order, he had to remind her that she needed to provide detailed information to him. To protect patient confidentiality, he had to make sure that Mrs. Romero’s records were complete and protected. He also needed to be sure that Ms. Ray did not discuss this interesting case with her colleagues over coffee. Mr. Sanders relied on Ms. Ray’s professionalism and the policies of SDHH to maintain this ethics obligation.

3. How important was knowledge of IM practices to the successful resolution of this case?

Knowledge of IM practices, specifically the practices of curanderos, was critical to the ability to resolve this case. First, Ms. Ray needed to be fully aware of the belief system of her Hispanic client, Mrs. Romero. This knowledge allowed her to communicate more completely and honor her autonomy. She also had to understand the philosophy and practices of curanderos. Many of these healers use practices that support traditional medicine and can actually be helpful. In Mrs. Romero’s case, however, the curandero was in fact giving harmful advice. Ms. Ray needed to be able to explain why it was harmful while respecting Mrs. Romero’s culture.

Most assuredly, the fact that Mrs. Romero’s physician operated an informed practice helped him understand her culture and explain what she needed to do. Without such knowledge, he might have ignored her beliefs (at best) or even ridiculed them. Either of those responses would not have ensured patient compliance with treatment and might have caused unnecessary harm. However, his knowledge and patience with Mrs. Romero led to a positive outcome in this case.
CHAPTER 6  MARKET FORCES AND ETHICS

Web Resources

CDHPs and HRAs
www.benefitnews.com/detail.cfm?id=4327
www.aahp.org

National Institute on Complementary and Alternative Medicine
http://nccam.nih.gov/

American Massage Therapy Association
www.amtamassage.org.

References


Social Responsibility and Ethics

“A community is democratic only when the humblest and weakest person can enjoy the highest civil, economic, and social rights that the biggest and most powerful possess.”

—A. Philip Randolph

Points to Ponder

1. How can health care be socially responsible and still meet its business goals?
2. How do prevention services fit into health care social responsibility?
3. What should your relationship be with public health?
4. How is quality assurance part of social responsibility?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- epidemiology
- Institute of Medicine
- morbidity
- social marketing
- infant mortality
- Leapfrog Group
- public health administrator (PHA)
- social responsibility
WHAT IS SOCIAL RESPONSIBILITY IN THE HEALTH CARE BUSINESS?

Health care is a business and it must operate on business principles. However, its roots and mission are unlike any other business. Health care’s foundations are centered in the idea of social justice, which as you learned in Chapter 4, is also called distributive justice. For example, in the early days, hospitals were established either to protect the community against contagious disease or to care for those who did not have the funds or the family to provide their care. Religious orders or communities were primary providers of such care. Admittedly, by today’s standards, these early efforts were abysmal, but their motivation was one of service, not profit (Shi & Singh, 2004).

The change in orientation to business happened for many reasons. After World War II, the health care system was not adequate to meet the nation’s needs and needed assistance in upgrading facilities and building new ones. The federal government passed the Hill Burton Act, which assisted in these endeavors. The use of these funds required documentation, accountability, and demonstration of the provision of charity care. Business functions to meet these requirements became more important. The rise in the use of employer-sponsored health insurance also made a strong contribution to the change to a business orientation. The advent of for-profit health care facilities and managed care are more recent and formidable influences on the change to a profit-centered orientation.

Despite the current business orientation, the public does not have business expectations for health care. Purchasing health care is not like purchasing a refrigerator, car, or even a home. The ability to choose is limited because health care is a monopoly. Although it has been regulated and controlled to some extent, it still wields great power and influence. Because of their knowledge and diagnostic ability, physicians control what procedures are used and when they are used. The public really does not have complete freedom of choice in its health care as it does in other businesses. In addition, there is a third-party payment system, which removes the consumer from the direct costs of service. Many have no idea about the real costs of their service and are shocked when they learn how it is priced.

Because service in the business of health care is not a direct choice, the public must trust its ethics and hold it to a higher standard than other businesses. They expect that the principles of ethics you read about earlier in this book will be honored. They also expect to be treated with dignity and be given care that benefits their highest good. With this level of expectation, you can see why the reaction is so strong when even a few violate this trust.

Just how are you to be socially responsible and keep your profit margin high enough to stay in business? Chapter 4 gives a beginning discus-
What Is Social Responsibility in the Health Care Business?

Darr (2004) also provides some assistance with potential solutions. He stresses that ethical practice in this case involves making well-informed choices about strategic planning, availability of services, and setting priorities. While economics is a factor in these choices, questions about how each decision can positively affect service to all patients, including those who are disadvantaged, should also be considered. Profits can be used to care for those who cannot afford care. In other words, profit, used appropriately, can have a positive impact on your ability to be socially responsible.

Serving as good stewards of your resources by controlling costs, improving efficiency, and reducing waste are also part of social responsibility. If you can keep costs at an appropriate level, it can mean that more people will have access to care because it is more affordable. It also sends an important message that you are not just interested in your profit margin or in a million dollar annual income, but respect your obligation to provide for the community’s health. This is especially important in managed care organizations where members can “vote with their feet” when they think that you are not putting them first. Perhaps your guiding question should be, “Who or what comes first in this organization?” If you can answer “The patient” and guide all of your decisions by this response, you make decisions that better exhibit social responsibility.

Social responsibility also is displayed in the daily interaction between patients and those who care for them. In health care facilities, there are often two types of economically disadvantaged: those you regard as deserving and those you regard as not deserving. The deserving poor can be people who have suffered from a natural disaster or some event that was not under their control. While they may be unemployed, homeless, and without health care coverage, somehow you feel that they deserve compassion and available treatment.

The undeserving poor are those who have made lifestyle choices with which you do not agree. They are addicted to alcohol and drugs, practice risky sexual behaviors, or fail to comply with prescribed health care practices. These individuals are often viewed as annoyances or drains on the profit margin. They are subtly or not so subtly told that they must take whatever you give them and be grateful for whatever that is. Because health care professionals are human, it is easy to understand that constant exposure to people who make self-harming choices could lead to such cynicism. However, society judges your facility by how it treats the poor regardless of the reason for their condition.

Those who provide service to the economically challenged in your organization should have the benefit of education and support. It is necessary to observe how care is delivered not just in terms of numbers of procedures. You might also have to evaluate the interpersonal communication between patient and care provider to see if basic ethical
principles are being applied. In-service programs in areas like patient relations, applied ethics, meaning in work, and living your mission should help to assist daily patient interaction. In addition, you should do whatever you can to reinforce ethical treatment of all patients. This might include reward programs, scheduling that includes sufficient time breaks, and recognition of service.

Social responsibility in the health care system is not just about fiscal policy or direct patient treatment. It can be seen in your commitment to providing prevention services and understanding and supporting public health efforts. In addition, ongoing efforts to improve the quality of health care services is also a form of social responsibility. In the next sections of this chapter, you will learn more about your role in each of these areas.

■ PREVENTION AS SOCIAL RESPONSIBILITY

An individual’s health is not determined by access to medical care alone. In fact, medical care is only credited with a 10% contribution to overall health (Shi & Singh, 2004). The remaining 90% comes from your genetics, lifestyle, and environment. This means that many of the determinants of health fall into areas where prevention can make a positive contribution. For example, research supports the influence of nurturing on early childhood health and future development. Prevention and treatment of obesity in children and adults can decrease diabetes, heart disease, and other chronic disease rates. Active prevention and treatment for substance abuse and dependency have been shown to have a positive impact on many areas including decreasing domestic violence, auto accident fatalities, divorce, and chronic disease. Prevention services have the potential to positively affect the health and quality of life for communities, regardless of individual income or status.

It would seem logical that a system that is called “health care” would be actively engaged in providing prevention services at every opportunity. Unfortunately, this is often not the case. To understand why prevention is not a priority or, in some cases, not even a consideration, you have to remember the system’s origins. For many years, the limited resources of health care were directed toward the treatment of acute diseases; they were a priority for the community. An acute care system was developed to meet this demand and capitalize on available funding. Today, the U.S. health care system is one of the best in the world for treating acute health conditions.

In addition, in the early stages of this system, evidence of the effectiveness of prevention was limited and little or no reimbursement was provided for these services. In a fee-for-service system, what did not receive reimbursement was ignored or given minimal attention.
With the advent of managed care, some prevention services were increased such as well baby checkups and certain screenings, but an all-out effort at prevention did not materialize. Cynics say that prevention is not part of the health care system because the system makes more money on the sick than on keeping people well. To follow that logic, it is a good business decision not to waste resources on screenings, education, and other prevention efforts but wait until illness is present.

Despite this cynical view, there has been some change in the attitude toward prevention services. Evidence has demonstrated that effective prevention practices can save money through less abuse of the emergency department, fewer preventable office visits, and disease management. More and more facilities are beginning to engage in community-based education efforts, for example, providing car safety education and infant seats to new mothers; engaging in parish nursing; and working in elementary schools in support of healthy lifestyle choices. These efforts help to demonstrate social responsibility and also improve the facility’s image in the community. On the business side, they provide marketing for the facility at minimal cost and can positively influence the bottom line.

What is your role in providing preventive services? As an individual, you can support prevention efforts by becoming involved. You can also contact the major charitable agencies in your community and become a volunteer. This can mean becoming a board member, being trained to provide service (such as disaster services), or supporting ongoing efforts. Remember that you always represent your organization in the community when you serve in these organizations.

In terms of your organization, you can begin by conducting an informal survey to determine what prevention services are already being provided and by whom. This information might not be known for the total organization, as this work is often done by individual departments. Then, based on data about your own patients and the community (public health data), you could begin to assess how to better meet your organization’s mission and provide appropriate prevention services. A team approach would be valuable to decide what you can do and how you can do it. Your plan should include supporting existing services from public health and voluntary agencies and finding ways to fund efforts within your budget. While this can be challenging, you get a return on your investment through the potential reduction of unnecessary care, increased patient satisfaction, and improved community image.

**Public Health’s Role**

Public health has its roots in the establishment of communities and the need to protect quality of life. Written evidence of this effort goes back to 1700 B.C. and the Code of Hammurabi (Tulchinsky & Varavikova,
Public health has evolved into a multi-disciplinary system whose mission stresses prevention of disease and injury, promotion of healthy lifestyle choices, protection of the environment, and prevention of epidemics. In addition, it is concerned with community access to quality health services. This system is parallel to the health care system and links the study of disease (epidemiology) to prevention and treatment. Its focus is on the community rather than the individual.

Public health’s philosophic roots lie in social justice and community action. This orientation means that it stresses the common good, tries to find public solutions to health problems, and assumes that everyone is responsible for the community’s health. It also tends to favor central planning and a government role in health care when it is necessary. Public health tends to view health care as different from other goods and services and focuses on access to care regardless of the ability to pay. It tends to take the utilitarian view of the greatest good for the greatest number (Shi & Singh, 2004).

Improvements in public health have been credited with the over 30-year extension in life expectancy that occurred between 1900 and the present. These improvements include protection policies that decreased the impact of infectious diseases through immunizations and early treatment. Improvements in water quality, food processing, and waste management also had major impacts on individual health. In addition, health promotion campaigns have increased awareness about sexually transmitted diseases, nutrition, exercise, and seat belt usage. While these efforts might not seem as dramatic as acute care, they have reaped benefits for society. Opinion polls (Turncock, 2004) have found that public health is highly respected in the United States, with most respondents stating that it was “very important” to their health. One study even found that almost half of its respondents found public health to be more important than medicine.

Despite the recognition of its contributions, public health only receives approximately 5% of the health care budget. If these services are so important, why are they funded at such a low level? Part of the explanation is that the public just expects public health to do its job; it is ignored unless something goes wrong. The public expects that whatever funds are available will be enough. The tragedy of September 11 emphasized the importance of public health, but even that did not substantially increase its funding.

In addition, there has been a long-standing conflict between the public health system and medical system (Turncock, 2004). As public health began to develop, physicians became concerned that it would infringe on their practice. In the area of clinical services, there was a fear that they would lose paying patients to public health programs.
Agreements were made and public health services were limited to those who could not pay. This relationship exists on many levels even today. The systems also have two different orientations that can often conflict. Public health wants to use its limited resources to minimize the harm to the population. Within these resources, it tries to widely distribute tests, immunizations, screenings, inspections, and so on, for prevention of possible negative outcomes. Medicine, in contrast, wants to provide the maximum benefit for the individual through customized treatment. The differences in views can lead to conflict or collaboration.

Today there is a greater need for collaboration between these two divergent systems because of the need to engage in prevention as well as treatment of disease (Turncock, 2004). One of the most common areas is in the reporting of data to various state and federal agencies for use in incidence and prevalence reports. While this might seem like a time-consuming effort, it does help to give a more accurate picture of the health concerns of the community. Increasingly, hospital and public health facilities are also working together to tackle problems of mutual interest including planning for community health needs. In fact, hospitals can even include community benefit areas in their mission statements, such as linking bonuses to community health goals, and educating staff on community as well as patient outcomes. Such efforts cannot be accomplished without cooperation between the hospitals and the various aspects of public health. In addition, the need to focus on homeland security and protection from bio-terrorism has also increased collaboration between public health and the medical system. All resources would have to work in cooperation if such an event occurred.

How does public health and its efforts relate to you as a health care administrator? First, you can be employed by any number of community-based facilities as a public health administrator (PHA). This career would afford you many opportunities to practice social justice on a daily basis. You would have to use your knowledge and experience to make the best decisions for the benefit of your community. You would be monitoring the pulse of your community to be aware of its health concerns and working to get them met. While your reward might be less financially, you would have the chance to really make a difference and engage in meaningful work.

Even if you are not working in a community-based setting, local or state public health departments should be part of your administrative resources. Practicing ethical decision making requires that you have a complete picture of whatever situation exists. Data from national, state, and local public health agencies can give you information about incidence and prevalence of conditions in your community. This knowledge can be extremely beneficial in strategic planning efforts including budgeting and program design. If you are employed in managed care, these
data can be a significant part of your financial success because you are not making decisions in a vacuum.

As the medical system begins to add a focus on prevention and community health goals, you might find yourself working more closely with public health agencies. It is a good idea to become familiar with the roles of these agencies and their key administrators. This is especially important when you assume a new position in a community. Perhaps a telephone call, a lunch meeting, or even an agency visit is appropriate to build collaboration. In addition, your facility can support public health efforts by offering space for meetings, being a part of research, or jointly working on grants to provide community programs. Such efforts not only increase your image in the community, but they can also decrease the unnecessary use of your services and actually increase your profitability.

### QUALITY ASSURANCE AS SOCIAL RESPONSIBILITY

CQI, NCQA, HEDIS, SPO; what do all these initials have to do with ethics and social responsibility? The answer is that they are attempts to assess the quality of services provided by health care facilities. Actually, many of them were developed by non-health care businesses because they recognized that quality assurance related to profits. General business still leads the way with quality assurance efforts such as ISO 9000, Malcolm Baldrige National Quality Awards, and poka-yoke. But several of these efforts have recently been adapted to health care with mixed results.

By working to ensure the best quality service in your facility, you are fulfilling your duty of beneficence and nonmaleficence (Darr, 2004). You are also practicing social responsibility through positive stewardship of resources and protecting the community against inappropriate or even fraudulent care. Because it is tempting to always put your facility in the best light, you must consciously practice ethics in the way that you collect, analyze, and present data on quality of care. When gaps between what should be and what exists are found, you can be diligent in finding the ways to improve, instead of being tempted to ignore the problem. This daily ethics requires your powers of persuasion and ability to use data effectively.

Most recently, the issue of quality of care and social responsibility has come to national attention through the efforts of the Institute of Medicine (IOM) and the Leapfrog Group. The IOM has published several books based on extensive research into the quality of health care in the United States. Its *Crossing the Quality Chasm* (IOM, 2001) demonstrated the progress that has been made in the American health care system but also stressed the gaps in quality. These gaps included issues of patient safety, incorrect use of resources, fragmentation, lack of
emphasis on chronic care, and failure to appropriately use information systems and technology. It has profiled what it considers goals for a new health care system. They include areas of safety; evidence-based care; care that is just; focus on the patient and not the procedure; and reduction of waste (IOM, 2001). They offer a whole book of strategies for achieving these goals, including how to take first steps toward meeting them.

What IOM is suggesting is a restructure of how health care systems view their mission and to take action for meeting this mission. The authors feel that anything less than this radical approach will just continue to decrease quality care for Americans. In this publication alone, they offer over 300 pages of information and suggestions about how best to implement the changes that their research suggests are needed.

The IOM reports and other health care concerns led to the development of the Leapfrog Group. It was founded by the Business Roundtable and supported by the Robert Wood Johnson Foundation (Leapfrog, 2004). This Group represents Fortune 500 companies and other large health care providers and became concerned about health care because of concerns raised in another IOM report, *To Err Is Human*. This report cited shocking information about unnecessary deaths caused by preventable medical errors and the lack of quality in the health care system. The Group wanted to use the purchasing power of employers to decrease these errors, improve patient safety, increase quality of service, and promote customer value in the health care industry.

The Leapfrog Group has been influential in getting hospitals to speed up implementation of the computerized physician order entry system, evidenced-based hospital referrals, and the National Quality Forum safe practices guidelines. These efforts are aimed at reducing medication errors and improving the overall safety of health care delivery. Standards have been developed for each of these major areas. In addition, to improve overall quality, members of this group have agreed to certain concepts when dealing with health care providers. These include incentives for systems that provide value and improve safety, increasing accountability of health plans through comparison ratings, and providing education for employees.

The IOM Report and the Leapfrog Group are just a few of the efforts that have been created to address quality in health care. It is clear that this will be a part of your professional career no matter where you are employed in the health care industry. How can you demonstrate your social responsibility in the area of quality control? You will need to understand the standards under which your facility conducts its practices and patient care efforts. The standards are not always stable, so you must check appropriate Web sites and other sources to make sure that you are working with the latest information. In addition, you
will be responsible for the quality of the data that is collected to demonstrate compliance with the standards. This means that your staff understand how to collect the data, how to report it, and the importance of its accuracy.

In addition, be sure that you practice the highest level of ethical behavior when you report data to your next level. While it can be tempting to present your department as being “perfect,” it will not benefit you in the long run. You cannot affirm your quality or make improvements if your data are inaccurate or even fraudulent.

Your responsibility for quality assurance can also be met by serving as a member of one of the evaluation organizations. Depending on your background, you can become a member of a quality review team or a policy review board. It is very beneficial to be part of the decision-making process that directly affects how you do business in health care. Remember that these organizations also need administrators; this is another career opportunity for you in the future.

**Summary**

Practicing social responsibility not only makes good ethical sense; it also makes good business sense. Remember that many health care organizations receive at least part of their funds through government or community sources. These funds are given in trust. In other words, the community expects that these organizations act with social responsibility and serve as good stewards of these resources. They want them to make every effort to provide necessary and quality care, reduce waste, and control costs. In addition, care must be respectful and compassionate regardless of a person’s social economic status or ability to pay. Reports by such organizations as the IOM point out the gaps in what should be and what exists and bring greater attention to the area of social responsibility.

The public sector is not the only group concerned about social responsibility. As you have seen, employers are also increasingly aware of the quality of services you provide to their employees. Awareness of issues such as patient safety and value for funds invested is increasing. Employers are trying to change the system by using their buying power to provide incentives for improving quality care and stewardship of resources through various organizations. Surely, social responsibility is part of your business and ethics future.

**Cases for Your Consideration**

**The Case of the Devoted Dentist**

1. What principles of ethics governed Dr. Francis Loreto’s business decision?
2. Why was Dr. Blaise Loreto concerned with his father’s latest business decision?
3. What compromise was made?
4. What lessons can you gain from the Doctors Loreto?

Case Information
Dr. Francis Loreto practiced dentistry in Maryville for over 40 years. As a young dentist, he made a decision to practice his own version of social responsibility by providing free dental health services to all of the clergy in his town. This included priests, nuns, ministers, and the local rabbi. This beneficent act, while not increasing his bottom line, was greatly appreciated and increased Dr. Loreto’s reputation in the community. Recently, a seminary was begun in the town and Dr. Loreto decided to extend his service to seminarians who needed care.

Dr. Loreto’s son, Blaise, joined his father’s practice five years ago and supported his father’s practice decision. However, he thought that extending this benefit to seminarians was just too much. He had a vision of hundreds of students demanding free care and bankrupting the practice. He actually wondered about his father’s business sense. He knew he had to talk some sense into him before he ruined the practice.

During their weekly business lunch, Dr. Loreto listened patiently to his son’s concerns and suggestions to stop providing free care to clergy or at least, not extend it to the seminarians. Then, he explained that he had made a commitment to those who serve God in Maryville, and his word meant everything to him. He did not want to renge on his promise. This service was also part of the practice’s image in the community; patients respected the practice because of it. To stop might actually decrease paying business because patients might see them as serving dollars and not the community. However, he did acquiesce to continuing to monitor the impact of his decision on the practice’s profit margin and being open to further discussion if it became a problem.

Dr. Blaise Loreto was skeptical but also wanted to honor his father’s ethical decision so he agreed. The practice continued as before with only a minor increase in uncompensated care costs. The seminarians respected Dr. Francis Loreto’s commitment and did not abuse his generosity. When he passed away after 50 years of practice, the whole community honored him as a man of ethical service. His son continued his commitment to the clergy of Maryville to honor his father.

Responses and Commentary on Questions
1. What principles of ethics governed Dr. Francis Loreto’s business decision?
CHAPTER 7  SOCIAL RESPONSIBILITY AND ETHICS

The most obvious principle involved here is beneficence. In this case, Dr. Francis Loreto decided to practice this ethics principle on an individual basis by providing uncompensated care for each clergy member. He also practiced beneficence for the community by caring for its entire clergy, regardless of their faith orientation. This practice decision was made early in his career as his way of honoring the work of these members of his community.

Dr. Loreto was also practicing social responsibility as he saw it. Even though providing the clergy free care lowered his profit margin, he was willing to take the financial risk. His practice experience told him that he could absorb these costs and that the community benefit was well worth the cost. Even though he did not intend it, his commitment to social justice was actually a practice builder. People chose his practice because they felt he had a strong moral compass and would provide them with quality care. They saw him as motivated by services and not just a need for more profit.

2. Why was Dr. Blaise Loreto concerned with his father's latest business decision?

Dr. Blaise Loreto was a recent graduate from dental school and was oriented toward maintaining and growing the business part of the practice. He did not always understand why his father would provide care when the clergy should be able to pay for it themselves. He tolerated his father’s practice because he respected him, but the idea of seminarians being given free care frightened him. He was justifiably concerned that such a practice might erode the profit margin too much and negatively affect the viability of the dental practice.

He saw social responsibility in a different light. He was thinking about the principle of the greatest good for the greatest number. Maintaining the practice and having a solid profit margin would keep them both in business. This meant that they could provide quality dental treatment to many people in Maryville. In addition, having this economic base would enable them to provide some charity care for those who really deserved it. If his father’s commitment to the clergy got out of hand, they might have to close the business. This meant that the many would suffer because of compassion for the few.

3. What compromise was made?

Dr. Blaise Loreto wanted to honor his father and maintain his practice. He listened carefully to all of his father’s ideas and they reached a compromise. He would monitor the financials of the practice and if his father’s decision began to decrease the profit margin, they would discontinue serving the clergy. Dr. Francis Loreto agreed to this compromise because he loved his son. But his experience told him that his decision was the right one. As it
Cases for Your Consideration

4. What lessons can you gain from the Doctors Loreto?

Sometimes it seems like the problems in society are so great that no one can make a difference. People can be overwhelmed by it all and just do nothing. The Doctors Loreto demonstrated that everyone can make a commitment to social justice in some way. This means searching for the correct fit between a community need and your ability to meet that need. Research and collaboration with public health and other community leaders can assist in finding your niche. Once the need is identified, it requires some creativity to find ways to address it and not overwhelm your profit margin. The goal is to make a difference in the community through action from your organization or from your personal commitment.

The doctors showed that social justice can also have a positive effect on business. The practice gained a reputation in the community for its service to all clergy. Of course, the two dentists were clinically competent, but many people chose them because they were also compassionate. The practice continued to grow by word-of-mouth referrals and both partners had a healthy profit margin, even with the uncompensated care for clergy. In addition, the clergy respected what the dentists were doing and never abused their generosity.

Comment

The 2004 tsunami disaster that took hundreds of thousand of lives underscores the need for social responsibility on a global basis. While governments all over the world responded with assistance, the contributions from individuals were projected to exceed this amount of funding. People of all walks of life—from billionaires to school children—responded to this natural disaster and wanted to provide life-saving assistance to those they had never met. They felt compelled to act as their brother’s or sister’s keeper and to do whatever they could to ease suffering and save lives.

Even with this outpouring of altruism, there were ethics issues to be addressed. Some less-than-ethical people set up scam organizations to personally benefit from the compassion and generosity of individual people. People who wished to contribute to the effort were cautioned to send their money to known agencies where the funds directly benefited the victims. Web sites were created to assist contributors with choosing legitimate organizations and making the best use of their money.

turned out, the clergy did not take undo advantage of his generosity, and he was able to maintain his commitment to social justice until he retired. His son also came to see this as a good business practice and continued it.
CHAPTER 7  SOCIAL RESPONSIBILITY AND ETHICS

The Case of the Proactive Public Health Administrator (PHA)

1. How does this case demonstrate the role of public health in social responsibility?

2. How important was social marketing to the success of the program?

3. How important was collaboration to the success of this program?

4. How did this program improve the visibility and image of the health department?

Case Information

Sandra Peoples was the director of a small county public health department. Frequently, she reviewed reports on the incidence of health problems in the zip codes served by her clinics. In her latest review, she noticed that her two zip codes showed the highest rates of infant injury and deaths from automobile accidents. She was startled by these numbers and contacted the chief executive officer (CEO) of the local hospital to check on its experience. He confirmed the numbers. She also contacted the local chief of police and found that tickets for noncompliance with infant car seat laws were also increasing for parents in her zip codes. When tickets were issued, the most common response was, “I can’t afford a car seat.”

These conversations made Sandra aware of a problem that hurt the most vulnerable in her zip code area. She knew that she had to do something. First, she made a visit to all of her clinics and talked with the staff and the clients. She soon learned that buying a car seat was not a high priority for the mothers served by the clinic. They were more concerned with feeding and clothing their children, paying rent, and keeping the electricity on. It became even clearer that car seat compliance was a problem.

Armed with this information, Sandra called a staff meeting to brainstorm solutions. It was decided to research sources for grant money, as the department’s funds would never cover this new expense. The staff determined that car seats needed to be provided along with an education program to ensure that parents would use them properly. They also found that the federal Department of Health and Human Services awarded grant money for creative projects that helped to save lives.

After several sessions, a grant proposal was filed. It included a three-pronged approach to the problem. First, parents would qualify if they were in the department’s service area (verified by proof of residency) and had a financial need. The program would consist of attendance at a 45-minute class on car seat usage and a demonstration of the participants’ ability to use it correctly. In addition, the chief of police agreed that when all officers who serviced the zip code ticketed a noncompliant driver, they would also provide a flyer about the program. The
Cases for Your Consideration

CEO of the hospital wrote a letter in support of the grant and agreed to provide data on reduction of infant injury and death.

It was funded. Sandra received funding for 9,000 car seats for the year. They would arrive in shipments of 3,000 so that storage would be less of a problem. However, the grant funding turned out to be a mixed blessing and a source for creative problem solving.

First, the shipment of car seats arrived in a semi and she had no one to offload them. However, she did have an acquaintance who was a director of a residential treatment center. He sent over some of the residents who made short work of the offloading process. She also had to find places to store all of the car seats until room could be made in a central supply area. Her clinic temporarily became car seat central with all available space used to store car seat boxes.

Next, her social marketing campaign using the police department, staff of the obstetrics department at the hospital, and clinic personnel was almost too effective. The first class day she had over 150 people lined up to take the class. She had to think quickly to schedule two additional class sessions that day and ask some of the clients to return on the next day. She learned to plan for the popularity of this program. She even learned to separate parents into groups to better facilitate their learning (teens, Hispanics, and others).

All of this planning paid off. Sandra checked with both police and hospital emergency department staff and found that there were fewer severe injuries and deaths reported for infants in her zip code. She also found a decrease in the state’s statistics so she was able to demonstrate the effectiveness of her program. Anecdotal evidence also supported the impact of the program. Almost every day someone in the clinic was thanked for their efforts to improve the safety of infants in the service zip code area.

Responses and Commentary on Questions

1. How does this case demonstrate the role of public health in social responsibility?

Sandra Peoples was a PHA who really took an interest in the epidemiology of her service area. She routinely scanned the statistical reports about the zip codes for her service area and tried to keep up with trends. In this case, she was alarmed by what she read about infant mortality and morbidity from car accidents. Her response was based on the social justice philosophy; she looked at the impact of this problem on the community she served. This included the families involved but also the emergency department and even the police department. She wanted to take a proactive approach to
solving the problem for the whole community. She also knew what her budget was for the year.

Also in keeping with the social justice focus of public health, Ms. Peoples used a team approach to find the resources to meet her community’s need. Her grant proposal had to be competitive to be awarded funding so as she wrote it, she tried to anticipate any objections. She got the support of the community for what she wanted to do, which certainly was a factor in gaining funding.

Once the program was in place, Ms. Peoples and her staff did everything they could to ensure that whoever received a car seat knew how to use it. It would not have been socially responsible just to give away free car seats without teaching the parents how to use them correctly. Improper use of the seats would also not be effective in solving the problem. The staff actually had the participants demonstrate the correct use of the seats before they would issue them a certificate for the car seat.

2. How important was social marketing to the success of the program?

Social marketing is used extensively in public health because budgets are usually very restrictive and do not have room for expensive marketing campaigns. In this case, Ms. Peoples used the police department (through flyers), the obstetrics department of the hospital, and her own clinical staff to make her community aware of the program. Evidently, it worked quite well because she was somewhat surprised by the number of participants in the early days of the program. She had to change her schedule of classes to accommodate. She also had to be careful not to run out of car seats between shipments. To not have car seats available when parents came for the classes would have been disastrous for the program.

3. How important was collaboration to the success of this program?

You probably have figured out that public health efforts often rely on collaboration with various members of the community. In this case, it began when Ms. Peoples contacted the police chief and the hospital CEO for information. Her efforts to build relationships with these important community members paid off. They also supported her grant proposal by writing letters and offering to inform clients about the program.

Once the grant was funded, collaboration was also needed. Ms. Peoples’s acquaintance with the director of the resident treatment center really helped when she needed some willing hands. The residents were happy to help in such a worthwhile effort. In addition, the police officers gave out flyers advertising the program when they stopped someone for an infant car seat violation. Ms. Peoples knew
this was effective because her staff reported that many clients came into the clinics with the flyer in their hands. Certainly, the hospital staff contributed to the success of the program by informing those clients who might qualify. The public health department clinic staff should not be overlooked. Their support of this program really made it work.

Finally, collaboration was important in documenting the program’s success. Hospital emergency department statistics, the number of police warnings and tickets, and documentation by clinic staff helped to demonstrate the effectiveness of the program. Without this support, it would have been more difficult to show how it improved the infant mortality and morbidity rates.

4. How did this program improve the visibility and image of the health department?

It soon became known in the community that the public health department was trying to do something to help keep infants safe while traveling in cars. The clients saw this effort as one of concern for their needs. They told others about the program, which also helped in the social marketing efforts. In addition, a local television program found out about the program and interviewed Ms. Peoples and two of her clinic staff. She told them how important the program was in preventing infant injury and urged others to be sure to use car seats. This program was so successful that it received funding for a second year.

Web Resources

Public Health information
http://www.apha.org/

The Leapfrog Group
http://www.leapfroggroup.org/

The Institute of Medicine
http://www.iom.edu/

References


Technology and Ethics

“It is only by the rational use of technology; to control and guide what technology is doing; that we can keep any hopes of a social life more desirable than our own: or in fact of a social life which is not appalling to imagine.”

—C. P. Snow

Points to Ponder

1. What is the relationship between technology and health care?
2. Why is information technology so important in health care administration?
3. What are the issues surrounding future technology development?
4. What is the relationship between technology and ethics?
5. What is your role as an ethics-based health care administrator?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

Computerized Physician Order decision support systems
Entry Systems (CPOE) electronic medical record (EMR)
Electronic Physician Order harmonic imaging
Systems (EPO) nanotechnology
pharmacogenomics pluripotent
Medicine has embraced technology, making it a driving force in the U.S. health care system from both a treatment and economic standpoint. Shi and Singh (2004) use the term “technology diffusion” to describe technology’s influence on values and culture. This diffusion is so extensive that many Americans equate “good medicine” with the amount of technology that is used, even if it is not appropriate. Diffusion also influences the education of practitioners, who increasingly rely on technology regardless of cost.

Technology has become an integral part of clinical practice. For example, where would diagnosis be without a fetal monitor or a CAT scanner? Can you imagine health care without intensive care units, pacemakers, or bone marrow transplants? Telemedicine has already made long distance consultation a reality. Will it change how medicine is practiced? As you will read in the next section, you will see that the increase in information systems technology has had a major impact on the business side of health care including processes of billing, materials management, budgeting, and quality control. Even the few examples presented here support the idea of high technology saturation throughout the U.S. health care system.

This saturation has many advantages but has also increased the cost of health care. Hospitals have been particularly affected by this increase because, to accommodate advances in technology, they have to invest large amounts of capital. Given the rapid improvements in many of these technologies and their quick obsolescence, this capital investment not be a lasting one. Sultz and Young (2004) use the example of magnetic resonance imaging (MRI) to illustrate this point. There are well over 2,000 MRI units in the United States, which constitutes more than a $3 billion dollar capital investment. Patients are charged from $900 to $1200 per scan, which adds an additional $3 billion to overall health care costs. These figures do not take into account the added salaries for trained professionals who provide the scans or those who maintain the equipment. To remain competitive and meet the needs of physicians, hospitals must provide what the authors call “glamorous technology” that includes MRIs and other diagnostic apparatus.

The diffusion of technology also poses problems beyond cost. Its benefits are extensive, but the apparatus might not be readily available in certain geographic areas or to certain populations. For example, rural Americans have just as much need for an MRI as their urban counterparts. However, access is not available because the technology can be just too expensive to purchase and maintain. Health problems can go undetected. Technology access is creating two health care systems; one for urban dwellers and one for rural.

When you add low income populations to the picture, the divergence becomes even greater. For example, the insulin pump as a treatment for
Technology and Its Impact on Health Care

Diabetes has been shown to provide health benefits. But the cost of the pump and supplies for one year averages $8,000. This means that benefit is limited to those who are well insured or wealthy. Does this mean that technology should be limited to only those who can afford it? Does technology create a two-tiered health care system: one for the insured and one for the noninsured? You will explore more of these and other ethics issues created by the diffusion of technology in a later section of this chapter.

Information Technology (IT)

Inexpensive computer systems and increased availability of the Internet has caused profound changes in the amount of available information and the speed of access to it. American businesses have increasingly embraced this technology and used it to great advantage. Health care, while slower to make the required capital investment, is beginning to catch up. Information is becoming a critical part of its potential for success.

There has certainly been an explosion of health information. For example, if you typed the word “health” into your search engine in 1996, you might expect to get 800,000 hits—a great deal of information. However, if you typed the same word in 1998, you would encounter 20 million hits (Ellis, 2000). This small example gives you an idea of the expansion of access to knowledge. However, there is a drawback. Although there are some Web sites with reliable information, currently there is no system for quality assurance. The lack of information filters can cause problems for consumers and providers alike because it is difficult to discern its quality.

Despite the gaps in quality, you cannot afford to ignore the impact of information technology on health care. Every aspect of the system from patient encounters to waste management has seen its influence. It has even spawned its own industry of health information management, or health informatics, administrative positions (e.g., Chief Information Officer), and degree programs. In order to appreciate technology’s influence, you need to consider its relationship to clinical care, business practices, and the consumer. These relationships also create significant ethics issues.

Clinical Applications

In the area of clinical care, technology is predicted to dramatically change the way that medicine is practiced. For example, by 2000, up to 85% of physicians used the Internet. While this use was commonly for research or checking guidelines, other uses such as clinical decision making are promised in the future (Institute for the Future, 2003). New graduates and current students of medicine are much more computer savvy, and clinical decision-making software continues to
CHAPTER 8  TECHNOLOGY AND ETHICS

E-mail is becoming more common as a vehicle for communication between physicians and patients. Some find this a highly effective tool for patient triage and a time saver. Others resent the intrusion e-mails make on their already busy schedules. However, as it becomes more and more common, consumers’ demand might increase its use in clinical practice.

Telemedicine is another example of the application of IT in clinical practice. It combines computers, videoconferencing, and digitized medical records that can be transported via satellite or high-speed telephone lines (Coddington et al., 2000). Consultation can even include remote reading of MRIs or X-rays. Telemedicine is used for consultation in military installations, correctional facilities, and some rural health care facilities. It also helps in physician education through live remotes and interactive sessions. Because telemedicine is new and not reimbursed by insurance, it currently does not add to the profit margin of hospitals that have incorporated it. However, it holds the potential to serve populations where access to specialists is limited.

One of the most visible examples of IT in clinical practice is the electronic medical record (EMR). This innovation not only has an impact on clinical practice, but it also affects health care business practice and law. The idea of the EMR is not particularly new. The Institute of Medicine (2001) called for a standardized electronic record as early as 1991 and stressed its importance again in 1997. However, even though evidence is building that the EMR can decrease medical errors and lower costs, progress toward automation has been slow.

A lack of standards and concern about patient privacy were two of the barriers to EMR adaptation. These concerns led to the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which is still in the process of being fully implemented. There remain concerns about financing such an extensive change. Capital investments for purchasing new equipment, locating and installing new software, upgrading the legacy systems, and providing appropriate training are significant. In addition, such capital investments can be very difficult for physician groups, rural health care facilities, and public health settings.

In addition to funding issues related to the EMR, health care administrators (HCAs) must be concerned with the work force that has varying degrees of knowledge and acceptance for it. Previous negative experiences with IT, frustration with necessary standardization, and the loss of income from disruptions have contributed to slow adoption by clinicians. Consumers also have concerns with this technology. While some find it to be an exciting innovation, many are distrustful of automation, or do not have access to it. This, coupled with a response
from physicians, can cause the health care system to operate parallel recordkeeping systems (paper-based and paperless). Imagine the expense, confusion, and error potential that dueling systems can cause.

The American Medical Association (AMA) has begun to use its political influence to call for policies that would reduce the barriers to the implementation of the EMR. The Institute of Medicine has been commissioned to recommend a standard EMR model, which should help to speed adoption. In addition, Senators Clinton and Kennedy have announced legislation that would support this effort.

These brief examples illustrate some of the changes that IT has made in clinical practice. In the next section on emergent technologies, you will encounter the change projections for the future. All of these changes will challenge your thinking on the ethical practice of health care delivery.

**Business Practice Applications**  IT now provides a foundation for many of the business practices used to operate the health care system. It holds the promise of providing accurate data to assist with critical areas such as strategic planning, financial analysis, quality improvement, and performance assessment. IT facilitates necessary reporting to external agencies, including accrediting bodies and government entities. It can also support daily operations of a health care facility.

In the financial aspects of health care, for example, IT can make payroll, accounts payable, cost accounting, and budgeting more accurate and timely. It can simplify claims processing by making it an electronic exchange of information rather than a paper one. This ability has greatly decreased the amount of time needed for reimbursement and could increase its accuracy.

In the area of human resources, IT can assist in maintaining employee records, as well as charting turnover and absenteeism, and it increases labor cost assessment. This technology has already decreased employee training costs by using an online format rather than a classroom one. IT also assists with providing continuing education programs and maintaining records of continuing education units.

IT makes strategic planning more efficient through the use of **decision support systems**. These systems include software that allows the HCA to create databases for efficient retrieval of information, to design decision models, and to create reports. To use these systems appropriately, you must be able to discern the quality of information and be sure that it was collected appropriately. To be useful, information needs to be timely, collected using a standard protocol, unbiased (as much as possible), and in sufficient quantity to allow for accurate decision making (Austin & Boxerman, 2003).

You can see that IT is a major tool for the business aspects of health care. However, this tool can be costly, especially when inappropriate
purchasing decisions are made. To avoid such decisions, the HCA must keep informed about advances without becoming overwhelmed by “techno-hype.” He or she must be willing to ask questions. Gathering information from users as well as vendors will enhance the ability to find the best fit for the organization and avoid wasting resources. In addition, HCAs need to play an active role in successful implementation of IT including scheduling, training, recruiting and hiring, maintaining systems, and ensuring security (Smith, 2000).

*Consumer Applications* The Internet is the most obvious consumer use of IT. The increased emphasis on prevention and patient responsibility has contributed their need for accurate and understandable health information. The Internet is perceived to be a low-cost delivery system for providing this information to large numbers of consumers. Web sites have been created to address everything from diagnosis to prevention. The most common consumer uses of the Internet include researching diagnoses, seeking information about drugs and their side effects, and looking for a physician. On the prevention side, consumers want information on nutrition and fitness and how to locate support groups. Even mental health interventions are included through sites called e-therapy, cyber therapy, or life coaching.

Just like the physician, the consumer can be overwhelmed by the amount of information on the Internet. Vehicles for filtering and credentialing Web sites are just beginning to be created. Until they are more available, consumers are cautioned to choose Web sites that are designated by reputable organizations, reviewed by experts, and clearly identify their sponsorship.

You can see that IT holds great promise for increased efficiency and patient safety. Of course, it also introduces ethics issues that will challenge both the system and the individual. HIPAA and other laws are attempting to address autonomy and privacy of records, but they will not be enough. As IT becomes more sophisticated, problems will surface that need to be addressed. Policies and procedures must be developed and staff must be trained in them. Ethics should be a part of both the development of these procedures and the training process.

## EMERGENT TECHNOLOGIES AND FUTURE ISSUES

*Clinical Applications* Technology is advancing at such a rapid pace that today’s fiction is becoming tomorrow’s reality. Books like Michael Crichton’s (2002) *Prey* are becoming closer to reality with the application of nanotechnology to health care. For example, Conley (2004) reports that Performance Software Corporation will have a prototype
of an ingestible biosensor available in 2005. This small pill will actually be a system to monitor a range of body functions with a projected ultimate cost of less than one dollar.

Other imaging technology appears to be moving in the direction of microelectronics, specific focus for energy forces, and improved analysis and display. Advances can lead to improved contrast media, greater availability of 3-D images, and more accurate high resolution data displays. When combined with current technologies, imaging quality can also be improved. One example is harmonic imaging, which will greatly improve ultrasonography for difficult-to-image patients. Few barriers exist to the advancement of imaging technology, but cost-effectiveness and economic restraints can be an issue (Institute for the Future, 2003).

Clinical genetics is perhaps the most controversial emergent technology. In 1831, Mary Shelley wrote the book called Frankenstein, which might appear to be just a horror story. However, it was actually about her fears for what might happen if technology went beyond socially acceptable limits. The success of the Human Genome Project has positioned science so that clinical genetic applications could make Shelley’s fears a reality. The applications pose ethics issues that go to the root of what it means to be human. Just what possibilities exist?

Genetic testing to identify faulty genes and provide counseling for parents already exists, but it is projected to become as common as X-rays. This testing will be extended to cover many other diseases and conditions in the future and has already led to the study of gene therapy. Gene therapy will allow clinicians to replace defective genes with appropriate ones. Although the treatment will take some time to refine, it is believed that it will be available in the near future.

There is also an area of clinical genetics called personal medicine or pharmacogenomics. This technology will link knowledge of genetic makeup to drug therapies and allow them to be customized for the patient. Physicians will have a genetic profile for their patients and will be able to prescribe the most effective drug for each individual. In addition, drugs can be tested on patient tissue (tissue fingerprinting) to determine their effectiveness (Institute for the Future, 2003).

Stem cell research is another controversial area of clinical genetics. Stem cells are pluripotent, meaning that they can become different kinds of cells in the body. Researchers believe that the application of this technology could lead to a treatment for diabetes, Parkinson’s disease, spinal paralysis, and Alzheimer’s disease. They project that by 2010 it should be possible to create replacements for solid organs such as livers or hearts. Both legal and ethical debates have arisen over this technology because the best source for stem cells is the human embryo.
In 1997 the world was surprised by the birth of a sheep named Dolly, the first cloned mammal. Her creation has led to rapid advancement in cloning technology. Actually, cloning now comes in three forms: DNA, reproductive, and therapeutic. Reproductive cloning, like the creation of Dolly, is a process of creating an animal with the same DNA as a donor. This process has already been used to clone goats, cows, mice, pigs, and other animals. Reproductive cloning is currently fairly inefficient with only one to two living for every 100 experiments. However, scientists believe that it will be possible to successfully clone humans in the near future. The ethics and legal issues around this technology are the subjects of intense debate.

Therapeutic cloning involves the creation of embryos that can be used to harvest stem cells. Cloned cells are allowed to divide for five days (blastocyst stage), and the stem cells are extracted. The embryo is destroyed during the extraction process. This form of cloning is also part of the ethics debate because it involves human embryos.

**Business Applications** There are also changes expected in the area of IT that promise to have impact on both the clinical and business aspects of health care. Although some of these innovations are already in use, their expense has precluded wide distribution. In the future they will become less expensive and therefore more available. For example, as a result of the Institute of Medicine Report and other research on medical errors, hospitals are investing in Computerized Physician Order Entry Systems (CPOE) or Electronic Physician Order Systems (EPO).

These systems allow physicians to type in (rather than handwrite) medication orders that can then be transmitted to the pharmacy. Use of CPOE/EPO has already lowered medication errors and improved patient safety. They will go a long way toward giving physicians what they want in a clinical information system: mobility, integration, reliability, affordability, and ease of use.

Bar coding is another form of IT that promises to be more extensively used in the future. While it has been widely used in many types of retail markets, it is just now being adapted to health care use. Increased use of bar coding promises increased patient safety because matching can occur for procedures, medications, and so on. It also assists with health care business applications such as inventory control and purchases.

These are just a few examples of emergent technologies that will have impact on the health care system in the immediate future. The rapidity with which they become readily available and cost effective for use depends on several factors. First, there is the willingness to make the capital investment in technology. Such a substantial investment of capital can be a major business concern for the facility, especially if it is not large or well funded. But there might be no choice; physicians and con-
consumers will demand availability of technology’s “latest and greatest.” The technology investment decision can mean that other services have to be limited, causing some true ethical dilemmas for the administrator.

TECHNOLOGY AND ETHICS

Because of its cost and scarcity, technology has always posed challenges concerning economics and ethics. For example, when dialysis was a new technology, hospitals had to create committees to decide who would receive treatment and who would not. Imagine how painful those ethics committee decisions were. As technology increases, insurance companies will also struggle to decide who and what to cover. In today’s health care system, HIPAA and other laws, while designed to protect patient privacy, lead to increased costs, training efforts, and policy changes. So, as technology dependence increases, so will the need for ethics-based decision making to balance economic and human concerns. The next two sections examine some of future ethics issues that emergent technologies can create.

Technology, Ethics, and Society

Profound does not adequately describe the potential impact of emergent technologies on society and ethics. Technologic progress, while highly valued, comes with a price. Many ethicists believe that such progress could create issues that will change how Americans value each other. “Ethics has to do with the question how we ought to live or act; technology with new ways and means to do (new) things. Why on earth should it be the case that what ‘we ought to do’ should follow from what we can do?” (Gastmans, 2002, p. 18). This is just one of the critical ethical questions. Society will have to decide the acceptable range of limits for technology’s progress and applications, and who is to receive these benefits.

Another major ethics issue for society is that, for the first time, technology will be able to do more than just improve life. It has the potential to alter the nature of being human. Eugenics will soon make it possible to create designer babies, cloned organs, and other medical wonders. Will this progress change how humans value each other? Could technology help to create two different species of humans (one genetically superior to the other)? Thinking ethically, does technology have the right to alter what has taken millions of years to create?

Some of the concerns about this progress are rooted in the fear that human dignity and autonomy will be lost. For example, what would happen to those who are not genetically superior? Will they still have rights in the society? What about clones that are not perfect or embryos
that are used as stem cell incubators? Those who benefit from technology have a responsibility for how it is used or abused, according to current ethics thinking. Emergent technologies will make this everyone’s responsibility.

An interesting example of emergent technology and its societal impact was discussed in a recent article in *Discover Magazine* (Behar, 2004). The technology of gene doping, where DNA in a viral carrier can be used to produce super athletes, is detailed. This technology is already listed on the International Olympic Committee’s prohibited substances list, but, unlike other performance enhancers, it cannot be detected. The author predicts that by the 2006 Olympics, this relatively simple technology will be common. The article’s title, *Will Genetics Destroy Sports?*, sums up the critical issue for society.

**Technology, Ethics, and the Business of Health Care**

Hospitals, both urban and rural, already feel the need to supply the “latest and greatest” technology to meet the demands of their physicians and consumers. This capital investment can strain an already tight budget and cause some administrative headaches. As technology advances and more choices for enhancing and prolonging life emerge, decisions about who will get technology and who will pay for it will become even more intense.

One ethicist discusses the need to apply utilitarian principles to making these decisions (Gastmans, 2002). If economics principles are used, the benefits of technology could be maximized to provide the greatest good for the greatest number of patients. Tough financial decisions based on scarcity of resources should be used to provide the best quality of life. Treating the worst off, while compassionate, might not make the best sense when it prohibits treatment for those who have a greater chance for quality life. While such issues have been debated before, emergent technology creates a greater need for serious consideration.

Because the goal of health care is supposed to be improving health, policies will have to be developed that considered factors like quality of life years remaining, severity of disease, and cost/benefit of treatment. Of course, such policies can be challenged by physicians who see their role as advocates for their patients and by consumers themselves. Denial of treatment, no matter how futile, will never be a popular solution. However, emergent technologies will increase the need to find an acceptable balance between economics and ethics.

In addition to financial concerns, emergent technologies will mean a change in the way business is conducted. Technology assessment skills of both clinical and business applications will be essential for administrative effectiveness. Cost-effectiveness analysis, including the expense of hiring tech support staff, maintenance, frequency of obsolescence, as well as the cost of the technology, will have to be a routine function.
Policies and procedures will also have to be developed for appropriate use for all of the technologic innovations. In addition, facilities will have to assess the level of risk they are willing to take if the technology does not turn out to be profitable. Ethical health care business practice involves balancing mission and margin. Technology can help or hinder this balancing act, depending on how decisions are made.

The health care insurance business will also be faced with some challenges from emergent technologies. It will have to decide what to cover and at what level. For example, many experimental treatments are not covered, so the financial risk for such treatments rests with the consumer. However, as technology increases the speed of innovations, more and more procedures will move from “experimental” to “routine.” Consumer demand will force companies to increase what they cover in their policies, which will most assuredly increase the rates. Employers are already taking a hard look at the value of providing employee health coverage versus loss of profit. Imagine what might happen if rates triple or quadruple.

On the positive side, emergent technologies promise to create new business opportunities. While these new businesses will provide job opportunities and revenue sources, they will also have an ethical obligation to provide value through quality services using appropriately credentialed providers. In addition, ethics will mandate that educational institutions adequately prepare professionals for service in these new entities. To avoid educational fraud, they will have to evaluate their curricula to be sure that graduates are ready for the ever-changing health care market.

TECHNOLOGY AND THE ROLE OF THE HEALTH CARE ADMINISTRATOR

Technology also changes your role as an ethics-based HCA. First, you have an ethical duty to make intelligent decisions about the purchase of technology. This means that you must rely on more than the information presented by vendors. You will need to seek out unbiased information from several sources and read it. This, on the surface, sounds simple but much of what you have to read can be saturated in techno-jargon. You can only make the best decision for your organization when you truly understand what you are purchasing, how much it costs to maintain, how quickly it will need to be replaced, and how easy it is to use. Making the best decision not only demonstrates your stewardship of resources; it also makes financial sense by limiting excessive spending and waste.

Technology can also force your organization to make tough decisions about rationing of care. Because trust matters in health care, it
should not be ignored when considering the impact of your economic policies on your patients and their families. If such policies are created based solely on economics and are not on your articulated mission and ethical principles, you can become vulnerable to potential lawsuits and/or negative community image. In short, you cannot make these policies in a vacuum; ethics committees, ethicists, and others will have to assist. You might have to assume what ethicists call a parentalistic position when deciding about technology’s role in your organization (Gastmans, 2002). This means that you will have to consider potential harm and threats to patient dignity.

Summary

The information in this chapter is just a beginning for understanding the impact of technology on ethics and ethical decision making. Consider the quote from Gastmans (2002) that challenges you to think about whether you ought to do everything you can do with technology. Each organization is going to be struggling with this issue. You will be faced with the challenge of balancing a lucrative revenue stream with the ethics base of your organization. The only way to be prepared to assist in this process is to stay vigilant. Read, surf, and conference to keep your knowledge at the cutting edge. Consider reading more than the health care literature to understand what is happening with IT in the business community. You will also have to consider “what if” situations before your organization is faced with a “must do” decision. Dialogue among practitioners, ethics committee members, and community representatives will also enhance your level of preparedness when decisions must be made.

Cases for Your Consideration

The Case of the Unlucky Brother

As you read this case, consider the following questions. Responses and comments will follow the case.

1. What ethics principles do you think were considered in the decision to have a Medicaid lottery?
2. How did the results of the lottery affect the Comstock brothers?
3. How did the results of the lottery affect the physicians and others who treated the brothers?

Case Information

Technology involves so many areas in health care including the development of new and improved drugs for treating disease. Often these drugs are very expensive and contribute to some difficult ethics deci-
Cases for Your Consideration

This case is based on a Medicare policy that was reported in several news sources including CNN news. Medicare will be scheduling a lottery for people who are victims of cancer, multiple sclerosis, and other diseases. The 50,000 winners of this lottery (25,000 cancer patients and 25,000 with other illnesses) will have the cost of their drugs covered, while the 450,000+ losers will have to wait until 2006 for coverage. Applications for the lottery will be taken for three months and a South Carolina company, Trailblazer Health Enterprises, will run the program. Concerns have been raised about the ethics of this decision.

The Case

Larry and Sam Comstock are identical twin brothers who have maintained a close relationship for all of their 67 years. Before their retirement, they even ran a business together that they passed on to their adult children. Unfortunately, both brothers developed stomach cancer in the last year before retirement. They were barely able to pay for their cancer drugs, so when they learned about the Medicare drug coverage lottery, they both decided to apply for a chance to participate.

When Larry received his letter from Medicare, he was over the moon. He was one of the winners and would get drug coverage. This would greatly reduce the financial burden that his disease was placing on his family and maybe give him several more years with them. He called Sam with the great news.

Sam was happy for Larry, but he had not heard from Medicare. He was still hopeful that good luck could strike twice. A few days later, Larry got a call from Sam. He was not chosen for the lottery and was told that he would have to wait until 2006 for coverage. Larry felt guilty that he had been chosen when Sam was not and offered to help pay for his brother's drugs to ease the burden on the family. Sam exploded, “I don't need charity from you!” and hung up.

It took several months for the two brothers to repair their relationship, but Sam was never again as close as he had been to Larry. He succumbed to his cancer less than one year after receiving his lottery denial letter. After Sam’s death, Larry always wondered if he was really the lucky brother.

Responses and Comments on Questions

1. What ethics principles do you think were considered in the decision to have a Medicare lottery?

Those who formulated the idea for a lottery to provide drug coverage for victims of cancer and other diseases were trying to balance scarce resources with the demand for those resources. They felt that providing benefit to some people was better than providing it
to none. To accomplish their goal, they tried to apply the principles of utilitarianism to reach a solution. By providing a random selection lottery where, technically, everyone who applied would have an equal chance of being selected as one of the 50,000 recipients, they were attempting to provide the greatest good for the greatest number. However, as you know from studying research, the lottery was not truly random. It was open only to those who applied. The application process itself, depending on its complexity, could restrict people from being eligible.

Those who designed the lottery model were also concerned with fairness and distributive justice. They saw their model as being fair because, as Medicare is an entitlement program, all of those with the designated illnesses were eligible for the lottery. Race, geography, or income level should not be factors that limited their application. However, you must consider if fairness truly exists here. Could those who are more affluent have easier access to the application process? Could those in rural areas have more difficulty applying for the lottery than those in urban areas? What about those who had a disease that was “not on the list”? They were not even eligible for the lottery at all. Does this seem to fit the concept of justice?

The concept of autonomy is also an ethics issue surrounding the lottery plan. While the planners might have been motivated by respect for the patients’ quality of life, the bigger picture shows a lack of respect for persons. Assuming the lottery provides coverage for 25,000 cancer victims and 25,000 patients with other identified diseases, what about the benefit for the other 250,000? Are they less valuable because they did not win the lottery? Kant and Frankl would say that each person is unique and of equal value whether he or she wins the lottery or not. They all should be given the maximum benefit available. The utilitarian view would disagree and advocate expending funds on those who have the best possible survival rates and quality of life outcomes. A lottery would not take this into account and might not be the best use of the finances. You can see that, whatever the position, the decision poses some difficult ethical challenges.

2. How did the results of the lottery affect the Comstock brothers?

This case illustrates what happens when utilitarian principles are the primary foundation for a policy decision. In using a lottery to provide a decision about who would be funded for treatment of disease, people are clearly the means to an end. Kantian principles would find this situation appalling because, in its view, people should never be used in this way. Regardless of circumstances, each person is of value and should be treated accordingly.
The application of utilitarian ethics can be seen in the impact of the lottery on the Comstock brothers. Participation in a lottery reduced each of them to numbers to be drawn. When only one of the brothers became one of the lucky numbers, it caused a split between them. Although they did eventually reconcile, Sam was not able to survive long enough to be qualified for his delayed Medicare coverage. Larry, while appreciating his good fortune, felt survivor guilt. He knew that Sam was a valuable person, yet he was not chosen. The questions of “why me”? and “why not him?” stayed on his mind. In addition, even though Sam’s family struggled financially and provided him with needed drugs, Larry always wondered if the stress of knowing that he caused this burden contributed to Sam’s death.

3. How did the results of the lottery affect the physicians and others who treat the brothers?

From the physicians’ viewpoint, the lottery seemed like a good idea. It was trying to provide some assistance to those who needed it. After all, some benefit is better than none. The idea of a random drawing among applicants seemed like a very scientific way to handle what could have been an uncontrolled situation. Having people fill out applications also made sense. You would want some form of screening here. As far as the brothers were concerned, at least Larry would be able to have his drugs covered even if Sam did not. Sam’s family could provide the funds for his drugs so his chance should be equal.

The situation with the brothers was more difficult in practice. While they had always supported each other, the physicians and office staff noticed some changes after the lottery results were announced. Both men seemed depressed and did not communicate as well as before. Despite taking his medications, Sam did not appear to be making as much progress as his brother. When questioned, he confessed that he was not taking his full dose each day. He was “saving pills to save his family some money.” His physicians encouraged him not to do this, but they wondered if he accepted their advice when he died sooner than expected.

What about Trailblazer Health Enterprises? They were delighted at winning the lucrative contract to administer the program. It increased their profit margin and provided national exposure to advertise their business. They saw this program as a fairly easy one to administer because the participants were selected by lottery and they did not have to deny services.

However, they did not anticipate the calls from families of those whose numbers were not drawn. The day the announcement was made, thousands of people called to find out if they were the lucky...
Chapter 8  Technology and Ethics

ones. Staff were swamped just trying to tell people that they would be notified by e-mail or letter. Then, after those selected were notified, the calls began to pour in again. This time there were the expected calls for information about how the program would work. There were also thousands of calls from families of those who were not chosen. Many of these were truly heartbreaking. Family members begged to know why their loved one was not chosen and if there was any way to be considered. Some even asked if there was a waiting list so they could be added to the program when a selected person died.

Staff could not help but be affected by this situation. Many questioned the ethics of what the lottery was doing and why Trailblazer chose to be a part of this. There were complaints about the stress of the long work hours and the emotional strain of dealing with so many destitute people. Turnover increased and morale decreased, which added to the employee costs and decreased the potential profit of the venture. Finally, the administrators had to add some automated phone messages to provide information to families and spare the staff so much direct contact with them. They also had to add some training courses on customer relations for dealing with families who were facing these problems. They hoped that these efforts would assist their employees, but they never anticipated that this contract would lead to these problems.

The Case of the Lemon Baby

As you read this case, consider the following questions. Responses and comments will follow the case.

1. What principles of ethics should be considered in this case?
2. How does this technology affect the business of health care?
3. How does this technology affect the nature of families?

Case Information

This case is based on a scenario that was used in the author’s ethics classes for several years. When it was first introduced, students thought it was so far out that it would never happen. They thought that it was just an academic exercise and that they would never have to deal with such a situation. Now, the case is much closer to reality; some clinicians are even providing this service at a basic level. The case illustrates the need to balance the business potential of technology with the ethics issues it creates. It goes back to Gastmans’s question (2002) of, just because you can do something, should you do it?

The Case

The Center for Reproductive Technology has made great strides in clinical applications of genetic engineering for reproductive services. For a
fee of $150,000 it can provide a “baby to specs.” The potential parents fill out an extensive questionnaire that gives their preference for gender, eye color, hair color and type, potential height and weight, intelligence potential, athletic potential, and other variables. They also complete three interviews including a psychologic evaluation and a marriage stability profile. Standard consent forms are also a part of the client acceptance process.

The procedure uses the egg and sperm of the parents, or donor if necessary, and genes are engineered to meet the parents’ specifications. The improved embryos are then implanted in the mother or surrogate mother for delivery. All efforts are made to ensure the quality of the product delivered. Customer satisfaction rates have been reported as 95%, and the Center has turned a very high profit share to its investors.

The Doctors Smalley took advantage of the services offered through the Center. They had long wanted a male child to carry on the Smalley name. Dr. Herbert Smalley wanted a male baby who had the ability to be a star athlete. Dr. Matilda Smalley wanted a child with high intelligence potential so he could maintain the family tradition of graduating from Harvard. The procedures went well and their surrogate mother gave birth successfully. The problem was that the child had the wrong eye and hair color, and was female.

The Center’s chief executive officer, Kit Ptolemy, received a call from Dr. Herbert Smalley, who was enraged at the lack of product quality. He had paid $150,000 for a male child with certain genetic traits and potentials. What he got was a female child who did not meet any of the stated characteristics. He demanded an explanation. Mr. Ptolemy calmed him down and told him that he would investigate immediately. After checking into the situation, Mr. Ptolemy found that there had been a mix-up in the computer system. The surrogate mother was implanted with improved embryos from another order, which was for a red-haired, blue-eyed, Caucasian female with high beauty and intelligence potential. Because the Doctors Smalley were African American, Mr. Ptolemy could see how they could be angry about this error.

Mr. Ptolemy called the Doctors Smalley back and explained what happened. He offered to reimburse them for their fees. That is when Dr. Herbert Smalley exploded. He told Mr. Ptolemy that he would not raise a white female child in his home even if she were free. He wanted his full refund and, tomorrow morning, he would be bringing the baby back to the Center. She would be their problem, not his.

Responses and Comments on Questions

1. What principles of ethics should be considered in this case?

   First, look at the business aspects of this case. The Center for Reproductive Technology made a risky financial decision that paid
off. They invested huge amounts of capital in technology and staff to be able to provide a service that many wanted and could afford. In fact, Mr. Ptolemy thought that the fee of $150,000 was a bargain in light of the Center’s capital investment.

The administration of the Center felt it was meeting their business obligation to provide a quality product as promised. They tried to prevent any unsatisfactory consequences by insisting on extensive interviews with potential parents of this product, including an assessment of their psychologic and marital stability. In addition, as part of a capital-based society, they felt that they had an obligation to make a profit and provide a dividend to investors. To fail in this effort would be bad for business and violate corporate ethics. Up until the time of the Smalley error, the Center was meeting these obligations and saw itself as a thriving business with great growth potential.

From a purely capitalistic view, the Center was an ethics-based business. However, when you look beyond the business aspects, you can see some serious ethics issues. First, the Center regarded human embryos and full-term babies as “products,” not humans. This is a clear violation of the principle of autonomy that values and respects human life. Buber’s idea of moral relationships also applies here. When humans become “Its” instead of valued individuals, it can change the way they are treated in society. The Center, through its designer baby technology, is actually contributing to a negative valuing of individuals.

How do other ethics principles apply to this case? Although it can be seen as providing a societal benefit, the Center’s policies are not in compliance with utilitarian ethics. The ability to design children is limited only to those who are wealthy enough to afford such technology. Therefore, the greatest good is not provided to the greatest number; it is limited to a few. Rawls’s principle of differences could be used to argue that these parents are helping to contribute to the future by creating genetically superior children and should, therefore, be given the special treatment. Kantians would reject this idea and say that the Center has an ethical duty to obey the categorical imperative. Apparently, they do not feel that providing designer children should apply to all in society—only to those who can pay for it. The Center’s action could not be defended by this ethical test. Finally, the principles presented by Mills also question the ethics of this business, because it does not seem reasonable to create a different type of human being without first considering the impact of such a decision on society as a whole.
2. How does this technology affect the business of health care?

This case goes to the root of how technology will be implemented in health care and the impact it can have. The potential for profit will make many technology-based businesses very attractive especially if traditional health care services begin to be less profitable. They hold the potential for changing how administrators think about health care delivery. So many questions need to be answered. For example, is health care going to continue to be centered on the service of increasing or maintaining health or is it to be a products-based industry? How do you invest capital in technology and still have enough resources to provide quality services? What about paying for technology applications? Will those who are uninsured or medically indigent be denied life-saving or life-enhancing benefits? What if the technology’s products are not needed, but are profitable? How do you make appropriate decisions?

Technology’s potential seems almost limitless in terms of what it can do for and to the human body. This potential can greatly benefit business and society as well. However, difficult decisions will have to be made to determine just how far technology should go. From an ethics standpoint, each organization will have to determine a balance between demand for new technology, investment versus profit potential, and ethical considerations.

3. How does this technology affect the nature of families?

Certainly, the Smalleys have a different view of the family than most. They wanted to have the perfect child who would grow up to meet their expectations. Their view of the ideal family was supported by their access to technology that could provide them with the kind of child that they wanted. They were able to pay for this technology, and it was perfectly legal. Frankly, they felt that it was nobody’s business what they did in their own home. Their only problem with this was that the Center did not deliver. Their error produced a totally unacceptable product—a red-headed, white, female child. They had no desire to spend their time and money raising a child who was not the correct gender or even the correct race. Full refund and a return of the defective product seemed fair. After all, if their Lexus child was really a lemon, it could be returned.

You can see from this response that the designer baby business can introduce whole new issues about the nature of what it means to be a family. Will there be issues about designer children versus “natural” children so that one will be valued over the other? Can you imagine the issues this change might create for social workers, psychologists, and counselors who have to deal with the psychologic
impact on the family and individuals? What about the schools? Are they prepared to educate a group of super children? How will the non-engineered children fare in school and in society in general?

In the author’s classes, several groups tried to grapple with what to do with the “rejected products” or children who were born but did not measure up to the specifications. They acknowledged that the Center might have to take these children back, much like adoption agencies do today. So, they decided that they could create a spinoff business by running a discounted adoption center that would place these babies in the homes of those who wanted designer babies but could not afford them. This suggestion, while made facetiously, sparked a class debate about what would happen to the children who did not measure up and the impact on the family and society in general.

### Web Resources

- American College of Healthcare Information Administrators Newsletter
  - [http://www.aameda.org/Specialtygroups/achiajuly01.pdf](http://www.aameda.org/Specialtygroups/achiajuly01.pdf)
- Article on e-POM systems
  - [http://medicalinformatics.weblogsinc.com/entry/8931594483760248/](http://medicalinformatics.weblogsinc.com/entry/8931594483760248/)
- Joint Healthcare Information Technology Alliance
- News story on Medicare Lottery
  - [http://search.netscape.com](http://search.netscape.com)

### References

INTRODUCTION

Ethics is not just theory or talk. It must be practiced daily in health care organizations. Organizational culture will greatly influence the application of ethics. In turn, your ethics decisions can have an impact on your organization’s culture. Your understanding of your organization’s mission, espoused values, structure, and financial status can enhance this symbiotic relationship. You also need to know your power position within the organization and how to be an agent for moral change. The chapters in this section explore the various organizational areas including finance, culture, compliance to the law, and view of the customer as they relate to ethics practices for health administrators.

In Chapter 9, *No Mission No Margin: Fiscal Responsibility*, you will examine how health care receives its funding. The complexity of health care finance adds to its ethics issues. But like other industries, health care must maintain a solid bottom line so that it can keep its doors open, pay its employees competitively, and maintain quality service. Unlike other industries, its mission is supposed to be based in service to the individual and the community and not on profit building. In this chapter, you will examine some of the ethical issues that occur when mission and margin compete. You will also study the concept of fiscal stewardship that should be prevalent in all aspects of health care delivery.

In Chapter 10, *Organization Culture and Ethics*, you will learn about the different cultures that exist in health care and how they present ethics concerns. You will also examine management culture and its influence on ethics and what can happen when administration is not controlled. Adams and Balfour discuss this in their 1998 book, *Unmasking Administrative Evil*. The chapter also includes a discussion on the functions of ethics committees and how they can assist in ethics decisions and policy
formulation. In addition, several ethics decision-making models are presented to assist you in working with these committees.

Chapter 11, *Corporate Compliance: The Letter or the Spirit of the Law* reviews some of the issues concerning required corporate compliance with mandated and voluntary regulations. This review presents the issue of compliance from the organization’s viewpoint, rather than from that of the community. In addition, the chapter goes beyond compliance to examine ways to address quality assurance in organizations. Areas that are new to health care such as poka-yoke systems, Six Sigma, and Malcolm Baldrige National Quality Awards are discussed.

In Chapter 12, *Patient Issues and Ethics*, you will look at the ethical issues affecting the patient from the organization’s view. In an era of health care accountability, the communities you serve hold you to certain standards of patient satisfaction. This chapter examines the struggle between paternalism and patient autonomy. It also explores the ethics of measuring patient satisfaction and how it can affect you as a health administrator. Finally, the chapter introduces the concept of patient-focused care and explains how organizations are trying to implement it for both ethical and business reasons.
No Mission No Margin: Fiscal Responsibility

“Can anybody remember when the times were not hard, and money not scarce?”

—Ralph Waldo Emerson

Points to Ponder

1. How are the financial aspects of health care different from those of other businesses?
2. Why does the way profit is made affect community trust?
3. How can mission and profit margin be balanced?
4. What other key ethics issues exist in the financial side of health care?
5. What can you do to increase stewardship and balance financial decision in your organization?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

medically necessary  O Team  stewardship
176  CHAPTER 9  NO MISSION NO MARGIN: FISCAL RESPONSIBILITY

**SHOW ME THE MONEY**

The quote by the 19th century philosopher Emerson that begins this chapter could easily have been written about today’s health care financial situation. The demand for health care has always exceeded its resources, especially in the case of the uninsured or underinsured. Despite government and private sector efforts, the system still has difficulties providing needed care and finding the funds to pay for it. Financing creates numerous problems for organizations that want to be true to their mission and yet stay fiscally sound. A quick review of how health care is financed should assist you to better understand health care’s unique monetary problems and the associated ethics.

Health care is a business, but its funding is like no other business. Suppose you have decided to buy yourself a Ferrari. Your budget can handle it and you have even selected the color. You go to the dealer, choose your car, and obtain appropriate financing. Your dealer is paid and you have a tangible product—your new car. In this situation, you are in charge of the purchase. If you cannot afford a Ferrari and/or cannot obtain financing, you have other options, like driving a lower cost vehicle or even using public transportation. The Ferrari dealer is not responsible if you cannot finance this purchase, but he or she does not make a sale.

In cases of most businesses then, customers have power because they decide to purchase items based on factors like need, perceived value, available finances, and even location of the services. The supplier does have certain obligations that can influence sales and profit, such as delivering a quality product at a competitive price. There are sometimes safety regulations to be met depending on the product for sale, but compliance can be used in product marketing.

What happens in the health care business? Shi and Singh (2004) discuss the maze-like complexity of health care financing, which includes a myriad of public and private sources. From the private sector, health care is funded through third-party organizations called health insurance companies. Access to these entities is most commonly provided by employer benefits, and options vary from Blue Cross Blue Shield types of payers to various forms of managed care (i.e., health maintenance organizations preferred provider organizations [PPOs], and independent practice associations). Employees usually pay part of the cost of such insurance through premiums, deductibles, and copays, but employers pay the majority of it.

The public sector also funds health, and this funding varies by population. Active duty military persons and their dependents, military retirees, and veterans have a funding system. State and federal government employees and retirees have a different system. Retirees and certain other qualified members have another system. Qualified poor persons, children, and those with disabilities have a system. Native Americans and other qualified populations also have a financing sys-
tem. Each of these systems has regulations, policies, and procedures for including or excluding people and services. Cost reimbursement schemes can be different in each system, which adds to confusion, time, and staffing needed for reimbursement.

What about those who are not employed or in a covered population? They fall into categories of the uninsured. If they are wealthy, they simply write a check for services rendered. However, many of the uninsured are not so fortunate. They often lack necessary coverage because their employer does not provide it and they cannot afford private health care premiums. They can also be unemployed, children, or not qualified for public sector programs. These consumers are sometimes given uncompensated care from hospitals or clinics or receive some government funding. They can also make financial arrangements with the facility (e.g., payment plans).

While the complexity of payment seems obvious, it should also be noted that not all health care is covered, even for the insured. For example, dental and eye care are not universally covered and often require separate insurance policies. Prevention services such as nutrition counseling, exercise programs, and integrated medicine services are just beginning to be included in health insurance plans even though their potential for lowering cost is proven. Mental health services, which could be of benefit to millions of Americans, also have limited coverage. Out-of-pocket payment is often the funding source for these types of services.

Because health care is so expensive, insurance serves to protect consumers from bearing too heavy a financial burden. However, it also removes them from having an accurate understanding of the cost of care. Many do not even look at the costs incurred and only pay attention to their deductibles or their out-of-pocket costs. Some health care reformers think that this financial distance is part of the difficulty in reforming the cost structure of health care.

In addition to the complexity of the payer system, you also need to consider what happens with the demand side of the health care market. In other businesses, the consumer, often influenced by marketing, creates a demand. But in health care, it is the provider or the payer that influences the demand. For instance, you cannot decide that you would like to have an MRI. It must be ordered by a referring physician and authorized by your insurance carrier. If you did not go to medical school and do not have the knowledge of a physician, you must trust the professional’s decisions about what is best for you.

In addition, the payer and the provider of care make the decisions about what is considered to be medically necessary. Physicians and other health care professionals are certainly well prepared to assist patients in making decisions about their health. However, many view the inclusion of the payer in deciding medical necessity with great distrust. They resent all of the rules and regulations that seem to question
their professional opinion, increase the complexity of practice, and restrict their practice decisions. Physicians and the public often question whether or not a for-profit company can make equitable decisions about who should be given care and when they should receive it (Pearson, Sabin, & Emanuel, 2003).

What does all of this complexity mean for the system? First, it adds to the overall cost of providing care. In order to receive payment for services rendered, a myriad of knowledgeable personnel must be employed. These individuals need to know ways to navigate through the complex rules and regulations and obtain optimum funding for the organization. Does the need for these personnel take away funds that could be spent on providing care? Or is it a source of employment for many who are on the business side of health care?

Second, the complexity can lead to many ethics challenges. The lure of profit over service can lead to both ethics and even legal problems. For example, while the most appropriate reimbursement code should be used for maximum return, there can be a temptation to code for the dollar and not for the diagnosis. What starts out as an ethics problem can become a legal one if the organization practices creative coding and then is audited. In addition, since certain services can be better funded than others, reimbursement, rather than community need, can become the driving force for the organization. While this might be helpful for the bottom line initially, when the market is saturated, organizations are forced to compete for “insured hearts” and “well-covered cancers.”

You are beginning to see that the financial complexity of the health care system poses difficulties for the organization in both the clinical and administrative areas. Reform efforts have been attempted to simplify the system, but these efforts have not resulted in simplifying its financing. While there is much that could be done to improve the overall funding process, any reform must fit within the uniquely American position of trying to balance market-driven business with social responsibility.

■ MARGIN VERSUS MISSION: A DELICATE BALANCE

Simply put, health care organizations need to make money. When an organization shuts down due to lack of funds, the community is angry and feels betrayed. Yet, being solely motivated by profit seems beneath the higher vocation of caring for the sick and injured. Profit-driven organizations can even be perceived as crass or unethical. No health organization wants to advertise itself as putting profit over patients, yet it needs to maintain an adequate profit margin.

As you just reviewed, care is provided in a uniquely American financial environment where the market is determined by the professionals and, to some degree, by the confusing array of payers. The ethical struggle for health care administrators is to find the balance of the yin
of quality care and the yang of profit and market survival. To achieve this balance and maintain an ethics-based organization, you must realistically assess both aspects and make decisions that are appropriate for the organization and the community it serves.

No doubt you have heard about the power of mission when it truly drives the functions and decisions of the organization. This can happen only when it is clearly and operationally defined, well understood by all, and used consistently at all levels of decision making. Mission, in an ethics-based organization, needs to include the elements of delivery of quality services within the framework of community needs and mandates (Boyle, DuBose, Ellingson, Guinn, & McCurdy, 2001). To function, it must also be founded in appropriate and adequate resources including personnel, equipment, supplies, and funds. While these recommendations make perfect sense, they are often difficult to achieve. Remember that unlike other businesses, health care must also comply with complex and conflicting standards from many external agencies. While these standards are intended to protect the public’s interests, they add to health care costs and must be included in financial planning.

In ensuring a balance between mission and profit margin, ethics-based organizations first must demonstrate congruence with their mission through their actions. For example, they cannot have two standards for the treatment of patients—one for those who are well funded and one for those who are not. Giving one group respect and the other minimal service does not demonstrate mission. Similarly, treating employees differently based on their ability to create revenue streams not only fails to demonstrate mission, but can also threaten quality of care and organizational image. In keeping with Frankl’s (1971) concepts, an environment should exist where employees are given the opportunity for meaningful work. Valuing employees as people and acknowledging their service is just one step in creating such a climate.

In addition, mission needs to be lived beyond organizational doors (Boyle et al., 2001). Community, as you read in previous chapters, plays an important role in how mission is articulated and lived. Employees are part of the community and need to provide quality service within the organization and be examples of ethical citizens outside of the organization. In fact, because of their place of work and responsibilities, they are held to a standard of behavior. They are often seen as a reflection of their organization and even health care itself.

Health care organizations also have a responsibility to model ethical citizenship by acting in accordance with community standards, being fair in their treatment of vendors, and paying their bills on time. When it is appropriate, organizations should act as community advocates. They can also encourage individual employees to provide service to the community through their volunteer efforts. Encouraging this commitment to community might include recognition of community service in newsletters and sponsorship of community events.
How does profitability fit in with mission? Boyle and colleagues (2001) and Pearson and colleagues (2003) present different aspects of mission and margin. First, ethics-based organizations need to take a big picture view of balancing patient care and profitability. This starts with the O Team (chief executive officer [CEO], chief financial officer [CFO], chief operating officer [COO], and chief information officer [CIO]) and the board of trustees. The budget must be seen as both a financial document and an ethics statement. It should be thoroughly assessed with attention to quality care, community needs, and adequate staff compensation and its statement about the organization’s ethics. If profit is the sole motivation for budget decisions, the organization can face problems with community image and marketability. In the end, profit-only organizations can actually lose revenue. As Annison and Wilford (1998) suggest, when trust is lost because the organization is perceived to be focused solely on profit, confidence is also lost. Because this confidence is at the core of your business, you run the risk of even more severe financial problems when it is lost. Your internal customers (e.g., physicians) and your patients will find other venues to meet their health care needs. The O Team and the trustees must begin the process of maintaining trust and confidence by considering both the fiscal and ethical aspects of any financial decision.

The O Team is not the only group responsible for making the budget a statement of ethics. All administrators should act as good stewards of resources that include money, equipment, and personnel. Stewards protect resources as if they were their own. They are trusted to ensure the quality, availability, and best use of these resources. Peter Block (1996), in his book called Stewardship: Choosing Service over Self-interest, discusses health care’s need to spend its money responsibly. This means taking ownership and accountability for what happens in the organization. It also means paying attention to fit—fit between the organization and the community and between staff and the organization. Block suggests that good stewards also hold their employees accountable. This means treating staff with real respect, trusting them with decisions, and avoiding excessive micromanagement.

Boyle and colleagues (2001) offer some specific ideas to address stewardship and work toward balancing mission and profit margins. These include paying careful attention to your patient mix. While it can be tempting to exclude uninsured or low payment Medicaid patients, it might not play well in your community image. In order to maintain a good profit margin, organizations should also work toward efficient use of all services and cut down on inappropriate use. This could mean programs like “Dial a Nurse” and community education efforts. Pearson and colleagues (2003) suggest that loss of income from low or non-
paying patients can be lessened by assessing needs, using outreach efforts, and working with community agencies.

Waste reduction has also been cited by Boyle and colleagues and is certainly an example of good stewardship. For example, when you authorize spending, be sure it is used for essential functions as defined in your mission. In addition, model behavior that you expect from your staff concerning the use of resources. Hoarding materials and over-ordering might seem like a good idea but can lead to waste. Your personal actions to reduce waste carry a strong message. Resources are finite and need to be used appropriately.

The authors also caution care about capital expenditure decisions. While growth is needed for organizational survival and maintenance, capital expense decisions should be carefully considered in light of mission and outcome. Technology can be helpful here by providing software to assist with projections on maintenance costs, projected obsolescence, and other data. Of course, conducting product research, using competitive bids, and astute questioning of selected vendors should help in making appropriate decisions.

To balance profit and mission, you might have to consider more drastic decisions such as staff and salary reductions and program elimination. In some cases, these options have become necessary for an organization’s survival. They should not be taken lightly because, while they can help short-term financial problems, they have a steep cost in diminished employee and community trust. It can take many years (if ever) to rebuild this trust, so drastic decisions should be made only after careful data analysis and with a plan for dealing with their impact. When they are made, attention must be given to communication, including providing an explanation for the action and treating those affected with dignity and beneficence.

Health care is a unique business with unique organizations. Therefore, there is no one formula for balancing mission and profit margin. The issue is not that health care has to make money. In fact, the community feels betrayed if an organization closes its doors. It is more about how the money is spent and if there is congruence between what you say is your mission and how you act fiscally on that mission. When profit appears to be a stronger motivation than patient care, trust can be lost. If Annison and Wilford are correct, then a loss of trust means a loss of the essential element for the existence of a health care organization. Decisions about ethics-based financial policies need to begin with the O Team and trustees and be consistently implemented throughout the organization.

**Beyond Mission/Margin Balance: Other Concerns of Finance and Ethics**

Nowicki (2004) also finds decisions about finances and resource allocation to be one of the top ethics issues in health care finance. However,
CHAPTER 9  NO MISSION NO MARGIN: FISCAL RESPONSIBILITY

he adds conflicts of interest and billing as potential areas of concern. Billing can include issues of fraud and abuse, which can move the organization into legal problems.

Conflicts of interest can exist for the individual (discussed in the next section of this chapter) or for entire organizations. A classic discussion of this topic is provided by Anderson and Glesnes-Anderson (1987) and supported by later works of Worthley (1997, 1999). Anderson and Glesnes-Anderson would have you consider the potential for conflict of interest during a merger between a for-profit organization and a not-for-profit. Conflicts can also exist within the external community and the internal communities of the facilities. Employees worry that “pink slips will fall like rain,” and often the most talented people bail out before the unpleasantness begins. Additionally, fiduciary boundaries become confused and trustees feel conflicting loyalties. Conflict of interest situations are further enhanced when the merger is between religious or civic-based organization and a for-profit one. Serious concerns are raised about mission, values, public image, and even service offerings.

Anderson and Glesnes-Anderson (1987) stress that potential conflicts of interest need to be clearly identified before policies can be written. They suggest that an organization must first identify their interests and the interests of the concerned party. Then, it must examine where conflicts might occur and whether or not the conflict is supported by law. If a conflict has legal support on either side, then the law must prevail. However, many conflicts of interest are not backed by law. In such instances, mission and values, fiscal impact, employee considerations, and other factors must be considered.

Examples of potential conflict-of-interest situations where there might not be legal support include employment outside of the organization and behavior during personal time. An organization has the right to expect its employees to provide adequate time on task for salary paid to these employees. Moonlighting can affect the employee’s ability to provide satisfactory performance. However, there might be circumstances in which outside employment does not adversely affect the organization and can even enhance its image. Therefore, each situation should be examined carefully for potential conflicts of interest and resolved in favor of the organization.

Another example of conflict of interest that is not backed by law could be personal time behavior. While the organization cannot and should not have policies to control all of its employees’ behaviors outside of the employment setting, certain behaviors negatively affect the organization’s image and should be addressed. For example, many organizations used to offer alcoholic beverages at social functions. This became a problem when employees did not limit their consumption and were involved in traffic accidents or other serious problems. Employ-
ees’ actions produced a negative image in the community when it became known that the organization provided the alcohol. Currently, most organizations either refrain from any alcohol at functions or restrict its use through cash bars and limited access. In addition, health care organizations have policies and procedures regarding the recreational use of alcohol and other drugs and support pre-hire and random screenings. Because this personal behavior has a direct impact on patient care and the facility’s image, action is taken to rehabilitate or remove employees who violate policy. The interests of the organization must take precedence in this situation.

Worthley (1999) discusses conflicts of interest for health care organizations. First, he states that the five “hallmarks of conflict of interest” are “competing obligations, appearance, myopia, fairness, [and] power” (p. 153). The first hallmark is similar to the Anderson and Glesnes-Anderson’s definition. You need to identify the interests involved and determine if they compete with each other. The second, appearance, is most critical in health care organizations. If the situation is perceived as a conflict of interest by the board of trustees or the community, then it is in fact a conflict of interest. Such situations need to be avoided if possible or resolved if necessary. He also notes that people engaged in conflicts of interest might not see them as a problem. They might be motivated by what seems to be good “business sense” and fail to perceive the potential impact. Fairness is also an element to be considered in conflicts of interest. Actions should be fair to all groups and not give one group an unfair advantage. Finally, Worthley says that power is usually a part of a conflict of interest. Organizations and people engaged in these potential situations need to think about the limits and impact of their authority.

Worthley (1999) suggests that conflicts of interest need to be addressed in both formal and informal infrastructures of an organization. On the formal side, policies and procedures should be designed to prevent potential problems and deal with them as they arise. For example, is it a conflict of interest when a pharmaceutical company pays for a continuing education unit (CEU) course and lunch for all of your nurses? Should your physicians and residents get free cruises masked as CEU opportunities? What about office supplies and other incentives that are given as gifts to your purchasing department? On the surface, this might look like business as usual and have little influence on decisions, but Worthley found that such practices do influence practice decisions. Because patients have a right to expect that prescribing or purchasing products for their care is based on their needs, many health care organizations have created policies to limit gifts, for example, from vendors. A dollar limit or a no-gift policy can be established and published for all staff and vendors. In addition, some organizations audit their purchasing departments to be sure they use fair practices in making
vendor decisions. Health care administrators are expected to be role models for these policies and to enforce them when necessary.

The informal policies of an organization also need to address the gray areas surrounding conflicts of interest. This is done through the organization’s attitude toward these behaviors. For example, does anyone question the appropriateness of eating all those free lunches or using all those free supplies? Do individuals honor the policy of outside employment? Are they aware that they represent the organization in the community by what they do or what they fail to do? Consistent policy application and reinforcement help to maintain a culture where conflicts of interest are reduced.

Finally, Worthley (1997) reminds us that conflicts of interest can be reduced when you take time to clearly define your responsibilities and values as an organization. This might not be an easy task, because all health care organizations have multiple responsibilities and often conflicting values. He suggests that you look at sources of conflict, such as responsibility to the community versus responsibility to the organization; and patient and professional success versus loyalty to your organization. To reconcile conflicts, he recommends using awareness, creativity, discussion, and reflection to move toward a common understanding and good policies. Professional organization statements like that of the American College of Healthcare Executives and of the American Hospital Association can provide guidance for working on this goal.

**Billing and Finance Ethics**

Nowicki (2004) includes billing practices as both an ethical and legal issue for health care finance. Some of these practices, while remaining within the letter of the law, violate basic ethics principles. For example, if an organization delays as long as possible in refunding overpayments from insurance companies or is slow to pay its vendors, it can help its bottom line. However, it risks a negative impact on its level of trust in the community and possibly its future contracts. More than just legality should be considered in billing practices.

May (2004) discusses ways to improve revenue cycles, as well as billing practices and financial outcomes. When the revenue cycle is handled appropriately, there is less temptation to violate the ethics of finance. She suggests that you include billing data in making decisions, model a processing cycle instead of a fixed stream, and increase ownership and accountability among employees. Efficient work processes coupled with staff training can decrease the time between charge filing, billing, and payment. Performance measures in several areas are provided including registration, coding, charge capture, and patient payment. Finally, May encourages you to discuss billing with patients to foster a clear understanding of deductibles, charges, and payment. She
even suggests the use of a financial counselor in the emergency department to assist with patient needs.

On the negative side, billing practices can become so unethical that they lead to fraud and abuse. Shi and Singh (2004), among others, have claimed that at least 10% of health care spending might be the result of these problems. Fraud and abuse have been a well-known secret in the industry and until recently were largely ignored. It was difficult to detect fraud and abuse and prosecutions were rare. In addition, the complexity of the regulations and changing interpretations made it easy to unintentionally defraud. This leads to a “Do it if we don’t get caught” attitude among some health care facilities.

How does fraud happen? It can occur if you intentionally falsify codes or costs or provide services that are not needed. You also defraud when you bill for services that were never provided. Examples of these practices include billing for restorations when the patient is edentulous; recording a higher code when the service was actually a lower code; and having a pattern of the same error without any effort toward correction. In addition, if you provide referrals for patients and receive kickback payments for those referrals, you are committing fraud. Shi and Singh (2004) cite fraud and abuse as a major concern for Medicare and Medicaid.

In an effort to better control fraud and abuse, the federal government has attempted several reform actions through the Department of Health and Human Resources and the Office of the Inspector General, including Operation Restore Trust. This program initially targeted home health, skilled nursing homes, and medical supply companies, but has expanded to other areas. The Health Insurance Portability and Accountability Act enacted in 1996 also has provisions for dealing with Medicare and Medicaid fraud. They include encouraging reporting of fraudulent practices, database construction, and increased conditions where penalties and sanctions occur (Nowicki, 2004).

While these and other efforts have increased attention on fraud and abuse prevention, they have also added to the expense of providing health care. Time spent (e.g., for completing reports), personnel, and money are being used to ensure compliance, track violations, and resolve any issues. As the system becomes even more complex in the future, it is likely there will be additional regulations from both the public and private sectors to try to control fraud and abuse.

**Summary**

What should you do to balance profits and mission? No matter what your position is within the health care system, money matters. You will be dealing with financial matters whether it is monitoring the budget, requesting funds, or planning for future needs. There are several things
that you can do to make ethics-based decisions on financial issues. Because of high levels of accountability and public scrutiny, sound ethics-based decisions are especially needed when it comes to finance. You should consider the organization's mission as you participate in the various aspects of the budget cycle and be careful to monitor expenses against budget codes. Remember that knowledge is power. You must read financial documents related to your area and understand them. Be sure to question codes that are not appropriate for your area and amounts that appear to be in error. Have correct documentation of expenses to support any questions that you have. Remember that to say nothing means you agree with the report. Your annual evaluations might well be based on your financial stewardship as well as your productivity.

Greenspan (2004) recommends that all health care organizations consider certifying their financial statements to avoid the perception of manipulation, deception, or even fraud. He suggests that you review your payments. He also stresses that in a time of financial constraint and staff shortages, there must be a balance between mission and cost accountability. Your stakeholders in the community must believe that you are truthful in your financial statements during such challenging times. Further, it is critical to educate all of your staff about how you do business so that they report information accurately and represent your organization well. Finally, he encourages all CEOs to authenticate financial statements even if the law does not require it. Making this extra effort can provide assurance that all is well in your financial house.

Remember that you are the role model for stewardship. Even though you have written policies in place, your actions create the real policy for your department. If you create unnecessary waste and abuse resources, you send a loud message that the policy does not matter. While it is not necessary to become the finance police, be aware that you are accountable. Be willing to ask for details about requests for funding whether it is to pay for CEUs, travel, or new equipment. Whatever you authorize should support the mission of your organization. If it cannot be justified, be prepared to say “No.” The ethics of finance is not just for the O Team; you are a large part of making it the norm for your organization.

Cases for Your Consideration

The Case of the Lost Chapel

As you read this case, consider the following questions. Responses and comments will follow the case.

1. What organizational ethics issues are illustrated by this case?
2. What could have been done differently?
3. What was the true bottom line in this case?

Case Information

St. Basil the Great Hospital was founded by the Sisters of Mary in 1894 with a mission of caring for those who had the greatest need. One of the first buildings in the hospital complex was a chapel dedicated to St. Basil, the patron saint of hospital administrators. This chapel became a spiritual center for the facility and the community and served as a site for many weddings and funerals.

In recent years, the hospital was part of a merger with a for-profit hospital chain but, because of community recognition, it was able to retain its name. The merged hospital placed great emphasis on fiscal stability and its commitment to shareholders for profitability. To that end, the O Team (e.g., CEO, CIO, COO, CFO) conducted a facilities review on utilization and cost benefit. The chapel did not make the cut for effectiveness because it was not used on a daily basis to meet patient needs and required funds for maintenance and upkeep. However, the land on which it stood was very valuable and could be used as a site for a high rise parking lot. Because parking was a real need at St. Basil’s and a profit could be made from fees, it was decided to tear down the chapel and put up a parking lot.

After some discussion, the Board of Trustees approved the proposal. A request for bids for demolition was to proceed immediately. However, when the news hit the community, a problem occurred. Local churches and community organizations had not been consulted about the potential demolition, and they demanded a meeting to discuss what, in their view, was a tragedy. The request was denied and they were told that the decision was a “done deal.” Next, they offered to fund its upkeep and save the chapel from demolition. They were told that St. Basil’s had an obligation to shareholders, and a parking lot more positively affected the bottom line. Finally, they tried to save the site by having it declared a historical landmark, but their request was denied.

Frustrated, the group, now called “Save Our Sanctuary,” went to media outlets for help. The local television featured several pieces on the issue including coverage of a candlelight vigil to mourn the death of the chapel. The local newspaper ran two feature-length articles telling the story of couples who had been married in the chapel, and the potential loss of a piece of the community’s history.

Members of the O Team, while not happy about the community response, felt that it was well within their rights to make business decisions that would have a positive impact on their bottom line. They
thought all this “sound and fury” would soon blow over, so the bulldozers and other equipment did their work and the 115-year-old chapel was destroyed. However, there was an additional cost for their actions. The positive relationship that St. Basil had with the community was severely affected. Because of its new image of profit over decency, many of its physicians and well-insured families chose to use other hospitals for their care needs. Contributions to the hospital were severely reduced. Census numbers were also reduced in both inpatient and outpatient facilities, and the parking lot soon became a liability and not an asset.

Responses and Commentary on Questions

1. What organizational ethics issues are illustrated by this case?

   First, you can see that this is a case about balancing mission with profit margin. The O Team was trying to make sound fiscal decisions based on their definition of contribution to mission and revenue generation. Certainly, a chapel could not produce the revenue of a parking lot. Besides, it was actually costing the organization money through the costs of upkeep.

   What the O Team did not consider was the impact of destroying the chapel on St. Basil’s image and ultimate financial situation. It did not see that destroying a chapel to put up a parking lot would cause great anger in the community. They did not think about the community’s response, which turned out to be extremely negative. Once they learned of their concerns, the O Team simply dismissed them. After all, the community would get over it and profit had to be made.

   This case also points out some of the difficulties in mergers between for-profit organizations and religion-based facilities. In the view of the O Team members, they were being fiscally responsible to their shareholders to decrease waste (the chapel) and increase profitability (the parking lot). Those from the religious-based organization saw the destruction of part of their history as a great loss. Despite their objections, they were outvoted in every way and money prevailed.

   This case also is an example of utilitarianism ethics without consideration for Kantian ideas. The O Team based this decision on trying to do the greatest good for the greatest number. By removing a building that was not frequently used and replacing it with something that would provide convenience, they were able to provide a benefit for more customers. In addition, the funds generated by parking fees could be added to the operational budget and help defray costs for areas like uncompensated care. In addition, they were practicing ethics by being true to their shareholders by increasing their return on investment potential.
By treating the chapel and the people who used it as a means to an end, they violated a basic concept of Kantian ethics. The community was not even consulted. When they asked to be heard, they were given only marginal attention. Buber would say that they were treated like “Its” and their protests, feelings, and recommendations were ignored. The O Team believed that, in the end, these people did not matter and the parking lot would be seen as an asset to the community. Did this happen?

2. What could have been done differently?

First, the O Team was correct in assessing St. Basil’s assets and utilization or resources. They wanted to be able to assure the shareholders that property was being used to its best advantage for patient care and profitability. In addition, they certainly had an ethical responsibility to be good stewards of the Hospital’s resources and to make business decisions.

However, what they failed to assess was the priorities of the internal and external community. They were acting with a one-sided view of the situation (tunnel vision) and lacked an understanding of the bigger picture. To begin with, they were now partners with a religion-founded facility. It should have been obvious that a 115-year-old chapel would have some meaning for those who chose to work at St. Basil’s and for the community it served. Conducting some form of information gathering to determine the importance of the chapel and the impact of tearing it down would have added to their understanding of the situation. However, they chose to disregard their own employees and the community they served.

They also failed to anticipate the long-term impact of their actions on the community. Although they might have realized that some protest would occur, they truly believed that the purpose of their business decision would provide a positive impact on their bottom line. Despite queries from the community and offers of alternative solutions, they chose the parking lot over the chapel. This decision, rightly or wrongly, painted them as Scrooge-like administrators who cared little for the community and its history.

There could have been other solutions to this case. First, the O Team, armed with data about the use of the chapel, could have presented the problem to its Board. Instead of using politics and power to overrule any protests, it could have asked the Board to develop a solution to meet the parking needs and the needs for preservation of the chapel. Perhaps the internal and external community could have been involved in a positive way to raise funds to move the chapel to a different site or find another way to provide parking and revenue. This solution would, admittedly, take more time, but decreasing the negative effort might have been worth the effort.
CHAPTER 9  NO MISSION NO MARGIN: FISCAL RESPONSIBILITY

Even if the chapel could not be saved, the O Team could have done a much better job with informing the community of its decision. Providing community members and media with the rationale for the decision might have helped. In addition, the O Team could have planned some type of ceremony honoring the chapel and what it meant. These actions might have been much better received than just going forward with plans. The message to the community was, “You do not matter—this is business.”

3. What was the true bottom line in this case?

The bottom line in this case was a loss of profit. Because census figures were even lower in the aftermath of the chapel incident, St. Basil did not receive a solid return on investment for the parking lot. In addition, it lost a more critical asset: the goodwill of the community. For many years, the community remembered how the chapel incident was handled and declined to support the hospital at the level it did in the past. As Annison and Wilford (1998) say, health care is based on the trust of the community; once lost, trust is difficult to regain.

As you read this case, consider the following questions. Responses and comments will follow the case.

The Case of the Faulty Estimates

1. What ethics principles do you think were considered in the decision to sign contracts with the PPOs?
2. What was the motivation to underestimate the revenue deductions?
3. How did these decisions impact the organization?
4. What would you have done if you were Mr. Seis?

Case Information

Mr. Para Seis was selected to be interviewed for the position of Senior Vice President for Operations (VPO) at Clairmont Hospital. He carefully researched and reviewed all of the financial data on this facility and found that it had a strong net worth. He also was impressed with the executive team including the CEO, CFO, and executive vice president (EVP). Of course, he was delighted when he was offered the position.

After being there only a month, Mr. Seis was called into the EVP’s office for a private meeting. He learned that the EVP had signed a confidential agreement with the local PPO. If patients chose Clairmont over other area hospitals, the facility would be given bonus money. The EVP decided to make this decision without informing physicians because they were also on staff at each of the competing hospitals. He did not want to deal with their “hassle.” However, once the physicians
learned of the “deal,” they decided to boycott Clairmont. During the last two weeks, the census had dropped by one-third and continued to fall. Mr. Seis struggled to help the organization overcome this problem.

However, Mr. Seis also did not know that the CEO, not wanting the boycott to negatively affect the financials of the hospital, ordered the CFO to purposely underestimate the deductions from revenue. By the end of the fiscal year, this inflated the net income and made the financial position look solid despite the income losses. All appeared to be well until an external auditor uncovered some problems with the figures and the true bottom line was revealed: It was zero. The CEO and the EVP were fired over the secret contract issue and the CFO for practicing “creative accounting.” Mr. Seis was the only senior management team member left to deal with this financial disaster.

Responses and Commentary on Questions

1. What ethics principles do you think were considered in the decision to sign contracts with the PPOs?

   The EVP considered the positive impact the agreement could have on Clairmont’s financial picture. If a significant number of patients chose this facility over others, there would be financial benefit through increased census and bonuses. The increased numbers might also be used in marketing the facility.

   He was aware that local physicians had staff privileges at each of the area hospitals, so he chose not to inform them of the agreement. He did not view his action as a betrayal of trust; it was just good business. However, the physicians did not see it this way and responded by conducting a boycott. Imagine their negative comments about Clairmont.

2. What was the motivation to underestimate the revenue deductions?

   Consider the position of the CEO in this situation. She sees the Hospital census dropping because of the actions of her subordinate. If the shareholders and the community found out that it was “bleeding assets,” there could be a panic. Surely, a bit of overestimation could bolster the financial picture until the problem could be fixed. She also knew her CFO would support this and practice his “estimation magic” on the books. She might even have seen herself as an ethical person in that she was taking this action to protect the solvency of the facility and the jobs of its employees. Apparently, the external auditor did not agree.

3. How did these decisions affect the organization?

   The CEO’s worst fear actually came true for Clairmont, and she was part of its creation. Although based on formulas, the estimates
did not come close to reflecting the true financial picture of the hospital. In fact, after the external auditor was through, the hospital’s financial position was in shambles. If this situation was not corrected, Clairmont faced bankruptcy and possible closure.

4. What should Mr. Seis have done?

Consider the unfortunate Mr. Seis. On the surface, he did all the correct things before accepting the position of VPO. He looked at the financial statements, assessed the working environment, and liked the personalities of the senior team. He had no way of knowing that he was walking into an ethics nightmare.

When he found out about the secret agreement and its aftermath, he was surprised. However, he tried to work within the situation as it existed and make sure that operations did all it could do to improve the bottom line. He instituted waste control measures, monitored staffing and overtime, and generally tried to do his part toward fixing the problem. However, the underestimation of deductions provided Mr. Seis with inaccurate information. Like the Board and others, he thought that Clairmont was financially stable. He was also betrayed by the actions of the CEO and the CFO.

Perhaps he would have been better off to resign the minute he learned of the secret deal. However, he did not have the whole picture at that time and decided to give Clairmont the benefit of the doubt. Besides, he had just uprooted his family and moved them. Resignation did not look like an attractive option after only one month on the job. By working to fix the problem, he gave the impression that he supported the action. However, he wanted to do all he could to help staff keep their jobs. This situation caused him many sleepless nights and bouts of acid reflux. In the end, he was the only one not fired for unethical financial practices, but he found it difficult to secure a new position. His professional reputation was tarnished by his association with Clairmont’s unscrupulous senior management team.

Web Resources

American College of Healthcare Executives
http://www.ache.org/

American Hospital Association
http://www.aha.org/aha/index.jsp

Environmental Stewardship
http://www.epa.gov/epaoswer/non-hw/reduce/epr/

Health Care Compliance Organization
http://www.bcca-info.org/
References


CHAPTER 10

Organization Culture and Ethics

“Every man’s ability may be strengthened or increased by culture.”

—John Abbott

Points to Ponder

1. How does culture affect health care organizations?
2. How do the forces of culture influence ethical decision making?
3. What is the function of ethics committees in health care organizations?
4. What can be done to increase the efficiency and effectiveness of ethics committees?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- acculturated
- ethicists
- institutional ethics committee
- professional socialization
- culture clashes
- institutional review board (IRB)
- pediatric ethics committee
Recall what you have learned about different cultures through courses in sociology, psychology, or public health, among others. You know that America is a nation of remarkable cultural diversity. This diversity adds to the country’s strength but also creates special issues. Some of these issues include differing values, practices, disease experiences, and access to health care. The health care system has an ethical obligation to provide care for all cultural groups, and to treat them equally as members of society.

The health care industry employs people from a wide variety of cultural backgrounds. For example, nurses are hired who perhaps have been educated in other countries and who are not completely acculturated to American thinking and practices. When you consider the patients you serve and the employees you hire, it is likely that you will encounter people whose values are different than yours. This situation can cause you difficulty, but as an ethics-based health care administrator (HCA), you need to make every effort to treat those who are different from you with respect, justice, and beneficence.

In this chapter, you will learn to view culture with a macro and micro focus. First, you will look at the cultural makeup of organizations and determine how this influences the organization’s self-image and way of doing business. You will also examine subcultures within departments and the potential for culture clashes. Finally, you will look at the subculture of administration itself and decide if the ethics of this subculture makes a difference in how people relate to each other.

In order to understand the impact of culture on an organization, you need to begin by defining what you mean by an organization. Daft (2001, p. 12) provides a concise definition: “organizations are (1) social entities that (2) are goal directed, (3) are designed as deliberately structured and coordinated activity systems, and (4) are linked to the external environment.” To explain the idea of organizational culture, he uses the analogy of an iceberg. The symbols and behaviors that the employees or the public sees are the tip of the iceberg. The culture in its entirety is below the surface and consists of the values, beliefs, feelings, and experiences that belong to the employees of the organization. These sub-rosa, or unseen, elements make up the practicing culture of the organization.

It is possible to grow a community within an organization’s culture when employees choose to believe and support the facility’s values. In turn, culture provides a common identity that gives employees the information they need to relate to each other and meet the organization’s mission. This common culture is filled with history, languages, ceremonies, stories, symbols, and traditions that help to establish a shared identity (Daft, 2001). These elements help new employees learn the way things are done, both formally and informally, and show them...
how to become part of the organization. Overall, this serves to repre-
sent your organization to the community.

Culture in this sense needs the capacity to adapt to the internal and
external environment in order to be successful. Daft (2001) provides a
greater understanding of this adaptation by subdividing organizational
cultures into mission-based, clan-based, bureaucratic-based, and learn-
ing-based cultures. In a mission-based culture, the needs of populations
are the focus and rapid change is not the norm. In the clan-based cul-
ture, employees’ needs are the focus and rapid change is common. In
the bureaucratic-based culture, things are done in a deliberate manner
and the environment remains stable. In this case change is made slowly.
Finally, in a learning-based organization, emphasis is placed on adapt-
ing to change and values: caring for each other; big picture thinking
and creative change are stressed. Learning-based organizations resist
the temptation to be “culture bound” or to say “we have always done it
this way” and emphasize the value of change as a mechanism for suc-
cess when the environment is unpredictable.

All of Daft’s examples can be found in today’s health care organiza-
tions. In fact, all four types can exist in the same organization. As an
administrator, you are supposed to be driven by internal mission, but
your external environment might experience rapid change. Professional-
als within your organization want to succeed and have a high quality of
life. They expect you to provide the means to accomplish their goals.
However, health care organizations are bureaucracies; that can make it
difficult to effect change, even when it is needed. Finally, the ideal of a
learning-based organization is being introduced into individual depart-
ments as a way to address the limitations of the other models. As health
care culture tends to be conservative, such a culture shift can take time.

Ethics is now becoming a cultural issue for all organizations (Daft,
2001). Ethics violations are increasing; employees lie to employers, falsify
records, and abuse drugs and alcohol at the workplace. There is an atti-
dute that if you are not breaking the law, you are being ethical. However,
organizational culture can influence day-to-day ethical conduct in posi-
tive ways through its rituals, ceremonies, and stories. If ethics is a part of
the culture’s traditions, it reinforces the idea that ethics matters and is not
just words in a mission statement. In addition, the O Team must support
and model the kind of behaviors it expects from others. As part of the
administration, you too must be a role model and use ethics-based leader-
sip. Don’t just “talk” the vision; “walk” it as well. Your actions will be
noticed far more often than your words.

Your stories, language, rituals, and ceremonies also serve to assist
employees to feel a part of your organization and become loyal to it
(Boyle, Dubose, Ellingson, Guinn, & McCurdy, 2001). Employees nat-
urally wish to be part of an organization that respects them and holds
the respect of the community. To this end, Rion (1996) identifies this as
your corporate ethos. He stresses that if the culture does not support ethical behavior, your job as a responsible administrator is much more difficult. It is wise to assess an organization’s corporate ethos before you accept a job there.

How Do You Merge Subcultures?
Health care organizations are a gaggle of subcultures. Think of all the possibilities. Groups include the health professionals, clinical support staff, and even individual departments. Finally, you have the subculture of management and administrative services. Each group has its stories, traditions, symbols, and rituals that are learned through formal and informal education and experience. The potential for culture clash is immense. To complicate matters further, issues also arise between loyalty to a profession and loyalty to the organization.

Each of the subcultures has shared experiences and common expectations. Subcultures hold beliefs (founded or unfounded) about the members of other groups in your facility. These can be destructive when assumptions are made about the motives and actions of others. How about a few examples? Physicians represent the most highly educated subculture within the health care system. As part of their professional socialization in medical school, they retain attitudes and expectations regarding the behaviors of others in the system. For example, they might view a nurse, respiratory therapist, or laboratory technician as subservient and without authority to question their orders. They might also see administration as a nuisance that is designed to make their lives unhappy. Even within their own subculture, they might view certain members as being “less than” other members. For example, a psychiatrist might be seen as less important than a neurosurgeon. These attitudes and expectations, when taken as truths, lead to behaviors that can be perceived as unethical and even cruel.

Nursing, a large subculture, has many myths and attitudes that vary by age and education. Some registered nurses (RNs) were taught to be the “handmaiden of the physician” and always to be submissive. It sounds like an exaggeration, but they were even expected to give up their seat if a physician entered the room. Other nurses were taught that they should make nursing diagnoses (a concept that is disliked by many physicians). You can see how culture clashes occur when the physician and nurse subcultures interact.

Culture clashes are also an issue between professional and support staff. Often support staff are stereotyped as not intelligent or not critical to patient care. Some report being treated as “invisible people” by the professional staff. In addition, support staff can view the professionals as self-impressed and unable to communicate with the “real people.” They might feel that the organization does not respect or
value them. Such feelings make it easy for them to violate ethics practices. Their message is, “If they don’t care about me, why should I care about them?”

You cannot leave this discussion about the power of subcultures without looking at administration. As an HCA, you have language, stories, and values that are specific to your discipline. Your particular version of administration culture is a factor in how you view the organization and how you make decisions. In addition, your position within your subculture gives you the power to influence the overall culture of the organization. For example, Maclagan (1998) suggests that the way you exercise control over operations helps to create the organization’s climate. If your amount of control is inappropriate, it can lead to low levels of trust, feelings of manipulation, and a poor work ethic. In this climate, the practice of ethical behavior becomes more difficult for everyone.

You will face some ethical temptations because of your power and influence over the culture of organizations. For example, Collis (1998) uses the term “managerial malpractice” as a way to describe what happens when administrators have too much freedom in decision making and cross the ethics line. His work is based on a national study of academics, chief executive officers (CEOs), union presidents, and others that found many areas of performance weakness in terms of attitudes, knowledge, and skills. These weaknesses contribute to what he calls “fatal management sins” (p. 53). Many of the areas discussed are related to organizational culture including attitude toward employees (seen as an expense not an investment), fairness of their treatment, and creation of trust.

Adams and Balfour (1998), in their powerful book Unmasking Administrative Evil, use history to illustrate the negative influence administration can have over culture. These influences lead to cultures that encourage malevolent behaviors. One example the authors use is the civil service administration during the German Third Reich. When ethics is valued less than technology, and bureaucracy less than people, it becomes easier to enact and implement policies that are evil. The authors caution that to be an effective HCA you need more than management theory to do your job. To be a conscientious administrator, you need to be proactively aware of the potential for evil caused by the abuse of power.

You can now see that the culture of an organization greatly influences whether ethics is valued, and how it is used (or not used) in making both corporate level and daily decisions. In an environment of multiple subcultures, often with conflicting loyalties, establishing an ethics-centered culture is not an easy task. However, as an administrator, you are in a position to influence the culture’s environment through rituals, stories, and ceremonies. You can articulate your own values, and most impor-
tant, show your ethics by your actions. In this way, it is hoped, the employees will respect the culture they work in and follow your example.

THE HEALTH CARE CULTURE RESPONDS: ETHICS COMMITTEES

The health care system and particularly hospitals have always been faced with ethics issues requiring difficult decisions. With the advent of new technologies, more issues have come to the forefront and expanded the need to have ethics committees in place. For example, in the 1960s when kidney dialysis was a new technology, the patients who needed dialysis vastly outnumbered the availability of machines. Hospitals responded by creating ethics committees to decide which patients would receive treatment. These groups were often called “god squads” because of the potential for their power over life or death situations. In the 1970s the well-publicized case of Karen Ann Quinlan made hospitals more aware of the ethics surrounding the use of technology to prolong life. Ethics committees were charged with developing policies on the withdrawal of life support and other end-of-life issues. Although the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not expressly mandate ethics committees, today they are present in almost every hospital in some form and have far more global responsibilities. They have even become part of other health care organizations, including health maintenance organizations and long-term care facilities.

Just what does an ethics committee do? To begin with, larger facilities often have three ethics committees. One is charged with general ethics responsibilities for the facility; one with issues related to pediatrics and ethics; and the last with research ethics (this one is called the institutional review board or IRB). These specialized committees will be discussed later in this section. The general ethics committee can be assigned different titles depending on the hospital’s culture. One title is the Institutional Ethics Committee. The placement of the committee on the hospital’s organizational chart can vary, and its position on the chart usually reflects its importance within the organization. If the administrative and clinical staff do not take the committee seriously, it becomes nothing more than window dressing. The internal organization and the external community is misled regarding the importance placed on ethics policies.

Regardless of the title, these general committees have functions in common, which include education, policy advice, and patient case review. The committee can provide in-service education programs on identified or upcoming issues to staff, patients, families, and even the larger community. The educational component can also positively influence the way that ethics is valued in the organization by enhancing ethics awareness, creating an ethics dialogue, and reinforcing the
vision, mission, and purpose of the facility. In addition, committee members must continually educate themselves on upcoming issues and decision-making models, and orient new members.

Another major function of a hospital ethics committee is policy development and review for all issues related to clinical ethics. The CEO, chief operating officer, Chief of Medical Staff, the Board of Trustees, or other key administrators can request these reviews. If policies need to be developed for recurrent issues, then an ethics committee can serve in a consultant role. Recurrent issues include advance directives, withholding treatment, withdrawing treatment, informed consent, and organ procurement. Ethics committees can even be involved in policies relating to allocation of resources and preservation of the vision and mission of the facility. For example, they can recommend policies on community outreach, charitable contributions, and fundraising. The committee tries to make sure that policies are written in a way that will be fair to all who are affected by them.

Finally, ethics committees review and advise on individual patient cases where there are difficult ethical concerns. The system for this review varies from facility to facility. In some cases, committee members are on call (similar to a specialist). Staff, administrators, patients, guardians, or family members all are eligible to pose a question or request an informal review from the ethics committee. Full reviews require the presence of all committee members and follow a formal procedure in making recommendations. Of course, the committee must work within the organizational structure and have a clear understanding of the articulated values and ethics position of the overall facility.

Who should be on the ethics committee? Again, the constitution of the committee will vary by institution. Generally, you find the CEO or his or her representative; clinical staff including physicians and nurses; a clergy member or a person with ethics background; and an attorney. Some facilities also include a quality improvement staff member, a member of the Board of Trustees, community members, and social workers. Members should be carefully selected. Beyond professional qualifications, a potential member should be open minded; work well in teams; have a knowledge base in ethics; and be able to work within a framework. In addition, all members should have a sufficient commitment to ethics so that they are willing to spend the required time in meetings, training, and updating their personal knowledge.

**Pediatric Ethics Committees**

Pediatric ethics committees, also called infant care review committees, have the special charge of dealing with difficult ethical issues that concern the care of newborns, infants, and children. End-of-life procedures, treatment for disabilities, reporting child abuse, and disagreements between the professionals and the family require particular attention.
Recommended members for such a committee include pediatricians, pediatric oncologists, neonatologists, nurses, and social workers. These members are responsible for maintaining currency on ethics issues related to infants and children, and might even have to be on 24-hour call (Darr, 2004).

**Institutional Review Boards**

Research contributes to the understanding of disease and the improvement of health for millions of people. Unfortunately, it also has the potential for ethics violations that can cause psychological and even physical harm to participants. The roots of the IRB can be found in the Nuremburg Code of 1949, which was formulated in response to the experiments on human beings by the Nazis of the Third Reich. It also is designed to protect people from abuses like those that occurred during the Tuskegee Syphilis Experiment in the United States.

The Tuskegee Experiment was conducted between 1932 and 1972. The Public Health Service conducted this research on 399 black men using misleading information about its purpose and procedures in order to ensure their cooperation. The real purpose was to follow the men until they died and then collect data from autopsy results. Even when information about the cure for syphilis became available, the subjects were not informed and were prevented from receiving medication. The thinking behind this human rights violation was that the benefit to society was worth the sacrifice of a few lives. It was also thought that the results would be of benefit to blacks by creating greater knowledge of how syphilis affected them. Researchers used utilitarian ethics to justify their actions, but Kantian ethics was not considered.

These and other research abuses led to the formation of IRBs in universities, hospitals, and other health care institutions. The functions of the IRB in a hospital are to protect research subjects and to see that protocols do everything possible to decrease risks to their well-being. This committee must also make sure that consent to participate in any research is given based on an understanding of risks and benefits, and that privacy is protected (Darr, 2004). The committee is responsible to see that informed consent procedures are stringently followed to protect potential subjects from being coerced to participate or misled in any way. Subjects vulnerable to these tactics include the mentally ill, the physically disabled, the elderly, or the economically disadvantaged.

Federal and state agencies mandate that IRBs review funding proposals before they are submitted for consideration. How a study involves human subjects defines the depth of the review, but the rights of those involved in the study are always a primary concern. Members of IRBs must have expertise in research designs and proto-
Assisting the Process: Choosing a Decision-making Model

Ethicists
In addition to the committees, large health care facilities sometimes employ an ethicist as a consultant or on a full-time basis. An ethicist usually has a doctorate in ethics, bioethics, religion, or a related area and serves in both policy development and patient case review. In addition, ethicists can be a resource for the ethics committee by providing continuing education on ethics topics. He or she can guide the decision-making process of the committee through the use of models and facilitation techniques.

ASSISTING THE PROCESS: CHOOSING A DECISION-MAKING MODEL

Members of ethics committees must sit on the board for more than just the “feel good” experience. To effectively influence culture and practices, committee members must view their responsibilities and status on a par with the top members of the O Team. The committee should be evaluated annually to ensure its effectiveness. By treating this committee the same as you would any other important administrative body in the facility, you send a strong message about the value the organization places on making sound ethical decisions.

As health care continues to evolve, the issues faced by ethics committees will become increasingly complicated. Committees will need to become more diverse by combining professionals with community representatives. Given these circumstances, the solutions to ethics issues will not be simple to derive. Committees will require tools to make decisions in the most effective and efficient manner. Ethics decision models can assist with this process by providing a structure to deal with situations that can be emotionally volatile. Tools or models can also enhance what Worthley (1997) calls your “ethical reasoning” ability (p. 229).

The first step is for the committee to have a selection of models from which to choose or adapt. Beginning with an agreed-on model ensures that the committee will work from a position of information and not from one of opinion alone. Knowledge of the existing models helps the committee choose the one that best meets its needs.

For example, Anderson and Glesnes-Anderson (1987) present a qualitative model that provides a rational and systematic approach. This approach is used to review alternative solutions and select the
most appropriate one for future implementation. Their qualitative model includes the answers to questions like:

1. What is the problem?
2. What are possible courses of action to resolve the problem?
3. What are the short and long-range consequences of each action?
4. What ethical principles support each action?
5. Weighing each of the answers to 2–4, what is the best decision?
6. Can I support this decision?

This model gives the committee freedom to explore several alternatives and compare them in terms of their ethical, organizational, and even financial consequences. The authors say that the last question allows the committee to double check its decision before communicating it. Committee members should be able to personally support their decision.

Darr (2004) suggests a schematic model for decision making that uses a decision-tree format. Like the previous authors, he suggests that the decision-making process begins with gathering information about and clarifying the problem. Then he adds a step where the committee’s assumptions about the problem can be identified and discussed. After these areas are understood, alternate responses can be formulated. Based on criteria such as the reality of implementation and cost/benefit analysis, responses can be evaluated. The best response is then chosen and recommended. Darr’s model also includes a comparison between what really happened during implementation and what was desired. This evaluation provides needed feedback concerning the effectiveness of the committee’s decisions.

The Ethics Resource Center (2004) has created a model with some of the same features suggested by the previous authors. The model contains the same steps of problem analysis, alternative identification, evaluation, decision making, implementation, and decision evaluation. However, it adds another dimension called “filters” for including ethics in the decision. It uses the abbreviation PLUS, which stands for policies, legal structures, universal laws, and self-standards. PLUS includes the application of the organization’s policies, any laws that apply, and the “universal principles/values” (p. 6) of the organization. Finally, each committee member considers whether he or she can support the decision as an individual apart from the committee. The model encourages the committee to consider both the ethical and legal ramifications of decisions and show how these decisions affect the organization as a whole. In addition, it allows the committee to describe the process it used to formulate its decision and to be able to explain its actions.

Several models (Worthley, 1997) that could be adapted for use by ethics committees include checklists, question-based formats, and principle-based designs. Checklists can be used to remind the committee to
get the full picture of the situation before discussing the solution. This can slow down the temptation to “jump to solution” before all of the information is assessed. There are a number of question-type models that can encourage the committee to look deeper into the problem. For example, Worthley cites a model that features specific questions about your skills, the process of dealing with the situation, knowledge of laws and policies, and response to patients. He also presents some examples of principles-based models that can stress the need to look beyond self-interest to that of the community.

Models are good only when they are used and only used when they are understood. This means that the committee must be thoroughly familiar with whatever model is chosen or adapted. The committee’s knowledge of the model can be continually refreshed as each new member is trained to use the model as part of his or her orientation. In addition, the model itself should be reviewed occasionally to determine if it is still meeting the needs of the organization and the committee.

Summary

Health care can be described as multicultural, which makes it a challenging work environment. It also makes this environment susceptible to culture clashes. Part of your responsibility as an ethics-based health care administrator is to become aware of the differences in the cultures in your organization and use your knowledge to prevent culturally based problems. In addition, you need to be cognizant of the influence you have on the overall culture of your organization. Your behaviors will be examined and speak much louder than any policy you create. Being the role model means thinking about how your actions will be perceived before you take them.

This chapter also presented some of the types of ethics committees that you will encounter in health care settings. While you may not be directly involved with all of them, it is important to understand their functions and how they assist your organization in meeting its ethics obligations. It is important to remember that having a decision-making model that can be easily understood and readily used increases the effectiveness of any ethics committee regardless of its emphasis.

Cases for Your Consideration

The Case of Code White Coat

As you read this case, consider the following questions. Responses and comments will follow the case.

1. How does this case illustrate the impact of internal health care cultures on behavior?
2. How did the administration choose to handle the cultural conflict?
3. What was the end result of having a policy and program that does not tolerate abuse?

Case Information
Josh O’Shaun, newly appointed CEO of Morris County Hospital (MCH), faced many problems in his 200-bed facility. One of the most pressing, in terms of patient service, was the nurse retention rate that continually caused understaffing. His root-cause strategic plan included hiring a Chief Nursing Officer (CNO) who would have equal status on the O Team. He was fortunate to hire Nicole Franz, a well-respected RN, for the position.

During the first staff meeting, Mr. O’Shaun asked for ideas on how to deal with the nurse retention issue. Ms. Franz presented research to show that the lack of respect given to nurses was one variable that contributed to this problem. With the support of their O Teams, other hospitals had instituted a policy of zero tolerance for physical, sexual, and verbal abuse. The policy was implemented through a program called Code White Coat. In this program, when a physician acted in an abusive way, the nurse could call a “code white coat” over the intercom. This action would bring available nurses to stand as witnesses to the event—and if possible, intervene in the immediate situation. Research results showed this policy led to a significant reduction of abuse incidents.

Her suggestion led to a lively discussion about the differences in perceptions of the nurse retention problem and lack of respect for nurses. The Chief of Medical Services (CMS) said that physicians were there to save lives and had a right to get angry if things were not done according to their standards. He believed that nurse abuse was not even a problem at MCH. The chief financial officer pointed out how much the current turnover rate cost the hospital but did not have an opinion about its cause. After much debate, the O Team decided to try a new policy that did not tolerate abuse in any form and then instituted the Code White Coat program at least on a trial basis. They would evaluate it after one year of its implementation to see if it made a difference in both turnover and morale. The CMS thought the program would never be used, but agreed to support it.

After the MCH staff was trained on this program, consciousness of the problem was raised and that, in and of itself, seemed to decrease the incidence of nurse abuse. However, after three months, Mr. O’Shaun heard a code white coat called. He quickly responded and found Dr. Peters, his only neurosurgeon, still screaming at a nurse. There were two other nurses present as witnesses to this action, but their presence did not stop the physician. He accused the nurse of being disrespectful, unprofessional, and not knowing her place.
Mr. O'Shaun asked Dr. Peters to come to his office immediately and contacted the CMS for a stat conference. He also called the CNO and asked her to have a stat meeting with the nurse and her witnesses. He needed Ms. Franz's report before considering final action on the situation. By the time the CMS had arrived, Dr. Peters was calmer and explained what had made him so angry. Many factors besides the nurse’s behavior contributed to his outburst. However, he felt that she did not act quickly enough to his order and that he had the right to treat nurses any way he chose when lives were at stake. He was aware of the hospital’s policy of zero tolerance for abuse, but he did not think he had been abusive. All he did was raise his voice.

The CMS explained that there were other ways to deal with the situation other than public outbursts. The zero tolerance policy applied to physicians as well as the staff at MCH. The CMS warned Dr. Peters that continuing such behavior could lead to sanctions, including loss of privileges if necessary. He also asked Dr. Peters if he would like to have assistance with anger management or other counseling. Seeing that the new policy was not just a joke, Dr. Peters said that he would apologize and watch his temper in the future. The CMS then said that the physician would be informed if further repercussive actions were to be imposed regarding the immediate matter.

After Dr. Peters left, Mr. O'Shaun, the CNO, and the CMS met to discuss the situation. The CMS said that he was surprised that this incident happened. He knew that physicians were demanding but never thought about the issue of nurse abuse. The CNO said that she was not at all surprised. The incident was in keeping with some of her observations of physician/nurse interaction at the facility. After much discussion, it was decided to write a letter of warning to Dr. Peters to document what was discussed in their meeting. To drive home the seriousness of the matter, the letter mandated the physician to attend an information session to refresh his knowledge of the zero tolerance policy.

Responses and Commentary on Questions

1. How does this case illustrate the impact of internal health care cultures on behavior?

Recall from previous chapters in this book that bullying and abuse are not considered ethical behavior, no matter who is doing it. However, because of the physician culture norms, Dr. Peters clearly did not see his behavior as unacceptable. He had been educated to believe that his status as a neurosurgeon entitled him to instant response from any nurse. His words were never to be questioned. While he was aware of the zero tolerance policy, he felt that it applied only if he physically abused a nurse; yelling was acceptable practice. The CMS was also part of the physician culture. Initially, he thought the whole idea of nurse abuse to be quite trivial. After all, he was not
aware of any nurse being assaulted by a physician at the hospital. He thought a policy of this kind was not needed, but if the new CNO wanted to try it, he would go along. He was totally surprised when a nurse actually had the guts to call a “code.” After this incident, he understood that abuse could be verbal as well as physical.

At this point you might well ask, “If the problem was so bad that nurses quit their jobs, how could the hospital not know about it?” You need to consider that the nursing culture is also a factor in this situation. Many nurses were taught that they were to serve as the “handmaidens of the physician.” Verbal and even some levels of physical abuse were seen as just part of the burden nurses had to bear in their service to patients. They did not question it; they just learned to take it or resign. These actions resolved the problem for the individual but did not provide any information to the organization. Recent graduates of nursing schools, while still influenced by this thinking to some degree, tended to regard themselves as partners with other clinical staff. They were taught to politely question actions that did not seem congruent with patient care. You can see how this “new nurse” paradigm could lead to a culture clash, especially if it is perceived as insubordination.

2. How did the administration choose to handle the cultural conflict?

First, you must recognize that the action taken to address this issue was not based entirely on altruism. Mr. O’Shaun was aware that the turnover rate among nurses was causing potential problems in quality of care, morale, and costs. He was educated to seek the root cause of a problem and had the authority to work with the O Team to find solutions. Notice that he chose what might be seen as innovative, if not radical, solutions.

Mr. O’Shaun created the position of CNO, which had equal status on the O Team. This decision goes against some administrative culture norms. Nursing has not always been regarded as equal to other departments in a hospital. In fact, in the early days, nursing services were considered part of the bed charge (like linens and disposables). Creating the new position was a risk, but he knew that he needed the expertise of nurses and the support of nursing services. Putting a chief nurse on the O Team helped the necessary culture change.

Also consider the courage of the O Team to create and support a policy that featured zero tolerance for all forms of abuse. While it is very easy to endorse a policy that declares it inappropriate to physically or sexually abuse someone, including verbal abuse is more controversial. The O Team had to be willing to apply sanctions for words as well as physical actions. This willingness could have had some financial risks. For example, the abuser could be
someone who helped to create revenue for the facility. To remain an ethics-based facility and demonstrate justice, the O Team had to risk taking actions that might jeopardize this financial asset. In light of these and other concerns, Josh had to encourage lively discussion of this innovative policy and gain support of all O Team members. In the end, even the CMS expressed support for implementation.

How about the Code White Coat Program? Making the decision to implement it was even more courageous. O Team members were willing to counter cultural norms that might be deeply held by both the physician and the nurse groups. While they had research that showed the program worked at other hospitals, they had no way of knowing how it would be received at MCH. They risked a backlash from physicians who might resent such a program or see it as giving nurses permission to gang up on them. Physicians might even view it as an encroachment on their power and authority within the hospital. Despite the fact that the program was for the benefit of the nurses’ rights and safety, the O Team had no guarantee that other nurses would respond to a code as witnesses. Perhaps the nurse who had the courage to call a code would not be supported. This could create even greater morale issues. The CMS was not convinced the program was necessary and said so. The whole team hoped that they would never hear a code called but implemented the program despite the risks.

Once a code was actually called, Mr. O'Shaun had to resolve the issue in an appropriate way. Notice that he involved the CNO and the CMS in data collection and problem solution. He needed all sides of the story to be able to make a just decision. The solution that was formulated demonstrated justice for both the physician and the nurse because it worked to change culturally ingrained behavior and was not intended to be only a form of punishment.

The CMS showed some ethics courage here. Despite his reservations about the program, he was willing to confront Dr. Peters about his behavior and let him know that it was not acceptable. In doing so, the CMS made an ethics-based decision. He had to risk alienating his only neurosurgeon, who might resign. This would affect the revenue source of the hospital. But if he did nothing, after agreeing to support the program, he risked being a hypocrite. After weighing all the elements of the problem, he used a reasonable approach that would prevent any further incidents. His decision to take the matter seriously also sent a clear message to other physicians and to the nursing staff that the policy was more than just a piece of paper.
3. What was the end result of having a policy that did not tolerate abuse? Creation of a CNO position was a part of the solution for nurse turnover in Mr. O’Shaun’s view. But this decision required an allocation of funds for salary and benefits that came from an already frugal budget. Then, he had to respect the person whom he hired enough to hear her ideas and expend the resources to act on them. This involved an investment in policy development and training for the entire staff. From a business standpoint, Josh had to be willing to make these fiscal decisions based on the potential benefits for the organization.

Although the case does not give you the results of the annual evaluation of the policy and program, you can make some assumptions based on your knowledge of ethics and the business of health care. First, in keeping with deontology, MCH sent a message to its nurses that they were valued. When a verbal abuse situation occurred, they were given the authority to call a code to stop the behavior. In addition, the program was supported by a policy that made it clear that all forms of abuse were not to be tolerated. When the first code was called, the nursing staff saw that it was taken seriously. Even though the physician involved was a major revenue contributor, his action was not covered up or glossed over. These actions created a better working environment for the nursing staff and had the potential to positively affect retention and patient care.

What about the physician culture? This new policy and program was particularly difficult for them. Even the younger physicians did not see nurses as partners and found it difficult to deal with what they perceived as a blow to their authority. However, they also learned that their Chief of Medicine took this issue seriously. After the first incident with Dr. Peters, they tended to be more careful about their verbal outbursts. The overall work environment became more pleasant for everyone and fewer and fewer code white coat calls were heard at MCH.

As you read this case, consider the following questions. Responses and comments will follow the case.

The Case of the Compassionate Committee

1. What ethics principles were part of the actions in this case?
2. How did the action of the Caneyville Hospital Ethics Committee benefit the hospital?
3. How did the action of the Caneyville Hospital Ethics Committee benefit Mrs. Smith?

Case Information

The March meeting of the Caneyville Hospital Ethics Committee in Peace City, Florida was a particularly unusual one. The eight volunteers
Cases for Your Consideration

on the board had tackled many difficult issues in the past, but the case before them this month was notably different. A member of the Caneyville community, who was not even a patient at the hospital, had asked for a consultation. This was highly unusual, for starters. Plus, the nature of the situation and the problems that it caused for the family warranted a departure from hospital protocol.

This was the presenting situation. Mrs. Judy Smith’s father suffered a closed head injury when he fell off a ladder at his home in New Mexico. At his local hospital, he declined into a permanently vegetative state and was placed on life support. He was transferred to a long-term care facility. Knowing that her father would not want to have such poor quality of life, Mrs. Smith did all she could to give him a death with dignity. She reviewed Do Not Resuscitate (DNR) orders and assumed power of attorney.

Because Mrs. Smith and her three children lived in Peace City, she could not visit her father on a daily basis. Her distance from the facility was causing her grave difficulty. Each time her father coded, the staff resuscitated him and contacted her after he was stable. When she asked them why they took these actions, she was told that the administration required a family member to be present before DNR orders would be honored. She was told that the policy was designed to ensure that the true wishes of the patient were being met. The facility could be sued if someone acting on the patient’s behalf had changed his or her mind at the last minute.

The situation was causing Mrs. Smith severe distress. She could not go to New Mexico and sit by her father’s bedside, waiting until he coded again, and then see to it that DNR orders were followed. Her vacation days and sick leave were exhausted. Resigning from her job was not an option because she were the sole support for her children. In addition, she was her father’s only next of kin. She was frustrated because it appeared that, while she had done all the right things, her wishes were not even considered at the New Mexico hospital. She came to the Caneyville Hospital ethics committee for advice.

The entire meeting was devoted to the discussion of this one case. The committee used the expertise of its members (which included a lawyer, ethicist, and physician), and its knowledge of ethics and law to discuss Mrs. Smith’s case. The CEO’s representative contributed some insight about the policy at the long-term facility. He said the policy had merit because it protected the facility from a potential lawsuit. He could understand why the administrators at the facility wanted a family member present. The ethicist pointed out that, while the policy was in the best interests of the facility, it neglected to honor the wishes of the patient and his family. The facility should be true to its mission of service to patients. Perhaps it might be willing to consider the application of the policy on a case-by-case basis instead of a blanket procedure (in other words, act with utilitarianism and deontology). The committee
used a decision-making model to evaluate several options and prepared a list of recommendations for Mrs. Smith. The recommendations were not binding on the part of Caneyville Hospital, but she could use them in her next discussion with the New Mexico administration.

Mrs. Smith was grateful for the time and effort the committee spent on her case. She made a trip to New Mexico to speak with the administrator she had previously dealt with and found that he was no longer employed at the facility. The new administrator met with her and reviewed the recommendations from Caneyville Hospital's ethics committee. Although he did not want to change the entire policy, he agreed to consider the circumstances of her case and make a reasonable accommodation to her circumstances. He instructed the staff not to automatically resuscitate. Instead, they were to call Mrs. Smith when a code occurred, inform her of the specifics, and get her final verbal approval of the DNR order. Two weeks later, she received their call. Her father was then at peace.

1. What ethics principles were part of the actions in this case?

This is a complex case involving end-of-life issues and the reality of DNR orders. In order to understand all of the ethics involved here, you need to analyze the situation and the actions of the committee. First, the situation on the surface seems to be a violation of the patient's right of autonomy. Mrs. Smith was resigned to the fact that her father was not going to recover. Knowing his wishes, she made every effort to secure all of the paperwork to protect his right to a dignified death. However, because of her personal circumstances, she could not be present to be an advocate for those rights and her legal documents seemed worthless.

If you consider the viewpoint of the long-term care facility, you might have a different take on this situation. With a history of being part of one of the most heavily regulated industries in America, this long-term care facility needed to go the extra mile to protect its residents. The administrator was aware that sometimes a family wishes to hasten the death of a patient for financial gain or other unethical reason. In addition, families have been known to change their minds once the DNR order becomes a reality. The facility wanted to protect its assets and its employees by making sure that a family member was present during a patient's death so that legal problems would not ensue.

Consider the actions of the Caneyville Hospital ethics committee. It had no obligation to consider Mrs. Smith's request for a consultation. After all, she was not even a patient in the hospital. However, this committee had a reputation of compassion for the whole community and decided to provide Mrs. Smith with their well-considered recommendations. They had to base their discussion on the situation presented to them by Mrs. Smith. Notice that they tried to
Cases for Your Consideration

discuss the situation from more than just her view by listening to the input of the CEO’s representative. Given more time, they could have contacted the administrator in New Mexico to get his opinion of the situation.

In deciding what recommendations to give Mrs. Smith, the ethics committee used the process that had assisted members on other occasions. It included use of a decision-making model and open discussion among all committee members. Knowledge of the ethical and legal ramifications of the situation was also part of this discussion. While this process was time consuming, the committee was able to develop a set of recommendations that could be implemented and resolve the situation.

Responses and Commentary on Questions

1. How did the action of the Caneyville Hospital ethics committee benefit the hospital?

   The decision of the committee to consult on the Metford case did not appear to have any direct benefit to the hospital in terms of increasing revenue or census. However, the committee’s reputation of compassion reflected positively on the hospital and added to its status in the community. By deciding to volunteer their time to address a community member’s needs, the committee let the community see that profit was not the only motivation for Caneyville Hospital. The community mattered.

2. How did the action of the Caneyville Hospital ethics committee benefit Mrs. Smith?

   The ethics committee consultation provided several benefits for Mrs. Smith. First, she felt that her situation was important enough to be addressed by people who had ethics expertise. Being able to talk about her case to such a compassionate body gave her a voice and helped to decrease her stress level. In addition, she felt that their recommendations provided her with some tools for a meeting with the administrator in New Mexico. She could present her viewpoint in a cogent manner and feel confident about her position. Fortunately, the new administrator of the facility was more open to patients’ rights than the previous one and listened to her with an open mind. A reasonable accommodation was made, and Mr. Metford was allowed to pass away with dignity.

Web Resources

Ethics Resources Center
http://www.ethics.org/
CHAPTER 10  ORGANIZATION CULTURE AND ETHICS

Hospital Ethics Committee Handbook Example
http://www.kumc.edu/hospital/ethics/ethics.htm

The Tuskegee Experiment
http://www.infoplease.com/ipa/A0762136.html

References

Corporate Compliance: The Letter or the Spirit of the Law

“Good quality is cheap; it’s poor quality that is expensive.”
—Joe L. Griffith

Points to Ponder
1. How do organizations view external evaluation?
2. What efforts are being made by JCAHO to go beyond compliance?
3. What lessons from industry are helping health care organizations reach for excellence?
4. How does ethics relate to corporate compliance?

Words to Remember
The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

Centers for Medicare and Medicaid Services (CMS)
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Malcolm Baldrige National Quality Award
Medicare Prescription Drug, Improvement, and Modernization Act of 2003
poka-yoke
Six Sigma Program
CHAPTER 11 CORPORATE COMPLIANCE

INTRODUCTION

In Chapter 5, you studied the community’s attempts to protect itself from the power of the health care system. You saw that, because this system literally holds the power of life or death, the community is compelled to find protection through regulations, licensures, and sanctions that are enforced by a myriad of organizations. These regulatory organizations are supposed to provide the whole community, including employers, with some assurance that these regulations are met. Certainly no one can argue with the community’s right to be assured of the “...sacred values of healthcare—competence, responsiveness, fairness, honesty, legitimacy, survival, and so forth” (Worthley, 1997, p. 150).

How do health care facilities view these organizations and their responsibilities? Do they merely try to comply with the letter of the law imposed on them or do they go beyond what is mandated? In this chapter, you will study compliance from the organization’s view. You will examine how this responsibility relates to ethics and learn how administrators can influence compliance and ethical behavior.

In the final sections of this chapter, you will learn about new efforts to take health care organizations beyond compliance to quality assurance. The discussion begins with the idea of corporate integrity programs and their potential impact. It features information about the combined effort between the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to increase health care quality in hospitals and other settings. The chapter also reviews efforts such as The Malcolm Baldrige National Quality Award program that is now open to health care organizations. The Six Sigma Program and Poka-yoke, which are being adapted to health care settings, are also discussed. In each case, you will be challenged to think about how these efforts relate to leadership in an ethics-based organization.

A HISTORICAL VIEW

A bit of history might be helpful to frame your picture of an organization’s interpretation of compliance. No doubt you learned in previous courses that the American health care system evolved from an apprentice structure to its current level of sophistication. This evolution occurred in a market-based rather than social-based context, making it unique among other industrialized nations. In its early stages, the health care system was exclusively controlled through its professionals. External regulation or community accountability was not part of its structure (Shi & Singh, 2004). Factors such as the development of
insurance, the increase in government involvement, the advent of advanced technology, and the rising costs of care brought about a greater need to demonstrate accountability and spawned the increase in external regulation in various forms including “voluntary” accreditation. Even though accountability was not founded in legal obligation, it soon became linked to financial and even state licensure requirements. For example, beginning in 1965 accreditation of hospitals became linked to reimbursement from government programs (JCAHO, 2004a). However, many in the system deeply resented government encroachment on their autonomy; this resentment persists today.

The type and style of health care regulation have also evolved. In 1918, the American College of Surgeons began a program to standardize practices in hospitals. Other organizations joined in this effort and formed the Joint Commission on the Accreditation of Hospitals. In 1887, it changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); by means of accreditation it influences the practices of ambulatory care, assisted living centers, home health, behavioral health, laboratories, long-term care, and office-based surgeries.

Initially, JCAHO’s accreditation process involved the construction of a set of standards to measure a hospital’s capacity to perform its functions. The standards were meant to identify acceptable hospital practices and to protect the community’s interests. The health care organization was required to correctly document its compliance. Regulators trusted that the documentation presented an accurate and correct picture of the facility’s capacities. Accreditation visits largely consisted of a review of the documentation and conferences with key leadership. Accreditation centered on trust between the accrediting bodies and the organization.

However, even at this stage of accreditation’s evolution, organizations struggled to comply with the many standards that they often saw as unrealistic and intrusive. Many hours of staff time were devoted to determining the correct wording and placement of information. Because the standards were not always clear, problems arose in the areas of omission and commission. Administrators were concerned about the value of this paper trail, but they also worried about their hospital’s rating and image if a “bad” site visit occurred.

Some non-ethics-based organizations took advantage of the vagueness of the standards and the lack of actual performance verification. For example, they “fudged” the data to make things appear better than they were or they attended to standards only when a site visit was due. Employees would joke that, “We’re going to have a site visit; this means the walls will be painted, and the carpets will be cleaned.” These organizations perhaps even viewed themselves as ethical because
they did not see the value of excessive paper documentation. It seemed to them that paperwork took time away from patient care.

As the process of regulating health care organizations became more sophisticated and expanded to include entities beyond the hospital, JCAHO began to change its method of assessment. In 1986, it began to explore a process of evaluating quality indicators rather than capacity standards. The switch to performance indicators and the measurement of actual performance evolved over several years and actually changed the survey process itself. In 1995, JCAHO began its new survey format, and the ORYX® system of documenting performance outcomes was initiated in 1997. During its 50th anniversary (in 2001), JCAHO began an emphasis on patient safety and decreasing medical errors, which continues to be an area of assessment (JCAHO, 2004a).

What was the impetus for making this change? Part of the decision was in response to reports issued by the Office of the Inspector General on oversight of hospitals by external agencies. While JCAHO surveys did reduce some risks for the public and draw attention to certain practices, they did not provide enough scrutiny to uncover substandard care (Cudney & Reinbold, 2002). The nature of these reports and the subsequent media coverage led to a serious review of JCAHO standards and survey processes. Standards and programs were created that focused beyond a review of patient processes and provided evidence of quality improvement. Now the organizations were required to identify high-risk factors that affected patient safety.

Once identified, data had to be provided to demonstrate a reduction of these problems. For example, there is a universal protocol for preventing errors that addresses the site for a given procedure, the procedures themselves, and for matching patients with the correct procedure. Compliance with this protocol is now mandated by JCAHO. Surveyors will look beyond paperwork to verify consistent implementation and compliance with this and other National Patient Safety Goals (Stewart, 2004). Administration leadership will be held accountable for compliance.

JCAHO decided on another major shift in the way health care organizations are evaluated (JCAHO, 2004b). It conducts its regular surveys on an unannounced basis as a continuation of its Shared Vision-New Pathways initiative. The change pilot-tested in 2004–2005 using all types of organizations that volunteered to participate. The idea behind this radical change is to move organizations beyond just-in-time compliance (i.e., getting ready for announced visits) to one of continuous compliance. It also increases the credibility of accreditation by observations taking place during normal operations, and it decreases the costs incurred from preparation for announced
visits. You can imagine the impact of this change on the organization and operations.

Through the Organization’s Eyes
Just how is accreditation viewed by the organizations? Has there been a change of attitude during its evolution? First, remember that JCAHO is not the only game in town when it comes to regulation. Health care organizations are scrutinized by a variety of federal and state agencies, private corporations, coalitions, and the public sector. Each of these groups sees itself as either protecting the public’s well-being, or protecting its own interests against the awesome power of the health care system. But their demands for accountability are many and often conflict with each other. Administrators often see themselves as drowning in a sea of regulations, paperwork, and site visits. Just as in the early stages of JCAHO, administrators view this process as unjust punishment and a huge waste of time. Hours and hours are spent checking the appropriate boxes on forms and sending electronic submissions. Staff are concerned that the facility is focused on minutia and not on making patient care better. They even question the ethics of being pulled away from patient care to verify documents or reiterate the mission of the organization (Fitzpatrick, 2003).

On an emotional level, administrators and staff can view this process as a threat to their values (Worthley, 1997). After all, they spent considerable time, effort, and money to become a professional in their fields. Now a bureaucrat can question their personal integrity and that of their organization. It is insulting, in their view, to be mandated to do things that they already do voluntarily in their capacity as professionals. The idea of someone “looking over their shoulders” seems degrading. Some view regulation as a game to be played and try to give it minimum attention. Others have even developed schemes to work around the red tape and do what they see as most appropriate.

The ethics of maintaining high quality health care and clinical competence is not disputed. However, the time and financial burden of demonstrating compliance for external agencies has been questioned. Worthley (1997) points out the standards, even in their latest iteration, can lead to a spirit of mere compliance. It is easy to blame the regulation for what you do or do not do. For example, using the justification “JCAHO says so” or “JCAHO won’t let us” is sometimes easier than tackling the real problems. When reimbursement is tied to compliance, it can also lead to ethics temptations such as stretching veracity (almost lying) or even legal problems such as committing fraud.

The move from capacity measurement to performance documentation and real-time evaluation through unannounced surveys should influence attitudes toward regulation. This change should be viewed as
moving toward quality as part of daily operations. However, the issues of documentation are always part of the picture. Some organizations have responded to the change by building layers. While they have encouraged ideas for quality improvement from staff, these ideas must now be filtered through a plethora of boards, committees, task forces, and officers (Roth & Taleff, 2002). These layers review, evaluate, prioritize, and delineate resources before any action is taken. The message can be, “We like your ideas, but we are still in charge” or “JCAHO is nice but this is business as usual” instead of staff empowerment and collaboration. It is hoped that timely surveys and new ways of regulating health care will cause organizations to grow beyond “business as usual” to creative problem solving. However, a change this radical will not happen overnight and must be reinforced by successes in financial and other arenas.

**Going Beyond Compliance: Efforts in Quality**

The regulation of health care is beginning to change from compliance with externally derived standards to continuous quality monitoring. The public already assumes that you are providing high quality service, so this change makes sense from both a business and ethics standpoint. However, the challenge is to find cost-effective ways to accomplish this goal. As it has done in the past, health care seeks to adapt quality improvement processes from its brethren in the business world. Efforts such as the Malcolm Baldrige National Quality Awards program, Six Sigma, and poka-yoke have been modified to fit the unique features of the health care business. In addition, JCAHO and CMS have collaborated in a hospital quality improvement project that warrants examination. As you might imagine, all of these efforts present ethics issues. You will find a discussion of the ethics impact later in this chapter.

**Malcolm Baldrige National Quality Awards Program**

The Malcolm Baldrige National Quality Award program was enacted by Congress in 1987 as a way to promote quality in American business and make industry more competitive internationally (National Institute of Standards and Technology [NIST], 2004). It is a voluntary program that is administered by NIST in cooperation with the American Society for Quality (ASQ). The annual awards are presented by the President of the United States. Quality is measured through rigorous processes based on seven areas: "leadership, strategic planning, customer and market forces, information and analysis, human resource focus, process management, and business results” (NIST, 2004, para. 2).

In 1999 health care organizations were allowed to compete for the Award based on criteria that were developed to address the mission, customers, and leadership that are unique to this business. Organizations that compete for this Award conduct several in-depth self-studies
and receive feedback in stages. Even if they do not actually earn a site visit by the award’s panel, the benefits of this competition are reputed to help improve organizational performance through a process of self-examination. It also encourages the implementation of best practices throughout a system. The competitive process is organized in a systems approach using a framework based on Core Values and Concepts. These concepts are translated into categories that have been given differing emphases through 1,000 assigned points (NIST, 2004). Core values for health care begin with leadership but also focus on the quality of care for patients, treatment of staff, evidence-based performance, meeting future needs, and using systems-based administration. Of particular importance to this text is the emphasis on ethics and community responsibility (50 points) found on page 16 of the current criteria and that of staff well-being (25 points) found on page 58. The social responsibility section emphasizes key processes, indicators, and results that demonstrate how the organization behaves in an ethical manner toward all of its stakeholders and works to improve its community’s health. Staff well-being includes ethics-related areas such as a healthy work environment, staff motivation and satisfaction, and respect for diversity.

The actual process used to compete for the Award begins with a review of eligibility and a brief profile of the organization. This review helps identify the gaps between what the Award defines as desired performance and actuality of performance. Even this brief document can be beneficial to the health facility because it organizes thoughts and analyses in a way that is new for many health care organizations. Once the profile is completed, the organization can apply to be reviewed by Award representatives. For each item in the system, there is a detailed explanation of purpose for inclusion, requirements for documentation, and guiding comments. Unlike other evaluation systems, the application criteria are not mandates. They are used for a goal-based self-assessment and allow for systems-level diagnosis. Organizations often report that completing this process alone is valuable for their performance improvement.

Once submitted, applications are reviewed by a team of six judges who provide extensive feedback to the organization. The best applicants from this are then evaluated by a team of judges. The outstanding applicants from this pool are selected for a site visit from trained examiners. Those who are not chosen receive extensive feedback from the judges. The results of the site visits are reported back to the judges, and the winners are recommended. Winners in the past have been Baptist Hospital of Pensacola, St. Luke’s Hospital of Kansas City (both in 2003), and SMM Health Care of St. Louis, Missouri (2002).

The Malcolm Baldrige Award process has several associated costs. First, there is an eligibility fee of $150 and an application fee of $2,000...
to $5,000 depending on the number of staff. There is also a site visit fee of $10,000 to $35,000, depending on size of staff. In addition, the process requires participation by a senior staff member, whose salary for the time devoted to this process needs to be considered, as well as the salaries of the many other staff members who help prepare the self-study. At least 25 copies of the extensive document must be submitted for review and a $1,250 processing fee is required if the report is submitted on CD (NIST, 2004).

What are the benefits of applying for the Malcolm Baldrige Award? SSM Health staff reported that developing the application alone increased their knowledge about their own organization. They made gains in performance improvement and became more aware of their gaps in process and how to close them. They also received many hours of review and 50 pages of written feedback even before they were chosen for a site visit. SMM Health reported that the level of consulting they received was excellent, and well worth the cost (NIST, 2003).

**Six Sigma® and Health Care**

Six Sigma® is a program for increasing quality and reducing errors and is based on problem identification, problem analysis using statistical processes, and management strategies. It has its origins in the work of a Motorola executive who developed the Program as a way for the company to be more competitive in national and international markets. They wanted to go beyond quality improvement jargon and be able to establish quantifiable goals. Motorola holds the trademark for this program, but it has been adapted by other major companies including GE, IBM, and Texas Instruments (Barry, Murcko, & Brubaker, 2002).

Instead of treating the symptoms of a problem, Six Sigma uses the approach of understanding its root cause and determining ways to correct it. Detailed analysis is used to establish how the problematic process is supposed to work and where any potential failures might happen. It then works to discover how to change the process so the failures do not occur or their consequences are not as serious. Operational analysis is conducted using statistical processes such as numerical benchmarking. This analysis also allows acceptable ranges of performance through control charts and other aids. Linear regression and other techniques can be used to monitor progress and demonstrate success (Barry, Murcko, & Brubaker, 2002). Statistics software that is easy to use makes this process more administrator-friendly.

In addition to operational and statistical analysis, Six Sigma provides a mechanism for change to occur. Using quantitative information, administrators can more easily pinpoint where intervention is needed. The system allows for trial solutions to be developed, implemented, and evaluated based on quantitative data before they are rolled out to the entire organization. Such actions can save the company money by using solutions that
A Historical View 223

are more likely to work and eliminating ones that do not change the situation. Change management also includes techniques for statistical modeling, performance tracking, and cost/benefit analysis to assist in measuring the impact of the selected prevention or solution efforts.

In industry, Six Sigma programs are designed and implemented by specially trained employees called Black Belts. The process of becoming a Black Belt begins by participating in at least one full week of rigorous training. The candidate then works on a project under the supervision of a Master Black Belt or coach from an outside firm of consultants. At the end of the month, there is a series of meetings to review the Black Belt candidates’ performance during the project. If his or her progress has been acceptable, he or she becomes a Green Belt. This “credential” allows persons to execute Six Sigma programs that have been designed by Black Belts. To achieve their Black Belt status, Green Belts must complete another full week of training and another month of project execution under supervision (Barry, Murcko, & Brubaker, 2002).

Six Sigma has been adapted to the health care environment but is not commonly used on a hospitalwide scale. Instead, it seems to be used on specific projects, particularly those that are linked to some type of error. Revere and Black (2003) found it to be a logical continuation of the JCAHO mandated Failure Mode and Effects Analysis, which is linked to reporting sentinel events in a facility. They view this process as an easy add-on to a facility’s existing Total Quality Management team because it can provide a mechanism for quantitative analysis and decision making through clearly established and accurately measured goals.

In health care organizations, Six Sigma can provide the metrics for error-proofing including the reduction of life-threatening and costly medical errors, misdiagnoses, and mistreatment. It has also been used to improve patient satisfaction and financial outcomes, to decrease length of stay, and to manage inventory. Through its focus on processes and not on blame, it helps to identify the root cause of a problem, design a mechanism for changing the situation, and apply numbers to document the changes. Assumptions about the cause of problems can be affirmed in this process or totally disproved. This means that it should be more likely that the best possible solution is implemented.

In terms of the requirements for the use of Six Sigma processes in health care environments, you need to begin at the top. A champion from the O Team must be present if a paradigm shift is to be successful. In addition, you will need some senior-level administrators to serve as sponsors for your program. This level of support is critical because the Six Sigma team will be accessing both public and proprietary information and needs release time from its usual duties. You will also need to spend time being trained on the philosophy, techniques, and management style used by this quality program. As you read earlier, this training can entail
several months for Black Belt status and will usually involve an outside company that specializes in Six Sigma.

Other requirements for Six Sigma efforts include the support of staff members at all levels. Without their buy-in, you cannot achieve the accuracy of data needed or the implementation of quick fixes or permanent solutions. Motivation of and training efforts for this group should not be overlooked. Speaking of data, they must be timely and accurate for the topic under study. This can require additional statistics collection, review of current findings, and scrubbing of existing databases. Six Sigma is based on statistical treatment of data for problem solution and monitoring of success; your data quality can make or break this process. Finally, you must select a project that has well-founded consequence for your organization so that the process will be seen as a serious attempt to eliminate the problem and not just as the “management toy of the month.” You cannot expect staff to put in the effort and time it takes to implement Six Sigma successfully on an issue that is trivial and has no real consequence. Remember the importance of physician relations in this process. You will want a champion from this group as well.

What about the cost? While Six Sigma can be used to address a JCAHO mandate, it is not without costs on many fronts. The most obvious cost comes from training. Depending on the project, you will need one to two Black Belts and several Green Belts. These individuals need to be selected carefully and have at least a basic understanding of college-level algebra and/or basic statistics. In addition, staff members who are involved in the process must be trained and motivated to participate. Such campaigns often include incentives, rewards, and other motivation costs.

While specific training fees are not always publicly available, ASQ’s Web site (ASQ, 2005) revealed a general information course for $3,200 for members and $3,500 for nonmembers. Their Black Belt courses were 20 days long, spread over four sessions. Costs included travel, hotels, and other expenses. Green Belt courses for the same organization were offered in two-week sessions. Another vendor, Six Sigma Qualtec (2004), offered a range of prices depending on the level of support they offered to the Black Belt and Green Belt candidate. For the Green Belt the cost ranged from $6,000 to $15,000 per participant and for the Black Belt from $11,000 to 23,000 per participant. Additional fees for champion training and Black Belt certification need to be considered.

There is also the cost of motivation and team building for all those who are directly or indirectly involved in a Six Sigma project. It is strongly suggested that team-building be a part of the initial efforts to implement this program. Incentives, both financial and nonfinancial, have been suggested as a way to maintain motivation for the tasks involved. In addition, celebration events should be held to assist in pro-
gram continuance. Celebrations do not have to be expensive; some of the most successful have been designed by those involved in the project.

In addition to the human resources costs of a Six Sigma project, you will have various technology and data collection costs. Software packages are needed for the necessary operations and statistical analysis. In addition, project management programs can make the monitoring and documentation functions more cost effective. The expenses for each of these programs vary but can add several thousand dollars to the overall implementation costs. Do not forget the hidden costs of the time it takes to collect quality data or to scrub existing databases.

This brief review of the potential expenditures for a Six Sigma project reinforces the idea that such projects must reflect real issues in the organization. Although implementation can be expensive, the potential benefits can also be high. For example, Revere and Black (2003) report that one hospital gained over $857,000 in net income from a Six Sigma effort. Another group reported a savings of $3 million in administration costs through the use of this program. In general, the Six Sigma, used even in a limited way, can have a positive impact on patient processes and reduce the possibility of medical errors.

**Poka-Yoke**

This term is new to health care application but has a history in the Zero Quality Control movement developed by Shigeo Shingo, an industrial engineer at Toyota (Grout & Down, n.d.). Poka-yoke is the Japanese term for mistake prevention and is based on the concept that it is the human factor that makes mistakes in a process. The point of poka-yoke is to design devices and systems that prevent mistakes before they can become serious problems for the organization. Inspections and other data collection processes are used to analyze the source of the error. A system of self-checks is also used so that the person who is involved in the process has a mechanism to assess his or her own work quality and prevent mistakes before they occur. The essence of poka-yoke is to:

1. Make it easier for the person to do the right thing than the wrong thing.
2. Make mistakes obvious to the person immediately so that correction can be made on the spot.
3. Allow the person to take corrective action or stop the flow before any irreversible step occurs (Barry, Murcko, & Brubaker, 2002, p. 19).

Poka-yoke is not an instant solution to all potential error, but it has had a major impact on error reduction in industry. For example, Wal-Mart stores were determined by shopper data not to be customer friendly. As a way to correct this error, Walton decided to hire people to be customer greeters and who smile at people who entered his stores. This small change helped to change Wal-Mart’s overall corporate image
Other examples of error-reduction systems include the manufacture of floppy disks so that they can be inserted only one way; installing on cars a gas cap tether so you do not leave your cap at the pump; and making car doors lock automatically when you reach a certain speed. Another poka-yoke device is plastic motor mounts on automobiles that cause the engine to drop during a major accident. This prevents further injury to the occupants from the engine being driven into the driver and passengers on impact.

Even though poka-yoke is new to health care organizations, its potential for quality improvement and error reduction is extensive. Obviously, you want your organization to be error-free. However, with the high levels of human interaction needed to provide patient care, a great potential for error exists. This potential and its actuality have been documented by numerous reports from the Institute of Medicine and others. One obvious area for poka-yoke application is that of medication error reduction. Information technology applications include physician orders that are electronically transmitted and bar code scanners for medications that alert physicians, pharmacists, and nurses when an error is about to be made. These systems—in addition to procedural self-checks performed by individual staff—can assist in error-proofing your facility.

Poka-yoke applications in health care can help patients and visitors find their way around the building by making signage more frequent and easier to understand. They can also provide backup systems for essential equipment, communication systems, and power during emergencies; and color coding to reduce the incorrect use of equipment. Kits with the correct set of supplies for a procedure, patient identification bracelets, and disaster training drills are all patient-centered examples of poka-yoke. Workflow and wait times can be improved by using observational and statistical analysis to determine where and when bottlenecks occur. This too is an example of poka-yoke (Barry, Murcko, & Brubaker, 2002).

Poka-yoke is not a panacea for all errors in health care. It can, however, proactively address problems so that the cost of the damages created by error is reduced. In this way, poka-yoke efforts pay for themselves. In your cost/benefit analysis, consider the price of time when staff are pulled away from regular duties to conduct observation and analysis. Training and equipment costs should also be a consideration when adopting various computer-based poka-yoke options. In the long run, keep in mind that poka-yoke devices and procedures have the potential of saving money and avoiding legal problems by preventing errors before they occur.

You can see that there are lessons to be learned from other industries for use in health quality improvement and error reduction. Obviously, any program from another industry needs to be carefully reviewed and
adapted to meet the unique needs of health care. Some of these programs might not be cost-effective to use in their entirety because they require a total cultural paradigm shift that can take years to make. However, as you saw with Six Sigma, they can be used to enhance existing programs that have already been accepted within the culture. In the next section, you will read about the key features of quality improvement efforts that are specifically designed for health care, including the Health Care Quality Improvement Project.

**Health Care Quality Improvement Projects**

Efforts to assess quality by health care–related external organizations are not new to the health care system. In 1987, JCAHO began the process by developing a system of standardized performance indicators called ORYX. In 2001, accredited hospitals were mandated to collect data on acute myocardial infarction (AMI), heart failure, pneumonia, and pregnancy-related conditions. In 2003, surgical infection prevention (SIP) was added to the list. Each of these areas has specific indicators that must be documented. For example, AMI requires that aspirin be given immediately upon arrival at the hospital and prescribed at discharge. This measure, like all of the others, is based on evidence drawn from numerous research studies.

Data are collected through a sampling process and include a risk adjustment index. Extensive information is presented in the *Specifications Manual for National Implementation of Hospital Core Measures* (JCAHO, 2004c) on preparation of reports, including medication tables that provide information on medications by condition, and assist in documentation. Hospitals spend many hours of staff and administrative time making sure that they provide the necessary information in an acceptable manner. The incentive is to maintain the status of a JCAHO-accredited facility.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* added a new dimension to the quality assurance process. It mandates that Medicare-certified hospitals provide data on three health conditions (AMI, heart failure, pneumonia) using a total of 10 indicators. In the near future, this list will expand to include additional conditions and indicators. The quality measures are supported by research, and each has a detailed explanation of how it is to be met in the hospital setting.

Looking at just one area will give you an idea about the level of detail and the staff commitment needed to document quality measures for AMI, heart failure, and pneumonia (CMS, 2004a). As previously stated, AMI patients are given aspirin upon arrival and at discharge. The quality measure standard stipulates that “arrival” is no later than 24 hours prior to or after admission. (Exceptions are made if the patient has an allergy to aspirin.) If the patient has left ventricular systolic dysfunction, you must provide an angiotension converting enzyme
inhibitor as soon as the patient has improved. Additional requirements for this measure include that you prescribe beta blockers at arrival and discharge. If you are a JCAHO-accredited hospital, you must document other measures in this category including smoking cessation efforts and measurement of reperfusion time and inpatient mortality. In addition, there are other indicators to include in your documentation, some of which will be added to the CMS mandate at a later time. While these measures certainly make sense in terms of patient care quality, their documentation can increase staff workload, particularly in systems that do not have sophisticated patient record technology.

Regardless of the system used, accurate documentation of all of the quality indicators is extremely important. This mandate is related to your CMS payments in that those who fail to provide these data in the form and delivery system required will have their payment reduced by 0.4% (CMS, 2004a). The reporting should conform to ORYX, which should be helpful for hospitals that are JCAHO-accredited. Facilities can also use the CMS Abstract and Reporting Tool system or any other reporting tool from an approved vendor. Data must be sent through an electronic format called the Quality Net Exchange.

The procedures for collecting data are detailed, including prescribed sample sizes based on the number of cases including non-Medicare patients and the designation of a Quality Net Exchange administrator. Data are sent to a data warehouse called the QIO Clinical Warehouse for storage and processing. Reporting facilities are subject to a chart audit using a random sampling of charts and must achieve an 80% to pass. In addition, aggregate data from the CMS quality reports will be published through its Hospital Compare system.

The joint effort between JCAHO and CMS is designed to make the process of compliance with this quality effort easier. However, there is still some concern among smaller and even medium-sized facilities. Implementation of the required electronic claims submission, sampling framework, data collection format, and other features necessitates extra expense for computerization and training. When budgets are already stretched, these costs can be a burden. In addition, physicians and other staff sometimes view this requirement as yet another imposition of government on their professional freedom and judgment. Still others disagree with the indicators, even though they are based on clinical evidence. It is always easy to criticize research when you do not agree with it. Compliance, while needed for full reimbursement, is not always easy.

Hospitals are not the only health care entity affected by the government quality improvement movement. All health care is included in some way. The CMS Web site alone includes initiatives for nursing homes, home health, and physician practices. A brief review should give you some idea of the quality improvement processes involved. The
Nursing Home Quality Initiative (CMS, 2004b) currently includes 14 quality measures that are based on research. These measures are supposed to provide consumer information on quality care in nursing homes and increase efforts for quality improvement within facilities. They are based on a mandatory reporting of data and onsite visits. Measures include percentage of patients who need assistance with, for example, the activities of daily living, pain, use of restraints, urinary tract infections, and depression. Results are posted on the CMS Nursing Home Compare Web site.

Similar efforts are underway for the home health industry, with CMS looking at a phased-in quality initiative. The effort is again geared toward providing consumer information and improving quality. The focus is on home health practices, using a subset of the Outcome and Assessment Information Set outcome measures already in use within the industry. Examples of measures include: upper body dressing, ambulation, transferring, and management of medications (CMS, 2003). Finally, physician office practices are part of demonstration projects to assess the impact of information technology on quality and to develop a data set that can be used to evaluate clinical performance and patient satisfaction.

■ ETHICS OF QUALITY PROGRAMS

At first glance, the issue of the relationship between health care quality assurance and ethics should be an obvious one. If you read many of the mission statements in this industry, you will find that quality service is featured in almost all of them. Certainly, Kantians would support the inclusion of quality in your mission statement as a moral duty. They might even think that it passed the categorical imperative test, given the amount of power and trust placed in health care. Providing quality care to all patients regardless of their ability to pay recognizes Kant’s theory that all humans have value and deserve quality. Buber and Frankl also would support this position.

The utilitarians would actually agree with the Kantians here but for a different reason. They would say that providing quality health care services is a way to achieve the greatest good for the greatest number and to avoid the greatest harm to the greatest numbers. For utilitarians, ethical decisions should be weighed against their potential consequences. In this case the consequences of not providing quality care could adversely affect individuals and the organization. For example, failure to provide such care could cause harm to the organization through poor patient satisfaction rates, loss of revenue, or even lawsuits. Would any health care facility like to be known for its poor quality? Quality assurance practices are just plain good business.
Rawls would also support the provision of quality service because it is in the self-interest of both the community and the organization. Using Rawls’s theory, you always want to protect those in a lesser position (the patient) because you could also be in that position. How would you like to be treated if you were a patient in your facility? In addition, organizations tend to be judged by how they treat their patients, and the standards are stringent. An organization’s image can be severely tarnished when quality is compromised and becomes public knowledge.

The principles of ethics that you studied in previous chapters also apply to the ethics of quality assurance. The principle of nonmaleficence certainly applies here. Giving poor quality service and making medication and patient identification errors can do harm to your patients. The sister principle of beneficence is also involved because you want to act with care and compassion in your treatment of patients.

What about the other principles? First, you give your word through your mission statement that your organization practices quality care. Failure to live up to this mission statement is a failure of truth telling and of promise keeping. Your veracity and your fidelity come into question. Quality assurance also involves justice. Do you have a duty to provide quality service to everyone or just to those who have insurance or deep pockets? The community can say that you are not being ethical if you provide dramatically different services to people who have the same or similar conditions, but different financial resources.

These arguments make sense in the big picture, but what about the view from the organization? First, you have to look at the ethics of competing resources here. The extensive resource commitment in money and time that is needed for JCAHO, CMS, and other mandated quality assurance efforts is often viewed as a resource drain. This is often seen in smaller and/or rural hospitals where budgets are especially tight. Some question the ethics of spending money on data collection and analysis, computers, electronic systems, and reporting when it could be spent on actually improving or providing patient care.

Still other organizations think that they are already engaged in providing quality service and find it difficult to justify all of the expense and paperwork involved in proving it to an outside evaluator. In addition, they question whether the measures are really a reflection of quality as the community sees it. Even so-called evidence-based measures can be questioned if you understand the nature of the studies on which they are based. Were the original studies valid and reliable?

Even though organizations take funds from government agencies and from insurance companies, some administrators do not think that they should have to account for their practices in such detail. They view the mandated quality improvement programs as an infringement on their autonomy to practice medicine. This can be true even if they are currently using the techniques outlined in the measurement bench-
marks. The source of this irritation may well stem from the history of the system, as government and business regulation is a relatively new practice. Some of the milder comments that you will hear are that this is the equivalent of “Big Brother is watching you” and that they are asked to practice “cookbook medicine.” Some practitioners believe they cannot be an advocate for their patients when practices are mandated. They should be free to choose what is best for the patient based on their years of education and experience and not on the mandates of an outside bureaucracy. As an administrator, you will have to be able to explain why this oversight is necessary and why you need the staff’s support. This might not be an easy task.

What about the quality assurance programs from industries such as Malcolm Baldrige or Six Sigma? In this case, the organization is not mandated to use these self-assessment methods but makes a choice to do so. These programs do not replace other external efforts but are added to them. Again there is an issue of the ethics of competing resources. Money, time, and staff must be devoted to training, data collection and analysis, and effecting culture change over and above that which is designed for government- or industry-mandated reviews. Funds needed for these programs might explain why they are used mostly in larger facilities, rather than systemwide. But even in a small facility, the programs can be viewed in a positive light because they can be designed to assess issues that are specific to an individual organization and are under the control of that organization. For example, the simple act of filling out the Malcolm Baldrige Award application can yield valuable insight into improving service quality, even for the smallest facility. That said, before any organization decides to implement these programs, it must carefully consider the benefits versus the costs and make sound ethical and business decisions.

**Summary**

Providing quality care is not just good ethics; it is good business. However, quality cannot be assumed. It requires that an organization comply with both the mandates and the intent of the regulations posed by external evaluators. It also requires that organizations exercise their ability to self-police so that quality practices become the norm. In this chapter, you were able to see how quality assurance programs from other industries might be used to assist health care in this effort.

This chapter also addressed the ethics behind quality programs including the Kantian, Rawlsian, and utilitarian views. You should be able to see how the many principles of ethics also apply to quality assurance. Understanding how ethics forms a basis for quality assurance should assist you to counteract arguments against it. In addition, this knowledge can be a tool for successfully administering quality assurance programs.
Cases for Your Consideration

The Case of the Obstinate Orthopedist

As you read this case, consider the following questions. Responses and commentary will follow the case.

1. What was the ethics foundation for adding quality measures to the CMS Hospital Quality Project?
2. What ethical arguments did Vice President Gormal make in asking for staff cooperation?
3. What ethical argument did Dr. Cathal make in response to her request?
4. How would you handle this situation?

Case Information

Although the medical staff at Dagma Memorial Hospital (DMH) grudgingly conformed to the annual CMS Hospital Quality Initiative, the new additions to this year’s indicators posed some serious concerns for Erin Gormal, Vice President of Operations. DMH was a 100-bed facility that had a strong commitment to meeting the needs of its community, even with its limited staff of specialists. The additional indicators involved surgical infection prevention, which made good sense from a quality standpoint. In fact, the facility was already complying with most of the new indicators. However, Ms. Gormal knew that collecting the additional data would stretch the resources of her clinical and administrative staff even thinner. She believed in providing the best possible care and in “living the mission” of DMH. Still, she dreaded the upcoming informational meeting with her medical staff.

Vice President Gormal carefully prepared for the session. In the meeting, she presented the indicators and explained the rationale for them. But when she got to the section on knee surgery and the quality indicator suggestions for pre-surgical medications, the orthopedic surgeon, Dr. Sean Cathal, became highly emotional. He slammed his fist on the mahogany table and said, “How dare CMS tell me how to practice medicine. What right do they have to dictate which meds I give to my patients?”

At that point, Pandora’s box was opened. Many of the physicians agreed with Dr. Cathal’s view and expressed frustration with yet another government mandate. They demanded to know why the administration did not fight against this outrage. The climate in the room went from discontented acquiescence to outright hostility.

Although Ms. Gormal was prepared for some displeasure, she was somewhat surprised by the hostile reactions. The Chief of Medicine intervened and brought the meeting back to order. Ms. Gormal then
calmly explained that the list of medications was not mandated but was included as a suggestion to assist in documenting the quality measures. Of course, the patient’s medical history must be considered first and foremost as to which drugs would be used. She also pointed out that the guidelines for SIP were similar to those already collected by JCAHO. They should not be a significant addition to the data collection process. She also stressed that CMS was basing its measures on clinical evidence from many studies. This information was provided in the package she prepared for each physician. Finally, she pointed out that if DMH wanted to continue its certification for Medicare reimbursement and not be fined for noncompliance, it had to document these measures.

After another lengthy discussion, the physicians agreed that, while still hating the “Big Brother” approach from CMS, they did not want to lose certification. However, they hoped that this infringement on their expertise as professionals would not continuously increase from year to year. Vice President Gormal breathed a sigh of relief as she returned to her office.

Responses and Commentary on Questions

1. What was the ethics foundation for adding these quality measures to the DMH CMS Hospital Quality Project?

Vice President Gormal viewed the new requirements from a broad ethics framework that included DMH and the larger community. First, she knew that DMH was already part of the CMS system for data collection as part of its commitment to maintaining certification. JCAHO had already asked for similar data, so the burden of additional staff time would not be too great. She had no desire to tax staff that were already overburdened but committed to caring for patients. In taking this approach, she exhibited what Buber would call an I-You ethical relationship because she valued the staff as people, not as just the means to the end of data collection.

Ms. Gormal was also able to view the situation from CMS’s viewpoint. They were not out to punish DMH but rather to work toward the utilitarian principle of the greatest good for the greatest number. By trying to ensure that all of their certified facilities used evidenced-based practices, they were hoping for consistent quality. From the hospital’s view, this could mean better patient outcomes, shorter lengths of stay, less use of resources, and higher patient satisfaction. Providing the greatest good for the greatest number would be a winning combination for both the community and the business.

She could also see some Kantian ethics in the CMS decision. Each patient, not just those who were Medicare-eligible, was to be counted in the data collection. This meant that patients were
important even if Medicare did not pay for their services. Buber and Frankl would also agree with this position. Although a new set of measurements might bring up issues of conflicting resources, Ms. Gormal could see that it would serve to protect those in a lesser position by making sure they received the same quality services as those who were better off economically and socially. Her critical issue would be to convince others of the merit of this addition.

2. What ethical arguments did Vice President Gormal make in asking for staff cooperation?

At first, Vice President Gormal tried to appeal to the rational nature of her physician group. Rational people would see that it is in everyone’s best interest to provide care based on the latest evidence of good practice. After all, if any one of them were a patient at DMH, he or she would want the gold standard of care. In addition, she tried to appeal to their science-based nature by providing copies of the studies used to justify each measure. She hoped the Rawlsian ethics might prevail but did not anticipate the emotional aspects of this addition to the CMS requirements.

What she did not understand was how this change could be viewed through different “ethics eyes.” Even though JCAHO had already required the collection of similar data, Dr. Cathal saw the new measures as an attack on his expertise and right to autonomous practice. As a scientist, he was taught to question reliability and validity of studies and to express a healthy skepticism. Perhaps he just felt overwhelmed by the increase in external regulations, which seemed to be growing almost daily. His colleagues echoed his dissatisfaction. They found the idea of control of their practice autonomy by non-physicians and external regulators to be an infringement on their authority.

Perhaps Ms. Gormal should have discussed her ethics rationale with the Chief of Medicine to get his input and assistance before the meeting. She might have been able to have greater anticipatory insight and to prepare an ethics and financial argument that would have avoided some of the emotional response. In the end, she was able to use ethics and fiscal data to obtain some level of support.

3. What ethical argument did Dr. Cathal make in response to the physicians?

Another side of the autonomy issue comes into view when you consider Dr. Cathal’s response. Often in health care you have a conflict of autonomy. Whose authority is more important? Is it more important for the practitioner to be able to use his or her professional judgment or should the autonomy of the patient be primary? When you decide to become a member of the health professions, you understand that in all things the patient comes first. While it is true
that these measures limit some of Dr. Cathal’s autonomy in practice, his obligation is first to his patients. First, he must determine medically if the evidence-based practices are appropriate for the patient. If they are not, he must be prepared to provide medical justification for his decisions. In this case, his autonomy is not violated. However, if he fails to support the requirements of CMS in total, the organization could be faced with losing its ability to admit Medicare patients. Whose autonomy would suffer in that case?

4. How would you handle this situation?

To answer this question, remember that you have the benefit of hindsight. Although the meeting was tense, Ms. Gormal was able to achieve her goal in the end. How would you have handled this? You can see the benefit of “homework” in this case. The more you can anticipate concerns about an issue and prepare a response, the more likely you are to obtain consensus. It is also a good idea to get support from a champion who is respected by the group you are trying to influence. In Ms. Gormal’s case, the Chief of Medicine could have been approached ahead of time for his buy-in. They might have even shared in the presentation of the information to indicate a united approach.

Think of a positive approach when preparing to deliver challenging news. Of course physicians want to be seen as practicing quality medicine. You can even reinforce how they are already using some of the practices that have been identified. You are more likely to get support if you ask for it by using a velvet glove rather than an iron hand. Finally, you must always be in charge of your emotions. If you lose your cool in such situations, you add to the problem instead of solving it. Since you are only human, emotional control takes practice, but it is worth the effort.

As you read this case, consider the following questions. Responses and commentary will follow the case.

**The Case of the Self-Assured EAP**

1. What assumptions were made about quality at Rampaire Manufacturing?
2. What actions did Mr. Rampaire take to ensure quality?
3. What was his ethics reasoning for taking these actions?
4. What was the result of his action?

**Case Information**

*Background.* This case is about an area of health care that is not currently regulated by JCAHO or CMS on a mandatory basis. Nevertheless, the owner and human resources director of the company featured
in the case were concerned about the ethics of quality. The owner chose to go the extra mile on behalf of employees and their families and his decision led to important decisions.

The case. Rampaire Manufacturing was a 2,000-employee company, internationally known for its manufacture of self-cleaning lavatories. The owner, Frank Rampaire, prided himself on his Buber-centered ethics and demonstrated caring concern for the employees in a number of ways. Recently, with the assistance of his human resources (HR) director, Ruth Washington, he negotiated a contract with a firm for an Employee Assistance Program (EAP).

The contract with Work/Life Associates (WLA) guaranteed certain quality assurance features. For example, all telephone triage would be done by licensed counselors or master’s level social workers (MSWs). WLA would maintain records on current licensure for all staff and keep up-to-date directories for appropriate referral to practitioners in the local area. It provided data on usage and referrals on which identifiers would be used to protect the privacy of the employees and their families. The EAP also agreed to annual onsite visits from Rampaire or its designee for quality assurance purposes. Mr. Rampaire believed he had negotiated the best quality EAP for his employees.

After the program had been in place for seven months, Mr. Rampaire was satisfied with the utilization reports he received but wanted some assurance about the quality of WLA’s daily operations. He consulted with the HR director about a site visit to the WLA facility. She suggested that the best way to obtain information would be to contract with a licensed professional counselor who could judge both the quality of the quality measurements and the actual performance of the EAP functions. Mr. Rampaire, seeing the merit of an expert outside evaluator, consented to pay a consultant’s fees and travel expenses for a two-day assessment.

When the consultant returned from her visit, Mr. Rampaire was surprised by the findings. WLA had one MSW on duty during the observed telephone triage sessions, but the rest of the intake personnel were students from a local university. The records for licensure and credentialing of counselors and MSWs were not current. In addition, lists of practitioners who were available for referral were not up-to-date and contained incorrect telephone numbers. Mr. Rampaire contacted WLA’s president about this situation. He saw the situation as reported to him as a violation of his contract and unethical practice. He was assured that this was not their usual way of doing business and that the situation would be remedied. However, when the WLA contract came up for renewal, Mr. Rampaire did not feel comfortable with the ethics of this EAP firm and declined to renew.
Responses and Commentary on Questions

1. What assumptions were made about quality by Rampaire Manufacturing?

Mr. Rampaire assumed that a business based on helping those who are experiencing problems in work or in life would have a high-level commitment to both professional and business ethics. He believed that they would exercise fidelity and be self-policing in their quality assurance efforts. By stressing features such as group data reporting, using well-prepared practitioners for triage, maintaining credentialing records, and being open to onsite visits, WLA gave the impression of being an ethics-based organization. Mr. Rampaire assumed that truth telling would be critical to their business and that this organization would share in his respect and concern for employees. He entered into the contract based on these assumptions.

2. What actions did Mr. Rampaire take to ensure quality?

Because there was no external evaluator for this organization, Mr. Rampaire decided to go the extra mile to be sure that his employees were getting the service that they needed and that he had funded. He knew that neither his HR director nor he had sufficient expertise to assess the actual performance of the intake staff and the quality of the recordkeeping. He was willing to spend extra funds to have a qualified person make the site visit and assess the situation. In addition, the counselor was licensed and would not divulge any information she heard while observing the intake process. Therefore, his employees’ autonomy and privacy would be protected.

3. What was his ethics reasoning for taking these actions?

Mr. Rampaire was working on many ethical levels here. He wanted to make sure that his employees were treated appropriately, using the best quality care. His quality assurance efforts can be seen as applied Kantian ethics in that he wanted each person to be treated as valuable. He also wanted there to be a categorical imperative that services provided would be quality for all. You can also see some utilitarian ethics here in that he was trying to avoid the greatest harm to the greatest number. If an EAP does not provide quality services, it has the potential to cause even more distress for his employees and their families. Imagine if an inexperienced student gave a distraught employee inappropriate information or made an incorrect referral. The potential for harm was great.

From a business standpoint, he had a fiduciary obligation to his organization to be sure that he was spending funds appropriately. Paying for services that were not rendered or a contract that was not honored could violate his own business ethic of fidelity to his
company. Because there was no outside evaluator for this organization, he felt ethically bound to spend some funds to get a more accurate, hands-on report of the performance quality.

4. What was the result of his action?

   The first result of his action was that he learned that his contract with WLA was not being honored. This information allowed him to contact its president and voice his concerns from a position of information. His immediate response triggered action to remedy the situation. However, the breach of trust left him with an unsettled feeling about WLA, and he was careful to question all of their reports. In the end, he decided to discontinue business with them because he did not trust them to be involved with the mental health needs of his valuable employees.

**Web Resources**

American Society for Quality
http://www.asq.org/portal/page?_pageid=33,32429,33_32554&_dad=portal&_schema=PORTAL

Joint Commission on Accreditation of Healthcare Organizations
http://www.jcaho.org/

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/default.asp?

Malcolm Baldrige National Quality Award
http://www.quality.nist.gov/

Poka-Yoke
http://www.isixsigma.com/tt/poka_yoke/

Six Sigma Program
http://healthcare.isixsigma.com/

**References**


Patient Issues and Ethics

“Private patients, if they do not like me, can go elsewhere; but the poor devils in the hospital I am bound to take care of.”

—John Abernethy

Points to Ponder

1. What is the impact of paternalism on how the organization views the patient?
2. How does society’s view of illness and health impact the organization’s attitude toward patients?
3. What are the ethical issues involved in measuring patient satisfaction?
4. What is the ethics connection in patient-focused care?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- human interaction
- paternalism
- patient-centered care
- Planetree Model
- Planetree Movement
- self-treatment
- the sick role
- societal stigma
PATERNALISM, OR “WE KNOW WHAT’S BEST”

The American health care system’s historical roots lie in two traditions—medical practice and medical ethics—that led directly to the attitude of paternalism. In medical practice, the system has been dominated by professionals, most specifically by physicians. Even though this profession stemmed from apprenticeship and proprietary education, it transformed itself into the controller of the medical system. After World War I, the power and prestige of the medical profession became so great that it controlled both the supply of medical care and the demand for its services. Little external control was placed on these “medical gods.” In addition, they were able to restrict those who entered their ranks through medical school admission standards and licensure laws. This power base enhanced the physician group ethos of, “We know what is best for you,” and the idea of patient compliance as a part of medical practice.

Two principles of ethics were also involved in the paternalism of health care. First, health practitioners were taught that they had a moral duty to avoid doing harm to their patients (nonmaleficence). However, many of the procedures used, including those practiced today, had the potential to produce harm. For example, think about how surgery has the power to cure you and also the power to kill you. Professional judgment was required to make decisions about the risks versus the benefits of any treatment. Patients began to trust the wisdom of the practitioner with almost blind acceptance. The physician knew best because he (pronoun used deliberately) had the knowledge to protect you from harm. Further, it was his ethical responsibility to do so.

Practicing nonmaleficence also involved professional decision making about what the patient should or should not know and the timing of knowledge. For example, physicians withheld information from the dying so they would not increase their suffering. The idea was that knowing you are close to death would cause you greater harm than remaining ignorant about your condition. Of course, family members also appealed to practitioners not to inform their loved ones about the seriousness of their conditions so that they would not lose hope or suffer too much. Even though it is rooted in loving concern and a desire to spare further pain, the idea of “don’t tell Grandma” is still a part of the autonomy versus paternalism struggle.

The sister principle of beneficence is also a part of paternalism in health care. In the beneficence-based view, practitioners have a moral obligation to use their knowledge for the reduction of pain and suffering for individuals and the community. While their superior knowledge of disease and treatment regimes should not be minimized, they were often ignorant about the patient’s view of his or her own illness. This resulted in the paternalistic definition of “doing good” without consid-
eration of whether that action was seen as “good” by the patient. Again there was a conflict of paternalism versus autonomy, and paternalism seemed to be the winner.

What happened to change the system’s paternalistic view and how does it connect to ethics? There are several factors at work here. First the increase in the number of people covered by insurance from various funding sources shifted the control for demand of care. Because of their expertise, physicians still diagnose and treat disease but the others, including the federal government and insurance companies, control payment for services. Those who control the money are beginning to demand accountability and fair value for their payment. Increasingly, they are defining what quality medicine is, right down to what drugs to prescribe and when. This strange business relationship leads to what some physicians see as a loss of control of the practice of medicine. They lament that they have to practice medicine “by the book” or not get paid. They feel their authority is lessened by bureaucrats who never went to medical school and who are keeping them from practicing the art and science of medicine.

The rise in the use of technology has also been a force to reduce paternalism. The increasing use of the Internet has led to a dramatic increase in the medical sophistication of the general public. Patients use Web sites to shop for physicians and learn about their practices. They prepare for their visit to their physicians by checking the Web and printing out information that may or may not be accurate or even relevant. There is an expectation that the physician will know all about these data.

While this is not a universal for all patients, it is enough of a phenomenon to help make the shift from paternalism to consumerism. It has changed the patient–physician relationship and even eroded trust in the system. For example, some physicians resent the intrusion of technology on their practice and view it as a threat to their authority. Others relish the collaboration of the patient in his or her treatment and are open to discussing Web information.

You should also note that the consumer-driven phenomenon of alternative/complementary medicine or integrated medicine (IM) has also influenced the change from paternalism to consumerism. People who use IM tend to view health care in a different light. Because IM emphasizes prevention, holistic healing, and partnerships between practitioners and clients, they are more aware of and active in their treatment. They assume responsibility for their own health and listen to the wisdom of their bodies. In turn, clients expect to have a similar experience in the health care system and try to share their involvement with their physicians. Although many physicians are coming to accept and even use IM approaches, many do not welcome this change. IM is viewed as a threat to their medical sovereignty and to their paternalism. The
results are that some physicians either do not listen to their patients, or even ridicule their practices. When such messages are sent, a “do but don’t tell” practice becomes the norm, often with disastrous results.

Regardless of the source of the challenge, paternalism, while certainly not dead, has been challenged by the new consumerism that does not appear to be on the decline. In fact, government involvement and emphasis on quality controls appear to be increasing. The new health care system might require a shift from an emphasis on professional control and paternalism to one of collaboration between physicians, administrators, payers, and patients. This strange set of bedfellows will make health care interesting and ethically challenging in the future.

THE PATIENT HEALTH CARE EXPERIENCE

To understand the differences between how the patient sees the hospital experience and how it is viewed by the professionals, you first conduct a systems and culture check (Press, 2002; Shi & Singh, 2004). As you read this section, think about the last time you had a health system encounter and see if your experience parallels what has been codified by the experts. Begin with patients. First, they are not patients until they are defined as such, and they do not have diseases until they are given a diagnosis. People can have a symptom or set of symptoms which, given a logical explanation for their cause, they might ignore. For example, if you just completed a marathon and you experience muscle pain, you do not run to the physician’s office. You attribute the pain to its source.

What happens if the symptoms persist or repeat? Do you then call for a medical appointment? Unless they are severe, you do not. Press (2002) believes that you try to figure out what is happening and why it is happening for yourself, which could be called formulating a self-diagnosis. Many variables can be a part of this analysis including your culture, life experiences, and medical knowledge. For example, suppose you studied all night and forgot to eat. Now you are taking your exam and your head feels like it will implode. You do not assume that you have a brain tumor; you use your life choices to explain your headache. Further, based on this assessment, you decide what you should do (e.g., take an aspirin) and what else you will do if that does not work.

The next stage in a person’s illness experience is to try to take care of the problem, what Press (2002) and others have called self-treatment. This can involve taking over-the-counter medications, changing lifestyle behaviors, or consulting your trusted family healer (Mom works well here). Because almost 80% of illnesses are handled by the healing ability of a person’s own body, self-treatment is successful and
people go on with their lives. They do not become patients in the health care system.

What happens if self-treatment does not work? If symptoms persist even after you have self-medicated and consumed doses of Mom’s chicken soup, and they are beginning to affect your daily life, you decide that you are sick. This puts you into what medical anthropologists identify as the sick role (Press, 2002; Shi & Singh, 2004). What does this mean? In families and society, when you are in the sick role, you have special benefits and responsibilities. For example, you will not be expected to attend classes but are expected to stay home in bed. Those around you might give you special treatment so that you have time for recovery. However, your responsibilities in the sick role include remaining true to your sickness. For example, if you have a migraine headache, you do not recover in 20 minutes and then go to the mall. Such behavior would be viewed as faking illness and being dishonest. You are also supposed to be compliant, participate in activities to promote your speedy recovery, and seek appropriate professional help for your condition. The specifics of how you interact in your sick role are influenced by your culture and family relationships and, to some extent, by your gender. Sick role behaviors are reinforced or diminished by their level of reward provided by these groups.

Your overall responsibility in this sick role is to get well as soon as possible and return to being a productive member in your family and workplace or school setting. Notice that this responsibility includes seeking out assistance from an appropriate professional and then complying with the treatment provided. Seeking professional assistance means that you must be willing to enter the alien world of medical care with its strange language and rituals. You are expected to share your most personal information right down to your body functions with an absolute stranger. In addition, you are expected to do this in an efficient manner so as to not waste his or her time. In fact, Press (2002) says that if you can present your symptoms in an organized way using appropriate vocabulary, you can receive a higher level of respect, more time in assessment and, by implication, a more accurate diagnosis. Being placed in an environment that, at best, is sterile and uninviting further exacerbates this potentially humiliating experience. As a result of this encounter, you are given a diagnosis, declared to have a disease or condition, and become a patient.

You are now a part of the health care system. Some would say that you have indeed become a stranger in a strange land. Press (2002) reminds you that this is a closed system whose function is to treat your body and get an appropriate outcome. It treats only what it labels as disease. Illness, which is the patient’s experience, is not recognized because the system is centered on reductionism and the mechanics of
A set of protocols is defined for treating each disease, which is supposed to be appropriate for all groups of patients with a few minor considerations for age and perhaps ethnicity. Professionals run this system and have many levels of power. They have certain expectations for patients who enter their system.

Patients come from an entirely different system, what you might call the illness system. In their open system (Press, 2002) sickness is deeply personal and affects not only their bodies but also their sense of self. They now have to add the identity of a sick person and a patient to their list of roles. Disease challenges their emotions, their faith, and even their relationships to others. It can change their lifestyles and threaten their ability to earn a livelihood. They also bring a set of beliefs, assumptions, and hopes about the medical system and its healers that influences their perception of the encounter. It is not surprising that such an encounter can create anxiety and a host of emotional responses.

When you go beyond the realm of physical health, the dynamics change even more dramatically. Not only do you have to go through the stages of ignoring symptoms until they affect your life, trying self-treatment, and assuming the sick role, but you now have a societal stigma about your illness. To complicate matters further, you have the responsibility of deciding whether or not you need to seek the help of a psychologist, psychiatrist, counselor, or priest. This decision is supposed to be made when your mind is already confused and frightened. Then, assuming you choose to do so, you are expected to tell this total stranger information that you would not tell your own mother. Then you must take whatever medication a psychiatrist prescribes or do any follow-up counseling. To fail to comply is to risk being labeled “uncooperative.” It is not surprising that clients are often uncomfortable or even wary of the mental health field.

You can already see that the patient is becoming part of a situation where a clash of cultures is inevitable. Professionals in health care also bring their own roles and concepts of appropriate behavior to the encounter. Through professional socialization, they are taught about their position and power in the system and to expect certain things from a patient. Often they make moral judgments based on how the patient acquired his or her disease. Rather than just focusing on the diagnosis, some physicians place patients into categories of “good” or “bad” people on the basis of whether or not their life choices are viewed as moral or immoral. For example, a nonsmoker who is diagnosed with lung cancer might be given greater value than one who is a lifelong chain smoker. In addition, patients are supposed to be grateful, suffer without too much complaint, and be properly humble. They are not to cause problems for the staff or upset others by their reaction to pain or bad news. Patients who do not follow the “rules” are often given labels such as “frequent flyer” (too many visits to the emergency
Measuring the Patient Experience

How does this clash of professional and patient culture affect the patient’s view? Patients judge care from their personal system and not from the professional’s system. They assume that the technical aspects of care, which are the center of your view, are provided by competent people. Those interactions that demonstrate your ability to care and communicate are seen as indicators of the quality of care. If the professional is aware of the patient’s fear, embarrassment, lack of understanding, and need for patience, privacy, and attention, and if those needs are addressed, then you will enhance the patient’s trust and compliance. If the patient is treated as an inconvenience or worse, he or she will judge your care as poor, even if it demonstrated great technical excellence. This view should remind you of a previous chapter where Buber’s ideas of I-YOU and I-THOU were presented. Minimally, the patient wants an I-YOU relationship with you but hopes for an I-THOU. The true skill is to provide this ethical relationship day after day to patient after patient.

MEASURING THE PATIENT EXPERIENCE

How satisfied are your patients and why should you care? As an organization, it makes good business sense to have a solid record of patient satisfaction. This credential can lead to better status in the community and increased patient referrals to help your practice grow. Press (2002) also says that patient satisfaction is linked to your employee satisfaction. High levels of patient satisfaction can actually mean decreased turnover and absenteeism and be a boon to your bottom line. Of course, patient satisfaction numbers are a significant area of review for your external evaluators (e.g., National Committee for Quality Assurance, Joint Commission on Accreditation of Healthcare Organizations [JCAHO]). In fact, the data often get translated to “report cards” that provide surface information about what is going on in your organization. These report cards find their way to various Web sites and publications and are used as a tool for the community to make judgments about how you treat patients.

How do you measure whether your patients are satisfied? There are actually many ways to do this, as you will read later in this section. However, some form of a survey or questionnaire is the most commonly used method. The instrument can be prescribed by an agency, purchased through a patient satisfaction measurement company, or created in-house. Regardless of the format, there are some limitations to these designs that can also present some ethics concerns. First, you need to remember that they do not measure actual real-time patient satisfaction (Press, 2002). Because surveys are often conducted weeks or even months after the actual encounter, what you are getting are data...
about perception and memories. In addition, your responders might be reluctant or even fearful to tell the truth. This means that the numbers can be based on a biased sample size and are often inflated. Yet, these same numbers are used to reward or punish staff through various incentive programs that could be viewed as an issue of justice.

There are several other ethical issues to consider in using survey data alone for measuring patient satisfaction. First, you have all of the statistical concerns such as sample size, random sampling techniques, population representation, and data manipulation. Knowledgeable and less-than-ethical staff can conduct surveys that are designed to make the data say only positive things about your institution. This “good news” can then be used to market your facility to an unsuspecting community. Even simple things like how you word your questions (or select the wording) can produce “halo type” results. In addition, ordinal or rank data can be treated as if they were arithmetic numbers and subjected to “numbers mania.” This can lead to all types of data manipulation to make your scores look better than they truly are. A strong ethical foundation for the whole survey process is needed, especially when bonus money relies on the results.

Along with the ethics of collecting the data, you need to consider what happens to them when they are collected. What is the ethics of patient satisfaction measurement if it is only for the “books”? What is the financial and ethical cost of just shelving data and never using them for any real purpose? If so, is it possible you are spending funds to conduct this useless evaluation that could be used on something more productive?

Of course, questionnaires are not the only way or even the best way to identify the root cause of patient satisfaction issues. Press (2002) and others encourage you to use the data collected through surveys as a spark for discussion and beginning the process of root cause analysis. However, you might also need data from other sources to make a real difference. For example, you can gain valuable insight into the real problem by practicing management by walking around. Observation is a powerful tool, even if it is not quantitative. Consider talking with patients, staff, and practitioners to get a better sense of how things happen in real time. Good administrators have been known to sit in the ED waiting room and talk with patients. They get a much better sense of the “ED experience” by being a part of it. Still others actually become mock patients and go through the admissions and work-up process. You can imagine the insight this brings. Some administrators make it a point to talk to the housekeeping staff because they are often a source for real information about operations.

Press (2002, p. 36) emphasizes “measurement is not management.” Regardless of its source, data alone will not change anything or bring about improved patient satisfaction. You will have to be engaged in some form of problem analysis and problem-solving strategy to make a
difference in this area. To paraphrase the Serenity Prayer, you need the courage to change the patient interactions that you can control, to accept the elements that you cannot change, and the wisdom to understand the difference. Remember to always use the internal experts (the people who really do the job) as part of your problem-solving team so that the plan becomes a reality and not just another piece of paper.

**HOW DOES MEASUREMENT RELATE TO ETHICS?**

You can conclude that measuring patient satisfaction is good for business, but is it good ethics? From a Kantian view, you have a moral duty to treat patients with respect because they are fellow human beings. In fact, this duty passes the categorical imperative test because it should be a universal feature of your practice. It fits the Golden Rule in that you would want to be treated with respect if you were a patient. In order to ensure that you are being true to this Kantian imperative, you must evaluate your practices even if this is not mandated by an external reviewer. How else will you know if you are acting in accordance with your Kantian mandate?

From a utilitarian view, you must provide the greatest good to the greatest number or cause the least amount of harm. Your actions have consequences that must be measured in order to determine if you are providing for the greatest good. Policies are created (rule utilitarianism) to ensure that your treatment of patients provides this greatest good. Collection of data from multiple sources assists you in obtaining a more accurate picture of what is really happening in the patient’s care experience and how you can improve it.

Rawls would also agree that gathering data on the patient’s experience and satisfaction enhances your ability to provide ethics-based care. Despite different diagnoses, patients are all in the same position. They have been diagnosed with something and want the best possible outcome from their medical experience. This is always true—even when the outcome is death. Patients wish death with dignity and without overwhelming pain and trust that you will be able to provide this outcome. The Rawlsian principle of protecting the least well off relates to your need for assessment and improvement of the patient experience. Because you want to be known for your compassionate care and not just for your profit margin, you must be able to make informed decisions about how best to provide this care.

When you consider the founding health care ethical principles, you can also see a connection to measuring the patients’ experience and satisfaction. For example, the principle of autonomy stresses the patient’s ability to own his or her body and make decisions about what happens to it. Infringement of this principle should occur only when it is in the
best interests of the patient and he or she provides consent. Being able to measure the patient’s view of autonomy and how you impact it should help you provide appropriate care and respect the patient’s boundaries. If you understand the patient’s view, you should also be able to move from paternalistic, professionally driven care to patient-centric care with greater ease.

The sister principles of nonmaleficence and beneficence and their relationship to patient satisfaction should also be considered. Perhaps you are causing harm unintentionally because the patient does not understand your procedures or intent. If you have a clear understanding of the patient’s experience, you can prevent harm by creating understanding. You also have a moral obligation to provide benefit, which should be easier to accomplish if you understand what the patient sees as beneficial. As you read earlier, there are different definitions of benefit depending on who is defining it. Finally, consider the principle of justice. How do you know that you are being fair and just to patients if you have no information? Patient satisfaction data from multiple sources help to determine your fairness and assist you in making any necessary policy and procedure changes.

■ PROVIDING CARE THROUGH A DIFFERENT VISION: PATIENT-CENTERED CARE AND ETHICS

How can a health care organization respond to the need for patient-centered care and satisfaction and still maintain a profit margin? How do you go about changing a paternalistic environment to one that is patient centric? What about the ethics of your actions? The Planetree Movement has been attempting to address these questions ever since its inception in the late 1970s. It origins are based specifically on the patient care experience of one woman, Angela Thieriot. She found the paternalism, sterile environment, and lack of attention to her needs “more traumatic than having a life threatening disease” (Frampton, Gilpin, & Charmel, 2003, p. xxvii). Her impression of the health care system was further reinforced by subsequent hospital experiences with her son and father-in-law.

Thieriot was not a physician or any other kind of practitioner, but she knew something had to be done to bring health care back to its roots of holistic patient-centered care. She founded a nonprofit organization named Planetree in honor of Hippocrates, who 2,000 years ago sat under a sycamore tree (“planetree”) and taught his students that a patient’s environment is an important part of healing. Thieriot began her process of changing the provision of health care with a thorough assessment of hospitals and their culture from the patients’ view. She also established a patient resource center to assist patients to under-
Providing Care through a Different Vision: Patient-Centered Care and Ethics

stand their conditions and the system that treats them. This Center became a model for similar programs across the United States.

In 1985, she opened the first Planetree Model hospital unit with the assistance of Kaiser Foundation and other grants (Frampton et al., 2003). Over 70 physicians participated in this unit and agreed to function within the Planetree philosophy. An architect assisted in the physical design and created a space where the holistic care could be provided.

Since that original effort, many other facilities have chosen to embrace the Planetree Model for patient-centered care. Some have completely revamped their facilities and practices while others have chosen to implement the changes in increments. As you would expect, the Model was challenged from both the medical and administrative components of the health care system. For many, it was just too radical a change to be accepted without resistance. Keep in mind that healthy skepticism is a good practice when the patient’s well-being is at stake, but taken to extreme, it can impede positive change.

The business sector, while understanding that patient-focused care appeared to be the right thing to do, questioned its effectiveness and return on investment. They wanted to see randomized studies that demonstrated cost savings and direct benefit to their profitability. Because of the nature of the Model, such data proved difficult to collect at first. Research studies now indicate a higher level of patient satisfaction under the Planetree Model but no reduction in the length of stay or decrease in services used. Despite the current lack of cost reduction data, this Model still holds promise for the business side of health care in the future. For example, the growth in the consumer movement, patient demands from the onslaught of the baby boomers, and the need for sustainable growth make the adaptation of Planetree more attractive. Through its use, even on a minimal scale, you can increase the quality of the patient care experience, which in turn can help to sustain trust in the healing system. In addition, the greater community concern about patient safety and medical error rates threatens the loyalty to individual health care facilities and to the system in general. Planetree, through its emphasis on meeting the patient’s needs, has the potential to decrease this threat and positively affect patient loyalty. This action should go a long way toward preventing costly malpractices suits that can drain your already stretched resources (Frampton et al., 2003).

What about the medical community? The champions of the Planetree Model have traditionally been nurses and other practitioners and not physicians (Frampton et al., 2003). This might be because these professionals have more of the daily contact with patients, while physicians see them only briefly throughout their hospital stay. In addition, because of their scientific background, many physicians view this Model as having insufficient empirical foundation and being unrealistic in terms of today’s economic situation. They also see too much emphasis placed on
CHAPTER 12  PATIENT ISSUES AND ETHICS

the softer side of patient care and worry that it might diminish the scientific rigor in which they practice.

However, this attitude is changing. Studies on physician satisfaction found that they preferred Planetree Units over others with respect to treatment of their patients. Use of this Model can actually have impact on the physician’s daily practice because, “A calmer, more secure, and informed patient is more likely to be better able to ask relevant questions and will be a better listener for physician responses” (Frampton et al., 2003, p. 210).

At this point you might be asking, “Just what is this Planetree Model?” The Planetree Model has evolved into a patient-focus care delivery plan that includes nine key areas (Frampton et al., 2003). These include: a focus on human interactions, emphasis on family and patient education, inclusion of social support networks, and an emphasis on nutrition as part of healing. In addition, the Planetree Model addresses the spiritual needs of patients, encourages touch in the healing process, and recognizes the role of the arts in healing. Finally, the Model applies IM practices and gives consideration to the environment as part of the patient care experience. The following is a brief summary of these key areas.

Human interaction is a key area in the Planetree Model because it reflects the essence of the patient care experience. As you read earlier, patients who are admitted to the hospital enter an alien culture where their life functions and dignity can be taken away. They are to assume the compliant and noncomplaining sick role and behave in a way that is convenient for the care giver. Human interaction in the form of kindness, concern for patient needs and comfort, and inclusion of the patients in their own care helps to reduce these feelings of alienation. Trust is built and satisfaction increased when quality interaction occurs. In addition, staff satisfaction seems to increase because they can see that they are really making a difference for the patients and their families.

Providing health information has always been a focus of the Planetree Model. In fact, one of the first accomplishments of this Model was the provision of information to patients who were often limited in their access to accurate and unbiased data about their own health. Today, with the increase in Internet usage, patients seem to be in information overload, yet there is still a need to have trustworthy sources. In addition, there are many groups in society who do not have easy access to the Internet or who are not computer savvy. These groups also need information. The Planetree Model addresses these issues through resource centers and libraries with patient-friendly classification systems. Community education including outreach to rural areas is a part of the information component of this Model.

As part of its educational component, the Planetree Model encourages patients to read their own hospital charts. This is suggested as a
way for patients to be informed about their treatment and status. While this feature of the Model has been somewhat uncomfortable for staff, it has been found to increase trust. Some patients even add their own comments to the record.

The family connections are acknowledged in the Planetree Model as part of patient-centered care. In this Model, a family member does not have to be a direct relative but can be someone who is important in the patient’s life. The Model includes many different strategies for involving these family members, including care partner programs and unrestricted visitation. Care partners are identified on admission and often serve as patient advocates. Some facilities choose to share clinical guidelines for treatment with these care partners. This action enables care partners to be an extra pair of eyes and alert the staff about potential problems. Some facilities have made room for family members by providing for overnight stays in the patient’s room or at a nearby facility.

Food and nutrition are also seen as part of the healing process in the Planetree Model. Food service staff are empowered to assist in improving the logistics of feeding patients so that the correct menu arrives at the correct temperature and at the correct time. Because food is more than just fuel, innovations such as pantries on nursing units, improved cafeteria design and service, nutrition education, and personalized menus have become part of this Model. In addition, some facilities use aromatherapy by baking cookies or bread on the ward to decrease hospital smell and increase the comfort level of the patients and their families.

The power of the spirit is not ignored in the Planetree Model. Despite the increase in double-blind studies about the power of prayer and spirituality, many health care facilities still cling to the separation of body and spirit model, which was first proposed by Descartes. However, the Planetree Model agrees with Frankl and others that humans are more than their bodies. The Model includes the mind and the spirit in patient-focused care. To implement this feature, Planetree-based facilities actively involve the hospital chaplain for inpatient treatment, conduct spiritual assessments, provide counseling, and honor rituals. Some have included interfaith chapels where patients and their families can go for solitude and prayer. In areas where Native American healing traditions are part of the culture, efforts are made to respect and include these practices in healing. One facility even has a Navajo ceremonial hogan (dwelling) on its grounds (Frampton et al., 2003).

The benefits of human touch have been known to traditional medicine for thousands of years. The Planetree Model includes touch in the form of massage as a way to gentle the impact of the hostile hospital environment. Massage is provided by licensed professionals who provide its benefits in a variety of settings. For example, massage is given on the same day as surgery, on acute care floors, and in cancer centers. Some hospitals include infant massage programs and others even offer
massage to employees. This service does not add a revenue stream, but it does provide an improved patient care experience, which may relate to improved healing and reduced length of stay.

The healing arts are also included in the Planetree Model as a holistic way to increase the patient experience. This practice is older than the Hippocratic system when beauty, from many sources, was deemed necessary for healing. In more modern times, Florence Nightingale also endorsed the power of beauty as part of the patient’s healing resources.

In the Planetree Model, the importance of the arts is reflected in facilities that do research to select healing-support paintings and sculptures for public areas such as lobbies and activity rooms. In addition, patients are allowed to select art for their rooms from “art carts” or to participate in an art therapy program. These programs are often very inexpensive because they use volunteers and donated equipment. Most important, they provide a “time out” from the stress of illness for patients and their families. Examples include artists-in-residence for both the visual and music arts, concerts by local groups, and pianos in the lobby and on the patient floors (Frampton et al., 2003).

Patient choice is important when providing patient-focused care through the Planetree Model. Choice is honored by integrating complementary and alternative medicine practices (CAM) with hospital-based care. After doing research to understand the practice and benefits of these options, Planetree Centers often incorporate them. For example, cancer centers can include gardens, spas, and steam rooms to increase patient comfort. Acupuncture and visualization can be offered to assist the patient in combating his or her disease. One faculty actually includes an evaluation by both an allopathic and naturopathic physician to provide maximum benefit for the patient (Frampton et al., 2003).

Finally, Planetree Model facilities are known for their attention to the total healing environment. Details in facility design and construction are not merely cosmetic. They are rooted in the concepts of holistic healing. Through careful choices in design, the hospital becomes a place where practitioners and patients work together for healing. The facility design makes this process easier and adds a more positive element to the patient care experience. The hospital becomes less sterile and foreboding and is viewed as a healing place.

Is ethics a part of the Planetree Model? The answer is, emphatically, yes. You can see evidence of Kantian ethics throughout the nine key areas you have just encountered. The emphasis on true patient-centered care acknowledges that each patient is individual and to be valued. The Golden Rule (do unto others as you would have them do unto you), which is a central concept in Kantian ethics, is very apparent in the Planetree Model. Planetree advocates see patient-focused care as a moral duty so that optimum care can be given for optimum healing.
How about the utilitarians? They also support the Planetree Model because it attempts to provide the greatest good for the greatest number and avoid the greatest harm. Even minimal adaptation of this Model seems to increase patient satisfaction and feelings of empowerment. When patients feel that they are in control of their own bodies, they tend to be more calm, cooperative, and appreciative of their care. Employees and the community also express greater satisfaction with the facility, and this has a positive impact on its image and support. While all of this satisfaction does not a revenue stream make, it does affect your bottom line. Kindness and attention to patient needs, while not adding to your expenses, can lead to greater trust in the facility and appreciation for care. It follows, then, that it will decrease the potential for lawsuits.

Summary

This chapter described how the patient is viewed by the health care facility and its employees. At the negative end of the continuum, patients are seen as whining interruptions to the daily flow of the day. If they do not remain in a state of quiet suffering and cooperation, then they are labeled noncompliant and avoided whenever possible. On the other end of the continuum, you find the Planetree Model and other efforts for patient-centered care. In this view, patients are partners in their own care and their needs are central to the existence of the facility.

The ethics of measuring patient satisfaction are integral. If you consider this logically, you can see that, like any business, you need information about what is working and what is not. You cannot improve what you do not know. Therefore, it makes good business and good ethical sense to acquire as much accurate data about the patient care experience as you can. However, the point is not just data collection. You have to determine the best way to use these data for ongoing improvement of your practices. Failure to use the data collected creates an ethics issue of wasting funds for useless surveys that could otherwise be used for patient, employee, or business benefit.

Today there is an effort among some health care facilities to move toward more patient-centered care. The Planetree Model was created because of one person’s experience with the alien culture of health care. Each of the key features in the Model is founded in good ethical and business practice. These keys will assist your facility in adapting this or other models in a time when resources are already strained and change is an almost daily event. However, the pressures of the increase in baby boomer consumers and greater scrutiny from the media should assist you in making the argument that these changes are good for business. They certainly make good ethics.
CHAPTER 12  PATIENT ISSUES AND ETHICS

Cases for Your Consideration

The Case of Kelly Beth’s Mother

As you read this case, consider the following questions. Responses and commentary will follow the case.

1. What factors contributed to Kelly Beth O’Brien and her mother Caitlin’s experience?
2. What ethics principles are illustrated by this case?
3. If you were the administrator at Dagma Memorial Hospital, how would you handle this situation?

Case Information

Three-year-old Kelly Beth O’Brien was brought into the ED at Dagma Memorial Hospital (DMH) by her mother Caitlin. X-rays revealed a lateral fracture of the left femur that would require several weeks of traction before a cast could be applied. Naturally, Caitlin was beside herself with worry. The information about Kelly Beth’s prognosis and treatment was frightening in itself, but she had other concerns that were troubling. Caitlin was a single mother who needed to keep her job to support her family. She knew that her department did not allow any time off for family illness, and she had no one to help her with this situation. What was she going to do?

Somehow Caitlin worked out a schedule that allowed her to spend maximum time with her daughter. She went to the hospital early enough in the morning so that Kelly saw her when she woke up. She took her lunch hour to check on her daughter and returned immediately after work. At night, she left only when Kelly was asleep. This schedule became a way of life and, although exhausting, helped Caitlin feel like she was able to keep her job and be there for her daughter.

Several days into this routine, Caitlin arrived at the hospital a little late, after lunch was served. When she kissed Kelly Beth and adjusted her bed, she found that Kelly was lying in food. It was in her hair, which was matted and filthy. When she asked Kelly Beth about this, the child said, “Mommy I tried to eat my lunch but it was too high and everything kept falling,” and then she began to cry.

Of course, Caitlin was extremely concerned about this event. So, after comforting her daughter, she went to speak to the nurses. Although she was upset about her daughter’s treatment, she made a conscious effort to control her feelings about the situation. The nurse who responded to her said, “We don’t have time to feed your child; that is your job. If you are not here, we just leave the tray. You are also responsible for washing your own child’s hair. You should bring the supplies and figure out how to do it. That’s what good mothers do.”
Caitlin was stunned. Not only was this response rude but also no one had told her about all of these rules. She knew she was being a good mother by juggling her schedule to be present at every possible moment, but now she was accused of neglect. She just assumed that because nutrition was important to Kelly Beth’s healing, someone would make sure that the child could eat. She also assumed that the nursing staff would help to maintain hygiene as well as changing the sheets. How was she supposed to know that her assumptions were wrong?

Caitlin called one of her friends who was a nurse to find out what supplies she needed to wash Kelly Beth’s hair while she was confined to the bed. She also made sure that she never missed a meal again to ensure that her daughter did not go hungry.

When Kelly Beth was discharged in her body cast, Caitlin had mixed feelings about DMH. While she was pleased with the technical care her daughter received there, she was not at all happy with the quality of the support care. In fact, she considered sending DMH a bill for patient care services.

**Responses and Commentary on Questions**

1. **What factors contributed to Kelly Beth O’Brian and her mother Caitlin’s experience?**

   In this case, you need to consider the situation from two viewpoints. First, consider what was happening for Kelly Beth and Caitlin. Kelly Beth was only three years old and had no experience with what she was supposed to do in a hospital. Her mother had not arrived yet and she was hungry. Being a resourceful child, she tried to feed herself but because she was so little, and in traction, her efforts created a mess. Had she been an adult or even an older child, she might have known to ring the call button and get help. However, the nurses had not taught her how to do this.

   Imagine Caitlin’s experience. She was trying her best to be there for her daughter and to keep her job so she could pay her bills. She happened to be a bit late for the lunch service and found her daughter lying in her lunch. When she inquired about the situation, she was treated with a rude response that increased her “mother guilt.” Now she felt like everyone knew the rules but her. While she was annoyed at the nursing staff, on some level she felt guilty because she was not holding up her part of the care burden. She did not know this was her role in the process. She even made the effort to learn how to wash her daughter’s hair. Once her daughter was recovering at home, she became angry at the lack of support from those she trusted with the care of the most precious thing in her life. She wanted to do something about this but felt that nothing she could do would make a difference.
What about the staff’s view of this situation? The nursing staff felt overwhelmed by the serious tasks of caring for children who are ill. They had to complete all of the physician’s orders, document their nursing notes on the computer, and take care of their own sanity. Here was this “Nervous Nelly” mother who was complaining about food in her child’s hair and one missed lunch. The nurses thought somebody should tell Caitlin how she was supposed to take care of her own daughter, and one of the nurses did just that. There might have been some other messages going on in the nurse’s response. Because she had “seen it all,” she might have assumed that Caitlin was just another one of those uncaring mothers who are not at their children’s bedside at all times. After all, how important can Kelly Beth be to this woman if she pops in and out all day? If she really cared so much, she would take off from work and be there 24/7 for her daughter. The nurse had no idea about Caitlin’s situation and how difficult it really was. Perhaps the nurse just assumed that mothers were with their children in the hospital at all times, because she had seen that in the past.

Regardless of which view you take, there was a serious lack of communication and kindness in this situation. Rules regarding the responsibilities for Caitlin and for the nursing staff perhaps existed but were not communicated to this mother. In addition, the simple act of kindness was forgotten. All the nurse had to do was to explain the rules to Caitlin in a nonjudgmental way. She could have taken a brief moment to instruct Caitlin on how to care for her daughter’s needs and what supplies she needed to purchase. Or, with even greater compassion, she could have assisted with the first shampooing of the child’s hair with the understanding that Caitlin was responsible for this care in the future. Such an action would have led to a much different patient care experience for both Kelly Beth and Caitlin.

2. What ethics principles are illustrated by this case?

It is easy to see issues with all of the major principles of ethics in this case. First, the idea of nonmaleficence should be considered. The hospital staff’s obligation in treating Kelly Beth was to do no harm. Certainly a missed meal and dirty hair are not as harmful as a medical error such as amputating the wrong limb, but the lack of attention to the needs of the child and mother did cause some damage. Kelly Beth was probably humiliated by not being able to feed herself and making a mess. She was worried because her mother was late. She was hungry. All of this did not enhance her ability to heal. When a child is the patient, the family is also part of the picture. Did the staff cause harm to Caitlin? Again, this is a matter of degree. While no physical harm occurred, the response to her ques-
Cases for Your Consideration

Tensions caused psychological damage to the conscientious mom. The tone of the nurse’s message implied that Caitlin was not following the rules and therefore was not being a good mother. Perhaps the harm was not intended, but it certainly was felt.

What about the sister principle of beneficence? Did the staff act with kindness and compassion in this situation? Obviously, they did not. It is true that they were extraordinarily busy, but letting a three-year-old struggle with a lunch tray that is placed out of her reach borders on cruelty.

The actions of the staff nurse toward Caitlin did not even resemble beneficence or respect for her autonomy. The nurse might have been acting from “compassion fatigue” and not from unkindness.

Nonmaleficence was also violated in this situation because the hospital experience caused harm to the mother and the daughter. It was unjust to expect a parent to care for her child’s hygiene when she was not informed of that fact. In short, all of the principles that form the basis of ethical health care behavior were violated on some level in this patient care experience.

3. If you were the administrator at Dagma Memorial Hospital, how would you handle this situation?

This seems like a facility that could benefit from the Planetree Model and from some lessons in communication. As an administrator, you have the obligation to consider the situation from both sides before taking action to prevent further incidents of this kind. Process improvement for the patient’s needs is your primary mission. What could you have done to increase Caitlin and Kelly Beth’s comfort level within the alien culture of DMH?

First, it might be helpful to include both written and oral communication about the expectations and responsibilities of staff and parents when a child is admitted to the facility. This could be accomplished through a brief conference coupled with an appropriate handout or pamphlet. Some facilities even include this information on their Web site.

You could also employ the principles of Planetree to find out more about Caitlin’s experience and her struggle to meet her daughter’s needs before passing judgment on the staff. When the situation is correctly assessed, you could try to provide appropriate support services. To do this, you could involve social services, pastoral care, or even a family support group. Perhaps there is a way to provide respite services for Caitlin when she has to be late and nursing services are too busy. The Planetree model includes volunteer care partners for patients who are alone. Perhaps this option could be
adapted to Caitlin’s situation. The driver for your efforts would be to try to secure the best healing environment for Kelly Beth. The nontangibles offered through the Planetree Model would also enhance this patient-care experience for mother and daughter. Kelly Beth and Caitlin needed a mechanism for asking questions and voicing needs without fear of staff retaliation. For example, showing Kelly Beth how and when to use the call button would have made a major difference in her care experience. It could also alter her mother’s negative perception of the facility. Other nontangibles like spirituality, touch, and the healing arts could be useful in improving this care experience. For example, Caitlin could have been taught how to provide massage for her child to help in pain management and sleep. Perhaps some CAM such as pet therapy or aromatherapy could be used to improve Kelly Beth’s healing process. Some of the healing arts like storytellers, clowns, or play therapy could also decrease Kelly Beth’s discomfort and assist in her healing.

Consider Planetree’s emphasis on the physical environment. Could the addition of a more home-like design have helped this situation? What about accommodations so that Caitlin could spend the night if she wished to do so? Think about the stress reduction potential of simply providing a bed or sleeping chair in the room.

In considering the patient’s viewpoint, you must also include Planetree’s emphasis on empowering the patient. There might have been a different outcome had Caitlin been educated about the rights and responsibilities of a parent whose child is hospitalized at DMH. Instead, without complaining she took on a burden of care that could have been shared or supported by staff. However, she left the facility with a deep resentment over the treatment that was received. She felt that Kelly Beth was treated with indifference and disrespect when she deserved so much better. The potential was great that Caitlin would voice her negative impressions to the outside community.

Consider the staff in your decision making. Surely their intent was not to cause harm to a helpless three-year-old. However, they might have been placed in a situation where they were stretched beyond their limits so compassion fatigue became normal. Planetree principles, which also apply to staff, might have been useful in preventing this situation. The Model stresses the way staff are treated and the way that they treat each other. For example, in this Model staff receive care and support as well as the patients. This might be as simple as increasing the number of volunteers so that “extra hands” are available during busy patient care times. Caring for staff might include creating a physical environment that supports their health
along with the patient’s. The Model includes areas where staff can go to regenerate their spirit and enjoy a respite. Staff also need to understand that they are valued and respected. Planetree stresses that they have a need for touch and a spiritual connection. As a way to demonstrate this, you could choose to provide chair massage to staff members during certain times in the week. Including staff in educational programs about CAM practices might also be helpful. Staff can enjoy the same music and art that you provide for patient healing.

Finally, good staff-patient communication cannot be overemphasized. You could begin this process by conducting a policy audit regarding proper communication methods. Perhaps it is time for a change or reinterpretation. If the policy is appropriate, you need to stress the ethical principle of first do no harm as part of patient communications. Acting with kindness and compassion in communicating messages could go a long way to prevent future situations like Caitlin’s. In other words, the same message conveyed with empathy might have had a totally different result.

As you read this case, consider the following questions. Responses and commentary will follow the case.

The Case of the Ardent Administrator
1. Why did Dorothy Dee find the Planetree Model attractive for implementation at DMH?
2. What was the CEO’s reaction to Dorothy’s proposal?
3. What ethical principles were involved in the implementation decision?
4. What benefits were derived from this decision?

Case Information
Dorothy Dee, RN and VP of Nursing Services at Dagma Memorial Hospital (DMH), read something extraordinary in her latest nursing journal. It was an article about a hospital that adopted something called the Planetree Model, where patients were the center of their business. She read, at first with disbelief, about the changes this facility made based on the principles of the Model. After reading about a hospital where patients are respected and the environment was dedicated to healing, she wondered how they were able to make such a complete change.

Becoming more curious, she found the facility’s Web site and located the name and number of her counterpart. She called and had a long conversation about Planetree and what it can accomplish. She also learned that workshops were available at the Planetree Annual Conference. There were even manuals to assist organizations that wanted to
try this patient-centered model. Dorothy really wanted to know more and if this Model might work for DMH.

Fortunately, she had a chief executive officer (CEO), Christopher Higgins, who was open-minded. In fact, he prided himself on being community-centered and progressive. When she told him about Planetree and the documented increase in patient satisfaction scores and employee retention rates, he agreed to support her attendance at the Conference and workshops.

Dorothy was amazed at all she learned at the workshop sessions. She even purchased the manuals and stayed up many nights reading them. She began to consider how the Model could be used to make DMH a more patient-friendly environment and one that could enhance healing. Because this Model made sense to her on many levels, she used her nights and weekends to develop a proposal for submission to Mr. Higgins. It included everything from changing the color of the wall paint to different modes of lighting. There were ideas for integrating music and art throughout the facility. She even had a plan to update the nursery using local art talent and staff assistance. She researched the budget to make these changes and attached it to her proposal. True, her plan included some costs, but they seemed minimal when compared to the potential benefits.

Dorothy submitted her ideas to Mr. Higgins and made an appointment to discuss the document. Because she knew his history of innovation and community service, she had hopes that her ideas would be accepted. Mr. Higgins told her that he had read the proposal carefully and that it did contain some promising ideas. However, it was just too radical and he worried about the reaction of the physicians. This much change might just be too much for DMH.

Dorothy was disappointed but, having learned to always have a Plan B, she asked if she could take alternative action. What if she put together a team and created a feasibility study using the short-stay unit only? She would keep the budget to bare bones and provide documentation that the changes produced a positive result. Would he green-light such an effort?

Knowing that Dorothy had the knowledge and skills to deliver on her plan, he consented. She assembled a team, making sure to include a physician champion. Other members included representatives from housekeeping, materials management, dietary, nursing, patient services, and other involved staff. After providing an information session, she said, “What if we changed short stay into a patient-centered environment? What would it be like?”

The group became enthusiastic about the chance to change things for the better. They came up with a way to get the rooms painted, add bedspreads and drapes to each room, and even provided aromatherapy by having cookies baked on the floor on Friday afternoons. Local artists were asked if they would like to donate healing art for the halls. The biggest change was in the family waiting room. It now housed a
small resource center with a computer, a fish tank, and plants. They also included a “Kids Nook” with bright-colored walls and children-sized furniture. The transformation, which was supported by all of the team, was nothing short of amazing and finished on a very limited budget.

Almost immediately Dorothy noticed a change in the routine of the short-stay unit. Patients were surprised by the nonhospital environment, and quickly appreciated it. Instead of being negative about the change, staff seemed to embrace it and want it to work. Their attitude seemed to be more positive with patients and each other. In fact, they seemed to want to be scheduled for short stay rather than traditional floors. Family members were also pleased to be able to learn more about how to care for their loved ones through the computer programs offered in the waiting room. The children used their own area and were less of a distraction.

Somehow the local paper found out about this patient-focused care effort, and Mr. Higgins was featured in an article as a community-caring administrator. The print article sparked the interest of the local TV station, which ran a human interest piece. DMH was given the title of a “Hospital That Cares.” Mr. Higgins was so pleased with the results that he gave the green light to Dorothy’s next innovation idea. Onward to the nursery and bunnies on the walls!

Responses and Commentary on Questions

1. Why did Dorothy Dee find the Planetree Model attractive for implementation at DMH?

The first question to ask is why Dorothy chose nursing as her profession. Even in her student days, she wanted to make a difference in the health of her patients. She understood that healing was a process between the patient and the professional. Her current position at DMH seemed so far removed from her original vision of nursing. She struggled with scheduling, JCAHO reports, staff complaints, physician complaints, and community issues. Where was the healing environment she had hoped to create? She was experiencing quiet discontent when she found the journal article on Planetree and its philosophy.

Being a realist, she knew that this would be a major change for the physicians, her nursing staff, and the other professionals. Yet she believed that if she was able to communicate the Model well enough, most of the professionals would want to at least try it. She knew that patients and their families would appreciate being treated with respect and allowed to be part of their own care decisions.

While her initial proposal was not well received because it was too far reaching, tackling the change in small steps and demonstrating
positive results seemed to work. Her data showed that staff morale increased as did patient satisfaction. An added bonus came when the press and TV media found the change newsworthy. DMH received priceless marketing through its improved community image.

2. What was the CEO’s reaction to Dorothy’s proposal?

Mr. Higgins’s response was not surprising. In fact it was almost predictable. Although Dorothy had done a good job showing cost-effectiveness for the change, Mr. Higgins had to consider the political element. The last thing he wanted was a staff revolt because they were asked to move too far out of their comfort zones. He worried that the physicians would not be behind this and a disaster might result.

Still, the idea had merit. So when Dorothy asked to pilot a more limited version of the Model with a fixed budget, he gave it the green light. As it turned out, she was right. The staff seemed to rally around the project, and the patients and their families were full of praise for it. The press coverage was excellent and several Board Members called to congratulate Mr. Higgins on his foresight.

3. What ethical principles were involved in the implementation decision?

There are many ethical principles at work here. From the patient side, autonomy is central to the whole Model. Patients were treated as valued people and not as noncompliant nuisances. As a result, there were actually fewer patient complaints on the unit. Certainly you can see beneficence and the sister principle, nonmaleficence at work in this model. Everything from the physical environment to the staff interactions was designed to provide compassionate care that produced an optimal healing environment.

Justice was provided by this Model for staff and for patients. Planetree stresses the value of both. While improving the physical environment for the patients was a clear goal, the process and the results also improved the environment for the staff. They were enthusiastic about work again because they were engaged in a process that respected their knowledge and allowed them to make a difference that could be seen. In fact, short stay became the place to be among the hospital staff. Dorothy felt certain she would have their support for other Planetree-type changes.

Web Resource

Planetree Information
http://www.planetree.org/
References


SECTION IV

The Inner Circle of Ethics

INTRODUCTION

This section completes the circle model that you saw in Figure 1. As you strive to function as an ethics-based health care administrator, all of the outer circles exert their influence on you. Given these influences, achieving this goal will not be easy. However, acting as an ethics-based administrator can provide you with a level of integrity that will last for your entire career in the field of health administration.

Figure IV-1  A system of health care administration ethics.
The format of the chapters in this section is slightly different. Because this inner circle is more personal, the text is written in the first person, rather than third person format. In this way I will be able to talk with you in my own voice. Case studies are not used in this section. Instead, I will pose some challenges that I hope you can use toward the formulation of your own administrative ethics statement.

This last section comprises three chapters that focus on your quest to find a code of ethics to undergird the foundation of your practice as a health care administrator. Chapter 13, *Moral Integrity*, presents various ideas about what it means to be moral within a challenging environment. The chapter begins with definitions of morality and its relationship to ethics. From there, you will explore expert views on practicing morally centered administration in a health care environment. You will also learn what happens when morality is distained from both a micro and macro viewpoint. Finally, you will be provided with some specific challenges to help you formulate your own position on morality and health care administration.

In Chapter 14, *Codes of Ethics and Administrative Practice*, there is a discussion about professional codes of ethics and how they relate to personal ethical practice. Your professional code as an administrator (the ACHE Code) is detailed and its application is also featured. Because many administrators have other codes that govern their actions, this chapter looks at codes from several professional groups to analyze their themes. By the end of this section, you should be able to understand how a “code clash” can occur and how to deal with it. To provide a balanced view, criticisms of codes are also discussed.

Chapter 15, *Practicing as an Ethical Administrator*, explores how to use the information gleaned in Chapters 1 through 14 in the practice of health care administration. The chapter presents the core functions of an administrator and how ethical practice plays a part in each of those functions. It also includes information on ethics challenges you might face based on anecdotal data from practicing administrators.

Chapter 16, *Where Do We Go from Here?*, provides a summary of the subject matter that you have encountered by studying this text. It also looks to the future and discusses some of the challenges you will be facing. Finally, it encourages you to write your administrative ethics statement in a way that is suitable for framing. If you do not wish to hang it on the wall of your office, you can keep it on your desk for reference.
Moral Integrity

“I have often thought morality may perhaps consist solely in the courage of making a choice.”

—Leon Blum

Points to Ponder

1. What is moral integrity?
2. How do the experts’ views of moral integrity differ?
3. What temptations will you face in choosing moral integrity as a basis for your professional actions?
4. What is the best way for you to maintain your moral integrity?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- administrative evil
- character development
- deceit
- evil
- extermination camps
- integrity self-assessment
- labeling
- moral integrity
- personal mission statement
- personal morality
- reconciliation

DEFINITIONS OF MORALITY

What does it mean to choose to be moral in a world that is often immoral? What does the idea of moral integrity mean for your role as a practicing health care administrator? What is the relationship between
mortality and ethics? The answer to these important questions begins with an exploration of the concept of morality and its meanings. As we have seen with other ethics concepts, there is no absolute definition of the term morality, but experts seem to agree on certain themes. Purtilo (2005) defines morality as everyday behaviors that allow us to live successfully with one another. She includes concepts like values (what we cherish) and duties (actions that we are required to do).

Purtilo (2005) further divides morality into personal, societal, and group categories. Personal morality includes those values and duties that you hold independent of work or social groups. For example, if you say, “I honor myself and give others the same honor,” you are expressing part of your personal morality. Societal morality is influenced by culture, geography, religious foundations, and even legislation. It is the values and duties that reasonable people expect of each other and allows for a secure and peaceful society. An example of this morality is the statement, “All people are created equal.” Because health care exists within a society, it is affected by its society’s definition of morality. As it serves to treat those who are least well off in a society, certain expectations adhere to this definition. You learned how health care organizations attempt to practice moral integrity in Section II, which covered external influences.

Finally, Purtilo (2005) introduces group morality. She points out that subgroups such as those found in health care facilities often codify their own set of values and duties. These desirable actions are expressed through policies and procedures so that all group members have an understanding of the subgroup’s definition of acceptable behaviors. You will learn more about this process when you study codes of ethics in Chapter 14.

Maclagan (1998) also makes distinctions between personal and societal morality. In his definition, morality also includes the application of values and duties. Values are obtained initially from family and community. These root values are then influenced by your education, professional socialization, and experiences. He includes a review of Kohlberg’s work on moral development, which you studied in Chapter 1, as a basis for understanding how values and duties are applied in the workplace. A need for greater understanding of moral diversity is needed, especially in health care. You cannot assume consensus on the definition of moral correctness and might have to provide operational definitions for these behaviors.

Finally, Gert (2002) concurs with the previous authors and includes variations on the definition of morality. He identifies differences between personal morality and what he calls normative or societal morality. Regardless of the form it takes, morality can be defined in terms of action rather than theory. It is also concerned with the impact of actions on others.
What Do the Experts Say about Morality?

How does morality relate to ethics? Purtilo (2005) explains that ethics is a way to examine moral problems by using a systematic and theory-based process. It allows you to analyze a situation using what she calls ethical reflection. This reflection can lead to resolution of the situation through appropriate action. Ethics differs from morality in that it entails a course of action based on reasoning rather than one based on habit.

Maclagan (1998) also stresses the theoretical base found in ethics as a mechanism for dealing with problems that occur in both professional and daily life. So if you summarize the differences, you could say that our study of ethics has provided you with the theory and tools to deal with health care issues. Morality involves your application of your ethics knowledge in your role as a health care administrator.

WHAT DO THE EXPERTS SAY ABOUT MORALITY?

Now that you have a baseline definition, your next step is to study expert views about this topic. This will help to establish your knowledge base and prepare you to address and solve the challenges posed for you later in this chapter. It should also allow you to deal with the real problems that you will encounter in your career. The following text comprises a survey of the extensive literature available on this topic and is condensed into palatable “wisdom bytes.” I have also included my own observations, interspersed with those of the experts.

To begin, I will offer general ideas on leadership and morality from Parker Palmer (2000), and then continue with more specific concerns raised by Johnson (2001) and Annison and Wilford (1998). Next, the chapter addresses what happens when morality issues are ignored or replaced by other concerns. Ideas from Johnson (2001), Dye (2000), Collis (1998), and Caplan (1992) are used to show the impact of the immoral or amoral action on health care facilities and society in general. This will be followed by concrete advice that you can use on a personal level to keep your moral center and still be successful in our dynamic, temptation-ridden health care environment.

Palmer (2000) believes that, because we all live in a community, we are all followers or leaders depending on time and circumstance. To be a respected leader, you must practice what he calls authentic leadership. This form of leadership stems not from the profit/loss statement, but from the heart. As a “co-creator” of the world in which you exist, you must make choices for positive moral action. Nowhere can the impact of these choices be seen more clearly than in your choices as a health care administrator.

Your leadership actions should be geared toward producing good and avoiding harm, which Palmer calls light versus shadow. In other
words, as morally centered leaders, you are to “...cast less shadow and more light...” (p. 85). To accomplish this you must be willing to explore your inner or spiritual life including your moral center. This exploration can be conducted through activities such as keeping a journal, allowing time to reflect or meditate, participating in discussions, and through prayer. Palmer also asks you to assess the role of fear in your decisions. While everyone who assumes a leadership role has fears, he or she should not be used as a basis for making decisions. You will need to draw on your knowledge, skills, and moral core to lead from a position of strength rather than one of fear.

Johnson (2001) devotes an entire chapter in *Meeting the Ethical Challenges of Leadership* to your character as a leader. His content is based on national and international research concerning characteristics of model leaders. These characteristics or virtues include areas like respect for others, integrity, judgment, persistence, honesty, and the ability to inspire. The author feels that these characteristics are more than mere “window dressing”; they are integral parts of the inner life and behavior of these leaders. He stresses that you should not change your core virtues to suit the whim of others; they should remain with you. To foster your character development, he suggests the utilization of the Rest Model, which includes developing awareness, practicing moral reasoning, and using moral motivation. None of these steps are useful unless you are willing to take moral action.

With respect to moral action, I often ask ethics students, “What is your personal bottom line? Over what issue or action would you be willing to quit your job?” When the questions are at this basic a level, these students struggle with the reality and fear of unemployment versus what they feel to be morally correct. However, when I turn the situation around and ask, “What are you worth? Would you be willing to sell your integrity for a paycheck?” a different vision appears. By going along with something that the students know is morally wrong, they are endorsing the action. While the immediate consequences might be negligible, the long-term effect could be extremely damaging. It is hoped that you will never have to face such a difficult situation in your career, but it is always important to formulate your fallback position should it occur.

Johnson (2001) suggests that you find examples of the daily application of moral behaviors and engage in projects that increase ethical practice. He even advocates exploring literature with ethical themes to discern useful strategies to develop or sustain your moral character. You might consider identifying someone who could function as your moral mentor. This would be a person who practices health care administration with high ethical standards.

Difficulties as well as successes can help to develop your personal moral code. Lessons can be learned from business failures, setbacks,
personal changes, and even from confronting problem employees. The important element of character building through this adversity comes from identifying the lessons and applying them to future situations rather than dwelling on the failure. Finally, he advocates, as do I, the formulation of a **personal mission statement**. This exercise will help you maintain the direction of your moral growth. You will learn more about this process in later chapters.

Annison and Wilford (1998) are concerned with what they see as the core of the health care business—trust. They stress that you are responsible for restoring individual trust in the health care system through your personal and corporate decisions. Their elements of trust can be applied to morality in leaders as well as in organizations. For example, to maintain high quality, trust-based leadership you need to demonstrate commitment to something larger than yourself. You should be thinking more about what is right for the community that you serve than you do about your personal financial portfolio. While you certainly want to live comfortably, the motivation for your work should be focused on beneficence.

The authors also stress your willingness to talk about your approach to leadership as a way to build trust among your staff. They need to know you to be able to trust you. You must also be willing to demonstrate integrity and accept responsibility for your actions. If things do not go as planned, you should have the moral courage to “step up to the plate,” accept responsibility, and do what you can to remedy the problem.

Integrity is a key element for maintaining trust. While perfection is not expected or even attainable, honesty is always possible. Honesty, in Annison and Wilford’s view, includes knowing who you are. You must also be able to analyze what your decisions mean beyond the technical level. Decisions are never neutral; they have a personal component.

Consistency and communication are also elements that can be used to maintain your moral core and build trust. The authors define consistency as having your words and actions match. When they do not, cognitive dissonance occurs and your actions will always speak the loudest. You also need to be consistent in your values, now and in the future. This way you are known for your ability to stand by your beliefs. Of course, being able to communicate well and in an honest way is important to building trust, even when you must communicate bad news.

The last aspect of building trust is probably one of the most difficult. You must be able to forgive past inequities and move forward in a positive way. This ability is particularly important in health care where today’s enemy can be tomorrow’s merger partner. In addition, if you unintentionally or intentionally break trust, you must be willing to ask for forgiveness. The ability to grant forgiveness and be forgiven, called
reconciliation, helps to restore the trust that is essential to your success as a health care administrator.

Morality Ignored: What Happens When the Compass Is Broken?

What happens when moral integrity exists but is ignored in the administrative practice? Are there really any consequences for being an immoral administrator? Dye (2000) speaks about behavior where normally effective leaders choose behaviors that are destructive and result in poor performance. He calls this phenomenon "managerial derailment" (p. 170). This management failure is attributed to negative or immoral behaviors such as pessimism, dependency, low self-esteem, laziness, lying, and excessive egoism. Unfortunately, these traits cannot be detected during the hiring process, but they can seriously affect employee morale and the organization’s bottom line.

Dye (2000) stresses that future and current employees should be assessed for their moral integrity beyond surface questions at an interview. You also need to be aware that a seemingly “good” administrator can be tempted by any of these negatives. Be sure to take the morality pulse of your staff from time to time. Most important, do not forget to monitor your own behaviors in these areas.

Griffith (1993), in a classic work, cautions that your financial net worth can increase by choosing to ignore moral integrity. In fact, you might have an easier time making your bonuses if you act ruthlessly and conduct yourself in ways that would make Machiavelli proud. In short, health care and society in general do not always give you financial rewards for keeping your moral integrity intact. Yet, there is evidence that both the organization and staff benefit when you take pride in doing what is morally correct.

Griffith (1993) advocates that you not only practice integrity self-assessment, but that you also promote moral behavior in others. Care should be taken to hire and reward employees who find satisfaction in service to others. You can structure employee promotions and reward programs to honor this behavior in the same way that you honor fiscal responsibility. To reinforce your commitment to moral integrity, even your training programs should include this concept.

According to Griffith (1993), you should also examine your own moral center to see if you are motivated primarily by intrinsic rewards such as service to others. While money is desirable, the commitment to service should be what sustains you at difficult times in your career. Frankl (1971) would agree. He sees work as a place to find meaning through what you give to the world as well as what you take from it. In his view, a meaning-filled life is one well lived. A life devoid of meaning, while possibly filled with “material goodies,” can be empty and unsatisfying.
What Do the Experts Say about Morality?

Johnson (2001) presents a view of the dark or shadow side of leadership and how it affects your moral center. All leaders have both a light and dark side. They must struggle to master the darkness and not let it be a dominant force in their administration. Leaders in healthcare are particularly at risk because of their tremendous power and prestige in the community. There are great temptations to engage in dishonesty, self-protection, disloyalty, and irresponsibility.

You cannot do your job without power. As you know from your management courses, power takes many forms, each with its own use. Of course, these power sources carry with them the potential for abuse if they are used inappropriately or excessively. How do you avoid the shadow of abuse of power? Johnson (2001) asks you to consider how you use each type of power and whether its use is appropriate. Be sure to balance delegated power with power that you own. Becoming impressed with your own sense of power can cause a loss of perspective leading to behaviors that can harm yourself and others. After all, you really do not have power unless people choose to give it to you and thereby comply with your plans and direction.

Because you assume a leadership position, your power is also linked to certain privileges. You receive more money, perks, and status than others in the organization. This is supposed to be compensation for the extra responsibility and accountability that you bear as an administrator. How much privilege is fair? Can you misuse privilege? Are you guilty of hoarding wealth and status, or feeling that you are better than others? Introspection to answer these questions should help you to avoid being overcome by the privilege shadow.

You learned in Chapter 2 that fidelity is an important part of your autonomy as a healthcare administrator. However, the dark side of deceit is also part of your choices in this position. You have access to greater sources and levels of information than others in your organization. This makes sense because you must be “in the know” to do your job, but your knowledge power can also add to your ethical burden. For example, as you saw in Chapter 2, you sometimes have information that could adversely affect your staff, but you might not choose, for whatever reason, to disclose it.

Deceit does not have to be as direct as lying. You can practice deception by denying that you have particular knowledge, withholding information to sabotage others (as in bullying behaviors), or using information for your own benefit. Deception, once uncovered, undermines trust from your staff and your community. Once you have lost their trust, it can take years, if ever, to be restored.

The idea of having favorites—known as “ingroup/outgroup” management—is also one of the possible administrative shadows. Johnson (2001) considers this choice to be a lack of consistency. Because you are
human, you will find some people more appealing than others. However, in the workplace, you have to strive for consistency of treatment. A way to avoid the temptation or even the perception of favoritism is to be careful about your lunch partners. If you lunch with only those you like, you have identified an “in group” even if this is not your intent. Your rule should be to have lunch with everyone or no one. Similarly, be very careful about socializing outside of work, particularly dating behaviors. Dating subordinates not only sets up the temptations of favoritism, but it can backfire if “love goes bad.” In the worst case analysis, a spurned subordinate might retaliate with claims of sexual harassment that can ruin your career. Indeed, it is lonely at the top.

Loyalty and responsibility are also key areas where shadows can overtake light in leadership. You have multiple loyalties as a health care administrator that can often conflict. Your first loyalty should be to the patient and the community that you serve. Obviously, you also want to be loyal to your boss and your staff. However, this loyalty cannot be absolute. For example, you must be willing to take appropriate action if your boss is engaging in behaviors that jeopardize the organization or the community. This is your moral Catch 22. You want to be loyal to your boss, but if you say nothing, you are supporting his or her behaviors. When you feel compelled to report your boss, you must always have appropriate documentation and go through the organization’s channels. Keep in mind, however, that if you decide to go over your supervisor’s head, you might shatter your career if you are labeled as a whistle blower. It is hoped this awesome decision will never be one that you have to make.

Responsibility is linked with loyalty. You are held accountable for your own actions and for those of the members in your department. You act irresponsibly when you do not do all that you can to prevent inappropriate staff behavior, blame others for your decisions, or expect more from staff than you are willing to do yourself (Johnson, 2001). Again, assessment of your level of responsibility and the expected accountability will help you maintain your moral integrity. It is also critical that you hold your staff accountable for their decisions and behaviors.

Collis (1998) conducted a national study involving Fortune 500 companies, unions, business media, business school deans, and others to determine why administrators succeed or fail. This study became his book, *The Seven Fatal Management Sins*. Of interest to our discussion is “Sin #1: The Character Flaw: Erosion of Trust and Integrity” (p. 71). His study revealed that managerial ethics has declined in the past 20 years and that hard work might not lead to advancement. The work force does not appear to be as loyal to employers as it once was. He attributes these changes to a lack of integrity among administrators.

When your word cannot be trusted and your integrity can be sold to the highest bidder, it is difficult for others to have confidence in you as a leader. Organizations that reward profit over integrity add to the
What Do the Experts Say about Morality?

problem. However, the reputation of your organization depends on your actions and those of its employees. You are the organization in the eyes of the community. Therefore, personal and organizational integrity do matter.

Collis (1998) found, just as Annison and Wilford (1998) suggested, that trust matters in business. If your staff do not trust you, they will not provide the information you need to make sound business decisions, respond to your direction, or demonstrate loyalty. Maintaining trust and your integrity, rather than greediness, should be your motivation for your administrative practices. Your conscience combined with solid business acumen should be part of your decisions and practices. Remember to ask yourself, “If this action were featured on the six o’clock news, would I be proud of it?”

Before we move to the next section that will provide some ideas for maintaining moral integrity, we need to examine your most difficult challenge—facing evil. Both Johnson (2001) and Caplan (1992) present aspects of this threat to your moral integrity and give ideas on how to combat it. First, you must acknowledge that evil exists and define it from an administrator’s view. Evil is a force for the destruction of health, happiness, and community. It causes human suffering on many levels and destroys dignity. In order for you to understand the impact of evil, Johnson (2001) organizes it into categories such as deceit and bureaucratic-approved injury. He also provides information on the role of choice in the practice of evil. Finally, Caplan (1992) presents a specific example of how health care practitioners and administrators produced great evil through their support of the holocaust during World War II. When considering moral-based leaders, Johnson (2001) found they understood that there is a force in the universe that is greater than them. Frankl (1971) would call this force the ultimate meaning and define our connection to it as conscience. Administrators who are capable of great evil might not even be aware that such a force exists or deny that it has anything to do with their practice. In so doing, they begin to think of themselves as the higher force—perfect and all powerful. Their goal is to control the behavior of others and bend them to their will. Their self-deception of omnipotence leads to actions that can destroy individuals and even the entire organization.

Bureaucratic or administrative evil happens when faith in technology, science, and the power of reason—devoid of compassion or conscience—becomes the driving force of a group, organization, or society. Ultimate faith in technology and science serves to remove you from the human part of your decisions and makes it easier for evil to exist. This belief also allows you to engage in daily operations that produce great pain and suffering for others without any sense of guilt or remorse.

Administrative evil has existed throughout time and explains many destructive actions in history. The classic example of this practice in
modern times was the extermination camps that existed in World War II. Through daily operational functions (e.g., providing on-time transportation, building camp sites, collecting taxes, and compiling records), civil servants supported and enabled the death camps to execute their deadly work. These citizens did not view their role as evil at all. They were merely doing their jobs with business as usual and paying attention to their profit margin.

Caplan (1992), in _When Medicine Went Mad_, brings the role of administrative evil in the holocaust even closer to home. He presents the case that certain elements of German society went beyond compliance with government policy. The medical community, through its scientists, physicians, and administrators, actually designed and implemented many of the government’s destructive programs. These endeavors were focused on racial hygiene and extinction of whole populations. The medical community viewed these programs as highly ethical since they were designed to prevent the degeneration of the human race via genetic contamination. Sterilization laws, euthanasia, ghettos, and eventually the death camps were all part of this effort. Technology made this evil much more horrific because it increased efficiency; more people could be killed with less gas, thereby improving the bottom line. It also removed people from the process so that they could deny its existence even when it occurred in their villages and towns.

Johnson also presents the category of “evil as sanctioned destruction” (2001, p. 77). In this view, evil occurs when you give direct or implied permission to victimize others. Victimization is deemed acceptable when the group or individual is not viewed as a valued member of society. Such action violates all of the ethical principles you have studied. However, if you are not careful, it can be business as usual for health care. It is not always easy to treat each person with dignity when you see pain and suffering every day. You might experience compassion fatigue and grow angry about the choices people make that imperil their health. It is especially frustrating when these choices also adversely affect your bottom line. Without reminders that your true mission should recognize the worth of all human beings, it would be so easy to deny care or treat only those whom you decide are the “deserving poor.” Johnson reminds you that even small doses of this evil, such as labeling those you find undesirable (e.g., GOMER, Frequent Flier) can lead to a loss of dignity. Even if you never use any of these labels, if you laugh at them among yourselves or remain silent when you hear them, you are supporting sanctioned destruction.

Johnson (2001) also notes that evil occurs through a series of choices rather than just one event. Even small choices can have large moral consequences. Therefore, it is imperative that you determine why you are choosing one option over another and think about the consequences of your choices. A rush to decision can lead to a wrong action
that is both morally and fiscally unsound. However, as you build your moral integrity, it will become easier to discriminate between a good choice and one that can have negative consequences. As in any skill, practice makes positive choices easier to make.

MAINTAINING YOUR MORAL INTEGRITY

The previous text has demonstrated that moral integrity is not genetic. It is developed through education, experience, self-assessment, and decision making. As in other areas of administration, you must create a lifelong commitment to cultivating and supporting your moral base. The following are suggestions from a variety of experts to assist you with this process.

Griffith (1993), a well-respected leader and educator in health administration, believes that you can be moral and still be successful in health care leadership. This is particularly important as you advance in your career and assume higher administrative positions. When you achieve these higher positions, you will serve as a moral beacon for those who follow you and for your community. You will not have the option to hide your commitment to doing what is right, and you will be known by your moral convictions.

Griffith also challenges you to administer your department or organization in a way that fosters integrity. This includes designing policies and procedures that encourage doing the right thing. Make it easy and nonpunitive for staff to identify and report problems, and be willing to act on these reports. Build working groups who do not jump to the first solution, but take the time to ask, “What is the right thing to do?” Be sure that you are not a moral hypocrite and that you truly put patients first instead of just writing it in your mission statement.

He encourages you to use true participative management. This means truly delegating both the task and the responsibility to your team. It also means that you provide rewards to those who deserve them and not just give them to those who curry favor. Certainly, Griffith (1993) asks much of you, but the benefits for your organization and your career are worth the effort.

Collis (1998) encourages you to think beyond utilitarian ethics. For example, the end might not justify the means if the end causes harm. You are challenged to make your means and your ends reflect sound ethical practice. He asks that you encourage others to speak out against injustice. You are supposed to welcome those who make waves. Without them, you could end up like the emperor in the fairy tale—naked and ridiculed for your ignorance of reality. You must always be aware of your accountability, because your reputation among your peers and your subordinates will be based on your choices, right or wrong.
Finally, he challenges you to explore your spiritual side and lead with “compassion, sympathy, and service” (p. 232). Indeed, this is part of your mission as a health care administrator.

Purtilo (2005) devotes an entire chapter to advice on how to survive in health care and keep your moral integrity at the same time. The principle of beneficence means that you must act with kindness and charity for others. This also means that you should treat yourself with kindness. Therefore, you have a duty toward self-care that, if you honor it, will enable you to function at your optimum level of moral integrity. This duty also entails giving yourself permission to care for your own needs as well as those of others. While the necessity of taking care of you might seem obvious, many find it difficult. Perhaps, the professional socialization process has been too effective. Health care professionals can feel guilty when they address their own needs. Some have even been known to come to work when they are ill. While this might seem to be noble, it actually is not. They are in fact increasing the risk of illness for their colleagues and patients.

You are also challenged to strengthen your personal moral integrity (Purtilo, 2005) through what I will call personal quality improvement (PQI) efforts. For example, take responsibility to engage in activities that improve who you are as a person. This will not only make you more interesting but also increase your resources when your integrity is challenged. You should also think about all the time you spend at work or thinking about work. Is it in balance with the time you spend on other aspects of your life? What are you doing to recharge your moral batteries? Do you spend enough time doing what you really love or with those you truly love?

I am reminded of a remarkable person who came to speak to my students. He was a chaplain in a hospice program and spoke to the class about his work. At the time, his clients ranged in age from 4 to 98, and he spoke about how he supported each of them through the end of their lives. One of my students asked him, “How do you deal with all of this as a person? How do you keep a sense of balance?” His answer is still with me. He said, “When I play, I play. I take time to be away from work physically and emotionally. I use the time to recharge.” When was the last time you played? Even a small “time-out” can help you gain better balance and a chance to maintain your moral integrity.

Be vigilant about your moral integrity—never take it for granted. Be careful to take time for self-assessment and think about your strengths, weaknesses, and moral bottom line. This process should help you avoid being deluded by self-deception. Self-deception is not just about lying to yourself. It includes decisions like choosing to be ignorant, ignoring the unpleasant, becoming emotionally distant, and rationalizing your behavior. Being true to yourself is not easy, but it has great long-term payoffs for a life well lived.
Summary

This discussion provides some insight into moral integrity and why it is difficult to maintain. It would appear that our culture rewards those who compromise their morality for financial or other reasons. As I write this, some baseball players are under attack for using steroids as a way to break all-time records for home runs. These players decided that individual glory and economic advantage outweighed their loyalty to the game. Imagine tarnishing an American treasure—baseball. The news pundits are already talking about what message this is sending to little leaguers everywhere.

As a health care administrator, you have the power to affect something much more important than baseball. If you believe the authors you have read, trust is the basic commodity of your business. Your actions and leadership qualities are called on to run a fiscally sound organization. But perhaps more important, they can help restore trust in the health care system and its organizations. Admittedly, it will not be easy. You will have to make a conscious choice on a daily basis to cultivate and maintain your moral integrity. You will have to be courageous enough to do what is right even if you do not personally benefit from that decision. You will also have to be willing to base your reputation on the moral position that you take. You can help to create a working environment where moral integrity becomes the norm rather than the exception. The last section of this chapter gives you challenges and ideas to assist in maintaining your lifelong efforts to serve health care as a moral leader.

10 Challenges for Maintaining Moral Integrity

The following 10 challenges are designed to assist your process of refining and maintaining your professional moral integrity. Each of the challenges requires introspection and a time commitment to reap positive benefits. I have included some comments under each of the challenges to give you additional insights and encouragement. This list is one that you can revisit at different stages of your career and use to confirm or re-establish your moral center. It will also help you with the final exercise that is part of Chapter 15.

1. Prepare an answer to this question, “Why do I want a career in health administration?”

Comments

On the surface this seems like an easy question. Some of my students would jump to an answer and say, “So I can earn the big bucks and buy fast cars.” Obviously, no one chooses a career in health administration to be poor—not even those who serve in public health where salaries are historically low. However, believe
it or not, the “material goodies” do not compensate for having a job that is unsatisfying or, at the worse, one that you hate.

Your reasons for wanting to be a part of this enormously challenging career are as individual as you are. However, when you get to the essence of most people’s decisions to choose and remain in a career, you see two powerful forces. The first is to make a difference through service and the second is to engage in meaningful work.

We can start with making a difference. What would happen if you chose a different career? Are there things that you can contribute through that job that will make a difference to your staff, your organization, and your community? When I consider these questions, I recall the root of the word “vocation.” It actually means having a calling rather than finding a job. If you are called to health administration, it means that you are willing to stay there even when things are not so pleasant. It means that you are willing to make a commitment to prepare yourself intellectually and ethically so that you can make a difference. It also means that you are willing to go beyond the minimum or “duties as assigned” to accomplish what is needed. Your goal is to create a better organization for your staff, patients, and community and really make a difference.

Of course, Frankl (1971) would encourage you to consider how your work contributes to your life’s meaning. Meaning, he tells us, comes from what you take from the world, what you give to the world, and what you choose to love. When service becomes a focus of your work, you are more likely to view it as a source of meaning rather than as drudgery. In contrast, if you view your work as meaningless and see yourself as just another cog in a great bureaucratic wheel, you can exhibit poor performance, unnecessary stress, disloyalty, and even depression. It is easier to be a shadow leader or even to succumb to evil when your work has no meaning.

The key becomes how you find this meaning and a way to make a difference on a daily basis. First, as Frankl (1971) reminds us, you must always remember that you have a choice. You can choose to take even small actions that create a positive work environment. You can choose to be a role model for moral integrity through your actions. You can choose to make a lifelong commitment to moral integrity. It is also helpful to remember how important you really are to your staff and your organization. Although your profession does not get its own TV show like the clinical staff does, your actions make saving lives possible.
2. Conduct a personal moral integrity cost/benefits analysis.

Comments

Does this sound strange to you? Would your economics or finance teachers wonder what this one is all about? First, I am not suggesting cost/benefits analysis in its traditional definition where dollar values are assigned. In my version, you assign a career “cost” to a decision to help you decide if it “benefits” your moral life. For example, you draw up a table to help you make a decision whether or not to accept a job promotion. Then, by filling in the blank cells, you can do cost/benefits analysis to help you arrive at the best decision for your moral health. Your table might look like this.

### Decision:

<table>
<thead>
<tr>
<th>Moral costs for making the decision</th>
<th>Benefit for making the decision</th>
<th>Moral Costs for NOT making the decision</th>
<th>Benefits for NOT making the decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notice in my example that I included columns for *not* accepting the promotion. The cost/benefits analysis of *not* choosing an action can be just as beneficial to your moral health as choosing the action, but this option is not always considered.

A simple self-brainstorming technique can help you think about possible benefits and costs. Remember to think “big picture” and include your family in the benefits and/or costs. They are often the beneficiaries or bear the emotional and financial burdens of your decisions. You can also use this technique, in addition to your fiscal and risk analysis, to assist in making organizational decisions that involve moral issues.

3. Define your “moral bottom line.”

Comments

This challenge is worthy of a television reality show such as *Survivor*. You are asked to establish the criteria that, if met, would cause you to resign from your job. It asks you to identify what you are really worth. Will you compromise when you know that your
boss is doing something illegal? What if it is legal but immoral? You might struggle with this for a while, but it is important for you to assess this area for your life career. Having this information can also help you decide whether or not to take a position in the first place. For example if, after doing your homework and participating in interviews, you detect something that would compromise your bottom line, your decision is easy. Do not take the job.

Your moral bottom line does not have to be solely about things that would cause you to resign. You need to identify those principles that will cause you to take action or speak out in meetings, even if it makes you unpopular. Because no one wants to be known as a complainer—or worse, a snitch—this is also a difficult assessment to make. The thing to remember is that failure to speak up or to provide a different view can actually lead to disaster. In several textbooks, this failure is called groupthink. It exists when no one wants to say anything that might offend the leader or appear to be disloyal. The result is a decision based on incomplete or erroneous information and can be a disaster for the leader and the organization. So, it becomes very important for you to assess and articulate these principles. The last thing you want to have to say is, “I knew and I should have said something.”

4. Engage in directed activities to build and maintain your moral integrity.

Comments

There are a variety of options available for taking on this challenge. However, all of them are useless unless you make a choice to do them. In your already busy world, it might seem unreasonable to take on yet another “thing to do,” but the payback is worth the effort. Remember to start small and simple so you will make this practice a part of your daily life (just like showering or brushing your teeth).

Palmer (2000) suggests several techniques that can be used for moral integrity. First, you can try keeping a journal. This technique is a variation of “freedom of speech.” You are free to write anything without any censor or restriction. You do not need any special books or tools, just paper and pen or computer. You do not have to write in your journal every day. However, it is a good idea to set aside time to write an entry at least once a week.

You can use a rhetorical question to gear your journal toward your moral integrity issues. Any question or issue that is of concern to you will do. You can ask yourself, “What is morality to me?” Or, “What is the moral way of dealing with this situation?” Or, “Who could be hurt if I make this decision?” Then just write. Keep writing until you have captured all of your thoughts about your question. I usually set my journal aside for a day or so and then go back
and read it. There is often some practical wisdom in my musings that can really help my decision making. I also save my journals and read about former areas of concern. This review helps me see how much I have grown as a person.

Reflection is also a way to foster growth in moral integrity. Reflection usually requires a trigger event or source to guide it and gear it toward moral issues. You can use actions of others and think about what you would have done if faced with that situation. You can use events in the news and reflect about the moral issues that relate to them. Certainly, with all of the corporate and personal scandals that have eroded trust in American business, sports, and even churches, you should not lack sources for moral integrity reflection. Sources for reflection do not have to come from the work setting. The arts can provide some great reflection opportunities. For example, photography captures a point in time and can lead you to muse about morality and growth. You can look at the photo and ask, “What would I have done or felt at that point in time?” Similarly, movies can illustrate many areas of moral and immoral behavior for consideration. In fact, Johnson (2001) features many movies in his book and provides ethical thematic analyses of them. His suggestions include *Dead Man Walking*, *Twelve Angry Men*, and *Schindler’s List*. I am sure you can find many more examples, including movies that relate specifically to health care such as *The Doctor* or *Hospital*. Regardless of your choice, take time to reflect on what critical moral decisions the characters experienced and what they did. How did the decisions affect the person and the organization? What would you have done in that situation?

Do not neglect the power of literature to create areas for reflection. I particularly like poetry because it can affect me emotionally as well as intellectually. One of my favorites is *A Brave and Startling Truth* by Maya Angelou. I have also had great conversations about moral integrity that centered on novels and short stories. You can find book clubs that reflect on the moral issues presented in a specific novel. If you do not have time to read for “fun,” then use your journal entries to spark this process. The main idea is to think about moral integrity and how you will practice it. You cannot assume integrity will be there without taking direct action to help it grow.

5. Identify a moral mentor.

*Comments*

Do you know a person whom you consider to be a highly moral leader? Is there someone who could serve as your moral mentor or as a role model for you? You have already heard about the benefits of mentoring in some of your courses. Perhaps some of you have completed internships or residencies where you were assigned a
This person taught you the inner workings of the organization and made your transition easier. A moral mentor, however, is someone who is willing to go beyond sharing information about how things work. He or she is willing to hear and understand your deepest professional concerns in confidence and provide guidance without judgment.

Because the health care system increases in complexity almost daily, it will be normal for you to have concerns and questions about the right thing to do. It is possible that you do not want to “lose face” by expressing them too publicly. This is where a moral mentor can be invaluable to your career. He or she will let you think through your options and conduct a verbal moral cost/benefits analysis. Your mentor will not solve your problem for you but will guide you in selecting your best plan of action.

How will you find a moral mentor? First, be observant. Observe how people interact with their staff. Are their behaviors consistent with their words? Can they be trusted? Second, when you identify such a person, take time to get to know him or her. See what he or she is like in a variety of settings. Is this someone you can trust?

If the answer is “yes,” make an appointment to talk with this person. Ask if he or she will be your moral mentor, and observe the reaction. If there is any reluctance, do not pursue it further. It has been my experience that if you choose carefully, the person will be honored to be your mentor. However, keep in mind that your mentor has many other duties. Do not abuse the privilege of having a personal adviser by engaging in “whine sessions” or “pity parties.” Instead, come to your mentor with the tough decisions and listen to his or her wisdom. The advice you receive will be a valuable asset to cultivate and maintain your moral integrity.

6. Examine your life experiences (successes and failures) and find their moral lessons.

Comments

This is a difficult challenge. It is easiest to start with your successes. You all have had shining moments when you achieved your goals and made yourself and your family proud. List those accomplishments and next to them write the moral lessons you learned from them. For example, one of my shining moments was the first time my major professor called me, “Dr. Morrison.” Because I was working full-time and raising a family, completing my doctorate was not easy. So this moment meant a great deal to me. My moral lessons were: Everything has a price, but the price was worth it; and follow your heart, even when you are tempted to give up.

Now look at the areas of which you are not so proud. All of you have actions you wish you had not taken, decisions you wish you
10 Challenges for Maintaining Moral Integrity

had not made, or words you wish you had not said. For this part of the challenge, you need to list at least some of these areas. Because they are in your past, you cannot change any of them. However, some good can still occur from these experiences. Beside each item on your list, think about a lesson that you learned from this experience and write it down.

Finally, go beyond just writing. Use these lessons, regardless of where you learned them. They can help you in the future by teaching you what to do and what not to do. In taking this last step, you can increase your moral integrity through the analysis of your own experiences.

7. Design a prevention plan to avoid moral derailment.

Comments

As you increase your success in your career, unfortunately there will be increased potential for moral derailment or moving closer to the shadow side of leadership. All of us have aspects of our personalities or behaviors that can cause us to derail as administrators. You need to have a plan to avoid derailment and understand its causes.

First, you need to think about who you really are as a person. For example, how do you feel about power? You already have it or will have it. Without power you could not be in an administrative position. But what will happen when your power increases? Will you maintain your judgment and humility or will it become the center of your life? Will you use your power to help others or to benefit yourself alone? The answers to these questions need to be formulated before power becomes an issue, and they should come from introspection as you look deep into your heart.

What about privileges? They can be a great temptation if you put too much value on them. They can also lead to shadow leadership if you see your possessions as a reflection of who you are. How much is enough for you? Are you what you wear and what you drive? While you will no doubt live comfortably as a health care administrator, you are part of a culture that puts great emphasis on externals rather than people. You might be tempted to buy the latest car or the best piece of real estate.

One of the many lessons that the events of September 11, 2001, taught us is that impressive creations and material possessions can be taken away in an instant. But as the death toll rose on that tragic day, what turned out to be of utmost importance were compassion, service, and heroism. These remained even when the man-made buildings were rubble. Perhaps there are moral integrity lessons to be learned from the loss of privilege as well as from gaining it.

Another way to move toward the shadows of leadership is through deceit. However, it is not just about lying to others or covering up
the misdeeds of those in higher positions. Sometimes we practice self-deception as leaders. McGinn (2005) expresses the caution that the ability for self-deception is almost limitless. You will be required to make difficult decisions when the solution is not easy to implement. In order to be successful in these cases, you must be able to stand up to pressure, motivate yourself, and have courage. Practicing self-honesty instead of self-deception requires that you take time to think. Ideally, you should have a minimum of 30 minutes per day to be alone and practice self-reflection. While this can seem like just another demand on your time, it pays off in terms of more effective and morally sound decisions for yourself and your organization.

McGinn (2005) discusses another shadow area that can easily trap you—complacency. When you become too comfortable with your job, you can cause yourself trouble. Complacency, he asserts, happens when you are too confident and become saturated with your success. It can also happen when you stop paying attention to the signs that warn you of trouble. When you are complacent, you think everything is just fine when, in reality, you might be in a downward spiral.

McGinn suggests that you stay away from the shadow of complacency by pushing yourself to make a difference and not just to do a job. You need to find a way to measure your success and use obstacles as challenges and opportunities. I agree with McGinn that caring about your work to the point of being passionate about it helps you avoid complacency. If you are passionate about the work, you will always want to learn more and strive for higher goals. Frankl (1971) would ask, “What makes your work meaningful?” Finding the answer to that question will help you avoid complacency because, if your work is part of your life’s meaning, you cannot take it for granted.

8. Engage in PQI.

Comments

You remember that PQI is my morality version of the total quality improvement/continuous quality improvement process. Think of your life beyond the work environment. Do you have a life fully lived? Do you work to live or live to work? McGinn (2005) suggests that you need a “work/life synergy” (p. 59) where your life and work augment each other. Your life experiences contribute to your overall moral integrity by providing physical, mental, emotional, and spiritual resources. You can bring these resources to your job.

Just how does this happen? Start with the most obvious: your physical health. Because you have only one body, you will want
to keep it as healthy as possible for as long as possible. However, your body cannot accomplish this task without your cooperation. It means that you must do what you counsel others to do—eat in moderation, exercise, take time to rest, and sleep. Yet, too often we think of physical selves as the exception. We ask our bodies to function without even the minimum of care. The truth is that you cannot take time for moral reasoning (or any kind of reasoning, for that matter) when you are tired, hungry, and out of shape.

How about your mental and emotional health? Are you learning and experiencing new things, or fighting to keep everything the same? In health care, we have no choice but to be lifelong learners. The changes happen too fast not to be on an active learning curve. How about the emotional side? Health care makes demands on you in that area as well. Yet, you cannot afford to get too blue, lonely, and stressed. Your effectiveness as a leader would surely be compromised.

To rejuvenate your emotional resources means to take time out for recreation. Remember my story about the chaplain? He took time to renew his mind and his emotional health through play. When was the last time you played? Hemsath and Yerkes (1997) created an entire book called *301 Ways to Have Fun at Work*. Their examples come from highly successful corporations and illustrate the impact of fun on morale and productivity. What about outside of work? What activities can you do to renew your resources? My students are able to create long lists of these activities. Actually doing them becomes their challenge.

Social health is also a component for building moral integrity. We all learn from our friends, especially those who know us well enough to be caring and honest. While you might not always like what you hear, when it comes from your friend's heart, it is worth hearing. Friends listen even when they have heard you talk about something many times. Having this empathetic sounding board is critical to your moral development because it lets you process your thoughts in a nonjudgmental and supportive environment.

There is a caution here. You cannot have this level of friendship without investing time and energy with your friends. It cannot be one-sided. Sometimes this means that you have to be the one to listen even when you do not feel like it. It can also mean that you have to show up and support someone when you would rather do something else. For true friendships to exist, they must be cultivated.

There are so many writings about emotional health and how to care for it that we would need another book just for this topic. There are two concepts that have been especially helpful for me in my roles in health administration. One is a phrase from a Beatles song, “Let it
be.” Sometimes you just have to let go of whomever or whatever is causing you emotional stress. This is especially true if it happened in the past, because you cannot change the outcome. I try to ask myself, “Did I do everything I could about the situation that was so stressful?” If my answer is “yes,” then I know that I should let it go. I also use the phrase, “It is not about me,” to remember that there are always at least two sides of a situation. This realization helps when you get a reaction that is not expected or when people say things that are rude or hurtful. Maybe they are having a bad day and the reaction has nothing to do with you. Try not to take it personally; this axiom is often used in business. Often, this is easier said than done, but reminding yourself that you might not be the source of the problem does help with maintaining positive emotional health.

9. Have a rich and varied spiritual life.

Comments

I mentioned spiritual health as a component of PQI. Your spiritual well-being is so tightly connected to maintaining your moral integrity that it presents its own challenge. Johnson (2001) gives a model for your spiritual maturation that is similar in some ways to the Kohlberg model of moral development. This model gives insights about the process you can use to become spiritually centered. Reflecting on your beliefs, understanding your part in the world, and learning to deal with life’s struggles and disappointments are all part of this process. Johnson also gives some specifics for exploring your internal and external spiritual health.

Spirituality that you practice in private can be enhanced through contemplation using either the Western tradition (connecting to God) or the Eastern (opening your mind). Prayer or connecting to a higher spiritual center, or what Frankl (1971) calls the ultimate meaning, is also a part of this process. Prayer helps you to concentrate on your spiritual issues and learn patience. Johnson (2001) includes study as part of private spirituality. This technique helps you to concentrate and explore various concepts related to spiritual health. Study includes reading and being present in nature as inspirational sources.

Spirituality that you practice in public can get you back to basics. If you can learn to bypass the glitz and dig deep into what is really important, you can have a deeper spiritual experience. For some, this can mean divesting themselves of things that once seemed so important, but that now feel like burdens. Living more simply allows more time and energy to live more spiritually.

Johnson (2001) suggests that you spend time alone, in silence, and in service as techniques for spiritual growth. The discipline of solitude is very difficult for most Americans because we live in such a sensory-
10 Challenges for Maintaining Moral Integrity

saturated environment. Still, the effort to find time for solitude can reward you with insight and ways to maintain your spiritual balance. Service is a major component of your public spirituality. Johnson defines it as putting others first when you are not rewarded for doing so. Your motivation is not to be recognized or receive prizes for your actions. Instead, you practice altruism in the fullest sense of that word. When you are engaged in service just because it is needed, you will find gratitude for the experience and be humbled by what you learn.

10. Work to create a climate of moral integrity.

Comments

This last challenge asks you to go beyond yourself and provide an opportunity for others to experience their own moral growth. You can provide a workplace where moral action is considered the way things are done. Such a workplace might be counter to our current culture. Those who strive to become better people or to treat everyone with respect might be viewed as trying to be “holier-than-thou.” Conversely, they might be considered naive for not taking advantage of their power. Cheating, dishonesty, and other moral flaws are sometimes mistaken as good actions when they get you ahead of the next person. But can you imagine trying to manage a department where everyone is out to get everyone else? Where would that lead?

Part of the creation of a morally centered workplace starts with you because, as the leader, you model the actions that you expect from others. Your behavior sets the climate for what is acceptable and what is not. For example, if you say you believe in diversity, then you must put together teams with this in mind. While you might not get much ego stroking from this, you could get answers to problems that really work. If you say that patient care is your real mission, you must do all you can to make this a reality in your department and organization.

Johnson (2001) advocates using practice-based “servant leadership” as a way to increase moral integrity in your department. This means that although you are a leader, you are also a servant to your staff in that you care, listen, accept, grow, and build community. Viewing staff as an asset instead of a liability can go a long way toward creating the trust needed for a morally centered workplace. Some bosses will criticize you for being a servant leader because they think you will lose control over “your people.” These are the leaders (and bullies) who prefer to use intimidation and fear to keep staff in line. The use of force and fear are only productive for a limited time and as a tactic do not work for all employees. The best way to lead is to understand the people with whom you work. Then you can choose the best way to work together so that goals can be met for the benefit of patients and the organization as a whole.
These 10 challenges are not easy ones; they will take time and thought. I hope that you will continuously work on them after you complete your course and enter the workplace. The ideas that these challenges generate will assist you with a major challenge that is presented in Chapter 15. Remember that this is a process, so be patient with yourself and others. The rewards for making this journey can be life affirming and life giving.

Web Resources

The Holocaust and Administrative Evil
http://www.ushmm.org/

A Brave and Startling Truth, by Maya Angelou
http://www.inspirationpeak.com/poetry/bravetruth.html

References


Codes of Ethics and Administrative Practice

“In the arena of human life the honors and rewards fall to those who show their good qualities in action.”

—Aristotle

Points to Ponder

1. Why do professional groups and associations create codes of ethics?
2. What are the key features of your professional code of ethics?
3. What can you learn from the codes of other health professionals?
4. What are the limitations of codes of ethics?
5. How can you apply your professional code to your practice as a health care administrator?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

ACHE Code of Ethics Ethical Policy Statements
self-regulating
CHAPTER 14  CODES OF ETHICS AND ADMINISTRATIVE PRACTICE

INTRODUCTION TO CODES OF ETHICS FOR PROFESSIONALS

From the time of Hammurabi and Hippocrates, attempts have been made to define the relationship between professionals and society. Because professionals have power over others, codes have been developed to use ethical reasoning to delineate their responsibilities and limit the abuse of their power. Codes have also been used to describe the necessary characteristics for membership in a professional group. In health care, codes of ethics for professionals do not replace those developed by the organization in which you are employed or those mandated by external organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association. Rather, they provide guidelines for your deportment as a professional within an organizational setting.

The major code of ethics for your practice as a health care administrator was developed through the American College of Healthcare Executives (ACHE), and it defines expectations for your ethical conduct as a professional. You will study the features of this code including its practice guidelines so that you are more aware of the expectations surrounding your use of the title of health care administrator (HCA). You will also survey features of codes from other groups of professionals and examine the wisdom those codes provide for your own field of practice. To balance the discussion, you will review the limitations and criticisms that have been made about the professional’s codes. Finally, you will be presented with five challenges that will help you define what a code of ethics means to your future practice of administration.

WHY BOTHER WITH CODES OF ETHICS?

Why would a group of professionals spend the time, energy, and ink developing a code of ethics for its members? Why not just say, “Do the right thing” and let that be enough? As you have seen, it is never that simple, particularly in the health care environment. You will continually face situations where an ethical course of action is not clear. In fact, these gray areas can be so disturbing they cause you to lose sleep at night. Codes of ethics can give you greater guidance and wisdom for making decisions. They are based on the past experiences of leaders in your profession (remember rule utilitarianism). Codes of ethics also serve as a prevention tool or “ethics vitamin” that sets boundaries for acceptable behaviors. This should assist you in avoiding some of the quagmires and shadow areas that could jeopardize your career. Of course, this assumes that you know your code and try to live your professional life according to its tenets.

Davis (2004), at the Center for the Study of Ethics in the Professions (CSEP), suggests that using an ethics code can assist professionals in
Why Bother with Codes of Ethics?

Defining themselves as members of a given profession, Codes serve as a defense for the decisions you make—and the decisions you refuse to make. Codes help define your boundaries when you act as a professional and help you justify or avoid certain decisions. Codes also help to determine minimal acceptable standards for the members of a profession. This function protects you from those who are less-than-ethical members of your group. However, because the decisions of any one member can reflect adversely on all, you must be willing to take action when your standards as a professional are violated. This means that you must be self-regulating.

Harris (in CSEP, 2004) also supports the concept that codes provide guidance about your role and responsibilities when you assume the title of professional. Adherence principles laid out by ethics codes can serve as a reminder about how to deal with specific situations as they arise and help to foster a more ethics-based workplace. He, along with Davis, stresses the need to analyze your ethics code and adapt it as needed. Finally, codes can be used to educate others including the community at large about your professional values and responsibilities.

Worthley (1999) presents information about organizational codes of ethics that can also be applied to your professional behavior. Codes are not just words; they are designed to regulate your actions. This is particularly evident when they are a part of practice legislation for licensure. In this situation, violations of the codes can lead to punitive action including being stripped of the license to practice. As a health care administrator, you are not licensed and do not currently face this aspect of regulation through codes.

However, his second function of codes does apply to you. Codes serve as a standard of practice that assists you in knowing your profession’s expectations. This knowledge can be used as a tool for problem solving. Worthley (1999) suggests that there are certain criteria that must be met if these standards are to prove useful in practice. First, you must know that they exist. This sounds almost silly, but you would be surprised how many professionals are clueless about the standards under which they practice. Second, you must understand what the standard is asking of you and be able to implement it. For this reason, the standard must be based on actions, not just theory, and remain reasonably stable over time. You cannot adhere to standards if they change too rapidly or capriciously. Finally, to be useful, the code must assist you with real practice issues. Without these features, a code becomes just a theoretical document with no relevance for your daily life as an HCA.

Codes are the most commonly used ethical device for professionals (Johnson, 2001). They help to define your position on ethical issues and provide an expectation for those who interact with you. If you use them, codes provide some protection from lawsuits and increasing
external regulation. As an HCA, your goal is to be self-regulating. You make the choice to maintain high standards of practice because it is the right thing to do. If you truly self-regulate, the public will put an extraordinary amount of trust in you. However, self-regulation is not absolute. If enough HCAs violate the trust placed in them through self-regulation, the public will demand that you be licensed like many other health professionals.

Codes of ethics help you resist behaviors that can lead you toward the shadow side of administration (Chapter 13). However, to be effective, they must contain certain features (Johnson, 2001). First, they must explain the minimal standard of acceptable behavior rather than make global statements. For example, the ACHE Code of Ethics (2003) includes specific areas of concern and supplementary materials called Policy Statements. These Statements delineate the organization’s recommended actions for specific situations that are reviewed and revised frequently.

Codes can help you act responsibly when they are designed for everyday practice; they use unambiguous language and are based on moral principles and theories. You should be able to identify the action to take and the rationale behind this action. Codes should be living documents that are used in practice and not just something you memorize in the classroom. They should be an important tool for operation and discussed frequently with fellow professionals. Finally, codes should be relevant to your profession and assist you in formulating your ethics position on issues that affect your profession, organization, and community.

Ethics has not always been the center of health care business practices, but self-regulation has always been expected (Darr, 2004). Codes for professionals serve to assist administrators who “want to do the right thing but need help determining what it is” (p. 62). For professional codes to be of benefit, they must be included in the educational process. However, if you are educated about them, but do not use them, they cannot serve as a resource. This is why Darr stresses your need for continuing education and discussion about ethics issues and codes.

In summary, no document is perfect, but the knowledge and use of an ethics code can assist you in determining the standards and expectations for conduct. It allows you to use your title with the full understanding of what it means to those in your profession and in the community. A code also protects you against others who choose not to abide by professional standards and helps you “know them by their deeds.” The choice to avoid association with these kinds of HCAs can protect your reputation and that of your organization. It also challenges you to truly practice self-regulation by not hiring unethical individuals and by taking action against their behaviors when necessary.
When appropriately written, codes provide guidance for decisions in the gray areas of health care. They can be used to foster a more ethics-based workplace by allowing you to be consistent in your actions and to educate others about your standards of performance. Remember that your words and actions have great power and that, as the leader, you set the moral tone for your workplace. If you are consistent with your own professional code, staff will have a better understanding of how you will make decisions and the rationale for those decisions. This understanding should be accompanied by greater support for you as a leader and for the decisions that you make. Finally, codes make it easier for you to avoid the shadow areas of leadership by giving you a fallback position and a way to avoid future difficulties. They allow you to decide not to take a position on issues that might be a violation of your ethics code.

**CODE OF ETHICS FOR THE AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES**

As HCAs, you can use the ACHE Code of Ethics as a mechanism for knowing the standards and practices of your profession. The ACHE Code of Ethics and Ethical Policy Statements (2003) can be found on the Web site listed in this chapter and are updated frequently. Notice that in this Code, your primary ethical duty is to serve those who seek health care. You fulfill this duty by working to create a better health care system in any way you can. You are also obligated to consider more than the financials when you make decisions. The community’s rights and needs must also be a part of your decision making.

The Code (ACHE, 2003) divides your responsibilities into eight areas involving the needs of your profession, patients, organization, employees, and community. Further clarification of your responsibilities and behaviors is included under each area. For example, you have a duty to your profession to act in a manner that honors it. You must also be careful not to use your power and knowledge to further your own finances or betray professional confidences. Avoidance of conflicts of interest is also expected.

As part of your duty to the patient, you are supposed to protect individual rights and resolve the conflicts when patients and staff’s values differ. Protecting patients’ rights also means that you preserve autonomy, protect confidentiality, and do not tolerate abuse. Quality assurance also is viewed as part of your duty to the patient because it serves to provide an environment where the best patient care is possible.

You also owe a duty to the organization in which you are employed. This involves being truthful in your communications, implementing a code of ethics for the organization, and providing the resources for the
staff when ethics issues arise. You are to be vigilant about your accounting practices to avoid fraud and abuse. When considering employees, you have an obligation to create a place where ethics is the norm. You must also protect employees from harassment and create a safe environment where they can use their talents to benefit patient care.

Finally, the Code (ACHE, 2003) provides examples of your duty to the community. You are to provide information that allows the community to make informed decisions about your services. There is an obligation to assess the community’s health care needs and work to provide access to needed services. While maintaining a strong fiscal position, your organization is supposed to be an advocate for actions that improve community health.

You can certainly see that this Code demands much from you as a professional. These demands are made because you have a great deal of influence and power and you represent both your profession and your organization to the public. When you are a member of ACHE, you are held to standards defined by this organization. Complaints about ethics violations can be made against you, and the College has a detailed process for dealing with complaints. The ACHE Ethics Committee has several actions it can take including censure and expulsion from the organization. While these actions do not carry the same weight as a loss of the licensure, they can have a negative effect on your career. For example, you might not receive positive consideration for new positions, particularly those in higher levels, if you are not in good standing with the College.

The ACHE (2003) goes beyond the code to provide you with Ethical Policy Statements. These statements serve as “mini white papers” on issues that affect your personal and organizational ethics. They define the College’s position on each issue and give recommendations for action. One example I find particularly interesting is their statement about staff shortages. In these recommendations, they expect you to prevent burnout even when shortages exist. You are urged to retain employees by treating them with respect, fair compensation, and flexible scheduling. They also suggest that, when shortages are too severe, you consider closing units rather than compromising care. The recommendations also include a plan for recruiting future employees by encouraging high school and undergraduate students to consider careers in health care.

In addition to the Code and Policy Statements, the College (2003) offers a self-assessment instrument available to use online. This scale measures the frequency with which you engage in behaviors that reflect compliance with the Code. Any answer that falls below the “usually frequent” should be given your attention. Of course, as with any other self-assessment, this instrument is only as valid as the honesty with which you answer its items.
While the Code (ACHE, 2003) provides you with guidance concerning the expected behavior for an HCA, it is not perfect. Some of the eight areas can be too vague to provide you with actual performance standards (Darr, 2004). However, if a code is too detailed, it becomes legalistic and loses its voluntary direction for ethical behavior. The issue in developing a code is to balance specificity with flexibility.

What should you do about this Code? Darr (2004) suggests that your role is to safeguard the public against potential abuse from the health care system. To accomplish this mission, you need well-identified, professional standards and the ability to act on those standards. Therefore, you must use the Code as a tool for self-regulation, even if you are not a member of ACHE. Failure to protect the public and to regulate your own practice can lead to licensure and additional regulation by external agencies. He also encourages you to use the Code because professional integrity is essential for your career progress. Adherence to its basic principles will help you maintain employee and community trust. Finally, using a set of standards should help you be a person of integrity even when there is no financial reward for doing so. He considers this to be “the right thing to do—it is a principle for life and the profession” (p. 90).

Learning from Other Codes

Many HCAs are “bi-codal.” By this I mean that they are members of clinical professions as well as being HCAs. In their education, they have learned the Code of Ethics that is specific to their profession. These HCAs must honor the tenets of both the ACHE Code of Ethics and those of their profession, in addition to the policies of the organization where they work. There is always some congruence between the codes, and therefore application may be fairly simple. Areas like integrity, honesty, appropriate communication, respect for others, and confidentiality are common features among virtually all the ethics codes. However, problems can arise if a provision is in conflict with the organization’s mission. As an HCA you must find a way to make the codes compatible with the policies of the organization, in order to arrive at the best interests of the patient and the community.

Darr (2004) and others go on to say that, even if you are not bi-codal, you can enhance your job as an HCA by familiarizing yourself with the ethics codes of the many other professionals who work under the aegis of the same organization. The Center for the Study of Ethics in the Professions (CSEP, 2004), cites ethics from hundreds of occupations with over 50 from the field of health care. Their Web address is included in the Web Resources at the end of this chapter. While it would be educational to examine all 50 codes, the following section
offers examples from the ethics codes particular to some of the health care professions. These examples will be followed by lessons that an HCA can learn and apply to running an organization that is ethical to patients, clinical staff, and the community.

**Code of Ethics for Nurses**

The Code of Ethics for Nurses from the American Nurses Association (CSEP, 2004) has nine provisions, each with detailed subsections on the subject of moral integrity. For the purposes of this example, I will paraphrase samples of the statutes within Provision 5 on what nurses must do to keep a high standard of moral integrity.

In addition to their duty to their patients, the organization, the profession, and the community, nurses are charged with a duty to themselves. This duty includes the practice of self-respect. One of many ways to achieve self-respect is by striving for the highest professional competence at all times. Continuing education and a commitment to lifelong learning are requisite to keep up-to-date on current practices and procedures. Courses, seminars, and workshops often must be undertaken at the initiative of the individual.

Self-respect also comes by respecting others. Nurses must be open to consult with, and seek advice from, other professionals. Respecting the knowledge and experience of others is a form of self-respect. Lifelong learning, expertise on current procedures, and knowledge gained from other professionals result in the best possible care of each patient and the community as a whole.

Under Provision 5, nurses submit to the notion that their personal and professional lives are inseparable. To practice nursing means being a nurse at all times, in the workplace and in the community. Nurses’ words, actions, and authority in public and in private lives reflect on the entire nursing profession. Paradoxically, they must separate the personal and the professional when communicating with patients, families, and the community. For example, offering advice, instruction, or comfort to their patients is good. Confiding personal opinions or conveying negative emotions is not. It is of utmost importance, under Provision 5, that nurses resist the temptation to compromise their integrity during times of stress, whether it is work-related or personal. Certainly the ability to compromise with others is a necessity to have a well-run department, but they should never violate patient safety or the standards of the profession, even if they are having a bad day. If a nurse finds that his or her professional integrity is at odds with the policies of the organization, Provision 5 states that the nurse can take the stance of a conscientious objector. But pursuant to that stance, the nurse has the obligation to try to effect change—in a respectful manner and working within the system. This is an extreme example, and it places a great deal of responsibility on nurses. They
might even have to put their jobs on the line rather than forfeit their moral integrity. Remember, the objective at all times is to provide the best possible care for patients.

Lessons from the Code

For an HCA, the following lessons can be derived from examining the Code of Ethics for Nurses. By applying the tenets of the nurses’ ethics code, you can become a better administrator.

1. As an HCA you have the responsibility to respect yourself and to balance your personal and professional life.
2. What you say and do in the community carries additional authority because of your knowledge and position in the health care system. Because the community relies on you, you must be careful about what you say.
3. A foundation in theory or business practice is not enough for your actions. There might be times when you have to risk your pride, and maybe even your job, to protect patient safety or the honor of your profession.
4. You must commit to lifelong learning. On your own initiative, take steps to ensure your own competency by being up-to-date on the latest procedures and taking continuing educational classes. Changes in health care systems and procedures are rapid and can sometimes seem chaotic. Do not be caught off guard by changes taking place in health care.
5. Be willing to compromise, but never compromise your integrity. In times of financial trouble, for example, you might be tempted to indulge in creative accounting or to cut corners. Look for alternative solutions. Compromise, while necessary, should never jeopardize patients or injure integrity—yours or that of your organization.

Code of Ethics for Pharmacists

Pharmacists have a code of ethics (CSEP, 2004) that was written by the American Pharmaceutical Association. It defines the principles, roles, and responsibilities of practicing members of this profession. Interestingly, the word “covenant” is used to describe the relationship between pharmacists and their clients. As defined by Merriam-Webster, a covenant is a “formal, solemn, and binding agreement.” This implies a moral obligation for the pharmacist to establish trust with and respect to the patient. In the Preamble to the pharmacist’s Code, patients or clients are described as the center of pharmacy practice. Emphasis is placed on respecting their dignity and autonomy. The actual Code is brief but stresses areas like maintaining competence and integrity, meeting the needs of the community, and acting with compassion.
Lessons from the Code

Even though it is brief, this Code provides valuable lessons that can be applied to your practice as an HCA.

1. Patients, and “clients,” are at the core of a pharmacist’s mission. Who are your “clients” as an HCA?
2. Apply the definition of covenant to your relationships with patients, staff, and fellow administrators. You have a “formal, solemn, and binding” duty toward them.
3. “Trust” is paramount in the Pharmacists Code of Ethics. Why is this? How does trust apply to your job as an HCA?

Code for Dental Hygienists

Health care takes place in many settings and encompasses many professional groups. The following is an example from the dental health component of health care and provides some lessons that HCAs can easily emulate. The Code is for dental hygienists, licensed professionals who, along with the dentist, provide preventive and therapeutic services. The Code of Ethics for Dental Hygienists is actually a series of documents that includes Standards of Practice and Principles of Ethics (CSEP, 2004). The Standards of Practice provides a detailed explanation of the hygienist’s role in assessment, treatment planning, implementation, and evaluation. The expectations for performance in each of these areas are made clear and provide a foundation for ethics-based practice.

In the Preamble of the Code (CSEP, 2004), dental hygienists are charged with living “meaningful, productive, satisfying lives that serve us, our profession, our society and the world” (¶ 1). This statement suggests that dental hygienists are more than cleaners of teeth; they have lives that must be fully lived beyond their professional roles. The Code also presents the foundational concepts and beliefs that are used to formulate its recommendations. They include the idea that people have value and should be allowed to make their own choices. In addition, dental hygienists are responsible for the quality of the care that they provide as part of their ethical obligation.

The Code itself is quite lengthy but is based on principles you have studied in this text. Mention is made of the value of trust, autonomy, beneficence, nonmaleficence, and justice. Additionally, dental hygienists are cautioned to avoid self-deception and to work toward their optimal personal health. Responsibility for maintaining professional competence through continuing education is also stressed. The Code spells out the dental hygienists’ duties to clients, colleagues, employers, the profession, and the community. This description provides clear direction for providing client services in an ethics-based manner. Finally, the Code includes a section on the ethics of research. Mandates
are presented for determining the benefits to subjects and the necessity for communicating results honestly.

**Lessons from the Code**

The Code of Ethics for Dental Hygienists (CSEP, 2004) is a detailed document, but you can separate out pieces that pertain to you in your practice as an HCA.

1. Again, in this Code you see the reference to ethics as part of your whole life and not just your professional one. The Code goes one step further and specifies that you have a moral duty to be physically healthy. Frankl would be proud.

2. Ethics statements for dental hygienists go beyond a code and include standards of practice. While this may seem too detailed for some, it does help to establish professional boundaries. Efforts to codify practice standards for HCAs have been underway for many years, and someday will be available for both educators and practitioners.

3. This Code demonstrates roots in common with other ethics codes, for example, the ethical principles of autonomy, justice, beneficence, and nonmaleficence. You can use these roots as a beginning when you design your own ethics code.

4. While the lofty principles expressed in this Code can be translated into specific recommendations for action in practice, balancing inspiration and practical application makes this a useable code.

5. Research ethics is prominent in the Code. A moral approach to research includes being truthful to the participants in a research project, and to do them no harm. How can you apply this principle to your practice of administration?

**Code of Ethics for Counselors**

The field of mental health includes unique ethics challenges because these practitioners serve clients who are in their most vulnerable state. Essentially, patients are disclosing their most private information to a total stranger. As you can imagine, counselors have the immense power and the potential for great benefit or harm because of their relationship to the client. Obviously, trust and confidentiality are critical. In order to foster a healing environment for clients, the Code of Ethics for Counselors created by the American Counseling Association (CSEP, 2004) is not just detailed; it is prohibitive.

The code contains eight major sections that provide specific information about client relationships and professional expectations. In the Client Relationship Section (A), there are guidelines about disclosure, choice, and patient dignity. There is also a section on dual relationships and specific language prohibiting sexual intimacy with clients, an area
not found in other codes. This section even spells out how long a therapist must refrain from having a personal relationship with the patient, even when therapy has ended (two years), and defines the nature of those relationships. This can seem to be a simple matter—do not date your clients—but it is actually more complex. What if you live in a small town and attend a holiday party where you encounter three of your clients? What should you do? Your action needs to protect their right to privacy, without causing embarrassment. This section is so detailed that it even prohibits bartering for services, dictates the use of computers, and has strict procedures for termination of a professional relationship.

Because it is so critical to counseling practice, there is an entire section on confidentiality. The section describes gray areas in which counselors can have heavy responsibilities, such as confidentiality when working in groups, dealing with minors, and maintaining client records. This section also includes confidentiality requirements when engaging in research, training students, and consulting with fellow professionals. As a cornerstone of client trust, this area must be given serious consideration.

Other equally detailed sections include clarification of a counselor’s duty to maintain professional competence and honor their colleagues. Counselors are expected to seek assistance if they experience personal impairment. They are also cautioned against advertising, providing advice on the media, and using their position for unethical personal benefit (such as financial gain or sexual favors). Counselors also have duties to comply with the moral standards imposed by their colleagues and licensing associations. These include submitting to regular professional reviews, being monitored for professional conduct, and refusing to accept referral fees.

Other sections of the Code (CSEP, 2004) deal with counseling functions such as client assessment and the use of psychological tests. A section on the responsibilities of counselors who serve as teachers is also included. It acknowledges the unequal power relationship between teacher and student and forbids sexual relationships between the two. It also stresses the responsibility to present a variety of theoretical viewpoints, design safe and effective self-growth activities, and maintain high levels of professional conduct.

The last two sections of the Code (CSEP, 2004) deal with the practitioner’s responsibility for research and for resolving ethical issues. The research section (G) contains detailed information about treatment of subjects, informed consent, and publication of results. Counselors also have the responsibility to report suspected ethics violations and cooperate with all investigations of the Ethics Committee. Finally, the Code contains Standard of Practice for each of the eight sections. The Stan-
Learning from Other Codes 305

dards clearly spell out the responsibilities and prohibitions expected for ethics-based counseling practice.

Lessons from the Code

This is one of the most detailed codes of any that have been presented. It can seem like “overkill” in some cases, but remember the potential for benefit or harm that lies in the counseling relationship. The level of detail most definitely provides a guide to acceptable behavior for the individual practitioner. The Code, while based on theoretical principles, also reflects rule utilitarianism. Areas have been included because, in the past, they have caused someone difficulty either ethically or legally. What lessons can you glean from this Code of Ethics?

1. Respecting the patient’s right to confidentiality is a prominent theme in this Code. These are also areas of great concern to you as an HCA. You, too, have access to confidential information about employees, and this confidentiality must be kept sacred. You also have knowledge about your organization that, if disclosed, could lead to financial losses or more serious consequences. You are trusted and your ability to maintain that trust is important to your current and future career.

2. This Code has many sections regarding personal relationships with counselors’ clients and students. These sections should make you think about power inequity and the appropriateness of certain behaviors of an HCA. While you are human, you should give great thought to the cost of workplace romances, particularly with your staff. These situations can be awkward at best and leave you open to accusations of favoritism. When they go bad, you are vulnerable to charges of sexual harassment that, even if unfounded, can play havoc with your life and career potential.

3. In this Code you can easily see the burden of competence that is placed on a professional. No one will force you to maintain currency in your field; it is something you should choose to do. There is so much to learn as an HCA that you will need to continuously update your knowledge base. You will be challenged throughout your whole career.

4. This Code parallels the ACHE Code in its inclusion of conflicts of interest as an ethics issue. You will always have access to information that you can use to enhance your personal finances as an HCA. Use of such insider information for personal benefit might or might not land you in jail, but it has the potential to ruin your professional life. The best advice from this Code is to be aware of potential conflicts of interest and to avoid them. This is not always easy to do; you must examine the opportunity with your ethics eyes as well as your business acumen.
5. Counselors, like HCAs, are charged with self-regulation within the context of their professional associations. They must deal with ethics violations when they encounter them and not remain silent. You too have the responsibility to speak out when you find a violation of your code. While this might not make you popular, you can handle these situations in a way that is both professional and compassionate. Remember the management rule of always confronting behaviors in private. However, you also need to be willing to go to the next level if the violation warrants doing so.

### LIMITATIONS AND CRITICISMS OF CODES

This chapter makes an argument for knowing and using your professional code of ethics. However, it would not be fair and balanced without presenting the limitations of such codes. This section uses a historical approach to address these limitations, beginning with Anderson and Glesnes-Anderson’s (1987) commentary. According to these writers, ethics codes are not used by many of the professionals for whom they were written. Many do not even know that they exist or how to locate their professional codes. For professionals of high moral character, perhaps a code is not even necessary. They would do their best to serve their clients even in absence of a formal code. Conversely, those professionals who are immoral by nature will not abide by a code.

Ethics codes are not fully intended just to assist in decision making in the course of day-to-day functions. In actuality, they are designed to secure the prestige of the profession and, by being stringent, discourage less-than-moral persons from entering into the profession. The authors identify five major issues with codes of ethics. They find that codes are too vague to assist with real-world practices and at times even contradict themselves within the many provisions. There is no real enforcement of professional codes, and the business of your profession is stressed more than its ethics. Finally, codes as delineated by the CSEP tend to promote status over morality. The CSEP makes specific reference to the ACHE Code as being guilty of all of the problems they address. However, CSEP does acknowledge that the ACHE is working toward greater clarity and emphasis on moral behavior. However, in the opinion of CSEP, the ACHE code has a long way to go before becoming a specific practice-based guide.

Darr (2004) points out that codes of ethics, even if they can be enforced, are only guides for behavior. Those who choose to be immoral can use codes as a way to do what they wish and avoid sanction. If the code enters into legalities, it is too difficult to apply. Therefore all codes have to walk the line between vagueness and constriction. Even without
a professional code, the principles of respect, justice, beneficence, and nonmaleficence should guide your behavior as a professional.

Johnson (2001) also takes the position that ethics codes are popular but not without limitations. His criticisms include elements of their design in the application. Like previous authors, he finds most codes to be too vague and more about professional image than moral behaviors. He also cites difficulty with enforcement.

CSEP (2004) reminds you that codes of ethics should be considered in light of the current situation or potential conflict. They are meaningless if they cannot be related to real-world practices. Codes should also represent the values articulated by your organization. They should be developed through thoughtful process that includes representatives from this group. A collective agreement should be made concerning what is ethical and unethical behavior, and the resulting code should be adaptable to a variety of situations. Finally, codes should be reviewed and refined so that they remain a viable document for the profession. The ACHE Code of Ethics does show evidence of this standard through its revisions.

Summary

As Darr (2004) says, a professional code of ethics helps you know the right thing to do. Certainly, they are not a panacea for all the ethics problems faced by HCAs or any other professional group. In fact, they can even assist those who choose the shadow side of administration to remain on the thin ice without falling in. Unless they are tied to licensure, they are very difficult to enforce.

So why bother? First, a code provides you with a way to understand your professional obligations and expected behaviors. In some codes, these behaviors are carefully delineated. When they are, they definitely help serious ethical and even legal problems. In any case, you can use the information provided in your code as a starting point when making professional and personal decisions.

If codes are responsibly read and referenced, they have a positive impact on administrative behavior. Keeping a copy of your professional code readily available, reading it, and using it as part of decision making lowers the potential for lawsuits and career failures. Darr and others feel that using codes also assists in the success of your career. Codes help you maintain integrity and public trust. Darr would say that living by the code is just the right thing to do.

Five Challenges for Living in Code

The following five challenges are designed to assist you in becoming more familiar with your professional code of ethics and learning how to
CHAPTER 14 C O D E S O F E T H I C S A N D A D M I N I S T R A T I V E P R A C T I C E

use it. You will need to do some research about the ACHE Code of Ethics and to examine at least one other code. Discussing the ACHE Code with other administrators should help you have a better concept of how it can be used in decision making. Finally, you are challenged to try including the Code in your operational decisions and developing a personal code with the ACHE Code as a starting point.

1. Really learn your professional code.

Comments
In this challenge, locate a copy of the ACHE Code of Ethics and all of its support documents and read them in-depth. Do not just scan the words on the page. Instead, thoughtfully peruse material and answer the question, “What do they mean by that?” You can get helpful insights just by slowing down as you read the document. It is supposed to define who you are as a professional.

After reading the Code, ask yourself, “Do I believe this, and can I support it?” This will allow you to formulate your position on the Code. Finally, ask, “How can I use this in practice?” The answers to this question will help you identify ways to apply the Code to your daily operation as an HCA.

2. Investigate codes from other professions.

Comments
This challenge can be met in a number of ways. First, you can use the CSEP Web site to identify a code that is interesting to you. You might select one from a professional group with whom you work. If you are bi-codal, you can investigate one from your co-profession. Try to determine just what this code is asking of its professionals. Read the section on limitations again and see if you can identify some of those mentioned in your study code. Finally, ask yourself, “What can I learn from this Code?”

Second, after you have learned about the code, have an informal conversation with a member of that profession. Find out if they use the code. If they do, how does it assist them in their practice? If they do not, why do they not find it useful?

3. Ask key administrators about the challenges of living by a professional code.

Comments
This will be an easy challenge if you have already identified your moral mentor. If not, take time to find an administrator who will give you some discussion time. Next, get on his or her calendar and discuss what the ACHE Code means. Why does he or she think that you need a professional code? Does he or she find particular features helpful? You can also ask for cases where the ACHE Code...
4. Try living the code in your daily operations.

Comments
Pick a decision that you must make in your daily operations as an HCA. If you have not begun your career, think of a hypothetical case for this challenge. Next, get out the ACHE Code or the appropriate Policy Statement. Along with the financials and any other data you are using, review the Code and add a question to the decision process, for example, “Would this decision fit with the ACHE’s recommendations?” What did you discover?

5. Design your own personal code starting with the ACHE Code as a foundation.

Comments
This challenge is by far the largest of the five. Think about what is expected of you by the profession as presented by the ACHE and what you have learned so far. Next, take your time and put your perceptions into your own words. Make sure that these are words that you are willing to stand by or have anyone read. This process should not be done lightly; make each word count.

By the end of Chapter 15, you will be formulating what some authors call a personal mission statement, or what I call a personal ethics code. It will combine your foundation beliefs about moral behavior, professional codes of ethics, and the application of ethics to practice. This statement should be something that you could frame and put on your office wall. In fact, some of my more brave students have actually done just that. They also review this ethics statement at least once a year to see if they are staying true to their personal morality and their professional obligations.

Web Resources

ACHE Code of Ethics and Support Materials
http://www.ache.org/aboutache.cfm

The Center for the Study of Ethics in the Professions Codes of Ethics for Professions
http://ethics.iit.edu/codes/index.html

References


Practicing as an Ethical Administrator

“Leadership is a potent combination of strategy and character. But if you must be without one, be without the strategy.”

—Norman Schwarzkopf

Points to Ponder

1. Why is it important to apply ethics to your daily practice as a health care administrator?
2. What can health care scholars teach you about the daily practice of health care ethics? Are there any lessons to be learned from popular writers?
3. How do ethics fit into the classic functions of health care administration?
4. What common ethics challenges do health care administrators face?
5. How can you better prepare yourself to be an ethics-based administrator?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

ethical hypocrisy  ethics of “bossdom”
Chapter 15  Practicing as an Ethical Administrator

INTRODUCTION

Ethics without action has no value. Just talking about your ethics but never acting on these convictions puts you at risk for ethical hypocrisy. Because your staff notice when there is a dissonance between your words and your action, this hypocrisy can go a long way toward undermining their trust in you. Without this trust, you will find it difficult, if not impossible, to be successful as a health care administrator (HCA). So, just how do you integrate ethics into your daily operations? What are some practical ways to be an ethics-based administrator?

This chapter assists in answering these questions. You will find wisdom from the scholars of practical ethics. The chapter also presents the sage advice from popular writers. Next, you will be asked to think about the classic functions of health care management. How can you apply ethics to each of them? Finally, the chapter gives you some anecdotal information from practicing HCAs. How can their challenges and solutions help you to improve your own practice? At the end of the chapter, take the three challenges and use them to refine your opinion on ethics-in-action in your daily HCA practice.

WISDOM FROM THE MASTERS: ETHICS IN PRACTICE

To determine the best way to apply ethics on a daily basis, you can turn to the wisdom of those who write specifically about health care. You can also study writers who influence HCAs. A good place to start is the much-discussed work of Steven R. Covey, including The 7 Habits of Highly Effective People and Principle Centered Leadership. These works have been studied by many generations of HCAs. In fact, there are whole university courses devoted to their content.

Even though his work is now almost a cliché, it still offers some basic advice about practicing ethics in health care. What wisdom does Covey (1989) give you about what he calls character ethics? He asks you to shift from being concerned about the power of your personality to living the power of principles. Making this choice not only makes you a more effective leader, but it also helps you grow as a person. He opines that these principles are universal, fundamental to all ethical systems, and linked to your conscience. The principles include “fairness, integrity and honesty, human dignity, service, potential, and growth” (p. 34).

Covey (1989) is concerned about how you make principle-centered health care administration a habit. The habits he delineates have their foundation in Frankl’s concepts of freedom of choice, responsibility, and conscience. Each day you choose how you conduct yourself as an
Wisdom from the Masters: Ethics in Practice

HCA. You are free to practice from your principles or have other centers for your life (Habit 2). However, Covey stresses that you must also take responsibility for each of your decisions. If you choose money, work, possessions, or pleasure as your life center, your choice can lead to decisions that have short-term rewards. In addition, these choices can actually hurt your life and your career.

Covey (1989) does not say that living by principle will be easy or even lucrative. You have to apply his 7 Habits consciously on a daily basis, and it requires a commitment of time and effort on your part. In fact, these Habits have to become your lifestyle. For example, he suggests that you conduct your work so that you function on a Win/Win rather than Win/Lose basis (Habit 4).

How does this translate into health care administration?? You have to make sure that you create an environment where people can be effective, where you provide clear expectations, and where you evaluate results not personalities. This also means that you must trust your staff enough to avoid micro management. When you feel that your performance is judged by what others do, and you believe that no one can do a task better than you can, then you cannot delegate effectively and you will find yourself mired in micromanagement. Creating Win/Win organization might be challenging, but if you believe Covey, the effort is worth your investment.

Covey (1989), like many other authors, stresses balance in your life and work, which he calls “Sharpening the Saw.” As you remember from previous chapters, you are body, mind, and spirit. Each of these areas must be nurtured if you want to have the ability to meet job demands and be fully effective as an administrator. Again, nurturing yourself is not always easy. Your education and experience might have led you to believe that you are indispensable. You feel guilty when you take time to meet your own needs. Covey gives you permission to take care of yourself and to make the changes you need to be an effective HCA. He does not expect you to do this perfectly or overnight. In fact he says, “I personally struggle with much of what I have shared in this book” (p. 319). He encourages you to keep trying because the benefits of a balanced life outweigh your cost in effort, time, introspection, and change.

Another writer who deals with the health care system and how it relates to patients is Patch Adams (1993). He tries to create a health care system where service, joy, and humor are part of practice. Although some HCAs do not agree with his philosophy on reimbursement and finance, his insights on ethical practice are quite useful. First, he suggests that you should always be thinking about the patient as you conduct your daily operations. Patients should never become just an inconvenience or a DRG Code; they should be the reason for your job.
He also asks you to make a decision to be happy when the world seems to reward you for being unhappy. Choosing happiness means that you grow friendships, remember when to let go, build community in your workplace, and choose wellness. You also need to increase the level of humor, laughter, and silliness in your life. Humor and silliness have not been stressed as part of effective health administration. Yet, they are the forces that assist in healing, maintaining morale, and decreasing burnout. He offers you advice on how to increase your humor levels, such as finding silliness from reading, watching television and films, laughing, and playing (with children, pets, or just by yourself). If you are happy, in the Adams’s definition, it should be easier to practice ethically.

Managers can find it difficult to concentrate on the big picture issues of ethics when their days are filled with multi-tasking and multi-decision making (Rion, 1996). You have to build your ethics sensitivity so that using ethics in your daily operations becomes as natural as considering finances. Achieving this level of sensitivity is a process, not an end. It takes knowledge of personal and organizational obstacles and the humility to know that you need assistance. Rion advocates that you find small groups of trusted peers and meet with them frequently (once a week or twice a month). Use this group to discuss your concerns, to learn how others handle issues, and to study ethics. When you discuss your choices, your group can support your decisions and hold you accountable for them. You must make a time investment to do this, but the payoff in support and learning is worth it.

Purtilo (2005) gives good advice on using ethics in your practice of administration. She says to begin by reading and understanding the mission statement of your organization. This knowledge provides you with an understanding of how the organization views its purpose in the community and allows you to evaluate whether or not you can support such a purpose. Assuming that you want to be part of the organization’s mission, you must next read and assess its policies and procedures. You should use the key principles of ethics (i.e., justice, beneficence, nonmaleficence, autonomy) to analyze these policies for their ethical foundation. If this analysis indicates the need for alterations or changes, you must work to achieve policies that are rooted in ethics and not just convenience.

Carson Dye (2000) has over 30 years of experience with health care and extensive background in practical health administration. He asks you to begin your practical application of ethics with the American College of Healthcare Executives Code that should be part of your daily operations. He then advocates, along with Covey and others, that you develop your own code and write it down. By writing it, you make it a tool and not just a theory.

He also suggests that when making a decision, you analyze the costs of not being ethical. You can ask, “What happens when someone finds
Wisdom from the Masters: Ethics in Practice

If the consequences are not acceptable for your organization, your community or yourself, you should think again, research some more, and make another choice. Avoid playing with the truth (stretching, padding, or bending it) and be sure to honor your promises. He also suggests that you be careful in using your power, take responsibility for your mistakes, and be vigilant in your personal financial management. By this he means being a good steward of your expense account, perquisites, and benefits.

McGinn (2005) is also an experienced HCA who offers advice on practical ethics. His 10 Laws provide assistance in being an effective leader in the challenging health care environment. Of particular interest is the First Law, which reminds you of your moral obligation as an HCA. Avoid taking actions that can bring harm to your organization and yourself. Self-deception is a factor that has led several leaders, including those in health care, to cause harm. He cautions you not to delude yourself and trade ethics for money, power, or fame.

Keeping your sense of purpose in mind as you make decisions is important. Have enough courage to act on that purpose when it is necessary. Never forget that you are in covenant with patients, staff, and the community. You are trusted to be doing what is in their best interest. They, in turn, trust you with their finances and even their lives.

Before moving on to the non-health-care writers for their wisdom, take a moment to consider what you have just read. What common areas did you find? Are there things that you can use? I notice that a great emphasis is placed on mission, either from a personal or organizational view. This makes sense as a source of thinking about practical ethics. If you do not know what you believe and what you are working toward, I think that it would be difficult to have high standards. I also find in the preceding text that there are no simple answers and that many intangibles are included like courage, humility, principles, responsibility, and trust. Think about all of these and find ways to make them a normal part of who you are as an administrator. In fact, consider ethics in the same way you do finances whenever you make a decision. This might require a new way of looking at what you do, but it is worth the effort. Ethics matters.

Wisdom from Other Voices

Jerry Harvey (1999) is well known in the business world for his work The Abilene Paradox. His book, How Come Every Time I Get Stabbed in the Back My Fingerprints Are on the Knife? and Other Meditations on Management provides useful insights on how to put ethics into action. He discusses the difference between sitting (doing nothing) and standing (taking principled action) in business settings. He encourages you to avoid sitting and use your energy to find the truth. This means being willing to ask questions and take a stand. Sometimes HCAs avoid
taking a stand because they want to fit in and not be seen as a troublemaker. However, making your position known on an issue, when you have information to support it, can actually enhance your career. You can save others from decisions that could decrease the image or even the bottom line of the organization.

Practicing ethics also requires that you recognize a high level of accountability (Dosick, 1993). Ask yourself, “Who is my real boss and to whom am I accountable?” In health care, the answer is complex. First, you are a direct-report to someone and should meet his or her expectations for performance, attitude, and loyalty. But as a middle manager, you are also accountable to your staff. They expect you to act in their best interests and reward you with service and loyalty. In the larger sense, you are accountable to the patients, their families, and the community. They expect you to oversee what happens in the system and protect them from its potential abuse. Quite a list of responsibilities, indeed.

There is a higher accountability that you must also consider. You are accountable to someone or something that is greater than yourself (Dosick, 1993). Knowing that you have a higher accountability, a purpose in life, and are not alone in your actions helps you to search your conscience for guidance. An active conscience will help you to direct daily operations with a greater sense of integrity and truth. Dosick suggests the acronym ETHICS as a foundation for action (p. 191).

\begin{quote}
Everywhere, all the
Time, be
Honest, act with
Integrity, have
Compassion. For what is at
Stake is
Your reputation,
Your self-esteem,
Your inner peace.
\end{quote}

In practicing ethics-based leadership, consider what it means to be authentic and how to use your head and your heart (Palmer, 2000). While money and measurable results are important to operational success, there are also intangibles that matter. You have to learn to balance the concrete (data, reports, and financials) with these intangibles (i.e., integrity and fairness) to be effective. Achieving this balance requires contemplation, conversation, courage, and conviction. You are encouraged to find time for solitude, overcome your fears, and learn to lead from strength. Palmer believes when you are called to the profession of health care administration, you must be able to balance the elements of life, and that will make ethics-based practice possible.
You can learn how to practice ethics by studying those who write about unethical leaders. Two books on this subject I find useful and entertaining are *Dealing with People You Can’t Stand: How to Bring out the Best in People at Their Worst* by Brinkman and Kirschner (1994); and *How to Work for an Idiot: Survive and Thrive without Killing Your Boss* by Hoover (2004). Brinkman and Kirschner provide excellent advice on working with staff and others who challenge your patience and your ethics. The authors include general advice on how to get the best from people regardless of their personalities. You should assume the positive when dealing with their actions, make sure you understand them, and take time to listen. You cannot change these people, but you can try to change your reactions to them. They also suggest getting advice from people who seem to be able to work with these people. What are they doing differently from you?

Hoover (2004), a recovering idiot boss, provides a satiric look at administrative ineffectiveness from the employee view. This information is invaluable in assisting you to understand how your staff view you, and how to avoid idiot behaviors. After identifying boss types (including god, sadist, masochist, buddy, and idiot), he provides information on how to be a good (ethical) boss. First, you need to treat staff the way you would like your boss to treat you (Kantian ethics). You also need to be clear in your communication and ask questions to be sure you really understand. Sharing information and treating staff with respect is also part of being a good boss. You need to be fair in the way you apply policies. Consistent use of these lessons will keep you from becoming an Idiot Boss (I-Boss) and increase your effectiveness.

What lessons can be gleaned from these examples? First, the idea of choice seems to be a theme. You must make the choice to practice ethics even if there is no immediate financial reward for doing so. You can choose to act on principles or not, become a respected boss or an I-Boss, and base your decisions on ethics or not. Your choices do make a difference.

Communication in its many forms also seems to be a theme. You are urged to use reflection to communicate with yourself and determine your vocation, motivation, and actions. You are also asked to be fair and honest in your communications with others as part of your practice of ethics-based administration. You have to be aware of the power of your communication and use it to reap benefit and to avoid harm.

Another thematic area is accountability. Although you are accountable to many in your role as an HCA, you have to define your ultimate source of accountability. When you identify your life-center and it is bigger than you are, it becomes easier to act with ethics in mind. Of course, you must be willing to spend some time thinking about the
ethics of your decisions, talking with trusted colleagues about your actions, and learning.

KEY PROCESSES OF HEALTH CARE ADMINISTRATION AND ETHICS

Many texts define the essential functions of health care administration. In general, the classifications include planning, organizing, directing, and controlling (Hodgetts & Cascio, 1995). Three examples of applied ethics are presented for each of these areas. I am sure, when you think about how the use of ethics fits into each of these functions, you will be able to add many others.

Planning

Planning means setting the direction of your department or organization and includes your ability to meet community needs. The design and management of strategies to place yourself in a favorable market position is also part of this function. Planning is also essential to keep your competitive edge and to maintain a strong bottom line. How can ethics apply?

When you think about all that is entailed in this process, you can probably identify several areas where the practice of ethics makes a difference. Ethics of data integrity, information presentation, and overall communication are three of these areas that come to mind. With respect to data integrity, remember that planning decisions ultimately rest on the quality of the data used to make them. If these data are collected appropriately, honestly recorded, and fully considered, you have a greater chance of making decisions that succeed.

Ethics has a major influence on the quality and integrity of any data set. You can begin with the ethics of those who are responsible for its collection. If they do not see this task as important, they might be tempted to rush through it. Too much speed can lead to errors and omissions and give you poor quality data. They might also be tempted to fabricate data when their integrity is not stressed. As an HCA, you have a duty to educate your staff concerning the use of the data they collect and the need for integrity. You also need to build time into the work schedules to allow for adequate collection. Finally, you should make it a published policy to conduct periodical data integrity checks so that you can comfortably “stand on your data.”

Data integrity is also influenced by how you conduct your analysis. Choosing the correct format is the first step in preserving integrity. While statistical packages assist greatly with creating information, they are only as good as the data you choose to enter. It can be tempting to
omitting those numbers that appear to be negative, especially when your bonus is derived from your numbers. However, in the long run, poor decisions made by faulty data can cost you more than a bonus. Remember that your data can also be qualitative, which can also challenge you ethically. You are trusted to honestly review all of the data, design codes that are accurate, and assign responses appropriately. Be sure that you can explain your coding systems and your data. It is often helpful to have a reviewer look at your categories and coding to help with their construct validity.

The ethics of presentation is an important one for the planning process. You have probably learned in your courses that numbers can be presented in a way that they can say almost anything. The temptation will be to present your information only in a positive way so that you and your department can shine. Providing an unbalanced account of your achievements by neglecting the whole picture (sin of omission) can serve you well in the short run. However, decisions made on incomplete data can hurt your department and the organization in the bigger picture. In addition, if you try “stacking the deck” with someone who has good business acumen, you will be questioned. Minimally, you will look foolish and dishonest and you might even jeopardize your career. Providing a balanced picture does not mean that you only present the bad news and neglect all of the accomplishments. It just means that along with successes, you diplomatically address the goals that have not been reached. This allows you to evaluate what you have done and alter the process as needed.

Presentation also includes the clarity of your information. To avoid addressing the real issues, some HCAs choose to obviate them through data dazzle and presentation confusion. They resort to these tactics because they know that the human brain can absorb only so many numbers and so they show too many PowerPoint slides at a time. After a while, people tune out (take a mental vacation). It can be tempting to use a data fog to keep from being criticized, but you are not providing good stewardship for the organization. Leaders need a clear and understandable picture of what is happening to avoid faulty decisions. Therefore, ethics practices mean that you make every effort to be clear, concise, and accurate in what you present. As you prepare a presentation, ask yourself, “Do I understand this, and will my boss get it?”

Applying ethics to communication facilitates successful planning. You can have the most beautifully designed strategic plan but, if no one uses it, it is worthless. First, you must support the plan yourself and communicate your support. You also have an ethical obligation to educate your staff about the plan’s purpose and implementation. In order for implementation to succeed, you have to create an environment where individuals feel that they can honestly communicate with you. This climate of cooperation is necessary for you to gain accurate information on the progress of the plan. Without it, “group-think” (thinking
only what you are told to think) will rule and you will learn only what your staff think you want to hear. The end result can be disastrous for a strategic plan.

You also need to be careful about “group-speak” (i.e., saying only what people want to hear) in your communications with superiors. While diplomacy and a spirit of cooperation are important in effective communication, you should not be afraid to (politely) express your concerns. No one can see all sides of a decision, so your courage to speak up can actually assist your boss in making the correct decision. Communication needs to be top-down and bottom-up if a strategic plan is to be successful.

Organizing

The organizing function of health care administration includes the correct placement of activities, materials, and staff to accomplish the objectives of the strategic plan. This process also includes designing specific jobs and educating staff about how to do those jobs. Delegation of authority and assigning accountability are part of the organizing function. As you can imagine, organizing involves many areas of human resources and finance. It also engages much of your time as an HCA. The potential for ethics challenges is great. Three of these challenges for discussion are the ethics of design, matching, and delegation.

Job design and redesign are important steps for the success of any organization. Designing jobs to be both effective and efficient also conserves scarce resources by avoiding unnecessary use and waste. In order for this task to be done well, an accurate picture of what is to be done and the best way to do it must be obtained. One ethics issue in job design is the rush to creation. It is too easy to take a job description or a set of practice guidelines from another facility or Web site, plunk it into a document, and say, “Do it this way.” The problem with this action is that there are no clones among organizations; everything must be customized to your workplace. While a draft can be invaluable to jump-start the process, it must be adapted to your particular organization. One way to achieve adaptation is to consult those who actually do the job and ask them to review a draft of the job description for accuracy and omissions. Taking this step provides you with two things. One, you capture a better picture of how the job is done in your organization. Two, you honor your employees and their knowledge by including them in the process. You should also have an easier time with implementation because the design is not just a top-down effort. Staff are included in its development.

Once you have the job design, you have to engage in the ethics of matching. Part of the art of administration is your ability to match the best person to the job. This is especially critical in health care where
many jobs involve higher levels of professional knowledge and skills. While it might be easier to just assign someone the new task, ethics practice asks you to avoid the easy way out. To make a decision for the best fit, you should first know the strengths and weaknesses of each of your staff members. Who is interested or educated in this area? Who would have the shortest learning curve if assigned this task?

You also need to take the workload of each staff member into consideration. It is been my experience that when certain staff members demonstrate job excellence, they are often rewarded by being given more work to do. Having a full and varied workload can make your day interesting, but overload can lead to burnout and resignation. Ethics requires that you avoid delegating everything to “old faithfulls” and take the opportunity to challenge someone who might be a “coaster” to strive for career excellence.

You must keep in mind that ethical matching also requires job training. Do not assume that the person you select fully understands the assignment. You have a responsibility to educate that person about any needed specifics. You also should recognize that a person’s pride could keep him or her from asking questions or requesting help. Just assume that some level of orientation is necessary for successful implementation. Finally, encourage the employee who takes on additional tasks. Encouragement does not have to be time consuming or expensive. It is often enough to just informally check in with the employee and ask, “How is it going?” If you have established a climate of trust, this management by walking around will head off problems before they happen.

Once a job is assigned, you face the challenge of the ethics of delegation. Delegation is often misunderstood; it is not just giving the “dirty work” to the “worker bees.” It is a decision of trust where you are willing to grant the implementation and authority to another person. The key word here is authority. Delegation does not work if there is a person who is responsible for the outcome but who does not have authority to make it happen.

Delegation is based on common trust. You trust the staff to do their jobs to the best of their abilities and to communicate to you when assistance is needed. The staff trust that you will allow them the autonomy to do their jobs without micromanagement. They also expect that you will recognize and acknowledge their efforts toward accomplishing the department’s objectives.

This sounds very easy on paper, but it is often difficult in practice. If you do not trust your staff or believe that they are competent, you will have trouble with delegation. You will wear yourself out checking and redoing everyone’s jobs. To avoid the temptation of false delegation, you should first get to know your staff. Can you work with each of them? If not, why not? You might also have to assess your attitude toward delegation and understand that you are not omnipotent. You
just cannot do it all. For the jobs to be done and the plan to be
achieved, you must be able to rely on staff.

Recognition is also part of delegation. A staff that is working well
will make you look like an organizational star. This does not mean that
you get to absorb all of the starlight. Ethical and effective administra-
tors know the basis for their success and acknowledge it. They celebrate
progress toward goals and thank their staff with humility and apprecia-
tion. Making this step part of delegation is not only ethical but it also
goes a long way toward making work meaningful for your staff. People
who are engaged in meaningful work and receive appreciation are less
likely to burn out and resign.

Directing

Directing is the process of getting the work done. It uses the tools of
communication, motivation, and education to influence staff to achieve
organizational goals and objectives. Three areas of ethics practice that
can affect the directing process are the ethics of “bossdom,” staff moti-
avation, and effective teamwork.

How do you behave when you are the boss? Do you respect your
employees in at least an I-You relationship? Do you see them as means
to an end? How do you feel when you have a staff resignation or termi-
nation? To avoid becoming an I-Boss or, even worse, a Bully Boss, you
must first consider what being the boss means to you. Along with the
benefits of increased salary and status comes the responsibility of using
your power astutely. Remember, you have no real power unless your
staff grant it to you. As free human beings, they always have the option
to do their jobs well or poorly or even to resign. Power based on
respect, honesty, and fairness will take you further toward meeting
goals than power based on coercion and fear. This is especially true in
the health care environment where employees tend to be highly skilled
and in demand.

The responsibility of directing also includes employee motivation.
To motivate, you must go beyond being an organizational cheerleader.
It’s more effective to influence people’s desire to make the organiza-
tion’s goals their own and work to successfully complete them. Many
administrators still believe that the best way to motivate employees to
do what you want is to pay them. If you pay staff enough, they reason,
staff will do anything. While money is a motivator when people cannot
pay their bills, it loses its influence as they become more secure.

What do employees need to motivate them? One, somewhat radical,
way to find this out is to ask them. Instead of planning something that
you think will be motivation, why not use management by walking
around or e-mails to ask employees for their ideas? Then you can build
your motivation strategies on things that might have a better chance of
accomplishing their goal. Of course, you can always check current liter-
nature for ideas. Research repeatedly shows that recognition, interesting, meaningful work, and loyalty are stronger motivators than cash. From an ethics view, employee motivation begins with an I-You relationship among you and your staff. Once this climate of trust and respect exists, it becomes easier to keep the mission and goals in the forefront.

Many administrative tasks are conducted by teams. A good example of a clinical team can be found in the emergency department (ED). Each team member knows his or her job and works together for the good of the patient. Teams also exist in the nonclinical aspects of health care and need to work equally well. Your responsibility is to practice ethics when establishing and leading teams so that each team member will work well with others.

The first step in meeting this responsibility is to consider whether or not a team is needed and who should be on it. Be careful to use teams for important tasks that cannot be done by one or two people. Otherwise it is just busywork. Make sure you select team members based on their knowledge and ability to contribute to the solution and not based just on their title. When you ask a person to serve, acknowledge his or her value and reason for selection. Being asked to serve on a team can be viewed as an honor or a curse, depending on the individual.

Once you have assembled the team, remember all of the key ethics principles. Respect the team’s time and autonomy by making sure they understand the task, organizing efficient meetings, and providing follow-up information. Meetings should be conducted to foster open and honest communication so that the best solution can be derived. As moderator, make sure that all voices can be heard and one or two members do not dominate the process. Do not schedule meetings if there is no real reason for them. This is disrespectful.

Teams, like individual employees, need to be recognized for their work. Include team members’ names on the final product or document. This acknowledges that the product was not the work of one person, but was the best thinking of the team. The names on the document also provide a source for information when outside staff members have questions. Team members become authoritative champions for the plan that they helped to develop. Finally, from the standpoint of reward, everyone likes to see his or her name in print.

**Controlling**

The controlling function is designed to monitor activities and ensure that organizational goals and objectives are met. The process includes developing performance measures, evaluating those measures, and taking corrective action if necessary. Financial controls are also part of this function, which include budgets, cost/benefit analyses, and inventory controls. Information systems provide valuable tools to assist with the controlling process if they are used ethically and effectively. Ethics
issues related to the controlling function include stewardship, patient and employee satisfaction, and justice.

Making sure that resources are optimally used and not wasted is part of your responsibility as a steward. Controlling waste in health care inventory is a serious challenge. A large part of the annual budget in any facility is spent on supplies and equipment. However, managing an inventory this large can be a real challenge because of the number and variety of products and supplies that are used. Of course, there are also problems with shrinkage (another word for theft) that must be addressed. You need to determine the best way to conserve resources and still provide quality care. This includes using technology such as computer monitoring systems to assist in the process.

To be a good steward, you must also pay attention to your balance sheets and other financials. Ask questions when you see entries that do not make sense. Of course, you must also be accurate and honest in documenting your expenditures and inventory. Creative accounting might solve your immediate problem, but this quick fix can come with a price you do not want to pay.

Controlling also includes documenting treatment outcomes and progress toward organizational goals. This aspect requires the analysis and evaluation of mandated and proprietary data sets, including those related to patient satisfaction. Patient satisfaction data have become increasingly more important and are often surveyed by external evaluators. In addition, individual departments can be granted bonuses through the use of these numbers. Because it can be linked to money and accreditation, patient satisfaction can become an ethics temptation.

As you know from studying the research, there are a number of unethical ways to obtain data that are favorable. First, if you limit the size of your mailings, you will get a smaller return. When this happens, you can make greater claims about patient satisfaction level but they will be based on only a small sample. This is not ethical. For example, if you have only a 5% to 10% return, you are dealing with numbers that have virtually no meaning. However, if they show you in a positive light, you might be tempted to use them.

Timing also affects survey data. If you do infrequent mailing, some of your patients will not remember if they received good treatment or not. Therefore, your data can be inaccurate. The length of the questionnaire also makes a difference. If it is too long, it will be tossed rather than completed, giving you lower return numbers. Questions can be slanted to provide more positive responses than negative.

To avoid ethical temptations from data collection, health care facilities are beginning to use a triangulation method for gathering patient satisfaction data. To improve data integrity, they use multiple methods such as telephone surveys, focus groups, and visits with patients who are still in the facility. While this data collection might be more expen-
Key Processes of Health Care Administration and Ethics

sive, it yields information that can be used to improve patient care. In this case, knowledge is power; once you are aware of a problem, you can fix it.

There is also a temptation to “cook the books” to show favorable numbers. After all, who would know? This is particularly enticing when written comments are included. If someone takes the time to write a comment, he or she wants you to have this information. However, it takes time to organize comments into categories for meaningful information and to match comments with the categories. Of course, all of the comments might not be favorable. When there are too many negative comments, you could show yourself in a more positive light if you used only the Likert numbers. In addition to being unethical, this decision robs you of important information for improving patient services.

Employee satisfaction needs to be considered under the controlling function. What can an ethics-based organization do to provide an environment where employees can engage in meaningful work? Is it important to measure employee satisfaction? Some organizations think that it is not. They take the, “You are lucky to have a job” attitude while still expecting staff to treat patients and families with care and compassion. This dissonance can lead to poor morale and soaring turnover rates. Employees, like patients, want to have at least an I-You relationship in the workplace. As the leader, you have the ability to demonstrate respect and value for your staff. This is good ethical practice and good for business.

As you have previously read, justice is a key principle of ethics. The area of controlling is one where justice and fairness can be tested. For example, when you design performance evaluations, are they fair or do they let favoritism rule? Are employees, regardless of their personalities, given appropriate resources to do their work? Or do you sabotage those that you do not like? These questions relate directly to how justice is used or not used in your department or organization.

Employee discipline and termination are also part of the job of the HCA. While these tasks are unpleasant at best, they can be handled ethically and respect the dignity of the persons involved. For example, corrective steps should always be done in private and agreements pertaining to necessary improvements should be provided to the employee in writing. Even though it is a frequently used tactic, it is not ethical to drive out an undesirable employee by making the workplace so miserable that he or she resigns. Even if you succeed in getting the desired resignation, you make yourself vulnerable to legal action and you send a powerful message of fear to the remaining staff.

This section has examined a few of the ethics challenges involved in the four processes of administration. You will experience many others in the course of your career. The key to dealing with these challenges is to combine your sense of ethics with sound business practices. Being an
ethics-based administrator requires much of you. You might have to risk being unpopular in order to be ethical. However, your conscience will be clear if you try to balance the right thing to do with what is best for business. The challenge of achieving this balance will always make your work interesting—boredom will never be an issue.

**VOICES FROM THE FIELD**

In an effort to capture some real-world examples of ethics challenges, I had several conversations with currently practicing HCAs from different areas of health care. This anecdotal information does not constitute science-based research, but it does provide insight into the current picture that you will soon face as you assume the role of a practicing HCA.

One issue that recurred in my conversations with HCAs was balancing money and mission. With managed care and other agencies trying to trim the budgets to the bare bones, there are real concerns about how to keep providing necessary services. The profit margins are so low for some facilities that there is even a fear of closure. Pressure is being exerted on administrators to do more with less and to stretch the salary dollar as far as it will go. This pressure is also occurring at a time when nursing and other professionals are in short supply. One administrator expressed the frustration that the best interests of the patient are becoming lost when the message of the systems sounds like, “Show me the money.”

Coupled with this monetary pressure is the growing awareness of consumers and their demand for what they consider quality care. Every time consumers see a new procedure or technology on TV or in a popular magazine, the phone seems to ring with requests for the newest miracle. The demand is not just for glamour services. Several administrators were gravely concerned about the excessive demand for their ED services. Patients seem to be using the ED as a clinic with greater frequency, and the problems they present are becoming ever more complicated to treat. Administrators are worried about how they will staff and fund these services and what would happen if they had to close the ED entirely.

Money and mission will always be part of your ethics challenge no matter what your position as an administrator is. Be sure that you do your part by acting as a good steward of resources to avoid mismanagement and waste and by staying current on financial and treatment trends. Always read your financial statements carefully and maintain accuracy of your records. Good financial health involves the bottom of the organization as well as the top.

In terms of mission, at all times, resist the temptation to forget about why you are in the business of health care. Some of the administrators
said that if service is not your motivation for being an HCA, you need to find another career. While being an HCA is prestigious, powerful, and even lucrative in some cases, a foundation in service is the only thing that will maintain your career longevity and happiness.

Another area of concern for practicing HCAs is the do not resuscitate (DNR) order. While this is of particular concern in long-term care facilities, it also affects those in the hospital setting. Perhaps patients have completed all of the necessary paperwork to let staff know that they do not want any heroic efforts made at the end of their lives. Perhaps they have even clarified this with their family members. Yet, directives are often ignored for a number of reasons. For example, if just one family member expresses reservations, if the emergency medical technician in the ambulance does not honor the patient’s request, or if the staff cannot find the DNR order, the patient will be resuscitated. Patients who are revived against their will might live several days or even weeks in pain because someone would not let them die. They are often cogent enough to be angry with the staff and their families for the suffering they must endure.

The decision to not honor a DNR order is often made as an attempt to avoid a potential lawsuit from a family member. However, the action actually costs the facility and the family thousands of dollars and, ultimately, causes unnecessary suffering for the patient. A lack of communication between the patient and the family is often a part of ignoring the DNR. In addition, if documentation is not present when a code occurs, the staff might be forced to resuscitate. It is hoped that innovations with the electronic medical record, smart cards, and other information devices will help in this aspect of the problem. In the near future, DNR orders will be available wherever the patient is located.

These are just a few examples of the issues you might face as part of the daily practice in health care. The key to being able to address whatever issues happen in your practice can be found in the old Girl Scout/Boy Scout motto: Be Prepared. Prepare for eventualities by designing an ethics-based workplace for your employees. This will go a long way in preparing you for any ethics challenges. Practicing ethical administration on a daily basis will make it the norm in your organization.

Summary

You might think that health care, with its emphasis on service and compassionate patient care, would be the easiest environment in which to practice ethics. The unfortunate truth is that health care must balance business and compassion. To achieve this balance, you must understand that employees are human, even though they are called to such a noble vocation. Pressure from finance, technology advances, personnel needs, and external evaluators can add to the burdens of finding this
balance. Conducting the business of health care that is centered in ethics will never be easy. However, your patients and the community expect nothing less. Trust, the basis for your business, is at stake.

Before you review the challenges for this chapter, I ask you to reflect on the following quote by Ralph Waldo Emerson. For me, it helps define a meaningful, ethics-based life as an administrator.

- To laugh often and much;
- To win the respect of intelligent people and the affection of children;
- To earn the appreciation of honest critics and endure the betrayal of false friends;
- To appreciate beauty, to find the best in others;
- To leave the world a bit better, whether by a healthy child, a garden patch, or a redeemed social condition;
- To know even one life has breathed easier because you have lived.
- This is to have succeeded.

Challenges

The following are your last three challenges. They should assist you in finding your own sources of wisdom to meet ethics challenges now and in the future. Remember that you always have a choice. The key is to make choices that are true to your conscience and benefit your patients, organization, family, and yourself.

1. Ask.
   
   **Comments**
   
   Repeat my informal study. Contact three or more health care administrators and ask them my question, “What are your top three ethics challenges?” Listen to their responses and learn. You can also think about what you would do if you faced a similar situation. Having thought about how to behave ethically is the first step in acting ethically when a situation arises.

2. Evaluate.
   
   **Comments**
   
   Conduct an ethics assessment and analysis in your department or organization. Look at the policies that most affect the services that you provide and how they are actually implemented. Do you see any ethics gaps? If so, create a team to clarify existing policies and practices so that they are more centered in ethics.

3. Go within.
   
   **Comments**
   
   Bring a notebook and pen and find a quiet place. List all the activities that are part of your daily operation as an HCA. Decide
whether or not you practice ethics when you do each activity. If the answer is “yes,” place a letter E by the item. If the answer is “no or maybe,” brainstorm some ways that you can use a more ethics-based approach. Here is the real challenge. Take your list and use it to make changes in your daily activities.

All of the challenges in Section 4 should assist you in creating your personal ethics statement, which can be a powerful resource for practice. My students are required to create this statement on one page, suitable for framing. I ask them, “For what do you want to be known?” The brave students actually frame their document and put it in their offices. Minimally, my students keep it handy as a reference for what they really believe and their definition of ethical practice. Graduate students also prepare a treatise to explain the foundation for their statements from theory, principles, and practice. Although some students find this a difficult assignment (especially those who are more quantitative in their views), they all report change in their views on and application of ethics in the operation of health care.

Web Resources

Patch Adams
http://www.patchadams.org/flash.htm

Articles by Parker Palmer
http://www.mcli.dist.maricopa.edu/events/afc99/articles.html

References

CHAPTER 15  PRACTICING AS AN ETHICAL ADMINISTRATOR

Where Do We Go from Here?

"Effective managers live in the present—but concentrate on the future."

—James L. Hayes

Points to Ponder

1. What have you learned by reading and studying this text?
2. What key ethical issues might you face in the future?
3. How can a foundation in ethics-based administration help you to deal with ethics issues in the future?

Words to Remember

The following is a list of key words for this chapter. You will find them in bold in the text. Stop and check your understanding of them.

- economic credentialing
- Office of the Inspector General (OIG)
- tsunami
- disaster preparation

SUMMARY OF PREVIOUS CHAPTERS

What have you learned about ethics? How will you use it in your future? These are some of the most important questions for teachers who assist future health care administrators (HCAs) and for their students who want to have successful careers. At this point in your study, you have been given
CHAPTER 16  WHERE DO WE GO FROM HERE?

a basic understanding of the key theorists whose work relates to health care administration. From this groundwork, you explored the fundamental principles of ethics that are used by health care organizations. This exploration included chapters on autonomy, nonmaleficence, beneficence, and justice, with real-world case studies in each of these areas. You should be able to see that these principles are not just words in books, but areas that can influence administrative decisions and behaviors. These theories and principles were included in Chapters 1 through 4.

Because ethics is not practiced in a vacuum, you examined what might influence your application of ethics theory and principles to daily administration decisions in your facility. In Section II, you examined sources of influence from outside the organization. In Chapter 5 you looked at the power and influence of the health care industry from the community’s viewpoint. You might not have realized that health care is so powerful that the community feels the need to be protected from its power. It protects itself in many ways including stringent, but often confusing, regulations and limitations on the scope of professional practice. The chapter also introduced you to the thinking behind some of the major regulatory organizations so that you now have a better understanding of their purpose. You were also given insight into your responsibility as guardians of the public’s health through your duty to advocate, ensure staff competency, and maintain your own level of currency.

Chapter 6 examined market forces that can greatly influence ethics temptations and ethical practice. While not every influence could be included in this chapter, it did feature two areas that are growing concerns. Managed care has become an influential force on both the finance and practice of health care. You learned about its history, future issues, and the ethics dilemmas it creates. Integrated medicine was also featured in this chapter as a reflection of the change in consumer attitudes and behaviors. These practices were once regarded as pure quackery, but now are being used and studied by well-known hospital systems. They cannot be ignored but there are certainly ethics issues of autonomy, respect, and competence to consider.

Chapter 7 also discussed external influences. In this case, you examined the health care system’s role in social responsibility. The problem here is to remain compassionate and still have a viable bottom line. The chapter explored the connections between prevention services and your relationship with public health in your community. It also introduced the idea of quality assurance as both an ethics and a social responsibility issue.

Technology is such an influential external force that it merited its own chapter. It has already influenced the way health care is provided and increased the number and complexity of ethics issues you must face. Chapter 8 addressed the current impact of technology on the system, including its cost/benefit. Current and future practices were dis-
cussed, including nanotechnology and pharmacogenomics. You saw how theories and principles of ethics could be used to help health care administrators deal with the complex issues created by the availability of technology. This chapter asked the question, “Just because we can do something, does it mean we should do it?”

The organization in which you work also has a great influence on how you behave as an administrator. Section III introduced you to ethics-related issues from the viewpoint of health care organizations. Financial viability is a primary concern of all these organizations. Chapter 9 provided insight into how health care organizations can balance finance ethics and the organization’s mission. This balance is exacerbated as the requirements to increase to provide quality care and budgets to fulfill those requirements decrease. Organizations struggle to avoid ethics temptations to cut corners and overwork staff in order to maintain the bottom line. In addition, business practices that are acceptable in other industries tend to be unethical in the business of health care. For example, garnishing wages might be acceptable for debt recovery in other businesses, but when hospitals do it, they are seen as heartless.

The culture of your health care organization can foster ethical practice or discourage it. No administrator would overtly tell staff to behave unethically, but their actions set the tone for unwritten but understood policies. Chapter 10 stresses the importance of culture on your day-to-day decision making. You will not only be faced with the impact of the overall organizational culture, but will have to deal with potential clashes between subcultures. The problems of cultural ethics are often resolved by inside committees, or outside consultants. As an HCA you will be involved with the Internal Review Board and other types of ethics committees. You might also be responsible for hiring an ethicist as a consultant and ensuring that the best possible person is chosen for the role. As an HCA you, too, will be part of your organization’s culture, but you have a major influence on it because of your leadership role.

Because of its mission, your organization must deal with regulations from external agencies that have much more stringent requirements than agencies that oversee other businesses. Chapter 11 introduced how the organization views this obligation and its compliance with it. The chapter pointed out that compliance does not always equate to quality, and that regulatory bodies are moving beyond this mere compliance toward quality assurance. Because quality is assumed by the community, health care organizations have borrowed ideas from industry such as the Baldrige Award, Six Sigma®, and poka-yoke for improving their quality. While such efforts on the surface seem ethical and laudatory, they carry a price. Cost/benefit analysis and the finance ethics associated with their implementation should be part of your decision to use these or any other total quality management/continuous quality improvement systems.
Finally, and most important, your ethics practice as an HCA must consider patient-related issues and how your organization responds to them. There is a movement away from the paternalistic view of patient care to one of partnership with the patient. This shift appears to be continuing and is emphasized by patients, payers, and regulators. Therefore, you need to ascertain the patients’ satisfaction levels regarding the care they receive (Chapter 12). Measuring this experience brings its own set of ethical issues and temptations. Finally, some health care facilities are shifting to a more patient-focused model. How does this influence your administrative ethics practices? What are the costs versus the benefits of making this paradigm shift?

After looking at some of the influences from the organization and the community, you were in a position to examine ethics on a personal level. It is ultimately your choice whether or not you use ethics as part of your daily practice, regardless of organizational policies. As you saw in Section IV, it is not always an obvious or easy decision to make. You will be tempted by the shadow side of leadership to use your abilities and power to improve your personal bottom line, often at the expense of the organization. In fact, there are people who would even consider you a “winner” if you took advantage of your position. The resources mentioned in Chapters 13 and 14 should help you to resist those temptations and remain true to the tenets of your profession and personal moral foundation. Remember that with power comes responsibility. Even if you are not “caught,” ultimately you are accountable for your actions.

The challenges set forth in the text are designed to help you be an ethics-based HCA, even when it is not expeditious to do so. The challenges ask you to use what you have learned to improve your daily decision making and practice. You are the future of this industry, and thus the patients, staff, organization, profession, and community will count on you to go beyond mere compliance with rules. They expect you to balance your business acumen with your ethics wisdom. They expect you to maintain at least an I-YOU ethics relationship in your dealings with them. They also expect you to maintain currency and competency in your profession through lifelong learning. They expect you to bring honor to the profession you have chosen. So many expectations create much responsibility, but you are up to the challenge.

THE FUTURE, OR WHO HID THE CRYSTAL BALL?

As I write this last section of the text, I am reminded of how fast the future can challenge everything we know. News of the hundreds of thousands of deaths from the tsunami fills the news media. The health care community around the world is beginning to respond to this almost unfathomable natural disaster. Imagine if you were a hospital
administrator in one of the affected cities. Or even worse, imagine if you were asked to work in an area where a facility does not even exist. If it does, you might not have the resources to provide care for the thousands of people in need. Of course, your profit margin would be dramatically affected by the priority of mission.

Does all this mean that you cannot prepare for the future? Should you just exist day to day and hope that you can meet whatever ethics challenges happen? The tsunami disaster provides some answers to these questions. First, there is no way to prevent a natural event, but there are ways to be alert. The animals in the affected countries paid attention to the subtle signs of sound, earth, and senses and escaped to higher ground. Technology could have provided a similar mechanism for humans through tsunami alert systems. Providing a way to be sensitive to changes could have saved thousands of lives. Of course, each person has to make the decision whether or not to act on the alerts or warnings.

It is certainly to be hoped that the health care system will not have to face a crisis as great as that created by the tsunami. Nevertheless, it is prudent to be aware of potential events that could present ethics challenges. Alerts will come from many sources, and it will be necessary to keep your eyes and ears open. Remain active in your community and state to keep track of the pulse of change and be ready for it. In this last section, I would like to suggest four ALERTS for your consideration.

**ALERT: Disaster Preparation**

The alert for disaster preparation is a logical place to start because you are already thinking about one of the world’s greatest natural disasters. Health care facilities must be prepared to provide service during natural disasters such as hurricanes, tornados, and earthquakes. Disasters that are not created by an act of nature must also be addressed by a specific organization. It can be the result of a human-created event such as an act of terrorism, airplane crash, multi-dwelling fire, chemical spill, or multiple-victim violence.

When any disaster occurs, the community expects you to provide compassionate care even when reimbursement is not immediate. You are supposed to put mission first. This cannot happen unless you take proactive action and work with “what if” plans. There are even computer programs that can assist you to work out logistics and financials. I suggest that ethics also needs to be part of contingency planning. For example, what is your ethics responsibility to your staff who must provide the care? Do you have to build into your budget counseling resources? Do you have any ethics responsibility to the community beyond the provision of care? Considering ethics as part of a contingency plan for any disaster can broaden the scope of the plan and assist you to address needs more compassionately, if or when a disaster occurs.
CHAPTER 16 WHERE DO WE GO FROM HERE?

ALERT: Technology Changes
Technology is another area where you must be alert to future changes because it can challenge both your ethics and your bottom line. As you read in Chapter 8, the future holds the potential for some amazing technologic advances, some of which are already being tested. Prominent scientists were polled about the greatest breakthroughs for the next 25 years (“Think tank,” 2005). Many of the scientists cited technologies derived from the human genome project as strong contenders. Diseases and conditions that exist today can be greatly improved or even eliminated through knowledge of their root causes and gene-specific treatments. Can you imagine the business opportunities here? What ethics issues might they create?

This is just one aspect where technology can create great benefits and great challenges. Endoscopic surgery, brain mapping, cell replacement therapy, implanted computer systems, and other potential applications are just around the corner. From a business standpoint, executive and physician decision-making computer systems are getting more and more sophisticated. In the future, it might even be considered malpractice if a computer analysis is not part of diagnosis or business decisions. Imagine the ethics discussions around these issues.

How do you prepare for such major change? The key is to stay alert. Keep reading both professional and popular sources of information. Attend conferences where technology is featured. Talk about the potential implementation of technology before it is imminent so that you can do an unbiased cost/benefit analysis. In other words, do not get complacent—stay ahead of the technology curve.

ALERT: The Boomers Are Coming! The Boomers Are Coming!
You cannot overestimate the impact the Baby Boomers will have on health care delivery. This generation changed every American institution it touched, from public schools to the housing industry. As a focal point of the consumer and integrated medicine movement, they have already begun to change health care delivery. Even more change will occur as they retire and need more services. Will you be ready? What challenges to ethics will they present?

Keep in mind that the Boomers have a different attitude toward health care than previous generations. They are likely to expect quality care (as they define it) and tolerate less inconvenience. They also want to have fair value for their economic investment and to be a partner in their own care. You can see that these attitudes will challenge the paternalism of traditional health care, but they can also create new markets for service. The key will be to balance the ethics of what is truly needed with what is desired and profitable. There will also be challenges
attached to health care for all of the Boomers and not just for those who are well insured or well funded.

In addition, you will face ethics challenges when the Boomer health professionals reach retirement age. It is feared that there might be a brain drain left for the fewer professionals from younger generations. Some hope comes from the Boomers who remain healthy and want to work into their seventies, but the potential shortage must be addressed. You cannot wait until you are in a shortage-based crisis to act. You need to keep track of the aging of your workforce and intentions for retirement. Of course, establishing policies and practices to make a positive work environment should help attract future employees and decrease your chances of being understaffed as people retire. To be proactive perhaps you could join in career fairs and events at high schools and colleges. Some health care organizations have established affiliations with colleges and universities. By offering internships, guest lecturers, and seminars, the organization can help “grow their own professionals.”

**ALERT: Economic Credentialing**

Loss of patients to freestanding, nonaffiliated ambulatory centers has caused some hospitals to begin a process that has been called “economic credentialing” (Danello, 2003). This process includes denying physicians the authority to admit patients, if they have financial conflicts of interest by having ownership in a competing center. It also includes requiring physicians to admit a certain percentage of their patients to the hospital in order to maintain admitting privileges. Some organizations even require physicians to admit patients only to their hospital. Decisions for privileges are made not by the quality of service provided but by the number of patients who are admitted.

The **Office of the Inspector General (OIG)** is already looking into this practice as a violation of anti-kickback laws. It found evidence that hospitals are using various schemes to obtain funds from admitting physicians including getting payments in excess of the market value of services, collecting a percent of their profits, and mandating equipment purchases. The OIG asked that hospitals be notified of the potential for legal problems if they choose to make these types of arrangements. In addition, over 11 states have already passed laws that restrict this practice.

Economic credentialing might not seem like a big issue, but it is a symptom of future ethical issues. As funding sources become more and more restricted, there will be greater temptation to find creative ways to finance needed services. While many of these solutions are completely ethical, the temptation to cross the ethics line will be great. For example, not-for-profit hospitals were the center of a television exposé when it was learned that, despite a large surplus budget, they were charging noninsured patients higher rates for services rendered and aggressively
pursuing payment. The practice was perfectly legal, but the publicity of shoddy ethics did not help the image of these facilities. Finding a way to finance health care and keep a high moral standard will continue to be a challenge in the future.

**Final Summary**

Writing this textbook has challenged my thinking about ethics as it applies to health care administration, and I hope it has challenged yours. I hope I have persuaded you to have the courage to use what you have also learned to become an ethics-based administrator and to create an environment where ethics is a normal part of practice. By making this choice, you will honor your profession, your organization, your community, and yourself. I wish you all the best in your career and your life as an HCA.

**Web Resources**

Office of the Inspector General  
http://oig.hhs.gov/

Sample Disaster Plans  
http://dhfs.wisconsin.gov/rl DSL/Providers/SamPlEmergPlans.htm

**References**


References

REFERENCES


REFERENCES


REFERENCES


# Index

## A

Abbott, John, 195
Abernethy, John, 241
The Abilene Paradox (Harvey), 315

### Accountability
- demand for, 219
- evolution of, 217
- levels of, 316
- overview of, 84–87
- source of, 317–318

### Accreditation
- for hospitals and long-term care facilities, 87–88, 217
- for integrated medicine practitioners, 126
- for managed care organizations, 90–91
- organizations’ view of, 219–220

Acculturated, 196

ACHE. See American College of Healthcare Executives (ACHE)

Acupuncture, 124
Adams, G. B., 199
Adams, Patch, 313–314
Administrative evil, 277–278
Advocacy, 91–93
Aging population
- future challenges related to, 336–337
- impact of, 112–113

AHA. See American Hospital Association (AHA)

Alternative treatments, 28. See also Integrated medicine (IM)

American College of Healthcare Executives (ACHE)

American Counseling Association, 303
American Hospital Association (AHA)
- function of, 88, 89, 184
- A Patient’s Bill of Rights, 34, 89

American Medical Association (AMA), 115
American Nurses Association, 300
American Pharmaceutical Association, 301–302
American Society for Quality (ASQ), 224

Annison, M. H., 273
Anti-kickback laws, 337
Aquinas, St. Thomas, 7–8

Aristotle, 291
Art therapy, 254
Authorization, 27

### Autonomy
- as confidentiality, 29–31
- explanation of, 25–26
- as fidelity, 33–35
- as informed consent, 26–29
- paternalism vs., 243
- as truth-telling, 31–33
INDEX

B
Baby boomers, 112–113, 336–337
Balanced Budget Act of 1997, 117
Balfour, D., 199
Baptist Hospital of Pensacola, 221
Beneficence
duty of, 140
explanation of, 46
in health care settings, 50–52
patient satisfaction and, 230
principle of, 45–46, 242
BFOQs. See Bona Fide Occupational Qualifications (BFOQs)
Billing, 182, 184–185
Block, Peter, 180
Blum, Leon, 269
Bona Fide Occupational Qualifications (BFOQs), 94
Buber, Martin, 14–16, 229, 247
Bullying, 49–50
Business Roundtable, 141

C
Case management, 116
Case of Code White Coat, 205–210
Case of Kelly Beth’s Mother, 256–261
Case of Patient Safety and BFOQs, 105–108
Case of the Academic Bully, 53–58
Case of the Ardent Administrator, 261–264
Case of the Beneficent Boss, 58–62
Case of the Compassionate Committee, 210–213
Case of the Concerned Managed Care Administrator, 127–128
Case of the Confused Abuela, 128–131
Case of the Devoted Dentist, 142–145
Case of the Dipsomaniac Veteran, 73–75
Case of the Faulty Estimates, 190–192
Case of the Just Downsize, 75–77
Case of the Lemon Baby, 166–170
Case of the Lost Chapel, 186–190
Case of the Misguided Relative, 3640
Case of the Novice Nurse, 101–105
Case of the Obstinate Orthopedist, 232–235
Case of the Proactive Public Health Administrator (PHA), 146–149
Case of the Self-Assured EAP, 235–238
Case of the Self-Serving Surgeon, 40–43
Case of the Unlucky Brother, 162–166
Categorical imperative, 9
Center for Complementary and Alternative Medicine (National Institutes of Health), 124
Center for the Study of Ethics in the Professions (CSEP), 299, 306, 307
Centers for Medicare and Medicaid Services (CMS), 216, 227–229
Certification, for integrated medicine practitioners, 126
Character development, 272
Chiropractors, 124
Cloning, 158
CMS Abstract and Reporting Tool, 228
Code of Hammurabi, 137–138
Codes of Ethics
challenges for working with, 307–309
for counselors, 303–306
for dental hygienists, 302–303
explanation of, 294
function of, 294–297
learning from, 299–300
limitations and criticisms of, 306–307
for nurses, 300–301
for pharmacists, 301–302
Collis, J. W., 199, 276, 279
Communication
ethics in, 319–320
staff justice and, 71–72
Communities, 79–80
Community organizations, 100
Competence
ethics and, 97–98
explanation of, 27
insuring staff, 93–97
self-assessment of, 98–101
Complementary/alternative medicine (CAM). See Integrated medicine (IM)
Computerized Physician Order Entry Systems (CPOE), 158
Confidentiality
autonomy as, 29–31
HIPAA and, 29, 30, 90
Conflicts of interest, 182–184
Conscience, 19–20
Consequentialism, 11
Consumer-driven health plans, 117
Continuing education
for HCAs, 100
for nurses, 300
support for employee, 96
Continuing education units (CEUs), 96, 183
Controlling function, 323–326
Conventional stage, 17
Corporate compliance
background of, 216–219
effects of quality programs and, 229–231
organizations’ view of, 219–220
Cost/benefit analysis
beneficence and, 51–52
personal moral integrity, 283
Counselors, Code of Ethics, 303–306
Covey, Steven, 98, 312–313
Crichton, Michael, 156
Critique of Practical Reason (Kant), 9
Crossing the Quality Chasm (Institute of Medicine), 140
Cultural diversity
of employees, 48–49, 196
in United States, 196
Culture
macro and micro view of, 196–198
organizational, 199–200
Culture clashes
examples of, 198–199
explanation of, 196
function of, 198–199
between patients and professionals, 246–247
D
Data collection, 324–325
Data integrity, 318–319, 324
De Angelis, Barbara, 45
Dealing with People You Can’t Stand: How to Bring out the Best in People at Their Worst (Brinkman & Kirschner), 317
Deceit, 275
Decision support systems, 155
Delegation, 321–322
Dental hygienists, code of ethics, 302–303
Deontology, 9
Descartes, René, 253
Dickens, Charles, 1
Diffusion, technology, 152
Directing function, 322–323
Disaster preparation, 335
Disclosure
explanation of, 27–28
managed care and, 121
Disease management, 118
Distributive justice. See also Justice
explanation of, 63–66
on organizational level, 68–69
theories of, 66–68
<table>
<thead>
<tr>
<th>INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not resuscitate (DNR) order, 327</td>
</tr>
<tr>
<td>Dogma, 87</td>
</tr>
<tr>
<td>Donne, John, 79</td>
</tr>
<tr>
<td>Dosick, W., 316</td>
</tr>
<tr>
<td>Downsizing, 48</td>
</tr>
<tr>
<td>Duty-based ethics, 9–10</td>
</tr>
<tr>
<td>Dye, C. F., 274, 314–315</td>
</tr>
<tr>
<td><strong>E</strong></td>
</tr>
<tr>
<td>E-mail, 71–72</td>
</tr>
<tr>
<td>Economic credentialing, 337</td>
</tr>
<tr>
<td>Eisenberg, David, 122–123</td>
</tr>
<tr>
<td>Electronic medical record (EMR), 154</td>
</tr>
<tr>
<td>Electronic Physician Order Systems (EPO), 158</td>
</tr>
<tr>
<td>Emerson, Ralph Waldo, 175, 176</td>
</tr>
<tr>
<td>Emotional health, 289–290</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP), 97</td>
</tr>
<tr>
<td>Employee training, 96–97</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>assuring competence of, 93–97</td>
</tr>
<tr>
<td>beneficence and, 52–53</td>
</tr>
<tr>
<td>checking references and credentials of, 94–95</td>
</tr>
<tr>
<td>cultural diversity of, 48–49, 196</td>
</tr>
<tr>
<td>discipline and termination of, 325</td>
</tr>
<tr>
<td>incompetence of, 97–98</td>
</tr>
<tr>
<td>motivation of, 322–323</td>
</tr>
<tr>
<td>nonmaleficence and, 47–50</td>
</tr>
<tr>
<td>satisfaction of, 325</td>
</tr>
<tr>
<td>Epidemiology, 138</td>
</tr>
<tr>
<td>Ethical hypocrisy, 312</td>
</tr>
<tr>
<td>Ethical Policy Statements (American College of Healthcare Executives), 297, 298</td>
</tr>
<tr>
<td>Ethicists, 203</td>
</tr>
<tr>
<td>Ethics</td>
</tr>
<tr>
<td>of advocacy, 91–93</td>
</tr>
<tr>
<td>of “bossdom,” 322</td>
</tr>
<tr>
<td>duty-based, 9–10</td>
</tr>
<tr>
<td>explanation of, 20–22</td>
</tr>
<tr>
<td>of integrated medicine, 125–126</td>
</tr>
<tr>
<td>of managed care, 114, 118–122</td>
</tr>
<tr>
<td>morality and, 271</td>
</tr>
<tr>
<td>normative, 21</td>
</tr>
<tr>
<td>organizational culture and, 173</td>
</tr>
<tr>
<td>patient-centered care and, 250–255</td>
</tr>
<tr>
<td>of patient satisfaction measurement, 249–250</td>
</tr>
<tr>
<td>in practice, 312–315</td>
</tr>
<tr>
<td>professional, 21</td>
</tr>
<tr>
<td>of quality programs, 229–231</td>
</tr>
<tr>
<td>of staff competency, 93–101</td>
</tr>
<tr>
<td>technology and, 159–161</td>
</tr>
<tr>
<td>utilitarian principles of, 11–12</td>
</tr>
<tr>
<td>Ethics committees</td>
</tr>
<tr>
<td>background of, 200</td>
</tr>
<tr>
<td>decision-making models for, 203–205</td>
</tr>
<tr>
<td>function of, 200–201</td>
</tr>
<tr>
<td>institutional review boards, 202–203</td>
</tr>
<tr>
<td>pediatric, 201–202</td>
</tr>
<tr>
<td>Ethics decisions, model for, 2, 3</td>
</tr>
<tr>
<td>Ethics Resource Center, 204</td>
</tr>
<tr>
<td>Ethics theorists</td>
</tr>
<tr>
<td>Aquinas, 7–8</td>
</tr>
<tr>
<td>Buber, 14–16, 229, 247</td>
</tr>
<tr>
<td>Frankl, 19–20, 229, 282, 288</td>
</tr>
<tr>
<td>Kant, 8–10, 31, 229, 249, 254</td>
</tr>
<tr>
<td>Kohlberg, 16–19, 270, 290</td>
</tr>
<tr>
<td>Mill, 10–12</td>
</tr>
<tr>
<td>Rawls, 12–14</td>
</tr>
<tr>
<td>Ethics theory</td>
</tr>
<tr>
<td>foundation for, 5–6</td>
</tr>
<tr>
<td>reasons to study, 6–7</td>
</tr>
<tr>
<td>Eugenics, 159</td>
</tr>
<tr>
<td>Evil, 277</td>
</tr>
<tr>
<td>Extermination camps, 278</td>
</tr>
<tr>
<td><strong>F</strong></td>
</tr>
<tr>
<td>Families, 253</td>
</tr>
<tr>
<td>Fidelity</td>
</tr>
<tr>
<td>autonomy as, 34–35</td>
</tr>
<tr>
<td>explanation of, 33–34, 275</td>
</tr>
<tr>
<td>Fiscal responsibility</td>
</tr>
<tr>
<td>billing practices and, 184–185</td>
</tr>
<tr>
<td>ethics and, 181–184</td>
</tr>
<tr>
<td>margin vs. mission and, 178–181</td>
</tr>
<tr>
<td>Food, Planetree Model and, 253</td>
</tr>
<tr>
<td>Foundations of the Metaphysics of Morals (Kant), 8–9</td>
</tr>
</tbody>
</table>
Frankl, Viktor, 19–20, 229, 282, 288
Fraud, 185
Friendship, 289

G
Gatekeepers, 116, 119
Gene doping, 160
Gene therapy, 157
Genetic testing, 157
Gert, B., 270
Gifts, 183–184
Golden Rule, 9, 11, 249, 254
Good will, 9
Greenfield, Meg, 83
Griffith, J. R., 274
Griffith, Joe L., 215
Group morality, 270. See also Morality
Group-speak, 320
Group-think, 319–320

H
Harmonic imaging, 157
Harvey, Jerry, 315
Hayes, James L., 331
HCAs. See Health care administrators (HCAs)
Health care
access to, 66–68
as business, 134–135
impact of technology on, 152–156
Health care administrators (HCAs)
continuing education for, 100
controlling by, 323–326
directing by, 322–323
ethics in practice for, 312–315
future challenges to, 334–337
organizing by, 320–322
planning by, 318–320
role of, 1–2
staff justice and, 69–72
technology and, 161–162
Health care financing, 176–178
Health care organizations
accountability of, 84–87
conflicts of interest for, 182–184
distributive justice and, 68–69
Health Care Quality Improvement Projects, 227–229
Health care system, 1, 273
Health insurance
integrated medicine coverage by, 124–125
statistics regarding, 66
technology use and, 161
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
autonomy and, 19, 26, 156
confidentiality and, 29, 30, 90, 156
function of, 89–90, 116–117
technology use and, 159
Health maintenance organizations (HMOs), 115, 120
Health Plan Employer Data and Information Set (HEDIS), 116
Health reimbursement arrangement (HRA), 117
HEDIS. See Health Plan Employer Data and Information Set (HEDIS)
Heinz’s Dilemma, 16
Herbal medicine, 124
High-risk patients, 69
Hill Burton Act, 134
HIPAA. See Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIV (human immunodeficiency virus), 31
HMO Act of 1973, 115
HMOs. See Health maintenance organizations (HMOs)
Holistic care, 124, 250–251, 254
Hoover, J., 317
Hospitals
ethics committees for, 200
technology use in, 152, 160
How Come Every Time I Get Stabbed in the Back My Fingerprints Are on the Knife? and Other Meditations on Management (Harvey), 315
INDEX

How to Work for an Idiot: Survive and Thrive without Killing Your Boss (Hoover), 317
HRA. See Health reimbursement arrangement (HRA)
Human Genome Project, 157
Human interaction, 252

I
I and Thou (Buber), 14
I-I relationship, 14–15
I-IT relationship, 15
I-THOU relationship
   explanation of, 15–16, 51, 247
   goal of, 65
I-YOU relationship, 15, 16, 51, 247
Incentive programs, 118–119
Information technology (IT)
   business practice applications for, 155–156
   clinical applications for, 153–155
   consumer applications for, 156
   explanation of, 153
   managed care and, 117, 118
Informed consent
   autonomy as, 27–29
   explanation of, 26–27
   integrated medicine and, 125
   managed care and, 121
Ingroup/outgroup management, 275–276
Institute for the Future, 117
Institute of Medicine (IOM), 140–141
Institutional ethics committees, 200
Institutional review boards (IRBs), 200, 202–203
Integrated medicine (IM)
   ethics and, 125–126
   insurance coverage for, 124–125
   movement toward, 80
   as threat to paternalism, 243–244
   trends in, 112, 122–125, 254
Integrity. See also Moral integrity
   challenges for maintaining, 281–292
   data, 318–319, 324
   trust and, 273
   value of, 276–277
   Integrity self-assessment, 274
   IOM. See Institute of Medicine (IOM)

J
JCAHO. See Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Job design, 320
Job training, 321
Joint Commission on Accreditation of Hospitals, 217
Journals, 284
Justice
distributive, 63–69
explanation of, 63
for patients, 64–65
staff, 69–72
K
Kaiser Company, 115, 158
Kaiser Foundation, 251
Kant, Immanuel, 8–10, 31, 229, 249, 254
King, Martin Luther, Jr., 18
Kohlberg, Lawrence, 16–19, 270, 290

L
Labeling, 278
Leadership
dark side of, 275, 276
ethics-based, 316
morality and, 271–272
servant, 291
trust in, 273
Leadership in Health Care: Values at the Top (Covey), 98
Leapfrog Group, 140, 141
Liberty principle, 13
Life experiences, 286–287

M
Maclagan, P., 270, 271
Magnetic resonance imaging (MRI), 152
Malcolm Baldrige National Quality Award, 216, 220–222, 231
Managed care
ethics and, 114, 118–122
future concerns of, 117–118
historical background of, 115
as market force, 114
overview of, 114–115
present state of, 115–117
Managed care organizations (MCOs)
accountability and, 84
accreditation of, 90–91
review of, 87
Man’s Search for Meaning (Frankl), 19
Market forces, 112–113
Marketing, 120–122
Massage, 253–254
Massage therapists, 124
Maximin Rule, 13
McGinn, P., 288, 315
Medicaid, 116, 120
Medical Group Management Association (MGMA), 93
Medically necessary care, 177
Medicare, 120
Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 227
Meeting the Ethical Challenges of Leadership (Johnson), 272
Mentors
function of, 99
moral, 285–286
MGMA. See Medical Group Management Association (MGMA)
Mill, John Stuart, 10–12
Mission
balancing money and, 326
fiscal responsibility and, 179
profitability and, 180–181
Mission statements, personal, 99
Moral bottom line, 283–284
Moral development, 16–18
Moral duty, 10
Moral integrity. See also Integrity
activities to build, 283–285
challenges for maintaining, 281–292
explanation of, 269–270
maintaining your, 279–280
results of ignoring, 274–279
Moral mentors, 285–286
Moral reasoning, 18
Moral reasoning theory, 18–19
Morality
explanation of, 269–271
group, 270
personal, 270
results of ignoring, 274–279
societal, 270
views of experts on, 271–274
Motivation, employee, 322–323

N
Nanotechnology, 156–157
National Center for Complementary and Alternative Medicine, 126
National Committee for Quality Assurance (NCQA), 90–91, 116
National Institute of Standards and Technology (NIST), 220
National Institutes of Health, 124
National Patient Safety Goals, 218
National Quality Forum, 141
Native Americans, 253
Natural law, 7
NCQA. See National Committee for Quality Assurance (NCQA)
Nehru, Jawaharlal, 5
Nixon, Richard, 115
Nonmaleficence
-duty of, 140
-explanation of, 46
-in health care settings, 46–47
INDEX

patient satisfaction and, 250
principle of, 45–46, 242
staff and, 47–50
Normative ethics, 21
Nuremberg Code of 1949, 202
Nursing
Code of Ethics for, 300–301
as subculture, 198
Nursing Home Quality Initiative, 229
Nutrition, 253

O
O Team, 180, 223
Office of the Inspector General (OIG), 337
Organization, 320–322
Organizational culture
ethics and, 197–198
explanation of, 196–197
function of, 173
Original position, 12
ORYX® system (JCAHO), 87, 218, 227, 228

P
Palmer, P. J., 271–272, 284, 316
Partnership for Human Research Protection, Inc. Accreditation Program (National Committee for Quality Assurance), 91
Paternalism
challenges to, 243–244
explanation of, 242–243
Patient-centered care
explanation of, 250
Planetree Model for, 250–255
Patient experience
dynamics of, 244–247
measurement of, 247–250
Patient justice, 64–65
Patient Rights and Organization Ethics (RI) (Joint Commission on Accreditation of Healthcare Organizations), 87
Patients, high-risk, 69

A Patient’s Bill of Rights (American Hospital Association), 34, 89
Pediatric ethics committee, 201–202
Performance Software Corporation, 156–157
Personal mission statement, 273
Personal moral integrity cost/benefit analysis, 283
Personal morality, 270. See also Morality
Personal quality improvement (PQI), 280, 288–290
Pharmacists, code of ethics, 301–302
Pharmacogenomics, 157
Physicians’ Desk Reference for Herbal Medicine, 124
Planetree Model, 251–255
Planetree Movement, 250
Planning, 318–320
Pluripotent, 157
Poka-yoke, 140, 216, 225–227
Policy Statement - Ethical Issues Related to a Reduction in Force (American College of Healthcare Executives), 48
Poor individuals, 135
Power, 32, 275
Practice profiling, 116
Prayer, 290
Pre-conventional stage, 17
Pre-moral stage, 17
Prevention, 136–140
Principled moral reasoning, 18
Professional ethics, 21
Professional socialization, 198, 246
Public health administrator (PHA), 139
Public health system
collaboration between medical system and, 138–140
roots of, 137–140
Purtilo, R., 270, 271, 280, 314

Q
Quality assurance
ethics and, 229–231
as social responsibility, 140–142
Quality Check™ program (Joint Commission on Accreditation of Healthcare Organizations), 87
Quality control, 141
Quality improvement programs
development of, 220
ethics of, 229–231
features of, 227–229
Malcolm Baldrige National Quality Awards Program, 220–222
poka-yoke, 225–227
Six Sigma, 222225
Quality Net Exchange administrator, 228
Quinlan, Karen Ann, 200

R
Randolph, A. Philip, 133
Rawls, John, 12–14, 230, 249
Reasonable person standard, 28
Reconciliation, 274
Reflection, 285
Reproductive cloning, 158
Rest Model, 272
Revenue cycles, 184
RI. See Patient Rights and Organization Ethics (RI) (Joint Commission on Accreditation of Healthcare Organizations)
Robert Wood Johnson Foundation, 141

S
Schiavo, Terri, 47
Schwarzkopf, Norman, 311
Self-assessment
of competence, 98–101
of integrity, 274
Self-determination, 26
Self-interest, 12
Self-regulating, 295, 296
Self-treatment, 244–245
Sense of meaning, 19
Serenity Prayer, 249
Servant leadership, 291
The Seven Fatal Management Sins (Collis), 276
The Seven Habits of Highly Effective People (Covey), 98, 312
Shared Vision - New Pathways initiative (JCAHO), 218
Shelley, Mary, 157
Shingo, Shigeo, 225
The Sick role, 245
Six Sigma® Program, 216, 222–225, 231
Six Sigma Qualtec, 224
SMM Health Care of St. Louis, 221, 222
Snow, C. P., 151
Social justice, 13–14, 230, 249
Social responsibility
explanation of, 134–136
prevention as, 136–140
quality assurance as, 140–142
Societal morality, 270. See also Morality
Societal stigma, 246
Solitude, 290–291
Specifications Manual for National Implementation of Hospital Core Measures (JCAHO), 227
Spinoza, Baruch, 25
Spirituality, value of, 290–291
St. Luke’s Hospital of Kansas City, 221
Staff. See Employees
Staff justice
administrators and, 69–72
explanation of, 64
Standards, of Joint Commission on Accreditation of Healthcare Organizations, 87–88
The State of Health Care Quality (National Committee for Quality Assurance), 90
Stem cell research, 157, 158
Stewardship, 180–181
Stewardship: Choosing Service over Self-interest (Block), 180
Subcultures, 198–200
The Subjection of Women (Mill), 10
Summa Theologoe (Aquinas), 7
INDEX

T
Taylor, Harriet, 10
Teams, 323
Technology. See also Information technology (IT)
ethics and, 159–161
future issues for emergent, 156–159, 336
impact of, 152–156
paternalism and, 243
role of health care administrator in, 161–162
Technology diffusion, 152
Telemedicine, 152
Telos, 11
Therapeutic cloning, 158
Thieriot, Angela, 250–251
301 Ways to Have Fun at Work (Hemsath & Yerkes), 289
To Err Is Human (Institute of Medicine), 141
Trust, 273–274, 277
Truth-telling, 31–33
Tsunami, 334
Tuskegee Syphilis Experiment, 202

U
Uninsured individuals, 120, 177
Unmasking Administrative Evil (Adams & Balfour), 199
Utilitarianism
explanation of, 11
justice in health care and, 66–67
Planetree Model and, 255
Utilitarianism (Mill), 10
Utilization reviews, 116

V
Veracity, 31. See also Truth-telling
Voluntariness, 27

W
Wal-Mart, 25–226
Wang, An, 111
Waste reduction, 181
When Medicine Went Mad (Caplan), 278
Wilford, D.S., 273
Workplace bullying, 49–50

Z
Zero Quality Control movement, 225