Mary Cipriano Silva, PhD, RN, FAAN (Dec. 31, 1998): Organizational And Administrative Ethics In Health Care: An Ethics Gap *Online Journal of Issues in Nursing*. Available at http://www.nursingworld.org/ojin/topic8/topic8_1.htm

Article published Dec. 31, 1998

ORGANIZATIONAL AND ADMINISTRATIVE ETHICS IN HEALTH CARE: AN ETHICS GAP

Mary Cipriano Silva, PhD, RN, FAAN

Abstract

Although much literature exists on health care clinical ethics, considerably less literature exists on health care organizational and administrative ethics. This situation is especially important to recognize during periods of restructuring, where too often what is good for health care business may not be ethical, causing an "ethics gap." Ethics gaps can be identified and corrected by careful analysis of an institution's organizational culture. Once the analysis is complete, the institution must focus on building a solid ethics infrastructure that permeates all aspects of the institution. A true case situation is presented to illustrate how a nurse was able to change a tainted organization into a responsible one by ethics infrastructure changes. Finally, implications for health care are addressed.

Introduction

"Just as the unexamined personal life is not worth living, the unexamined work life is not worth working." (Petrick & Quinn, 1997, p. xi)

According to Frank Bucaro (1998), a speaker and trainer on business ethics and values, "good ethics is good for business" (p. G 11). But Bucaro also discusses what he calls an "ethics gap." This gap is the difference between what is ethical and what is desirable for business. In today's business atmosphere of "downsizing," and "rightsizing," too often ethics is sacrificed for corporate profits.

Health care organizations, which are a part of big business today, are not immune from the "ethics gap." In fact, they are in the thick of it— a result of the restructuring of health care over the past decade. This restructuring typically has taken the form of some type of managed care. Recently,

Canavan (October, 1996) discussed questionable ethical practices in managed care (or, more appropriately, **mismanaged** care); these practices include gag rules, lack of full disclosure, and compensation plans that reward the withholding of health care services. These practices sacrifice ethics for legal technicalities and profits. In addition, the reality of political ethical conflicts where ethics and politics don't mix compound the ethics gap (Brosman & Roper, 1997).

Despite professional and public concerns and sometimes outrage about these ethical transgressions, little about organizational and administrative ethics has appeared in the health care literature. To help fill this gap, I will first focus on the role of organizational culture on ethics and on building an ethics infrastructure. I will then discuss an administrative ethical issue and conclude with implications for health care.

Organizational Culture and Ethics

According to Brodeur (1998), "health care institutional ethics [are] broader than clinical ethics" (p. 497). "Isn't this self-evident?" you ask. I maintain, however, that the health care profession's history with ethics would suggest otherwise. For the past 30 years, health care institutions have focused primarily on clinical and not on organizational or administrative ethics. This approach represents both "the cart before the horse" and "the Band-Aid" phenomena. Regarding "the cart before the horse" phenomenon, health care organizations have sought to deal with specific clinical ethical issues surrounding death and dying, organ transplantations, and informed consent, to name a few, **before** they have assessed the ethical organizational life and ethical infrastructure of the total organization. Regarding "the Band-Aid" phenomenon, health care organizations have attempted to resolve ethical issues primarily through one or two approaches (e. g., clinical ethics committees or ethics consultants) rather than using a wholistic systems approach.

Grosenick (1994), who believes in the holistic systems approach, notes:

In any attempt to change the values of an organization, whether it is through the education of its participants in moral principles, or the imposition of leadership committed to higher ethical principles, the contents of the existing organizational culture must be dealt with directly for positive change to occur. Ignoring culture in attempting to refocus the values orientation of an organization is similar to ignoring causes and treating symptoms. (p. 183)

Accordingly, Grosenick (1994) believes that values and ethics are not only central to organizational culture but also to positive organizational performance. The approach is group rather than individually oriented; that is, ideally, all persons within an organization, as well as the public they serve,

must share common positive values and beliefs.

Although Grosenick (1994) considers an organization's leadership as important, he is convinced that it is not enough. He bases this belief on real-world experiences where strong moral corporate leadership in and of itself was unable to change the existing morally deviant value structure of an organization. In other words, not only the leaders but also the followers must ascribe to common, sound, and shared ethical values. Just as unethical leadership can taint followers, morally tainted followers can impede or stop the goals of ethical leaders.

The notion of the tainting of values or "dirty hands" has been discussed by Mohr and Mahon (1996). According to them, "dirty hands cases are those instances in which one agent is morally forced by someone else's immorality to do what is, or otherwise would be, wrong" (p. 29). They elaborate further: A crucial component of a dirty hands situation is "*creating situations* [italics added] that necessitate and justify acting with dirty hands" (p. 29). Such a deviant organizational culture may pervade all aspects of an organization.

Health care organizations and the persons who work within them are not immune to the dirty hands phenomenon. It is particularly prevalent today as health care in the United States has become big business. As a result, the health care organizational culture has shifted from a service oriented one to a monetary oriented one characterized by product lines, stocks, profits, competition, megamergers and, ultimately, survival. However, survival of a health care organization may entail charging patients for services never received, falsifying diagnoses, discharging patients before they are ready, rendering services not needed, and rewarding cost-effective care without regard for quality.

Unfortunately, survival of health care providers in the preceding morally deviant organizations may mean doing what the organizations request of them or losing their jobs. In research conducted by Mohr and reported in the Mohr and Mahon (1996) article, nurses reported feelings of pain, suffering, fear, grief, anxiety, rage, and powerlessness when they grasped that they were working in morally deviant organizational cultures. These nurses felt like statistics and doormats instead of human beings. They also feared loss of their jobs as "people were fired right and left without going through the guidelines of the policies and procedures" (p. 33). Ultimately, in order to survive in deviant organizational cultures, many of these nurses disengaged from their work, with resultant guilt and alienation. As Reiser (1994) has noted, "institutions have ethical lives and characters just as their individual members do" (p. 28). Clearly, in dirty hands situations, the ethical life chosen by such health care organizations is to be unethical.

Building an Ethics Infrastructure

What can be done about unethical organizational cultures? Renz and Eddy (1996) offer four strategies to build a solid ethics infrastructure:

1. Conduct a formal process to clarify and articulate the organization's values and link them to the mission and vision.
2. Facilitate communication and learning about ethics and ethical issues, including values clarification and reflection on their link to practice.
3. Create structures that encourage and support the culture.
4. Create processes to monitor and offer feedback on ethical performance. (p. 33)

Link Organization's Values to Mission and Vision

According to Renz and Eddy (1996), one must first clearly articulate the organization's most important values and then link them to that organization's mission and vision. To accomplish this goal, organizations successfully have tried the following approaches:

1. building the vision and values statement into the introduction of the strategic plan,
2. involving all employees and consumers in the design of the vision and values statement,
3. using retreats and facilitated group approaches to discuss the vision and values statement, and
4. using team building strategies to enhance common organizational values.

Facilitate Communication and Learning about Ethics

Renz and Eddy (1996) see facilitating communication and learning about ethics as a way to develop a culture of integrity in which all employees within an organization act upon its vision and values. The process typically follows the stages of "awareness, trial and experimentation, adoption, and institutionalization" (p. 34). Specific strategies include placing mission and values statements in highly visible locations throughout the organization; offering training programs that encourage interaction about the organization's values; using role-playing, case studies, and grand rounds to facilitate communication about ethics; and engaging employees in values clarification techniques. The preceding strategies cannot be done in isolation but rather in consort with an employee's specific roles within an organization.

Create Structures that Support an Ethical Environment

The important point about creating an ethical environment within an

organization is that the proposed structures are multiple, interconnected with one another, and diffused throughout the organization (Renz & Eddy, 1996). Examples of such multiple structures are ethics committees; utilization review committees; designated executives who have specific responsibilities for maintaining the organization's ethics infrastructure; ethics task forces; surveys of a community to evaluate an organization's ethics; and integration of ethics structures with quality control structures such as total quality management (TQM) systems and with performance management systems (e.g., annual performance evaluations).

Monitor and Evaluate Ethical Performance

All of the preceding strategies are diluted if executives within an organization do not see the need for monitoring and evaluating performance to determine the effectiveness of the organization in light of its mission. According to Renz and Eddy (1996), "This process is especially significant around ethical issues since problems in this domain are less likely to become obvious before severe problems take hold and derail the organization" (p. 37). To prevent such derailment, strategies that can be used include obtaining patient feedback; using ethics and integrity audits; examining processes and/or outcomes of ethical decision making; and regular evaluating of the organization's mission, values statements, and/or codes.

Administrative Ethical Issues: Jane's Story

The following paraphrased summary of administrative ethical issues based on the inappropriate distribution of primary care funds is true except for the use of fictitious names and places (Chapin, 1990a, pp. 210-212). The issues serve as a backdrop for an analysis of both administrative ethical issues and of an ethics infrastructure in one health care organization.

Jane, a 31-year-old master's prepared public health nurse, held one of the highest level positions in the State Health Department, that of Director, Division of Primary Care. Although employed there for only two months, Jane was responsible for monitoring millions of dollars of federal and state appropriations specifically earmarked for pediatric disease prevention in District 10. However, District 10 had two indigent populations: young families with children and elderly persons with chronic diseases. Jane soon discovered that her predecessor Dr. Ralston — an elderly physician who had held the position for 35 years — diverted much of the appropriated pediatric funds to the indigent elderly. She brought her concerns to Dr. Mason, the Director of the State Health Department for the past 20 years. He dismissed her concerns and reminded her of his power and her lack of longevity with the agency. Jane knew that the federal and state appropriations were the **only** monies for pediatric disease prevention for the indigent children in District 10. She also knew that the indigent elderly in District 10 desperately needed

services too. What ought Jane to do?

Before ethics infrastructure building can occur in Jane's situation, she must first analyze the administrative ethical issues she faces.

Analysis of the Ethical Issues

Analysis of an ethical issue is often complex and may include such factors as data collection and assessment of situational, health team, and organizational variables; problem identification that differentiates ethical from nonethical dilemmas; consideration of possible actions based on ethical justification; decision and course of action based on factors both internal and external to the issue; and reflection on the decision and course of action taken (Silva, 1990, pp. 109-126). Using these factors for analysis of the preceding administrative dilemma faced by Jane, Harper (1990, pp. 212-227) analyzed Jane's story as follows:

1. Jane first collected relevant data related to **the situation, the health team, and the organization.** Of particular interest was organizational considerations. The main one related to the goal of the Division of Primary Care of the State Health Department. Its goal was to "oversee and [appropriately] fund several programs delivering primary care services to special populations in need of health care across the state" (Harper, 1990, p. 216). In District 10, both the oversight goal and the appropriate allocation of fund goal were severely compromised.
2. From the data collected, Jane identified the **major ethical issue** as meeting both the health needs of the indigent children and the health needs of the indigent elderly in District 10, although insufficient funds existed to meet both groups' health care needs. Jane identified the **major nonethical issues** as the legal ramifications that could occur because of the misappropriation of specifically targeted funds and the absence of a clear organizational vision in District 10.
3. In considering her possible **actions based on ethical justification**, Jane considered several ethical theories and principles. However, her moral justification ultimately was most influenced by utilitarian thinking, that is, the consequences of the greatest good for the greatest number. (This thinking is primarily based on the writings of the philosopher John Stuart Mill (1979), whose original work was published in 1861.) Jane's reasoning went something like this:

   According to a utilitarian approach, the greatest good for the greatest number would be served by developing a system to monitor the distribution of funds to the indigent children. The consequences of this action would produce the greatest happiness by providing the pediatric services to those who deserve them....For [Jane] this means she would meet her obligation to provide health care to the indigent

and would not risk losing her job....[If checks and balances could become a part of the system], Dr. Mason would receive the administrative supervision he needed and would be forced to comply with the policies of the Pediatric Program....Although the indigent elderly could potentially lose benefits under this plan, they were not due these services from a distributive justice perspective. Using this approach, justice would be served for the elderly if they could have their needs communicated to the appropriate decision makers. (Harper, 1990, p. 221)

4. Jane's preceding moral reasoning led her to the **decision** to honor the commitments made to the federal and state funding agencies, that is, to ensure that the primary health care funds were allocated to the indigent pediatric population in District 10 (Harper, 1990, pp. 224-226). To accomplish the preceding decision, Jane took the following **course of action** to strengthen District 10's ethics infrastructure (Harper, 1990, pp. 211-212):
    a. She instituted new policies for the distribution of federal and state funds. To receive funds from the Division of Primary Care, all state agencies were asked to comply with the new policies.
    b. Jane then convened a Task Force with the goal of developing specific procedures for the preceding new policies. (Members of the Task Force included representatives from the federal government and all agency administrators of state-funded primary care programs.)
    c. Jane also required all state agencies to submit monthly reports regarding program performance in accord with a designated format.
    d. Along with these monthly reports, Jane assigned peer administrators from the 20 districts in the State Health Department to make unannounced site visits to all agencies funded by the Division of Primary Care.
    e. Regarding District 10, peer administrators were assigned to help Dr. Mason and his staff interpret the new policies and procedures. Several misinterpretations were found and corrected. As a result, Dr. Mason and his staff followed the new policies and procedures, improved the care in the Pediatric Program, and sought new funding sources for the indigent elderly.
5. When Jane **reflected on her decision and course of action**, she said that as a new administrator it was hard to work through this administrative ethical dilemma. She was concerned about Dr. Mason and his staff's dismissal of the misappropriated funds and their use of improper administrative procedures. Let's listen to Jane's own words

in this matter.

> I did not believe that explaining the errors to Dr. [Mason] would have produced the desired results. This approach was too simplistic and did not take into account social and political factors. It seemed to me that what was needed was an accountability system that included, but was not limited to Dr. [Mason]....Although the ethical analysis was paramount in this case, I felt it was possible to be morally right and still be unable to implement the desired outcome...alone. Since there wasn't enough power within the Division, nor did I have the personal power to accomplish the change alone, I harnessed the support of a significant group of allies throughout the Health Department. The strategy was developed to include others, particularly peers of Dr. [Mason], to induce Dr. [Mason] and his staff to change their practices. (Chapin, 1990 b, pp. 227-228)

Relation of Ethical Issue to Ethics Infrastructures

If we return to the four strategies to build an ethics infrastructure noted previously by Renz and Eddy (1996), we can see that Jane, by sheer will and hard work, was able to tame and turn around a tainted State Health Department district without resorting to either "the cart before the horse" phenomenon or the "Band-Aid" phenomenon. Jane assessed the ethical life of her organization **before** she acted and, when she did act, she made changes that not only involved District 10, but also **all** 20 Districts in the State Health Department.

By instituting new and ethical policies for the distribution of federal and state funds, she helped to clarify and articulate her organization's values, mission, and vision **(strategy 1)**. By convening a strategic Task Force composed both of representatives from the federal government and all agency administrators of state funded primary care programs to operationalize her policies into procedures, Jane was able to teach the Task Force about administrative ethics and ethical issues. In addition, in District 10, she assigned peer administrators specifically to assist Dr. Mason and his staff to learn about and interpret the new ethical policies and procedures **(strategy 2)**. In addition to the Task Force, Jane created a structure that supported an ethical organization by embedding in the culture peer administrators who made unannounced visits to the 20 Districts **(strategy 3)**. Finally, to monitor ethical organizational performance, Jane not only received feedback from the peer administrators but also required all state agencies to submit monthly reports regarding program performance (which if not directly, then indirectly, gave her information about ethical performance too) **(strategy 4)**.

What Jane as a 31-year-old master's prepared public health nurse accomplished was extraordinary. The fact that Jane's story is true only adds to the feeling of joy. Jane's story gives inspiration to all health care administrators and providers who not only want to make their already ethical organizations better but also those health care administrators and providers who toil daily in organizations that are ethically tainted and who want to improve them. It is each administrator's or provider's choice to do so and, according to Weston (1997), "choosing is inescapable" (p. 25).

Implications for Health Care

Too often persons in health care leadership positions tend to micromanage or ignore ethical issues or to allow legal concerns to override ethical decisions. When executives micromanage, they are unable to see their organizations as a whole. Consequently, they are unable to see the necessity for an ethics infrastructure that not only includes their own departments but also all other departments within an organization. When health care executives are blinded to ethical issues, they are prone to act with insufficient knowledge and insight, often resulting in inadequate decision making. A common example is the allocation of scarce resources. If a health care executive views such allocation only as a fiscal decision, the executive is blinded to the fact that **all** allocation of scarce resource decisions are, ultimately, ethical in nature. And, lastly, when health care executives allow legal principles to override ethical principles, the executives are often operating at a minimum, rather than a maximum, standard of practice (Darr, 1997, p. 7).

To prevent some of the preceding problems from occurring in organizations, I recommend that health care executives:

1. extend their horizons beyond their own discipline and attend business classes and seminars on organizational ethics,
2. read business journals and books on ethics and organizational structure,
3. understand that hidden behind many decisions they make is an ethical issue waiting to be explored, and
4. believe that ethics should override law in executive decision making and act on this belief.

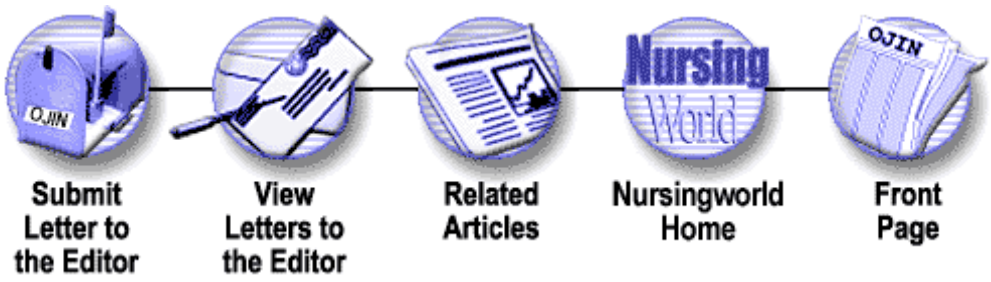
If the preceding four recommendations are followed, health care executives should have a firmer grasp on organizational and administrative ethics in their institutions and, as a result, help close the "ethics gap." By helping to close this gap, health care executives and providers may find that, unlike the words in the opening quotation, the **examined** work life **is** worth working.

The Author

Mary Cipriano Silva, PhD, RN, FAAN

msilva@gmu.edu

Dr. Silva received her B.S.N. and M.S. from the Ohio State University, her Ph.D. from the University of Maryland, and her post doctorate in health care ethics from Georgetown University. She is a professor and the Director of the Office of Health Care Ethics, Center for Health Policy and Ethics, College of Nursing and Health Science, George Mason University, Fairfax, Virginia (http://www.gmu.edu/departments/chp/ethics.htm). She currently teaches a doctoral course on "Ethics in Health Care Administration" and is engaged in scholarship and research related to health care ethics. Dr. Silva currently serves on the ANA Code of Ethics Project Task Force to revise the 1985 *Code for Nurses with Interpretive Statements* and is a member of the American Academy of Nursing Expert Panel on Ethics. The article presented here was adapted from a keynote address given on April 30, 1998 at the Second International Conference of the Global Network of WHO Collaborating Centers for Nursing and Midwifery, Kongju, Korea.



Submit Letters to the Editor | View Letters to the Editor | Related Articles
NursingWorld Home | Front Page

REFERENCES

Brosman, J., & Roper, J. M. (1997). The reality of political ethical conflicts: Nurse manager dilemmas. *Journal of Nursing Administration*, *27*(9), 42-46.

Brodeur, D. (1998). Health care institutional ethics: Broader than clinical ethics. In J. Monagle & D. C. Thomasma (Eds.*), Health care ethics: Critical issues for the 21st century* (pp. 497-504). Gaithersburg, MD: Aspen.

Bucaro, F. (May 24, 1998). Ethics gap provides dilemma for businesses. *The Akron Beacon Journal*, G11.

Canavan, K. (1996, October). Nursing addresses troubling trends in managed

care. *The American Nurse.* Washington, DC: American Nurses Association.

Chapin, J. L. (1990a). Case study 2: The inappropriate distribution of primary health care funds. In M. C. Silva, *Ethical decision making in nursing administration* (pp. 210-212). Norwalk, CT: Appleton & Lange.

Chapin, J. L. (1990b). Case commentary. In M. C. Silva*, Ethical decision making in nursing administration* (pp. 227-228). Norwalk, CT: Appleton & Lange.

Darr, K. (1997). *Ethics in health services management* (3rd ed.). Baltimore, MD: Health Professions Press, Inc.

Grosenick, L. E. (1994). Governmental ethics and organizational culture. In T. L. Cooper (Ed.), *Handbook of administrative ethics* (pp. 183-197). New York: Marcel Dekker.

Harper, D. C. (1990). Principle of justice versus principle of beneficence: Case analysis. In M. C. Silva, *Ethical decision making in nursing administration* (pp. 212-227). Norwalk, CT: Appleton & Lange.

Mill, J. S. (1979). *Utilitarianism* (G. Sher, Ed.). Indianapolis: Hackett. (Original work published in 1861)

Mohr, W. K., & Mahon, M. M. (1996). Dirty hands: The underside of marketplace health care. *Advances in, Nursing Science 19*(1), 28-37.

Petrick, J. A., & Quinn, J. F. (1997*). Management ethics: Integrity at work.* Thousand Oaks, CA: Sage.

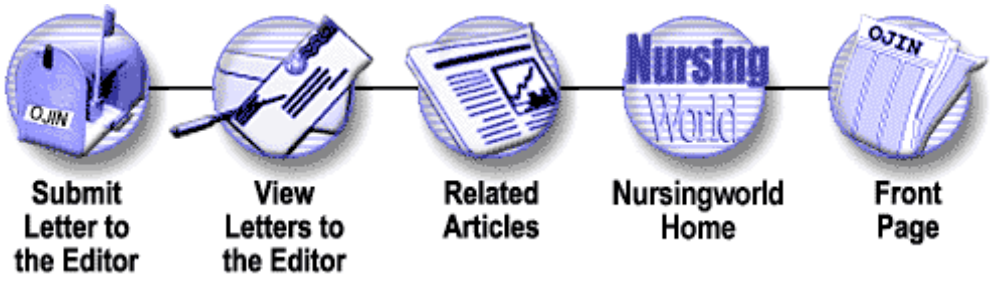
Reiser, S. J. (1994). The ethical life of health care organizations. *Hastings Center Report*, 24 (6), 28-35.

Renz, D. O., & Eddy, W. B. (1996). Organizations, ethics, and health care: Building an ethics infrastructure for a new era. *Bioethics Forum, 12*(2), 29-39.

Silva, M. C. (1990). *Ethical decision making in nursing administration*. Norwalk, CT: Appleton & Lange.

Weston, A. (1997). *A practical companion to ethics*. New York: Oxford University Press.

Article published Dec. 31, 1998



Submit Letters to the Editor | View Letters to the Editor | Related Articles
NursingWorld Home | Front Page