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Part II
ORGANIZATION ETHICS

ETHICS AND ECONOMICS IN HEALTHCARE: THE ROLE OF ORGANIZATION ETHICS

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Introduction

There has been considerable transformation in the way healthcare is financed in the U.S. in recent decades, and particularly in the last five years. As fee-for-service medicine is gradually being replaced by various arrangements with managed-care organizations for large segments of the population, expectations are shifting for all groups involved with healthcare delivery - patients, providers, and payers, as well as for the larger society. Change can be very disruptive, and rapid change is particularly difficult to accommodate. These changes have had an impact on healthcare ethics, on ethics in hospitals, and to some extent on professional ethics as well. The ethical challenge the economic changes pose is how to deliver high quality healthcare to the highest possible ethical standards in the hospitals and clinics of the next century.

To explore the ethical problems arising in a healthcare system in transition is to focus on the hospital. Hospitals are centrally placed in the healthcare system. If you are tweaking the system — and at the moment there is a lot of tweaking going on — you are tweaking the hospital. Of all the groups impacted by these recent changes, and of all possible levels of accountability, the hospital is the best place to address the ethical problems created by the changes in healthcare reimbursement. But if hospitals are to meet this challenge, we are going to have to change the form that our ethical concern takes. We'll either have to forget about ethical healthcare - an option we don't really have - or we will have to re-conceptualize the role of ethics in hospitals. We shall have to supplement clinical and professional ethics in their present form with an expanded, organization focus.

There are a number of things that can be done to support and improve the ethical climate of institutions under financial duress. But not all the problems hospitals face can be addressed by ethics initiatives. Some of the problems will need to be the subject of wider social or political strategies.

The ethical life of the hospital

The hospital, since the earliest days of the republic, has had a widely-acknowledged and respected social function. Before the Civil War, hospitals were primarily charitable institutions, a place where the worthy poor received care, while the well-to-do were treated in their own homes. At that point hospitals had a strong social mission, and were often supported as philanthropic institutions by churches or wealthy donors. They were expected to attend to the moral, as well as the physical, well being of the poor.

The period from the civil war to World War II saw the professionalization of the American hospital. It became the locus for more advanced medical techniques and knowledge, and thus a resource for all who were ill rather than merely a catch-all for the community's obligation to its poorer citizens. Since the Second World War, hospitals have occupied a larger and larger place in healthcare delivery. More and more medical care is provided in hospitals, and physicians have become increasingly dependent upon them and their technologically sophisticated facilities. Hospitals have also become increasingly bureaucratic, and the administration has supplanted the medical staff as the primary decisionmaker in many areas.

Healthcare has always had both ethical and economic aspects and implications. But in earlier eras, economic considerations tended to be trumped by ethics — by the social imperative of providing healthcare, on some terms, to whoever needed it. The non-profit hospital, supported by charitable institutions, included in their operating expenses provision for the destitute ill. Professional ethics urges physicians to treat people in need of their services, regardless of their ability to pay, and the small-town general practitioner typically balanced his practice, charging those who could pay and treating for free or for reduced rates those who could not. The residual effects of this priority of ethics to economics are visible today in ethics consultation in hospitals, where financial issues are seldom raised in determining what treatment options are preferable in problematic cases. But the relation between ethics and economics is becoming less tacit.

Throughout the course of this changing history, the social expectation has remained constant: the hospital has the responsibility for providing **appropriate care for reasonable cost**. Society judges hospitals ethically by how well they meet this social expectation. Not only the external judgment of hospitals, but internal morale as well depends upon the success of hospitals in meeting social expectations. People who deliver care in hospitals believe that it is an important social function. They need to feel that they do it well, and that it is valued.

It is becoming increasingly difficult to sustain either internal morale or external trust in the healthcare system. There are at least two reasons for that. First, the emphasis has sifted in the social expectation. In the "golden age" of American medicine, the tacit social contract was that as long as care quality continued to improve, costs would be met. Recently the emphasis has shifted to challenging the reasonableness of costs, while assuming that the quality will remain constant (or continue to improve).

Second, hospitals and individual providers are less and less in control of, are less able to influence, what counts as "*reasonable* cost." Those decisions are made elsewhere, and the risk of those decisions (and the price of their implementation) is often shifted to providers, or the patients. The healthcare system is no longer expected to provide what patient care demands, "whatever it costs."

The pressures of cost containment are having a significant impact on morale and upon trust in the healthcare system. The responsibility — the social expectation — the ethical imperative for hospitals - is to maintain and if possible to improve the quality of care in the face of cost containment.

Quality as an ethical issue

There has been considerable debate about what quality is, and how it should be measured, and one of the most visible effects of the recent transformations in healthcare reimbursement has been the proliferation of research on quality of care. There is agreement that under-use of resources, over-use of resources, and misuse of resources constitute low quality. There is agreement as well that appropriate, efficient and reliable care — managed clinical care — **is an attainable goal** for a well run healthcare system. For our purposes perhaps we can simplify and give a quasi-Aristotelian characterization of what quality represents:

Appropriate treatment at the right time in the right way by the right person in the appropriate setting represents a high quality of healthcare.

Determining what treatment is most effective for which health problems, or what setting or level of skill is necessary for delivering that treatment, is important research which is leading toward consensus on treatment protocols and tending to make outcomes information more available. Although the measurement of quality can indeed be very complex, recent efforts have shown that quality of care can be measured in many ways, and there have been more efforts at empirically measuring quality in the last five years than in the preceding fifty. Various "report cards" and protocols are ways of standardizing and measuring quality of care [1] (1)(2).

There are ethical dimensions to high quality healthcare as well. The hospital is subject to moral judgments with respect to all facets of its ethical conduct: its goals, which are defined by social expectations and expressed in the institution's mission statement and ethical codes; the morality of its means to those ends; and particular characteristics of the way patients, employees, and contractual partners are treated in and by hospitals.

Hospitals and the Hippocratic matrix

For the last three decades, discussion of ethics in hospitals has focused in several areas. Starting in the 70s considerable attention has been paid to the protection of patients as research subjects, expanding to attention to ethical issues which arise in patient care: the right to informed consent to all medical treatment, including the right to refuse unwanted treatment; the right to privacy and confidentiality of medical information; to disclosure of relevant medical information, protection of vulnerable subjects, and so forth. Since 1993, hospitals have been required as a condition for accreditation to have an ethics review process, e.g., an HEC which is available to care providers and patients and their families to address ethical issues which arise at the bedside.

Professional ethics has been prominent as well. Physicians and nurses have professional codes that govern their practice and have traditionally been a major source of confidence and trust in medical treatment. Hospital administrators too have professional organizations with associated codes which resemble in many respects the Hippocratic codes of the medical professions.

Hospitals, then, and the individual providers who work in and with them constitute a relatively integrated "Hippocratic" network. They share the common ethical imperative of providing the best possible care at reasonable cost to the patients they serve. In the decades in which physicians had the

greatest decision- making power within hospitals, there were few countervailing forces to the professional ethics that determined hospital policies and informed the ethical climate of those institutions. That situation is changing.

Ethics, economics, and managed care

One of the important changes in healthcare since the defeat of the Clinton Plan in 1994 has been the entry into healthcare of organizations that have grown up outside of this traditional Hippocratic social and moral matrix, which operate on different rationales: the new Managed-care organization (not the old "managed clinical care" organizations of the 40s and 50s, but new administrative intermediaries which do not deliver services, but exist primarily as "managed- cost" organizations) and the insurance company (several of which no longer sell insurance, but only mediate healthcare)[2] It is these intermediaries, rather than healthcare providers directly, with whom employers increasingly contract to provide healthcare for the employees for whose health they are responsible. Decisions about what counts as appropriate care for reasonable costs have devolved onto those new players in this old game. They occupy the position of greatest power in the contemporary healthcare scene, for they are the mediators between the patients and the payers of healthcare, and they control the purse strings.

Whatever the advantages of our new method of reimbursement for cost containment, the advantages for quality care seem problematic. Some of the new players in the healthcare arena often seem to be operating in ways which are outside the Hippocratic matrix, that has united hospitals and their employees under shared ethical imperatives. People are beginning to worry about how much quality we are going to have to sacrifice in order to contain costs.

In a recent article on the American Health Care System, health economist, Robert Kuttner, summarized the present state of the dialectic between cost and quality as follows:

> For more than a decade, "market-driven health care' has been advertised as the salvation of the American health care system. In the early 1990s, entrepreneurs succeeded in obtaining the easily available cost savings, at great profit to themselves and their investors. By the late 1990s, however, pressure to protect profit margins had led to such dubious

> business strategies as the avoidance of sick patients, the excessive micromanagement of physicians, the worsening of staff-to-patient ratios, and the outright denial of care. In an industry driven by investor-owned companies, the original promise of managed care — greater efficiency in the use of available resources and greater integration of preventive and treatment services — has often degenerated into mere avoidance of cost (3).

The problem does not lie in the desire for economic sustainability and the emphasis on appropriate use of resources. These are imperatives for any respectable hospital, and need to be recognized as such. The problem lies in the separation of cost management from clinical management, and the uncoupling of cost and quality.

Accountability and quality

The problem represented by this shift of power is being discussed in the bioethics literature under the rubric of "accountability," and there has been a proliferation of writing on the subject. In a recently-published article, "managed care" was defined as "a system of health care delivery that manages resources, quality and access associated with the delivery of health care," and the question was posed: Of the candidates suggested, who should manage care? The candidates offered were [1] payers (employers, government and insurance companies), [2] patients, and [3] providers (physicians and other healthcare professionals) (4). Other influential commentators have suggested that [4] the managed care organizations, arguably the most influential intermediaries between those three groups, are the appropriate level for management of all three factors [3] (5).The proper answer may well be that accountability needs to be managed on all levels, by all players.[4]

There is also a fifth candidate. The hospital must be included as the most appropriate locus for the consideration of some of the many factors which complicate managing care as so defined. Much of the current work on how to improve quality care is currently being done in the hospital setting. It is within hospitals that patients at their most vulnerable moments encounter the health care professionals upon whom they are dependent, and it is the shared values of the hospitals and their associated providers that represent the Hippocratic matrix that has traditionally been the guarantor of the societal

trust in our healthcare system. Hospitals are already ethically sensitized and have relatively well-established procedures for addressing ethical issues, as well as many of the other issues, of quality of care. It is a mistake to think of the "providers" of healthcare as including only individuals: the physicians and other health professionals.

Rethinking ethics in the hospital

But if hospitals are to serve as agents of accountability, we need to pay attention to ethics in hospitals in a different way than we have in the past. We need to develop further and in different ways some of the procedures and ethical approaches already present within those healthcare organizations.

First, we have to begin thinking not just of individuals, but of institutions, as moral agents, as morally accountable (to the society in which they function, to other institutions with which they interact, and to the individuals who constitute and who interact with them). Hospitals themselves, as institutions, have goals, and a specific social function that they fulfill either well or poorly. They conform to, or breach, broader social expectations of ethical practice: they treat their employees well or badly, meet or fail to meet their commitments to contractors, are fair and honest or not. Their agency is secondary, rather than primary, for it is derived from the primary moral agency of individuals who occupy various roles in the institution. But it is the institution that we praise or blame; often we do not know, or cannot identify, individual decisions or agents. It is the hospital AS institution that has a social responsibility as the locus of healthcare for the communities in which they function.

Second, we have to start thinking of ethics in hospitals in a more global way. We need to think of the hospital as an integrated ethical unity, and as a source for a "culture of excellence." At present, ethics is compartmentalized as one of several things hospitals do, or as something it does in several localized contexts. We have a research ethics IRB, a clinical ethics consult service, a professional ethics review committee to handle professional misconduct. This fragmented ethics review model allows us to ignore the fact that all action has ethical implications; and allows us to avoid scrutinizing all organizational decisions for their impact upon the ethical climate and for their compatibility with the institutional mission. We have to ask not only "is this a case that should be brought to the ethics committee?" but also: "how do we orient all institutional activities more closely upon our institutional function?"

Third, we need to use the ethical resources we have more efficiently. We need to conceptualize our ethical issues more broadly; and we need to supplement and better utilize the HEC already in place. Our current ethics review processes within hospitals deal with a variety of issues, but often only on the level of individual clinician behaviors, or specific patient/clinician encounters. But the same issues that perplex us in individual cases can have broader, institution-wide implications.

Consider two examples: The ethical requirement of maintaining confidentiality is a central concern of clinical ethics. The traditional ethical focus in healthcare is on the physician-patient relationship, and the attention to keeping patient information confidential is central to the willingness of the patient to entrust to the physician sensitive information that might be needed for her care.

But institutionalization of healthcare changes the confidentiality problem. In the modern hospital, medicine is practiced in teams. Up to 75 persons can have authorized access to patient information. Medical information and medical records are increasingly computerized. So protecting the confidentiality of patients' information is an institutional obligation, and must be addressed at an organizational level, if the patient is to have trust in the healthcare system.

This not only involves attention to computer security, but also involves ethical attention on the part of the hospital to what happens to information that is legitimately gathered in the course of patient care. Does the pharmacy sell utilization rates to pharmaceutical companies? Are patients' records scrubbed of identifiers before they are perused for outcomes reviews?

Another example: informed consent. In a recent law review article, a bioethicist starts from clinical criteria for valid informed consent to treatment, and applies the same criteria to the whole process of healthcare treatment. Did the patient know what her employer's health plan would cover? Did she have a choice about which plan to adopt? Does she know the plan's reimbursement mechanisms for providers? It is this broader, analogical and systemic thinking about ethical issues which the current healthcare system requires (6).

Clinical ethics, ethics focused on particular physician-patient relationships, is a starting point for organization ethics. For one thing, many of the clinical ethics issues have organizational or institutional **causes.** A particular ethical issue may turn out to have been created by changes in unit staffing patterns, by details of specific contracts or changes in formularies.

Some clinical ethics issues can best be **cured** by organizational changes. And as seen in the cases of confidentiality and informed consent, there are **analogues** on the organizational level to many clinical ethics issues. Conflicts of interest are an institutional, as well as an individual, ethical problem. This is particularly obvious in times of turmoil in the healthcare system. The hospital is currently engrossed in a constant balancing act between conflicting interests: between research, education, and patient care, or between the conflicting priorities of cost and quality - hardly a trivial matter, when as in some cases the economic survival of the institution itself may be at stake.

Clinical and professional ethics are not the only considerations appropriate to addressing ethical issues in hospitals. Some of the ethical issues now drawing attention in hospitals are issues most appropriately addressed with business ethics. Healthcare is a business; indeed it's Big Business. But it is also a social responsibility, and very centrally, a matter of social welfare. Business ethics has many insights and approaches that are useful in the new health-business context; but it needs to be integrated and coordinated with concerns addressed by clinical or professional ethics as well.

Hospitals as an ethical force in the healthcare system: Organization ethics

Various initiatives are encouraging hospitals to begin thinking in broader terms about ethics in their institutions. One of the most powerful external incentives has come from accrediting agencies. In 1997 the Joint Commission for the Accreditation of Healthcare Organizations instituted a standard requiring an institutional or organizational ethics procedure or process. This has been an very open-ended initiative. Noone knows exactly what the standard implies, except that it requires hospitals to pay attention to such (ethical) issues as billing, employment practices, marketing and contractual relations which are fraught with ethical features but which have previously and erroneously been viewed as purely administrative decisions. Institutions which do not demonstrate progress in this area will be penalized in their accreditation attempts: a serious threat, since no unaccredited hospital may receive any federal funding.

There are internal incentives as well. Neither the hospital nor the professionals associated with it wish to lose control of the conditions of medical practice. They know the value of the Hippocratic matrix at the heart

of healthcare, and know that it is in their interest to protect the interests of the patient. There is a great deal at stake.

As a result there are many exciting social experiments going on in hospitals across the country in the name of organization ethics: experiments with expanding extant HECs (in membership and responsibility); with supplementing existing clinical ethics committees with separate organization ethics committees, programs, or officers; and theoretical work on developing **systems**-ethics to supplement **situation**-ethics.

The hospital today is to some extent a house divided within itself. It responds, as it has always responded, to social expectations; but society (on all levels) is issuing conflicting imperatives. The government simultaneously reduces its payments for care and proposes legislation which will raise its cost; individuals when well cry for reductions in health-insurance costs, and when ill desire expensive treatments. In hospitals, administrators face increasing demands for documentation on the same days that they face the need to reduce the number of employees; nurses struggle to meet their own demanding professional standards of adequate patient care while faced with increased patient loads. That is life in a period of transition. Ethical initiatives cannot control all the political and economic factors external to the hospital which buffet it. But it may be possible to strengthen the hospital to survive. Organization ethics initiatives represent an opportunity to open communications between compartmentalized centers of responsibility within hospitals; to unify the hospital as an ethical force behind its self-avowed (and socially sanctioned) mission. The hospital is the best place — indeed, it may be the only place — to balance cost and quality, and to address both ethics and economics.

Conclusion

The healthcare system faces many challenges. Considering the economic problems that face the American hospital, it may seem the wrong time to shift our emphasis and balance from cost to quality. Recent evidence regarding non-health- related businesses reveals high ethical standards are not incompatible with economic viability. Indeed they can enhance it. If the American healthcare system can survive the wrenching dislocations of current reform, it will only do so by paying attention to both components of its proper business: that of providing access to the best possible care at an affordable cost. It is the role of organization ethics in hospitals to scrutinize all activities of the organization in the light of high ethical standards.

Hospitals cannot afford to allow cost-containment measures to force them to act badly.

Organization ethics is not an imperative for hospitals alone. The ordering of values which gives quality of patient care priority needs to be extended, to be common to all players in the healthcare field. We need to threaten (with legislation and regulation) or bribe (with increased market share and accreditation) new players, the managed-cost organizations to join the Hippocratic matrix, to include ethical quality among the important considerations of the way they operate.

People mistrust their health plans more than they trust their providers — an imbalance that has to be reversed. Unless hospitals take the initiative to preserve the values of quality in patient care, they will end up doing as badly by the insured patients who are admitted to hospital as by the uninsured and underinsured who are presently excluded from hospital care.

NOTES

1. For a brief review of approaches to improving quality in healthcare, see (1).
2. The distinction is important since many of the older "managed-care" organizations such as Kaiser are integrated systems that incorporate physicians and hospitals, rather than being purely cost-management organizations.
3. In a series of articles, the AMA Working Group on Accountability has addressed the accountability of the MCO. See (5).
4. One of the problems with the definition posed in the article is that "access" is not being addressed by any of the parties suggested. See (4).

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