# Reconceptualizing the Organization Ethics Process as a Vehicle for Change in Healthcare Organizations

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**ABSTRACT**

The healthcare organization is facing intransigent pressure for change. Cost and quality issues are affecting internal and external stakeholders, including both payers and patients. But structural impediments in the healthcare system make it difficult for the healthcare organization to react productively to these pressures. Introducing change strategies without attention to the culture of the implementing organization is predictive of failure. Viewing healthcare organizations as complex adaptive systems this paper explores these impediments to change and points to the importance of an organization ethics process as a vehicle for the implementation of change technologies.

**Reconceptualizing the Organization Ethics Process as a Vehicle for Change in**

**Healthcare Organizations[*]**

Two recent publications from the Institute of Medicine show the healthcare

industry that the healthcare system must change.  The first report, <u>To Err is Human:</u>

<u>Building a Safer Health System</u>, described studies that found that between 44,000 and

92,000 Americans die each year as a result of medical errors (Kohn, Corrigan, &

Donaldson, 2000).  Industry leaders have called the rate of medical errors in healthcare

delivery unacceptable, and the need for reform has been called urgent (Becher & Chassin,

2001; Chassin & Galvin, 1998).  The second report, <u>Crossing the Quality Chasm:  A New</u>

<u>Health Care System for the 21<sup>st</sup> Century,</u> expands its focus from safety to include other

values, and recommends that the delivery system as a whole work toward a future in

which it will exemplify the values of safety, efficiency, timeliness, equity, effectiveness

and patient centeredness (Committee on Quality and Health Care in America, 2001).  It

recommends strategies the various components of this system might pursue to better

instantiate those values.  The report states that change in the system of healthcare

delivery will not be easy, but its authors make a compelling case that change is necessary

if the system is to adequately fulfill its social role.

Crossing the Quality Chasm addresses all components of the delivery system.  We

will focus on a central organizational population, the healthcare delivery organization. In

response to the two reports, many healthcare organizations are embracing quality

initiatives as appropriate technologies for change. (Berkowitz & Checkley, 2000)  These

technologies were developed in manufacturing industries, and are being extended into

service industries, including health care. The healthcare organization, however, is a particularly difficult locus for the introduction of change technologies. Although we find that these technologies are consonant with the goals for the healthcare system outlined in Crossing the Quality Chasm, they may be insufficient to meet the challenges posed by the characteristics of the healthcare organization and the environment in which it functions. We examine the advantages and disadvantages of change strategies and consider whether the philosophy and goals of quality initiatives are adequate to meet the goals of healthcare reformers. We defend a different approach to fostering change in the healthcare organization, a process that may stabilize and unify the healthcare organization as it changes: the organization ethics process. As a vehicle for change, this process can help align the interests, values and competencies of the individuals within the organization with its vision and culture, while supporting specific technologies the healthcare organization may wish to employ as it seeks to change.

## CHANGING THE HEALTHCARE ORGANIZATION

**Complex Adaptive Systems**

In what follows we adopt the assumption made in Crossing the Quality Chasm that the healthcare system can usefully be seen as a "complex adaptive system." Adaptive systems contrast with mechanical ones. In mechanical systems we can predict in great detail and with considerable certainty what each of the parts will do in response to a given stimulus. Unexpected deviation from the anticipated response is perceived as an error or failure, and provokes an intervention, generally a study of the deviation and some form of corrective action to prevent it from reoccurring. When the unexpected occurs in an adaptive system, it may be perceived as an error or as innovative. The larger

the system is, the less predictable its responses to outside stimuli. In health care the

unpredictable, both innovations and errors, can occur on any level, and any one

component of the system may affect the whole. (Plsek & Wilson, 2001) Desired results

can be achieved by a variety of different means in complex adaptive systems, and so

flexibility in achieving the desired improvements should be encouraged. (Plsek &

Greenahigh, 2001).

If the healthcare system as a whole is a complex adaptive system, so too are its
components, including the healthcare organization. Certain functions employed
by many healthcare organizations can be best carried out by approximating the
mechanical system ideal. For example, packing surgical kits, which are expected
to contain predictable instruments, or billing procedures, should occur in the same
way time after time. But many activities in the healthcare organization fall in a
"zone of complexity" where professional and social agreement about the
desirability of outcomes has little or no correlation with the certainty of achieving
those outcomes. (Plsek, 2001)

What substitutes for mechanical predictability in adaptive systems is their orientation
toward a purpose or desired goal. Crossing the Quality Chasm states this purpose
for the healthcare system: "All healthcare organizations, professional groups, and
private and public purchasers should adopt as their explicit purpose to continually
reduce the burden of illness, injury, and disability, and to improve the health and
functioning of the people of the United States" (Committee on Quality and Health
Care in America, 2001: 5). The logic of complex adaptive systems suggests that
change should be introduced through a few simple rules rather than a multiplicity
of complex rules, and Crossing the Quality Chasm supplies ten (Committee on
Quality and Health Care in America, 2001: 61-89).[a] Since the report directs its
attention to the entire system, some of the explicit recommendations of the ten
rules represent imperatives that are out of the control of any individual
component. From the perspective of the healthcare organization, however, these
ten rules call for the patient to be its primary focus, that decision making rely on
evidence based medicine,[b] that the processes it uses in patient care be flexible
enough to allow for individual patient values and preferences, and that waste and
error should be continuously decreased.

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[a] These ten rules are: 1. Care based on continuous healing relationships. 2. Customization based on patient
needs and values. 3. The patient as the source of control. 4. Shared knowledge and the free flow of
information. 5. Evidence-based decision making. 6. Safety as a system property. 7. The need for
transparency. 8. Anticipation of needs. 9. Continuous decrease in waste. 10. Cooperation among clinicians.

[b] Evidence based medicine is defined in Crossing the Quality Chasm as being composed of three prongs –
best research evidence, clinical expertise and patient values (Committee on Quality and Health Care in
America, 2001: 74). From the point of view of quality initiatives, evidence based medicine is a benchmark
or a standard that variations can be measured against.

**Tools for Change: Quality Initiatives**

Change may be local or global, abrupt or incrementally adaptive; but change, as described in both reports released by the Institute of Medicine, requires individual organizational components of the system changing in a fundamental way through some form of process re-engineering.   In other industries process re-engineering and the techniques, initiatives, and strategies, associated with it have been variously called Total Quality Management or Continuous Quality Improvement, and the most recent to claim the attention of healthcare managers is Six Sigma.  There are many more commonalities than differences among these various initiatives – the differences primarily being in the degree to which statistical measurement is used in process control and the intensity with which key philosophical aspects of these initiatives are emphasized (Grant, Shani, & Krishen, 1994; Grol, 2001; Pande, Neuman,& Cavanagh, 2000). We will discuss them all under the heading of quality initiatives.

Quality initiatives comprise a group of ideas and techniques, primarily sampling techniques, for enhancing competitive performance by improving the quality of products and services.  There are three important commonalities among the various initiatives (Grant, Shani, & Krishen, 1994).

First, quality initiatives rely on identifying, measuring, and if possible eliminating, variations in production processes in order to improve either the quality of a product (manufacturing) or the quality of a process (service).  Variations are seen as contributing to costs.  But it is important that whatever procedures or processes are followed to either produce the product or offer the service are analyzed in detail, and contextualized in terms of how they contribute to the end result.  The production or service process is seen as an integrated whole, each stage seen as one moment in a

seamless stream of process, rather than as a series of isolated events. Process reengineering coordinates the stages in order to achieve the appropriate process flow as well as identifying and resolving problems that occur.  Frontline workers, those workers who are most proximately involved in the creation of the product or delivery of the service are presumed to have the skill or knowledge to detect problems, and they are generally empowered to shut the process down when a problem occurs. These front-line workers are seen as the source of suggestions for improvement.

One result of positioning the customer as the driver of the organization is increased accountability.   If the customer is the final arbitrator of the quality, the organization must know the customer's profile. This allows the organization to develop matrixes to identify whether or not the organization has met its goal of serving the customer.  This target introduces accountability into both management and operational decisions and functions (Grant, Shani, & Krishen, 1994).

Second, quality initiatives place the end result – be it product or service—in the context of the end user.  Rather than viewing the result as an end in itself, the process is externally focused, designed to serve the customer.  This gives the organization a goal each function can support and a focus that can help unify the organization. The customer exerts a demand-pull leverage on the organization, so that each stage of the process is designed with the expectations of the customer in mind.  This customer focus can be diffused through the organization's relationships with others, including the demands it makes on its suppliers.

Third, all quality initiatives purport to be organizational philosophies.   Observers of the implementation of quality initiatives insist that the organization's culture and its

strategic direction will change as a result of implementation (Detert, Schroeder, & Mauriel, 2000).   In for-profit organizations, profit results from the relationship between revenues and costs and many organizations are tempted to focus on cost reduction to achieve greater profits.  The assumption of quality initiatives is that profit results from customer satisfaction, and so the focus and first priority of the organization must be on the customer, not on the profits themselves.  The organization's reason for being is to meet or exceed the expectations of the customer.  It is assumed that organization viability is achieved through enhanced quality (increased efficiency and the elimination of waste) that results in a stable and growing customer base (increased revenues).  Strategic and operational decisions made from the perspective of pleasing the customer, keeping the customer loyal, and generating new and loyal customers, will be different than those that focus on short-term profit making.  Those decisions will change the beliefs and behaviors of organization members and so change the culture of the organization (Victor and Cullen, 1988).

These three ideas underlie all quality initiatives.  But reports from other industries suggest that quality initiatives often fail. Despite the attention that healthcare industry leaders have given them (Blumenthal, 1995; Buck, 1998; Chassin, 1998), some critics are not impressed with their success over the long run (Grol, 2001). Quality initiatives are change initiatives in that they seek to change the core processes by which organizations conduct their business (Laffel, & Blumenthal, 1989).  But Beer and Nohria report that 70% of all change initiatives fail (Beer and Nohria, 2000:133).  Other evidence supports Beer and Nohria's assertion.  Cohen reports that in a 1991 American Electronics Association survey of 300 electronics companies, 85 percent reported quality programs

underway, but less than one third had achieved any significant positive results.  In the same essay he notes a McKinsey & Company study that found that two-thirds of quality programs failed to yield any real improvements (Cohen, 1998).  Similarly, Basu notes that despite the spectacular success General Electric has had with Six Sigma, its originator, Motorola, announced in 1998 that its second quarter profit was almost non-existent and that consequently it was cutting 15,000 of its 150,000 jobs (Basu, 2001). Various reasons for the failure of change initiatives have been given, including a lack of appropriate resources for implementation, and a lack of consistent commitment from top management. (Pande, Neuman, & Cavanagh, 2000). Another often-cited reason for failure is a mismatch between the culture required to support the initiatives and the culture of the implementing organization  (Detert, Schroeder, & Mauriel, 2000).

If quality initiatives fail in other industries, how can they be enhanced to support change in health care?   When quality initiatives began to be implemented in health care, there was some question about whether they were appropriate for hospitals, because of resistance from doctors and other professionals to interference from administrators, because of the bureaucratic nature of  hospital organizations, and because of fairly wide-spread suspicion that quality initiatives might be used by hospitals as a cover for cost cutting that would reduce the quality of care (Blumenthal, 1995).  Nonetheless, since 1990 quality initiatives have been increasingly important as managerial strategies for change in healthcare organizations. (Westfall, Gulati & Shortell,1997:380).  Quality initiatives are congruent with the recommendations for improving quality in healthcare organizations made by the authors of Crossing the Quality Chasm.  First and foremost, they emphasize the importance of a customer (patient) focus.  They are consistent with

the Institute of Medicine's emphasis on evidence-based medicine, supplying a standard

by which decisions are to be made ( the analogue of benchmarking in statistical process

control).   Flexibility can be achieved through empowerment of the physician, the front

line worker, and the elimination of waste and error can be targeted and measured. Yet

successful implementation of quality initiatives in healthcare organizations will be

difficult unless they are congruent as well with the culture of the organizations in which

they are being implemented.

**Three Components for Successful Change in Healthcare Organizations**

How do organizations change?  Retaining organizational identity and coherence

while making fundamental changes in the orientation or process of an organization

requires a balance between mobility toward change and stability through time. The

importance of leadership in times of change is often crucial, but the mobilization power

of the leadership varies depending upon the organizational structure and the integration of

the various forces for change (Huy, 2001).   The healthcare organization is characterized

by a division of leadership between the administrative and the clinical functions

(Johnson, 1979), a dilution of managerial power by the influence of professionals and

external regulators, and competing, sometimes irreconcilable, environmental demands

(Pavia, 2001).

Three Canadian researchers sought to answer the question of how leaders can

achieve deliberate strategic change in organizations where leadership roles are shared,

objectives are divergent and power is diffuse (Denis, Lamonth,& Langlely; 2001).  They

chose as their focus the healthcare organization and investigated how "first and second

order" strategic change occurred in five cases over a ten year period in the Canadian

healthcare sector – a nation whose healthcare organizational structure approximates our own.  First order change, examined in three hospitals, is an organizational attempt to alter their internal practices, or to redefine the mission of the healthcare organization.  They also examined two cases of second order change, where the integrity and existence of the organizations came in question because of mergers.  Their findings were consistent for both types of change.

In developing a process model to explain how change could occur in such organizations, the Canadian authors identified three levels of "couplings" that must be mobilized for successful change to be introduced. These couplings are strategic, (occurring between members of a leadership team), organizational (between the leadership team and their internal constituencies), and environmental (between the leadership team and the organization's external environment).  The success of a change strategy in an organization, they hypothesized, is a function of the adequacy, stability and duration of couplings on all three levels.  Inadequate coupling on any level reduces the probability of success.

Strategic coupling, coordination between leaders of different groups, can be particularly complex when power is decentralized, as it is in healthcare organizations. For successful strategic coupling, leadership roles must be complementary, with "adequate coverage of all activity domains as well as the existence of mechanisms allowing different actors to play their respective roles in a concerted manner" (Denis, Lamothe, & Langley, 2001; 811).   A successful leadership team will also be consistent. Organization leaders must be united in their vision of the organization and espouse the same ideas of how to achieve that vision.  Strategic coupling is fragile and may unravel

from pressures from unsuccessful coupling on the other two axes, organizational or environmental coupling.

Organizational coupling refers to the relationship organization leaders have with their internal constituents, and their ability to influence those constituencies. A successful organization coupling will occur when leaders and their constituents are in agreement about the goals of their respective functions within the organization and what must be done to realize these goals.

Environmental coupling refers to the relationships the organization has to its environment, which includes government bodies, other healthcare organizations, managed care organizations, and the community. The relationships between the organization and its environment can be supportive of change or antagonistic to it. If environmental expectations are inconsistent or incompatible, successful change may be difficult.

It may be that one of the three levels of coupling may dominate the others to initiate change. For instance, a strongly united and aggressive leadership team may start an organization down the path of change in spite of organizational or environmental hostility. But in such a divided organization it is doubtful that successful strategic coupling will endure over the long run. The more spontaneously these levels couple to initiate change, and the more coordination between them, the more chance the organization has of successful change.

There is difficulty in achieving successful couplings at all three levels simultaneously, and the authors' research shows that change tends to proceed in fits and starts, with sequential coupling and uncoupling occurring over time at different levels.

Factors providing stability become particularly important for allowing the organization to function during these cycles. Successful couplings on the three levels they identify—of organizational leaders agreeing on the goals and instrumentalities of change, of all internal constituencies uniting behind the leadership on the importance and modalities of change, and of support from external stakeholders during the vagaries of change—would support a healthcare organization's effort to change in the way required to realize the goals prescribed for the healthcare system outlined in Crossing the Quality Chasm.

**Structural Impediments to Change in the Healthcare Organization**

Change in organizations is not easy, and the more complex an organization, the more difficult it will be to marshal the unity and stability necessary to introduce change without fragmentation and disruption to the organizational culture (Strebel, 1994). Leadership in the healthcare organization is distributed between the administration, physicians and governing board. The three may, and in some situations do, have differing objectives and goals. The healthcare organization's workforce is highly professionalized, and while that represents a powerful source of expertise and possible source of innovation in the institution, it also represents a possible source of resistance to externally imposed changes (Blumenthal,1995; Starr,1982; Stevens, 1999). Prime revenue generators for healthcare organizations are physicians, the front-line workers most proximate to care decisions; but typically many physicians associated with a health care organization are not directly employed by it (Bloche, 2000; Stevens, 1999).

There are environmental factors that impede change as well. As a component of the healthcare system the healthcare organization is currently being subjected to inconsistent but very powerful environmental pressures that both force and hinder change (Greenwall, 2000). Crossing the Quality Chasm, addressed as it is to the provider community, does not deal directly with one important element that has shaped and continues to shape the development of this complex adaptive system – the financing of healthcare. The report explicitly includes 'private and public purchasers' in the constituencies addressed by the report, and they are one element in the entire system (Committee on Quality and Health Care in America, 2001: 6). But from the standpoint of the healthcare organization, the payer, like the governmental regulator, is an environmental influence—one of the stakeholders in the system as a whole, but one over which the organization actually delivering care does not have complete control.

There is an important role that payers play that confuses the strategic alliances and couplings necessary for successful change which are related to the split in the "customer" of health care (Morreim, 1995: 22). Most healthcare related services and products are only partially paid for by the people who use those services, the

patients. The bulk of the financing of health care is either through government agencies or though employer sponsored coverage (Bodenheimer & Sullivan, 1998; Kuttner, 1999). This split in the customer profile has profound implications for the possibility of change in an environment where both quality and cost are important considerations. Strategic decisions oriented toward payers will be different than if the patient is considered the primary "customer" of healthcare organizations (Bailit, 1997). The payers who finance the delivery of care have introduced a variety of strategies to slow the growth in healthcare costs (Kleinke, 1998). Healthcare organizations have often had to accommodate to these cost-containment initiatives or risk losing their contracts with payers (Meltzer, 2001). Healthcare organization leaders who are most responsible for the financial stability of the organization may prioritize the interests of payers. Obviously, this confusion will make it more difficult for organization leaders to agree upon a vision of the healthcare organization and the appropriate strategy for achieving it. Not only strategic, but organizational, coupling can be impacted by this confusion

over the customer of the healthcare organization. Operational decisions and the way in which processes to deliver care are designed will be different depending upon whose interests are prioritized. Some cost-containment strategies have included strictures that involve actual medical decision-making, or come perilously close to doing so (Tzeel, 2002). Statistical control methods underlie quality initiatives that target and isolate deviations in care for the purpose of eliminating waste and inefficiency and increasing the customer's perception of quality. But unless they are involved in the design of any quality initiatives affecting direct care, physicians practicing within the healthcare organization may be uneasy about the way statistical process control is being introduced into medical decision-making, and have questions about issues of accountability and the threat of loss of autonomy that statistical process control introduces (Bovbjerg, Miller & Shapiro, 2001; Kaiser Family Foundation, 2002). This may make it difficult for organization leaders to mobilize support from their important clinical constituents for change. But successful organization coupling, though perhaps difficult to achieve, is crucial to process redesign (Coddington, Fischer, & Moore, 2000).

Alignment of organizational objectives with the expectations of the environmental

stakeholders is more difficult if there is divergence among the external forces, and that

situation certainly holds with respect to the balance of cost and quality in health care.  As

anxious as payers, government agencies, and enrollees in health plans may be to

constrain increases in cost, they have all indicated that they are unwilling to compromise

quality of care in the process (Editorial Staff, 2002).  As a result both lower costs and

excellent quality are environmental demands on the health care organization.  The

question of how to balance the two is left to the institution.   It is tighter linkage between

cost and quality, and explicit justification of costs, that underlie the quality movement,

both driving it, and impeding the alliances that will make it successful (Bringewatt,

2001).

Hostility from the environment to proposed change in the healthcare organization will
have to be taken seriously by organization leaders, for it can either undermine or
support proposed change.  Hostility or support from the financers of care will
largely depend on which group the healthcare organization identifies as its
primary customer.  If in the process of improving care costs are lowered, then
payers will support quality initiatives. If the result of quality initiatives is more
costly care, it is uncertain whether payers will support them (Bailit, 1997).  In
either case, environmental forces can act to disrupt or divide team leadership and
organization constituents so as to hamper positive change, either by reducing
momentum for change or destabilizing the organization's unity as it tries to move
forward.
The authors of Crossing the Quality Chasm recommend organizational unity

around its central purposes and focal values.  The quality initiatives most readily

available for implementing these values seem to be consonant with these

recommendations, and if they are successful, purport to eventually transform the

healthcare organization to an orientation toward quality (Berkowitz & Checkley, 2000).

But the divisive force of the environment, the complex financing that separates payer

from patient-consumer, and the complexity of the internal structures of the healthcare

organization call for a different process, one designed specifically to further the integration and unification of the internal constituents and affiliated staff of the healthcare organization. This process is to be found in the organization ethics process and its effect on the ethical climate of the healthcare organization.

## ORGANIZATION ETHICS IN HEALTH CARE

Crossing the Quality Chasm states that change in the healthcare organization must occur; that the consequences of ignoring the deficiencies of the healthcare organization will be preventable harm, if not death, to its customer, the patient. Change has been deemed necessary by many observers; but many quality initiatives in other industries have failed. Many perceive that "culture" is an important variable-- perhaps the most important variable--in determining whether an organization can change (Sims, 2000). The ethical climate of an organization is an important component of the organization's culture, and is particularly important in an organization with a highly professional membership. Change initiatives of the sort discussed in this paper can only succeed if they are accommodated to the organization's values and accompanied by strategies and mechanisms to notice conflicts and address them in the context of a stable, integrated and flexible culture.

An organization ethics process can serve as a useful context for such initiatives. The aim of an organization ethics program is to produce a positive ethical climate where the organizational policies, activities and self evaluation mechanisms integrate patient, business and professional perspectives in consistent and positive ventures that articulate, apply and reinforce its mission in value-creating activities throughout the organization. Thus an organization ethics process can promote the structure a complex adaptive system

needs to support and sustain change.

### Ethical Climate and Organization Stability

There seems to be a consensus that organizational culture represents a set of systematic beliefs and behaviors and manifests itself in a set of norms of organization life.  It is holistically, historically, and socially influenced and exists at a variety of levels in the organization.  (Detert, Schroeder, & Mauriel, 2000)  The culture of an organization is analogous on the organizational level to personality on the level of the individual:  habitual patterns of response to similar situations, a goal orientation and pattern of value priorities.

The relationship between the culture of an organization and its ethical climate has not been precisely defined. Though definitions of the two concepts vary, the culture and ethical climate of an organization are intimately linked (Jose & Thibodeaux, 1999).   If the organizational culture is the personality of a particular institution, the ethical climate is its character:  the extent to which it is perceived by its internal constituents to live up to the values and principles that it espouses.  Victor and Cullen state that the ethical climate of an organization consists of the shared perceptions of the "general and pervasive characteristics of [an] organization affecting a broad range of decisions" (Victor & Cullen, 1988: 101) .  In an organization of the complexity of a healthcare organization, the strength of the couplings between leaders of the clinical and administrative functions, and between those leaders and their constituencies, the people who carry out those functions, are strong determinants of the ethical climate of the organization.  If the directional imperatives issued by different leaders conflict, functionaries may be confused and feel disempowered.  Recommendations that are difficult to reconcile with the role obligations of members of the organization may impede their function. These effects on internal stakeholders may affect their morale and the unity of the organization as it mobilizes for change.

The ethical climate of an organization can be either negative or positive.  A positive ethical climate has at least two important characteristics. (Spencer, Mills, Rorty & Werhane, 2000)   First, it is an organizational culture where the mission and vision of the organization are consistent with its expectations for professional and managerial performance, and consistent with the behavior of the organization as it actually operates.  If the mission and vision of the organization are consistent with its expectations for professional and managerial performance, and the organization acts in accordance with them, it suggests some degree of complementarity, a strong strategic coupling, among organization leaders**.**  Equally, strong organizational coupling will also exist in an

organization with a positive ethical climate, as communication and shared expectations mean that leaders are expressing clear and consistent expectations for their constituents.

There is a second condition for a positive ethical climate in an organization. It embodies a set of values that reflect societal norms for what an organization with its particular social role should value, how it should prioritize its mission, vision and goals, and how the organization, and its component professionals and managers, should behave. If the people internal to a healthcare organization feel that their organization is doing what a healthcare organization should do, in the way it should do it, the healthcare organization may have achieved some degree of environmental coupling with at least some of its environmental stakeholders. Of course an organization subjected to competing environmental imperatives will have a greater problem with environmental coupling. The extent to which those competing imperatives are openly discussed and negotiated within the organization among all affected stakeholders is another important condition for a positive ethical climate.

A positive ethical climate signals an integrated and coherent organization. If an organization is in the process of cultural change, as it will be through the implementation of quality initiatives, a positive ethical climate is important not just as a result of past integration and coherence. It is even more important as a source of future integration and coherence. A positive ethical climate can be an important factor of stability for an organization facing cultural change. Deliberate strategic change is sometimes both necessary and desirable; but methods of implementing change that have a negative effect on ethical climate reduce its chance of success.

The idea that a positive ethical climate may provide some stability for

organization change is not new.  Scholars and management theorists are interested in the question of what makes an organization thrive.  Studies suggest that employees in organizations that are characterized by adherence to their core values are more committed to their organizations than employees in organizations that are not (Weaver & Treviño, 1999; Treviño, Weaver, Gibson & Toffler 1999).  Studies suggest that organizations that are characterized by adherence to their core values perform better in the long run than those that do not.  Further, those values have been shown to be a useful force for continuity and stability as the organization reacts to changes in its environment. (Collins & Porras, 1994).   If some organizations have been successful in implicitly or explicitly relying on their core values for stability in reacting to internally or environmentally generated change, then the healthcare organization should emulate their example.  Attention to the ethical climate can provide stability as a healthcare organization deliberately seeks to change.

External and internal forces working against coherence and unanimity in an organization can imperil change strategies.  In the next section we discuss organization ethics and its potential for strengthening strategic, organizational and environmental coupling, as a factor contributing to institutional stability and as a vehicle for change.

**Organization Ethics**

Organization ethics is the articulation, application and evaluation of the values and moral positions of an organization, by which it is defined both internally and externally (Spencer, Mills, Rorty & Werhane, 2000: 5).  The aim of an organization ethics process is to produce a positive ethical climate where the organizational policies, activities and self-evaluation mechanisms integrate patient, business and professional

perspectives in consistent and positive value-creating activities that articulate, apply and reinforce its mission.

Traditionally ethical functions in healthcare organizations have been compartmentalized in different areas of the healthcare organization, with medical boards dealing with professional ethics (Starr, 1982), institutional review boards (IRBs) addressing research ethics, (U.S. Department of Health and Human Services, 1998) institutional ethics committees addressing ethical issues surrounding patient care (Fletcher, Lombardo, Marshall, & Miller, 1995) and legal departments, or more recently, compliance programs, concerning themselves with financial accountability (Mills & Spencer, 2002). The articulation of organization-level ethics was prompted by the introduction of a new requirement for accreditation by the Joint Commission for the Accreditation of Healthcare Organizations ( JCAHO) (Joint Commission for Accreditation of Healthcare Organizations, 1995), and was supported by The American Hospital Association, which introduced a multi-faceted educational program designed to help hospital and health system leaders make operational and business decisions that align with the values and ethical standards of their institutions (American Hospital Association, 1997). The organization ethics process the JCAHO recommended was initially focused on the ethics of the business side of health care, but it quickly became obvious that in health care, any decision that impacts business has implications for clinical and professional ethics as well (Spencer, Mills, Rorty, Werhane, 2000). Thus, organization ethics in healthcare focuses on the intersection of professional, business and clinical ethics, and seeks to sensitize all members of the organization at all levels to the ethical implications of organizational activities. It represents a unified, rather than

compartmentalized, approach to the ethical ramifications of healthcare organizations operations.

As they have been developed and instituted in various hospitals in the last few years, organization ethics processes or programs take a variety of forms. Some are under the jurisdiction of an institutional or system-wide "ethics officer" (West & White, 2001). Some are separate committees within the healthcare organizations (Myser, Donehower, & Frank, 2001), and others are subcommittees or new functions added to the obligations of already extant committees (Spencer, 1997). They share the common goal of helping healthcare organizations develop and sustain a positive and consistent ethical climate within their organizations, introducing a mechanism for coordination, communication and collaboration toward common institutional goals. Since many clinical ethics problems arise because of structural or institutional impediments to excellent clinical care, some clinical ethics committees have begun to take an increasingly large role in organizational ethics processes (Spencer, 1997).

Ideally, the organization ethics process involves representatives from both administrative and clinical functions, from all levels of the organization, and is authorized and supported by the highest levels of management. Thus it can mobilize internal constituencies in locating and eliminating structural impediments to excellent clinical care. It provides an informal forum for information exchange, and provides a platform for organizational leaders to acknowledge internal and external tensions that confuse stakeholder boundaries and roles (Spencer, Mills, Rorty and Werhane 2001, Khushf 2001).

Issues that might be brought to the attention of the organization ethics process

include:

- Prospective deliberation about the impact of proposed changes on the culture of the institution

- Retrospective monitoring and evaluation of the effects on morale and function of introduced changes

- Formation of *ad hoc* teams to study sources of recurring problems affecting institutional functions, and brainstorming possible structural changes to reduce them within the parameters of the ethical climate the institution wishes to support

- Questions of who should be accountable for what areas of practice and function, and what are the appropriate mechanisms of accountability,

- Questions of how to equitably address tradeoffs on such issues as marginally beneficial care, or institutional versus individual accountability for clinical decisions

- What quality improvement mechanisms are appropriate in what areas of organizational functions?  Where is standardization most important, and where flexibility?

- Information gathering on changes that do not threaten core values but do affect internal morale, community relations, or institutional traditions.

Other components of the organization serve as "policeman" or "decision-maker"—but a healthy organization also needs a mechanism for "open debate, research and critical reflection" (Khushf, 2001: 181), a forum for recourse if the mission and values espoused by the organization seem to be at odds with some behavior of the

organization.

Organizational change is disruptive, important to everyone, and may affect all institutional functions. An organization ethics program that is instituted, supported, and listened to by organization leaders is an indication that minimizing disruption and mobilizing support is important to the leadership.

## ACKNOWLEDGING TENSIONS AND PROMOTING STABILITY

The discussion of change and its difficulties in five Canadian hospitals provides food for thought as healthcare organizations in the United States face increasing pressure to change in the directions suggested by quality initiatives.  Change initiatives require certain conditions for success that are sometimes difficult to arrange in complex pluralistic organizations.  Using the framework of organization ethics, we suggest some ways in which nourishing the ethical infrastructure of a healthcare organization can contribute to the viability and duration of change initiatives.

### Strategic coupling and institutional mission

The organizational mission and the ethical principles espoused by the healthcare organization provide common values upon which all constituencies can agree. Prioritization of those values may differ among the leadership groups, but making explicit that the values are not distributed among the groups, but common to all of them, can provide a basis for discussion and negotiation. The organization ethics program can provide a safe space for such discussion.  The alternative approach, in which the values as well as the tasks are distributed between the different leadership groups, can break the strategic coupling that is crucial for successful change.  Open discussion of conflicts may be essential to retaining organizational morale in the face of necessary compromises.

**Organizational coupling and organization ethics**

Keeping leaders of each of the groups in touch with their constituencies is crucial to organizational coupling. It is important to institute and nurture mechanisms of communication and feedback. If physicians who accept administrative roles in healthcare organizations adopt the language of cost and quality and neglect considerations of clinical or professional ethics, their fellow clinicians may not recognize the ways in which common goals are furthered by administrative and clinical activities. But providing care of low quality is an ethical issue; good care is better if it is efficient; and impediments to care of high quality are perceived as, and discussed as, an ethical issue in clinical contexts. Establishing a common language, or at least discussing all issues in both the language of quality and the language of ethics, facilitates the communication that is necessary between groups with different roles in a complex institution.

**Dealing with two customers**

The balancing act of meeting payers' demands for cost constraint and society's demand for excellent, and constantly improving, care, is a problem that is not going away. Denis, Lamothe and Langley's study of leadership in transition refers to a "see-saw theory" of shifting alignments in collective leadership (Denis, Lamothe & Langley, 2001: 826). A comparable negotiation between competing values in the myriad of particular clinical cases where these demands conflict is an all-too-frequent reality in organizations facing conflicting environmental pressures. While organization leaders must balance these conflicts in forming organizational policies and strategies, the clinicians confront them daily on a case-by-case level. A forum for collective discussion of exceptional cases and how to accommodate them provides an important intermediate

stage between policy formation and isolated individual decision-making, and can provide an opportunity for the exercise of moral imagination within an institution (Khushf, 2001; Werhane, 2002). Denis, Lamothe and Langley speak of "creative opportunism" that allows the formation of win-win proposals, and "a plausible space in which a variety of organizational aspirations and capabilities seem reconcilable with environmental pressures and opportunities"—a space in which "there is some chance that change can gather sufficient momentum to survive." (Denis, Lamothe & Langley, 2001: 826) The organization ethics program can provide some of that space.

**An Adaptive Program in a Complex Adaptive System**

Organizations survive and flourish by accommodating to the conditions of their environment. In a social sector in rapid change that is subject to contradictory environmental pressures, healthcare organizations need both flexibility and stability to thrive. Such conditions require a great deal of internal cohesiveness and unity, which can be achieved only with maximal communication and coordination among its diverse constituents. In describing the healthcare system as a complex adaptive one, Crossing the Quality Chasm notes the extent to which boundaries and roles are in flux throughout the system. What is true of the whole is also true of the parts. Flexible team leadership is necessary for strategic change in healthcare organizations, and teamwork and strategies of accommodation are necessary for effective organizational function.

**Conclusion and Implications for Future Research**

The organization ethics program, as viewed through a system lens, is itself an adaptive system on the micro level, with the goal of formulating, articulating, and enhancing the organization's ethical climate. Because the organization ethics program

can act in unpredictable ways it may be able to serve as a source of innovation and moral

imagination within the organization (Werhane, 2002). If modeled correctly, it will

change the organization as it modifies or enhances the beliefs and behavior of those

associated with the organization. Its potential is positive if the organization ethics

program follows one simple rule – maintain a positive ethical climate. It can be a force

for stability in the organization by promoting and sustaining coupling on all levels, and it

can support change by acting to assure that quality initiatives of the sort that are being

urged on the healthcare organization are instituted in a way that aligns them with the

organization's values.

Our thesis is that organization ethics programs are necessary elements in
any change initiatives in healthcare organizations. Without the unifying umbrella
of organization ethics programs, most quality initiatives will fail. Since to date at
least 70% of quality initiatives in all industries are judged to have failed, the task
for future research is to study healthcare organizations with well-organized,
respected and practicing ethics programs and compare their results on a quality
indicator such as the reduction of medical error with organizations without
organization ethics programs. A finer-grained analysis would then compare error
rates of healthcare organizations with strong organization ethics programs and
quality initiatives with those healthcare organizations that had no organization
ethics program but had in place a quality initiative. Such data, if confirming our
thesis, would provide convincing evidence that healthcare organizations can
change in ways that support the goals of the Institute of Medicine as detailed in
Crossing the Quality Chasm while preserving and enhancing a positive ethical
climate.

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