From Clinical Ethics to Organization Ethics: Working with Systems

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The growth of organization ethics in health care is an extension of business ethics into what is in the United States the latest beachhead of industrialization: what is now being known as the "healthcare industry." It is also an appropriate extension of clinical ethics—a necessary extension, under contemporary conditions of health care delivery in the United States. It is the articulation, application and evaluation of the values of an organization, by which it is defined internally and externally. In health care delivery, organization ethics is an integration of business, professional and clinical ethics, and expressed in processes addressing the ethical issues associated with the business, financial and management decisions of healthcare organizations as they affect patient care.[1] Business ethics, clinical ethics and professional ethics all acquire different inflections and roles as we consider them in the context of the U.S. healthcare system. Professor Werhane has talked about how to think about business ethics in the context of health care. In my brief commentary I would like to talk about organization ethics in health care institutions as a supplement and support to professional and clinical ethics. [2]

To do that, I will briefly revisit a history that has been presented by Mattias Kettner and Arnd May in this Wissenschaftszentrum:[3] the growth of clinical ethics committees (CECs) in the United States, and the relation of such committees to the professional ethics of medicine in our current rapid transition of health care from a professionally dominated social function to an economically driven business.

Background

The differences between the US healthcare system and most European systems have been widely discussed. We have a pluralistic and individualistic society, and compared to most European countries, the healthcare system in the US is very decentralized and disorganized. There is considerable variation across populations of availability of resources and of standards of care. What governmental oversight and coordination we have affects only some, not all, of the stakeholders in the system. There is considerable private utilization of publicly funded advances in technology and research, but little public control over equity of access or uniformity of application. Because we lack that most enviable of German amenities, the Krankenkasse, access to healthcare is variable. Only the insured have access to many treatment options, and the number of uninsured is large and growing. Our current emphasis on cost constraint is an additional stressor. With the failure of Clinton's proposal for a national health care plan, concern for economical utilization of medical resources has by default been left to market forces. The increasing influence of economic considerations on hospital administrative decisions represents a new area of concern for clinicians.

Threats to the Hippocratic Organization

As in all countries, the ethics of healthcare in the US is a strongly Hippocratic one, drawing on a long tradition of physician ethics, which is incorporated into the ethical codes of other clinical professions as well as the ethical codes of hospital administrators. For most of the last century, medical professional ethics, buttressed by professional codes

of other health care professionals that incorporated many of the same provisions, dominated the hospitals and other health care organizations and determined organizational policies. According to some scholars, the balance of power in the operation of hospitals in the United States has begun to shift in the last few decades from physician domination to increasing power of managerial decisions.[4] This tendency has increased as the society becomes increasingly concerned with the cost of medical care. The intervention of for-profit "managed care" intermediaries between payers for health care (primarily employers and government) and the providers of health care (individual physicians and the organizations with which they collaborate) has complicated the relationship of patients to providers, and raises the question of the balance of cost of care and quality of care, on the public and policy level, and in individual institutions, on the level of individual cases.

The balance of cost and quality is not a new one, but it has never been more pressing. It sometimes seems as if health care delivery in the US is laboring under two incompatible but simultaneous demands: "Improve quality, whatever the cost!" and "Constrain (or even better, reduce) costs, or risk going out of business." As Professor Werhane has indicated, the system as a whole, and every institution and individual in it, accepts as the mission of the system the provision of good quality care at a reasonable cost. But implementing this common goal can become problematic when the two imperatives of cost and quality are used as whipsaw alternatives, for the policies and decisions that serve the one can impede the other. Communication and coordination among disparate functions within healthcare organizations becomes of paramount importance.

Clinical Ethics Committees

Public revelation of abuses in medical research in the '60s, as well as some important legal cases concerning end of life care, generated wide pressure for mechanisms for more social scrutiny of medical decision making. On the national level, a series of presidential commissions and committees advised on federal policy in the '70s and '80s. On the level of health care and medical research organizations, both research ethics committees (IRBs) and clinical ethics committees (CECs) mandated involvement of non-medical laity in medical research and care issues, a social development that has been widely discussed as "the birth of bioethics."[5] One of the important results has been a closer scrutiny of the relation of medical research and medical care, hedging the former about with protections for research subjects that assure the primacy of the mission of care in the medical context.

CECs were introduced in limited contexts and around specific problems. In the US, as in Germany, they were first instituted in denominational hospitals. They were more widely spread in response to legal initiatives around specific problems—abortion, neonatal decision making, and other problem areas created by increasing technological sophistication in medical care. Because they had been useful in those limited situations, the first presidential bioethics commission in the early '80s recommended that wherever possible ethically troubling cases be adjudicated within individual institutions rather than being resolved by the courts—a useful recommendation in our litigious society. The Joint Commission for the Accreditation of Health Care Organizations instituted a standard for institutional ethics processes as a condition for the receipt of federal funding

in 1991, and every hospital of over 200 beds in the United States now has an ethics committee (or "equivalent process") as a condition for accreditation.

The initial impetus for clinical ethics committees, as they began to be introduced in hospitals during the last quarter of the last century, was as a counterweight to unilateral medical decision making on the part of physicians. Although the physicians retain responsibility for patient care decisions, the introduction of multidisciplinary ethics committees represents an opportunity for other health professionals and for patients and their families to openly examine and discuss the values implicit in controversial care decisions. They serve within individual hospitals as a locus for what Kettner and May have called a "discursive community" on a local level, to which particular physicians or other affected parties can bring troubling cases. Their importance in hierarchical and highly bureaucratized institutions is evidenced by the percentage of cases that involve, one way or another, failure of communication: communication between the various clinicians involved in the care of complex cases, or communication with the families of children or seriously ill patients.

Organization Ethics

If publicity about abuses of professional ethics in the context of research led to the development of clinical ethics, fear of constraints on professional responsibility in the context of cost cutting is fueling the development of organization ethics. In 1997 JCAHO added to its standards for accreditation a requirement that each health care institution it accredits introduce "a mechanism" to address ethical responsibilities on the organizational level.[6] A similar standard prompted the universalization of CECs in 1991, and the development of organization ethics is now in its first stage in the US. The standard explicitly reinforces the primacy and integrity of clinical decision making, encouraging communication between clinical and administrative functions. It calls attention to the ways in which business considerations might impinge on clinical integrity—a growing concern as managed care becomes more dominant in the US.

There is no single mandated approach to organization ethics, and just as in clinical ethics, where there are a variety of alternative structures suited to the idiosyncrasies of particular institutions, health care organizations in the U.S. are experimenting with a variety of ways to meet this new requirement. Some institution have specially constituted "organization ethics" committees. Some have ethics officers, and others have subcommittees of their already functioning CECs. Our assumption is that committees analogous to those that dominate clinical ethics in the US today are one very effective way of addressing ethical problems on the organization level. The problems traditionally brought to CECs will not go away, and must continue to be accommodated. But many clinical ethics problems arise from systemic, structural problems within the institutions, and many can be satisfactorily resolved only on the organizational level. Further many clinical ethical issues—confidentiality, privacy, informed consent, truth telling or disclosure—have analogues on the level of the organization that need to be addressed in order to maintain an ethically sound health care system. A clinical ethics committee on the traditional model can be expanded to incorporate some of those functions, if some changes are made both in the membership of the CEC and in the range of topics that fall within their purview. The effectiveness of OECs in protecting professional ethics and

patient interests in the rapidly changing healthcare system in the US is still being determined in these various experiments.

Conclusion

Many of the problems that beset the US healthcare system have sources outside of the control of the individual healthcare organizations that are delivering services. In particular, the question of equitable access to care in our technologically advanced and medically sophisticated system remains unaddressed by any of the organization level mechanisms I have been discussing. We can continue to work to improve the health care system, improving quality of care, reducing errors and waste and making care and administrative processes more efficient. But because of the intensity of the pressures and the rapidity of the changes on all levels, we consider it very important to establish mechanisms proximate to the level of the clinician-patient encounter to insulate patients from adverse consequences of change.

The systems approach that Professor Werhane is recommending is an attempt to overcome the provinciality of place and perspective. Changes at any level of an interrelated system affect everyone; and for adequate solutions to problems caused by change, the stakeholders at each level need to be cognizant of the imperatives of the other levels. Under current conditions of health care delivery in the US today, we need to think about our ethical responsibilities organizationally, and our organizational responsibilities ethically—and both systemically.

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[1] Edward M. Spencer, Ann E. Mills, Vary V. Rorty & Patricia H. Werhane, *Organization Ethics in Health Care*. New York/Oxford: Oxford University Press, 2000, p. 5

[2] Several books have appeared addressing this new field, including Robert Hall, *An Introduction to Health Care Organizational Ethics,* Oxford University Press 2000, and Philip J. Boyle et al, *Organizational Ethics in Health Care* , Jossey-Bass 2001.

[3] Matthias Kettner & Arnd May: "Ethik-Komitees in der Klinik: Zur Moral einer neuen Institution." *Jahrbuch 2000/2001.* Kulturwissenschaftliches Institut Essen*,* 2001.

[4] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century.* Baltimore: Johns Hopkins Press, 1998; W. Richard Scott, Martin Ruef, Peter J. Mendel & Carol A. Caronna, *Institutional Change and Organizations: From Professional Dominance to Managed Care.* Chicago: University of Chicago Press, 2000.

[5] See for instance David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991) or Albert R. Jonsen, *The Birth of Bioethics* (New York/Oxford: Oxford University Press, 1998).

[6] Joint Commission 1997, RI 24-32.