First Principles: Substantive Ethics for Healthcare Organizations

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EXECUTIVE SUMMARY

Healthcare organizations (HCOs) often face ethical dilemmas, but ethical principles analogous to those of clinical ethics have not been established to guide resolution of such dilemmas. To date, most progress in business and organizational ethics has been made in developing processes that promote responsible behavior in complex organizations.

In this article we offer a normative framework to guide value-laden decision making of HCOs. We propose four substantive principles—provide care with compassion, treat employees with respect, act in a public spirit, and spend resources reasonably—that are derived from the roles that HCOs are expected to play as caregivers, employers, citizens, and managers, respectively. We anticipate that these principles can clarify and resolve tensions between different spheres of HCOs' responsibility, help to promote organizational values and trust in HCOs, and aid discussions about the appropriate roles of HCOs in our society.

For more information on the concepts in this article, contact Dr. Winkler at Eva.Winkler@med.uni-muenchen.de. To purchase an electronic reprint of this article, go to www.ache.org/pubs/jhmsub.cfm, scroll down to the bottom of the page, and click on the purchase link.
Medical ethics evolved to guide decision making that is in the best interest of the patient without giving due consideration to the organizational context in which this decision making takes place. Today, deliberative bodies such as ethics consultation services and committees address ethical problems in clinical practice—for example, the withdrawal of life-sustaining treatment. Commonly these deliberative bodies resolve clinical ethical problems using four guiding principles: beneficence, nonmaleficence, respect for autonomy, and justice (Beauchamp and Childress 2001).

However, healthcare organizations (HCOs) and their employees face problems that are not adequately addressed by the principles of clinical ethics. The first category of such problems includes those arising from the influence of organizational context on individual behavior. The focus of clinical ethics on individual agency fails to recognize the effects of the organizational culture—that is, informal and formal rules on ethical conduct and decision making. Most of the work in the new field of organizational ethics responds to this void. Problems of the second category arise because HCOs’ responsibilities are multiple and complex, and tensions between these responsibilities often result. For example, while physicians have responsibilities to their patients, organizations have responsibilities to their whole patient population as well as to employees, payers, and other stakeholders, and all must comply with legal standards and government regulations (Kassirer 1998). These issues apply to for-profit and not-for-profit hospitals, nursing homes, hospices, and institutions involved in health services that do not provide direct patient care such as insurance companies and managed care firms.

Clinicians’ obligations to patients are often discussed using the principles of clinical ethics, but no comparable and agreed-on set of ethical principles exists to guide decision making within organizations involved in healthcare (which, for simplicity, we will refer to as HCOs). In this article we offer a normative framework for organizational ethics using four guiding principles that are derived from the differing roles that an HCO is expected to play. In clinical ethics, beneficence, nonmaleficence, respect for autonomy, and justice convey intrinsic moral values and therefore describe the moral obligations of physicians to their patients. Similarly, the proposed principles of organizational ethics represent intrinsic values and should help to illuminate the relevant moral aspects of problems faced in organizations. We illustrate how these principles can clarify and resolve tensions between different spheres of HCO responsibility and aid discussion about the appropriate roles of HCOs in our society.

**WHY DO WE NEED ETHICAL PRINCIPLES FOR HCOs?**

Recent research in organizational theory and business ethics has focused on understanding the factors that influence ethical conduct in organizations (Trevino, Butterfield, and McCabe 1998). Organizations have been shown
to promote ethical conduct if their leaders encourage and model ethical behavior, reward ethical conduct and discipline unethical conduct, provide forums for discussing ethical problems, and emphasize fair treatment of employees (Cropanzano 2003).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has prompted much of the recent development of organizational ethics in healthcare. Following well-publicized reports of unnecessary admissions and insurance-driven discharges by some hospitals in the early 1990s, JCAHO raised specific concerns relating to marketing, billing, admission, and discharge practices and since 1995 required that HCOs have formal procedures for addressing organizations' ethical problems (JCAHO 2003; Schyve 1996). Some HCOs established organizational ethics programs, and others combined them with compliance programs (Blake 1999; Childs 2000; Goodstein and Carney 1999; Mills, Rorty, and Werhane 2004). Most organizational ethics programs have aimed to facilitate ethical behavior by creating a climate that is consistent with the mission of the HCO (Spencer et al. 2000). Such programs have developed processes to clarify and articulate the organization's values, facilitate communication and learning about ethical issues, and monitor and offer feedback on ethical performance (Potter 1996).

Approaches to organizational ethics have, therefore, been largely procedural in that they aim to institutionalize agreed-on values (Giganti 2004). For example, protecting patients' confidentiality requires more than the physician's commitment to being discrete, as directed in the Hippocratic oath (Thompson et al. 1992). It may also require processes such as password protection of electronic records and reminders that patient information should not be discussed in public places. These steps help to institutionalize the shared value of patients' confidentiality.

Institutionalizing values, however, solves only the first category of problems, which includes those that arise as the result of organizational barriers to enacting values. When values are agreed on, processes can be developed to successfully institutionalize them. The second category of problems, which includes those that arise from the HCO's conflicting obligations, are unresolved precisely because values can conflict. Ethical questions, such as the amount of care to provide to uninsured patients or the allocation of intensive care unit beds, need to be resolved before their solutions can become institutionalized. To resolve unsettled questions we require substantive principles that will guide deliberation about ethical dilemmas and promote understanding of the broader moral concerns within the HCO setting. To date, such principles have not been offered for debate among HCOs.

FOUR PRINCIPLES OF ORGANIZATIONAL ETHICS

To define what constitutes moral responsibility in HCOs, we should first consider all of the roles that an HCO is expected to play. These are closely linked to its purposes, as perceived both from within the organization.
and by society in general. We propose that HCOs and their managers should fulfill four major roles: caregiver, employer, citizen, and manager. We now examine the values and ethical concepts inherent in each role and propose ethical principles that derive from them (see Table 1).

1. Provide Care with Compassion
At the heart of caregiving is an asymmetric relationship between providers with expert knowledge and skills and patients who are vulnerable, not only because they are sick but also because they usually lack expert knowledge and are therefore reliant on caregivers to act in their interests.

The nature of the caregiver-patient relationship confers fiduciary duties on caregivers to promote patient-centered values such as competence, compassion, trust, and shared decision making. In an HCO, competence is ensured by setting high standards, promoting continuing professional development, tying incentives to quality of care rather than to costs alone, and ensuring adequate staffing. Compassion and kindness are the appropriate responses to suffering and can be promoted by formal and informal rules and rewards (Emanuel and Dubler 1995). Another fundamental component in this relationship is that patients are able to trust HCOs and health professionals to provide care that is tailored to their needs ahead of the interests of other parties. One way that an HCO can be a trustworthy caregiver is if it enables those actually delivering care to be advocates for their patients and help create, critique, and improve organizational guidelines that affect patient welfare (Buchanan 2000; Shortell et al. 1998). HCOs must ensure that caregivers are able to provide unconflicted, patient-oriented care (Crawshaw et al. 1995). The final element is shared decision making. Patients and caregivers should jointly decide treatment by sharing information, understanding each others' values, and following the principles of clinical ethics, especially autonomy and beneficence.

Within an HCO's caregiving role, therefore, competence, compassion, trust, and shared decision making form the basis of an overarching principle: provide care with compassion.

2. Treat Employees with Respect
While the role of caregiving is primarily informed by clinical ethics, the remaining roles—employer, citizen, and manager—draw on the field of business ethics. The duties of employers to their employees are rooted in the trade union movement and workers' rights (Beauchamp and Bowie 2001). Business ethicists reject the view that employees' labor is simply a commodity subject to the laws of supply and demand, both because this notion is likely to undermine loyalty to the HCO and, more importantly, because it is fundamentally at odds with the respect owed to any person. Kant's principle of "respect for persons" is invoked to argue that businesses should treat their employees as ends in themselves, rather than merely as means to increase productivity and profit (Werhane 1985).

In this sense the relationship between employer and employee is one
TABLE 1
Principles of Organizational Ethics in Healthcare

<table>
<thead>
<tr>
<th>Normative Principle</th>
<th>Role</th>
<th>Stakeholders (in addition to the HCO)</th>
<th>Values</th>
<th>Field of Ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caregiver</td>
<td>Patients</td>
<td>Competence, Fairness, Common good, Quality</td>
<td>Clinical ethics</td>
</tr>
<tr>
<td></td>
<td>Employer</td>
<td>Employees</td>
<td>Compassion, Empowerment, Community benefit, Equity</td>
<td>Business ethics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community</td>
<td>Trust, Participation, Efficiency, Sustainability</td>
<td>Workplace ethics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shared decision making</td>
<td></td>
</tr>
</tbody>
</table>

Note: The four ethical principles that should guide ethical decision making in HCOs are derived from the different roles that HCOs are expected to play. They reflect different stakeholders’ interests, underlying values, and the fields of ethics that inform them.

of reciprocal accountability but with a clear power differential in favor of employers. Employers’ duties include providing fair salaries, ensuring safe working conditions, and rewarding and disciplining fairly. This requires protecting employees from discrimination and persecution in the workplace and allowing them to voice opinions about policies on ethically contested questions (Gilbert 1991; Wynia et al. 1999). Organizations can and should empower their employees to become responsible actors by creating an ethical climate and serving the self-actualization of their employees (Hartman 1996). Such empowerment is a prerequisite for employees taking responsibility for their actions and not hiding behind rules and structures—a challenge that all complex institutions and bureaucracies face (Margolis 2001).

We incorporate these characteristics in the principle treat employees with respect. The first two principles, therefore, focus on the internal organizational setting and may conflict. Consider this example: A nurse sustains a needlestick injury from a high-risk patient, and the patient then refuses to undergo an HIV test. If the patient is HIV-positive, prophylactic treatment may reduce the nurse’s risk of HIV infection. If the patient is HIV-negative, prophylactic treatment offers no benefit, is costly, and exposes the nurse to risks.
of side effects such as gastrointestinal disturbance, bone marrow suppression, and unnecessary stress. Clinical ethics, with its focus on patients' rights to self-determination, may favor respecting the autonomous decision of the patient to refuse an HIV test. The nurse, however, also deserves respect, and the HCO has a moral duty to its employees to minimize workplace-related health risks. In this case the duty to an employee may outweigh the patient's right to refuse an HIV test.

3. Act in a Public Spirit
The citizenship expectations of caregivers and HCOs fall into three main categories: participation in democratic society, particular responsibilities to society that businesses in general may have, and special responsibilities that come with healthcare. The fields of political ethics and business ethics inform all three.

Analogous to the basic citizenship role, HCOs have a duty to obey the law. In return, they benefit from the state's obligations of service, protection, respect for rights, and responsiveness to citizens as consumers and taxpayers. Citizenship is based on interest and participation in the state's affairs and ideals of mutuality and reciprocity, whereby citizens offer proportionate returns for goods received (Gutmann and Thompson 1996).

Corporate citizenship and the social responsibility of businesses have been central to much recent business ethics literature. The perception of business as the narrow-minded pursuit of profit to the exclusion of all other considerations has been widely challenged.

Some business ethicists have argued that, in return for granting companies their legal status as separate entities, society is entitled to expect from them a significant net positive contribution to the general good (Kitson and Campbell 1996).

This is especially true for businesses engaged in providing healthcare, because healthcare, in a dual sense, is a basic social good. First, providing care and compassion has intrinsic value that complements the social dimension of humanity. Second, like food, education, and housing, healthcare is a good that people need to thrive and make the most of their opportunities. Adequate healthcare is a prerequisite for the normal functioning of modern societies; therefore, businesses that provide this kind of good bear special social responsibilities irrespective of their profit-making status (Daniels and Sabin 2002).

A positive and widely publicized example of corporate social responsibility occurred in 1982 when several Tylenol containers were sabotaged, resulting in seven deaths. Johnson & Johnson's chief executive officer was candid with the press and the public, recalled all stock from store shelves at a cost of $105 million, and immediately ordered the development of tamper-proof packaging (O'Reilly and Lieber 1994).

Corporate citizenship in healthcare, therefore, refers to the promotion of the optimal health of the community it serves, and its guiding principle is *act in a public spirit*. Reasonable ways in which HCOs can be expected to fulfill their citizenship role include proper...
disposal of hospital waste, provision of outreach and free services for those unable to access care, and advocacy on issues that are in the interests of the public’s health (Repenshek 2004). Citizen representation on boards of trustees is one way that HCOs can give voice to community concerns (Emanuel and Emanuel 1996).

The principle of acting in a public spirit is also relevant to choices about the kinds of services that are provided, how to ensure access to them, how the actions of organizations and their members are perceived, and how those actions may affect the wider community. Consider, for example, the dilemma created if a Caucasian patient refuses care from the assigned African-American nurse and Asian medical resident and demands a Caucasian nurse and physician (Rose 2002). Should the HCO accommodate the patient’s request? To clarify the obligations, at least three of the four principles are invoked. The principle of caring with compassion emphasizes trust and is likely to direct care that the patient regards to be in his or her best interests. The HCO may therefore feel compelled to reassign a team of Caucasian clinicians. However, the principle of treating employees with respect demands that the employer protect its employees against discrimination, ensure that they are treated justly, and maintain staff morale. Furthermore, acting in a public spirit emphasizes the community role of the HCO. Acceding to the patient’s request may perpetuate prejudice and discrimination and sends the wrong message to non-Caucasian communities. Respect for a patient’s preference in this case may therefore be outweighed by respect for employees and the possible social implications of fostering racism. On these grounds the HCO would be justified in refusing the patient’s request, as it protects its employees from racist insults.

4. Spend Resources Reasonably

HCO managers are charged with promoting their organization’s success within the constraints imposed by the available resources (Repenshek 2004). Choices must often be made for reasons of both efficiency and equity. Stakeholder theory is often applied in business ethics to discuss the responsibilities of managers and executives when making corporate decisions (Werhane 2000). HCO stakeholders include patients, insurers, shareholders, business partners, payers, the government, and the public. Stakeholder theory posits that stakeholders’ claims should be prioritized according to the purpose and mission of the organization. Because an HCO’s raison d’être is to minister to its patients’ health, the basic obligation is canvassed in the principle of caring with compassion and is independent of profit-making status.

Economic incentives, however, have led some HCOs to pursue ethnically dubious strategies that result in, for example, gag clauses for physicians, declining staff-to-patient ratios, and adverse selection of patients by health plans (Kuttner 1999). Clearly, market forces may be counterproductive to an HCO’s core mission, and HCO managers must balance the sustainability and financial success of the organization with its other roles and respon-
sibilities. The underlying principle derived from the HCO administrator's role, therefore, is to spend resources reasonably. All administrators face the task of setting limits, which is central to this principle, and the processes for ethical limit setting should be deliberate, fair, and transparent (Daniels and Sabin 2002).

**THE PRINCIPLES IN PRACTICE**

A set of ethical principles should provide an analytical framework that expresses values underlying rules in the common morality (Beauchamp and Childress 2001). The four principles for organizational ethics proposed here should guide resolution of ethical conflicts that arise in HCOs. Because the principles are derived from the various roles of HCOs, they will often represent diverse points of view. Reflection on the roles and application of the principles are likely to allow some prioritization of their relative importance in each HCO or any particular issue.

An example of a clinical conflict that becomes a problem at the organizational level is the refusal of blood products by Jehovah's Witnesses (JWs) (Winkler 2005). Because the courts have consistently supported the right of adult patients to refuse blood on religious grounds, some hospitals have set up so-called "bloodless programs" that include blood-conservation techniques such as erythropoietin administration to reduce the need for blood transfusions. An HCO without such a program may be faced with questions about whether it should transfer JW patients to hospitals that have a program and whether it should initiate its own program.

As a caregiver the HCO should strive to provide the best care possible for its patients. Although patients who refuse transfusion therapy voluntarily assume a greater risk, the hospital can minimize that risk by becoming competent in blood-conservation techniques. Guided by the principle of caring with compassion, the hospital may feel compelled to establish a bloodless program.

As an employer the HCO should be aware of what it calls on providers to do; at worst this could involve watching a JW patient bleed to death when intervention may save the patient's life. Caregivers may be reluctant to care for JW patients to avoid the distress that may result from the conflict between respecting the patient's wishes and providing life-saving care, or because this potential situation may seem morally unjustifiable. Under the principle of treating employees with respect, HCOs have a duty of care to employees regarding both concerns. Provided that patients are not abandoned, individual caregivers should be permitted to opt out of care based on conscientious objection to actions that violate deeply held moral beliefs. While distress when providing care cannot always be eliminated, it may be alleviated if an HCO fosters the support of colleagues and of the broader institutional community.

As a corporate citizen, the community served by an HCO judges the organization's decisions, including how acceptably it provides access for all community members. The JW community, which may include HCO staff,
may feel abandoned or even discriminated against if the HCO policy recommends transferring those patients to other hospitals. This feeling may be intensified if the HCO offers specialized care not available elsewhere. Therefore, acting in a public spirit dictates that, provided the resources are available, the HCO should consider setting up a bloodless program, thereby respecting patients’ values and religious beliefs.

On the other hand, investment in a bloodless program must be evaluated against the needs of other groups of patients. If the resources are unavailable, the principle of spending resources reasonably is likely to direct that patients be referred to hospitals experienced in bloodless treatment.

**DISCUSSION AND CONCLUSION**

The four principles of organizational ethics provide a framework for discussing the moral obligations of healthcare providers and HCOs. In general the principles apply to all organizations involved in the delivery of healthcare. However, the relative weight carried by each principle depends on the type of organization. In provider organizations, caring with compassion will figure prominently, whereas in an insurance company, acting in a public spirit may be of special importance.

The limitations of this framework are those of abstract, universal principles in general. First, agreement on principles alone does not provide a method for resolving conflicts between them. Instead they help to clarify what is morally at stake and identify the irresolvable aspects of a certain situation. Second, the scope of the principles is not defined—for example, how much care for the poor does the principle of acting in a public spirit require? Obviously this depends on many internal and external factors. Third, principles do not obviate the need for good and virtuous character in carrying out in real life what the principles prescribe. Fourth, principles do not address specific, nonuniversal, moral norms, such as proscription of abortion in Catholic hospitals.

As has been the case for principles in clinical ethics, however, principles for HCOs should raise awareness of existing obligations of HCOs and allow their prioritization in specific situations. The processes previously developed in the field of organizational ethics are likely to help communicate the values underlying the substantive principles (Blake 1999; Childs 2000; Goold et al. 2000; Potter 1996; Spencer et al. 2000).

All HCOs should be encouraged to reach consensus on their general realms of obligation and guiding ethical principles. This effort would promote ethical behavior and help to minimize any resulting competitive disadvantage faced by ethical HCOs. Defining the corporate responsibilities of HCOs and setting benchmarks for ethical conduct may best be achieved through a consensus conference or other joint endeavor. HCOs’ obligations can then be defined in a form to which managers, administrators, providers, and consumers can commit. Such consensus also has the potential to promote the public’s trust in HCOs. Until then, to assist in resolving ethical dilemmas within organizations, we propose that clinicians, institutional ethics commit-
tees, and administrators apply the four principles described in this article.

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**Practitioner Application**

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The goal of applying structured ethical principles to healthcare organizations (HCOs) as business entities creates some significant challenges. A set of such principles is well outlined in this article. The authors offer these principles as a framework to evaluate the three fundamental challenges that arise for HCOs aspiring to implement these ideals. The first challenge is straightforward and relates to fulfilling the obligations in the quadrants of HCO responsibility suggested by the authors: providing competent and compassionate care based on provider trust and free of conflict will ring true as the most fundamental aspect and a high priority for nearly all HCOs. The HCO as employer is also a critical part of most HCO management agendas, with some variability in the intensity with which organizations rigorously pursue ethical conduct. When the principles move to “acting in a
public spirit," the strategic goals of the HCO may parallel the public good, but not always. In these instances the final principle, which deals with wise stewardship of limited resources, is helpful to balance cost-containment and quality-of-care decisions and is a fundamental priority of most HCOs. The notion of "spending resources reasonably" can be interpreted as if it is very much in the eyes of the beholder, but the authors make it clear that the basic obligation of an HCO is to serve its patients' health. Therefore, although an HCO may find investing in a plastic surgery center in an affluent neighborhood to be a wise financial use of resources, whether that would meet the ethical standard depends on the degree to which the other ethical principles are met.

The second challenge to implementing ethical conduct is that the principles represent somewhat diverse points of view that are likely to conflict. The example of investment in a bloodless program to accommodate Jehovah's Witness patients shows how the principles can be used to think through the conflicting obligations. In essence, all of these ethical principles must be viewed in the context of competing demands, weighed on a scale of underlying mission objectives that help to raise or lower the priorities of each principle depending on the situation and its applicability to the mission. While a public hospital devoted to care of the poor may favor a free care program at the expense of an enhanced employee pension plan, a private institution may favor its role as an employer with outstanding benefits over provision of more indigent care.

The third major challenge relates to embracing these sets of ethical principles in the context of the competitive healthcare landscape. If behaving ethically has the potential to create competitive disadvantage, how is a level playing field maintained? The authors call for a drive to consensus among HCOs on ethical obligations, structure, and practice for decision making. Even though it is doubtful that, with consensus, the implementation will be undertaken with equal vigor and interpretation across organizations, reaching consensus is an appealing first step. Despite variability in implementation based on mission and market issues, there is still substantial value in each HCO prioritizing a set of principles to guide ethical decision making.