From Clinical Ethics to Organizational Ethics: The Second Stage of the Evolution of Bioethics

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Bioethics has succeeded to an important extent in clinical ethics. In order to meet the challenges of clinical ethics in a highly systematized health care industry, it will be necessary to move to a full engagement in organizational ethics. Re-engineering the institutional ethics committee as an integrated ethics program is one strategy for creating an ethical corporate culture where clinical ethics can flourish. This expansion from clinical to corporate ethics is a return to a broader vision of the goals of bioethics.

Introduction

Clinical ethics should be expanded into health care organizational ethics. This movement is the next logical and practical step toward achieving the patient-oriented goals of clinical ethics and is a turn to the broad ecological version of bioethics. This step will require the reorientation of clinical ethics from issues concerning the individual patient to a wider sociological context. A set of assumptions about the behavior of health care systems can guide this movement. Practical action can be implemented by an integrated ethics program, which is a re-engineering of the institutional ethics committee. The outcome of an integrated ethics program will be an ethical corporate culture for health care organizations.

The Call for Clinical Ethics to Embrace Organizational Ethics

Thirty-five years of high level commitment by health care professionals and ethicists has produced a proficient field of clinical ethics. Well-developed bioethics organizations which hold periodic meetings for the exchange of ideas, the publication of journals and books in the field, and a level of professionalism among bioethicists, are evidence of the existence of a "field." Moreover, a majority of health care organizations have ethics committees, consultants, and interested colleagues who carry out the agenda of bioethics.

Bioethics has become understood and accepted by clinicians who seek help with conflicts and dilemmas. Resistance among medical staff and management is now easier to diffuse. A justifiable sense of success exists in the bioethics movement.

Passionate bioethics reformers who are not satisfied with partial success have been looking for the next "edge to push on." The growing edge is the new frontier of organizational ethics. Although it has been there all the while, only recently has it become the cauldron of ferment and change.

What has brought the bioethics movement to the moral maze of organizational health care ethics? Paul Starr has reported the history of how medicine has been transformed into the image of business and government (Starr 1982). The advent of the health care corporation and government regulation in the industry is a historical reality of the 70s and 80s. Group practice formation, managed care growth, and hospital mergers into mega-systems are all signs of the incessant corporatization of medicine. The regulatory power of government, evident at every level of the health care industry, has motivated small

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organizations to seek the shelter of large organizations.

The Joint Commission on Accreditation of Health Care Organizations has also responded to the corporatization of the health care industry . By introducing standards related to organizational ethics as a companion to patient rights standards, the Joint Commission has anticipated the future direction of bioethics. Despite its importance, the organizational ethics standard is only a preliminary sketch of what is necessary to frame a completed picture of an ethical corporate culture. It is clear that in order to follow the direction of medicine bioethicists must get ready to move into organizational ethics.

Organizational ethics, with its emphasis on managers, markets, and money, is unfamiliar to many ethicists who have, until now, concerned themselves with issues such as advance directives and informed consent. A map is needed for orientation to the new geography of organizational ethics. It is not going to be an easy journey.

In practical terms, doing organization ethics means making ethics as important for health care decisions as clinical data, financial concerns, and legal issues.

I will define organizational ethics as the intentional use of values to guide the decisions of a system. The intentional use of values implies that members of a cooperative group have articulated and reflected on a set of values and have accepted them as normative for the culture of that organization. Because this intentional set of values is normative, it is the guide that primarily shapes the multiple decisions required to drive that system toward the goal entailed in the agreed upon set of values. A health care organization that agrees to a set of values respecting the autonomy of patients would create policies and procedures that maximize the involvement of the patient in the decision-making process. The decision points at various levels from the board room to the bedside would have to be oriented to the value of respecting the autonomy of patients. In practical terms, doing organization ethics means making ethics as important for health care decisions as clinical data, financial concerns, and legal issues.

The Bioethics Movement Needs a Paradigmatic Shift

The bioethics movement needs to shift from the paradigm of dyadic patient-physician relationships in a clinical setting to a larger ecological paradigm in which the clinical encounter is understood in its larger context of the corporate system (Annas 1995).

Joel Barker has given a functional definition of paradigm, which I will use here:

> A paradigm is a set of rules and regulations (written or unwritten) that does two things: (1) it establishes or defines boundaries; and (2) it tells you how to behave inside the boundaries in order to be successful. (Barker 1992)

Following this definition of a paradigm, I recommend shifting the boundaries from the clinical to the corporate arena, and argue for adopting a set of behaviors for creating an ethical corporate culture that values ethics in decision making with the same importance as clinical data, financial concerns, and legal issues.

I interpret this shift of paradigms, or an enlargement of the boundaries, to be a return to the broad version of bioethics originally proposed by Van Rensselaer Potter (Potter 1971). According to Potter's ecological vision of bioethics, there are several levels to the full realization of bioethics. Nestled inside the organizing image of "global bioethics" is the biospheric, international, societal, corporate, and clinical levels of ethical concern (Potter 1988).

Van Rensselaer Potter envisioned that the proper boundaries of bioethics stretch from the bedside to the biosphere. When Potter coined the

word "bioethics" in 1971, he envisioned a wide spectrum of issues. He was interested in the health of persons, but equally interested in the ecological framework that sustains the existence of individual persons as biosocial organisms. His work in basic cancer research led him to inquire about the connections between the processes of cells within organisms as well as the processes of individual organisms within ecological systems. The connections are myriad, and systems have a very powerful influence on the life potential of individuals. Potter has expressed his belief that what happens in the biosphere is as important to the person as what happens at the bedside. The biosphere and the bedside are closely related.

Another view of bioethics arose at the same time as Potter's. Warren Riech refers to a "bilocated" birth of the term and concept of bioethics(Riech 1994, 1995). Andre Hellegers and Sargent Shriver of the Kennedy Institute of Ethics used the new term to describe a more limited spectrum of clinical issues related to "medical ethics." According to Andrew Jameton, the restricted meaning of "bioethics" generally has been used within the health care community:

> For the past twenty years or so, research on each of these two areas of bioethics has proceeded separately. While bioethicists have focused their casuistical microscope on the fine details of clinical work and explored the clinician-patient relationship, patient choice, confidentiality, etc., ecologists and environmentalists have discussed a broad range of ethical and value questions concerning the intensifying global population and biosphere crisis that Potter and others identified. This separation is somewhat surprising, because both ecology and clinical ethics are concerned with the deep relationships among biology, ethics, and human affairs; ethical theory strives to relate daily decisions to a larger theoretical context of basic principles, and daily health care decisions interconnect with global phenomena of human biology, population, and natural resources. (Jameton 1994)

Jameton's description is consistent with Potter's broad image of the bioethics field.

The ecological metaphor which organizes this broad image can be displayed as an hierarchical ladder or as a series of concentric circles. George Engel represented his ecological version of the biopsychosocial model of the human as an hierarchical ladder (Engel 1980).

Another way to visualize the concept of a total matrix from the health concerns of individual persons to the ecological concerns of the biosphere is through the metaphor of concentric circles (Glaser 1995). At the center of circles can be placed the traditional concern of bioethics: the specific case of an individual person in a health care situation requiring a decision.

personal decision

The next embracing circle could be the person's family or most intimate support system.

family of support

The enlarging context of personal existence can be represented several ways, but in terms of health care decisions it could be the health care team.

health team

Next could be the specific health care agency in which the team functions.

health agency

Next could be the health care delivery system within which specific agency functions.

delivery system

Then the larger societal context could be displayed. There could be intermediate circles depending on how detailed the analysis.

societal context

Beyond this broadly embracing circle would lie cultures, nations, federations, political systems, international human rights statements, and other units of analysis that have been useful (Foss and

Rothenberg 1988).

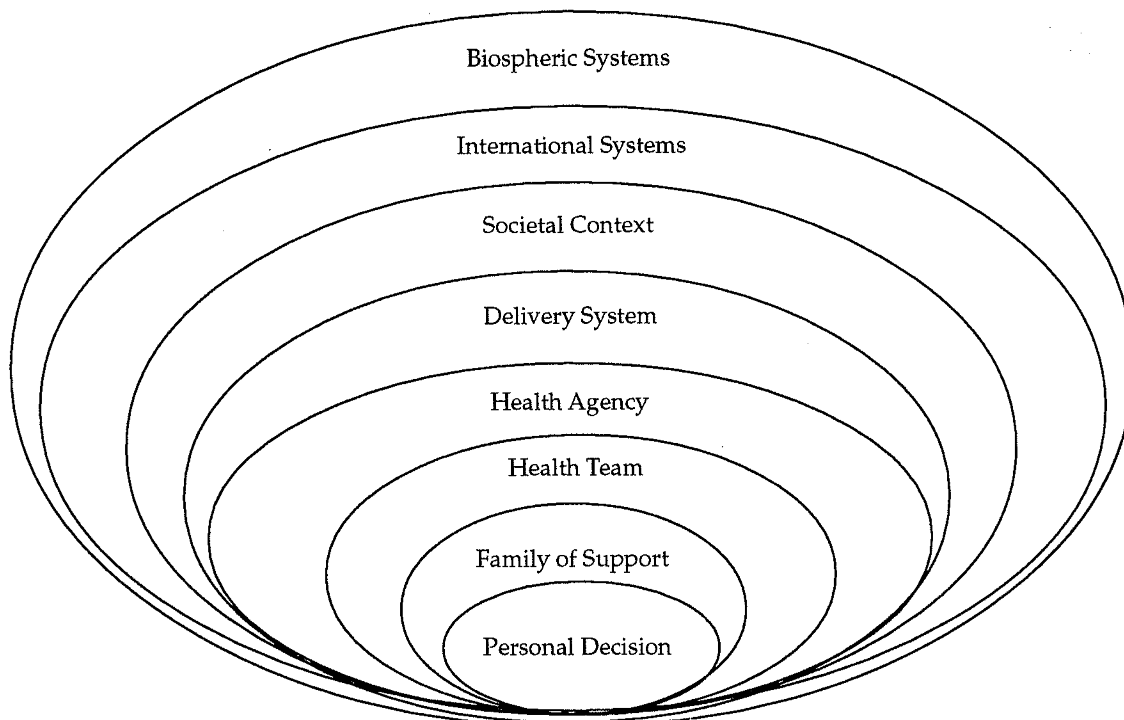
In order to embrace Potter's ecological paradigm, bioethics should be going global one step or ring at a time:

- clinical
- corporate
- social policy
- international human rights
- the ecological.

"Clinical" refers to the bedside decisions that immediately affect the individual person in the context of the patient-provider relationship. "Corporate" refers to the health care delivery system, which is the organizational context of the patient-provider relationship. "Social policy" represents the social structures that are the context in which all delivery systems are embedded. "Human rights" refers to the declarations of agreements about what rules should govern the international community. "Ecological" refers to caring for the biospheric dimension, the largest total context before one leaves the planet for the next largest embedding field of the solar system.

This movement is not a rigid sequence of steps up the hierarchy or out through the circles, but there is a reciprocal kind of progression. The main idea is that in order to secure development at any one level, it is necessary to take into account both the levels below and above. One must move back and forth from the various levels to maximize interaction of the various levels. Hence for corporate ethics to be fully developed, it must take into account both the clinical ethics and society ethics levels.

What most health care providers have been slow to understand is that the clinical box can be confining, whether one is dealing with therapeutic intervention or bioethical concerns. Getting out of the clinical box and into a larger context of forces that directly impact the clinical situation is a necessary step for clinical ethics to thrive (Lavizzo-Mourey 1996). Ideally, in order to think and work holistically, all levels would have to be engaged at once. However, this does not work well in practice. The slogan of "thinking globally and acting locally" can be applied here: think about bioethics globally, but act at the clinical and corporate locale to solve practical problems. We cannot leap from the clinical box into the global



biosphere in one jump. Instead, the bioethics movement should aggressively give attention to the intermediate level of organizational ethics: that corporate context in which the decisions made by managers and decisions made by providers and patients are strongly interactive.

Translation of the concept "global bioethics" into a practical program is required in order to shift to an ecological paradigm. There is a temptation to spin out sterile abstractions about the interaction of the very local situation and the broader global context. It is expected that there will be an accumulation of practical concretion regarding the connections between the specific local situation and global bioethics as we proceed through the paradigm shift. The basic strategy is to create a clear, convincing, and practical image of what this broader version of bioethics means in relation to clinical and organizational ethics. When building a matrix of relationships between clinical and organizational behavior the goal of the good for the individual patient should not be lost.

We must be able to do an ethical analysis of the moral matrix of relationships in which all our decisions and actions are embedded. At one level this involves knowledge of moral psychology, while at another level the moral foundations of social processes must be clarified. Each level must be bio-polar so that it can understand itself in relationship to both the lower and higher levels. In order to solve its problems clinical ethics must be skilled in moral psychology as well as appeal to the next higher hierarchical level of the moral matrix, i.e., the moral sociology of organizations. Likewise, in order for corporate ethics to understand its own set of problems, it must understand clinical ethics and appeal to the next higher hierarchical level of the moral matrix which is societal ethics.

According to this ecological vision, the initial stage of the evolution of bioethics in which the field of clinical ethics has been defined has been accomplished. It is time for the second stage of the evolution of bioethics during which the more narrow focus may now be laid aside in favor of Potter's broader vision of bioethics. The practical link between the widely separated but strongly related subjects of clinical and global bioethics is the next contextual circle: organizational ethics.

We must learn how to maintain our skills of analysis of the patient/provider relationship and, at the same time, account for the patient/system relationship.

Strategy for Making the Paradigm Shift

In order to implement this paradigm shift, members of the bioethics movement must move from the clinical context to the systems matrix of the corporate world.

First, we will have to learn how to integrate clinical and corporate aspects of bioethics. We must learn how to maintain our skills of analysis of the patient/provider relationship and, at the same time, account for the patient/system relationship. We must learn how to understand populations of patients as well as individual persons. Medical sociology and epidemiology must become our working tools.

We will have to create a change in quality language that envisions ethics at the core of quality care. This will be the first step in developing a practical formula that relates quality of care and cost of care in ethical terms. The balancing of quality and cost is central to applied business ethics (Aguilar 1994).

Second, we will have to enter into the dynamics of corporate culture and experience first hand how to meaningfully interpret organizational behavior. This means becoming sensitive to working with new colleagues who have a professional culture that is different from the clinical orientation with which we are familiar. Cultural

anthropology tailored to the institutions of business will assist our study.

Third, we will have to explore carefully the basics of moral leadership that justify community trust in the management of health care institutions. The public expects a high standard of ethical behavior of health care executives as they guide health care delivery. Moral psychology, which studies the character of persons, must be adapted to explore the business mentality.

Fourth, a consensus must be reached on what defines a virtuous and principled organization. It can be argued that organizations are not moral agents, yet they are real entities, exhibit actions, and are judged by codes of ethical behavior. They will need to reframe vision statements to express the true core of corporate values.

We will have to weave all the subjects suggested here into a synthetic new field of study to achieve this goal. This new field of corporate health care ethics has been struggling to define its working assumptions.

Working Assumptions about Health Care Organizations

As an ethics program is integrated into a health care organization, two primary questions need to be answered:

> Is health care a commodity to be treated as a for-profit business or a service to be treated as a not-for-profit public utility? and
>
> How do we create an ethical corporate culture that makes ethics as important for health care decisions as clinical data, financial concerns, and legal issues?

The first question involves "business ethics," which is subsumed under the term "organizational ethics." Organizational ethics entails all the activities of organizations; one of these activities may be conducting business as an economic function. The issue of whether or not a health care delivery system should be understood as simply selling a service and responding to the competitive forces of the marketplace is important, but I will not deal with it here (Black 1995; Garrett 1993; Jennings 1995; Weber 1990; Werhane 1990; Woodstock 1995).

The second question about creating an ethical corporate culture is the primary subject of this paper. As a beginning point, the following set of assumptions have been developed through conversations with managers of health care organizations. As clinical ethicists learn more about the culture and conduct of health care organizations, the list will become more refined.

1. All human action has moral import including clinical and organizational business decisions.
2. Persons make decisions based on values.
3. Organizations are composed of persons who make decisions based on values.
4. Organizational decisions require ethical analysis.
5. Organizational ethical analysis is analogous to clinical ethical analysis.
6. Principles used in clinical ethics can be used in organizational ethics with appropriate modification.
7. Organizations can be analyzed for ethical pressure points at which critical decision making occurs.
8. Organizations can change behavior based on intentional change of values.
9. Organizations tend to resist behavioral change because of inertia and intentional adherence to chosen values.
10. Guidance of behavior of an organization and individuals within an organization is complex — values, expectations, incentives, character of employees and managers, and larger cultural factors all share in the determination of behavior.
11. Organizational ethics is a means promoting value-oriented corporations.

12. Codes of ethics are helpful because they promote discussion; however, they are not sufficient for guiding decisions in health care.
13. The goal of an ethical corporate health care culture is strongly related to the goal of medicine to take the right action for the good of the patient.
14. The primary goal of medicine is the good of the patient, and the secondary goals which support the primary goal, must be translated into practical and ethical organizational activity.

An integrated ethics program has at its core an augmented ethics committee that is positioned to introduce ethical concerns into the decision-making process at every level of the organization.

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15. Because the secondary goals of medicine are unclear, specifying the practical and ethical direction of the health care delivery system is also uncertain.
16. Management of the health care delivery system affects clinical outcomes.
17. Health care organizations cannot succeed with being bifocal: concentrating on both the clinical and corporate levels at the same time.
18. Clinicians and managers do not always maintain the dual focus and are in conflict over which focus is primary.
19. Greater clarity in organizational ethics will be acquired gradually by experience of doing organizational ethics.
20. The same three dynamics of institutional ethics committees — education, policy review, and case consultation — apply to organizational ethics.

A set of assumptions like the foregoing can become the vision statement framework for a coherent approach to an organizational ethics analysis. If appropriate assumptions are made, then the solutions can be created, justified, and implemented with greater confidence and accuracy.

Integrated Ethics Program as a Framework For Organizational Ethics

Some leaders in the bioethics field are convinced that the institutional ethics committee is not adequate for the broadened task of clinical and corporate ethics (Christopher 1994). The typical ethics committee is not prepared for, and may even be resistant to, the task of organizational ethics. A narrow focus on clinical case consultation to the relative neglect of education and policy review has not prepared the ethics committee for the task of organizational ethics.

We will have to invent another level of ethics mechanism to implement this shift to corporate ethics while maintaining attention on clinical ethics. The new ethics mechanism recommended by Christopher is intentionally patterned after the older institutional ethics committee model and can be understood as an intensification of its three basic functions of education, policy review, and case consultation. As a second generation of institutional ethics committee, an integrated ethics program is the mechanism that can more completely fulfill the goal of making ethics as important for health care decisions as clinical data, financial concerns, and legal issues.

An integrated ethics program has at its core an augmented ethics committee that is positioned to introduce ethical concerns into the decision-making process at every level of the organization. The membership of the committee will include persons of power and position within the organization. The same functions of education, policy review, and case consultation, which are currently associated with institutional ethics

committees, will be retained and intensified. However, the emphasis on case consultation will be balanced with an increased attention to organizational education and policy formation to guide organizational behavior at every locus of decision.

The integrated ethics program will be managed by a multidisciplinary team made up of persons in key positions in the organization so that they may act as the ethics faculty to enable ethics to be at the center of decision-making processes.

The authority and capacity of an integrated ethics program will be more comprehensive than the typical ethics committee. Usually ethics committees have given their attention exclusively to clinical or treatment issues. An integrated ethics program will be positioned to serve as a resource for both clinical and organizational ethics. The integrated ethics team will have climbed out of the clinical box and into the corporate board room.

An integrated ethics program seeks out the pressure points of an organization in order to introduce ethics into every decision-making process. With ethics team members positioned in key decision-making nodes throughout the organization, there need not be a waiting period for consultation, but rather an ongoing, timely, and persistent raising of ethical issues. For example, as economic pressures demand restriction of nurse staffing patterns, the ethical consequences to the patient, the nurse, and the organization must be given optimal consideration.

An integrated ethics program is a proactive approach. The emphasis is on prevention of ethical crisis through education and policy formation. The strategy is to "get up stream" rather than waiting to deal with the next crisis. Preventive ethics is central to an integrated ethics program.

An integrated ethics program establishes an action plan with short and long-term goals that parallel the organization's strategic plan. It does not simply react to problems but, rather, it creates alternative futures through short-term action plans to reach long-term goals This kind of program intentionally forms the future.

In summary: an integrated ethics program is an integration of clinical and corporate ethics which engages all levels and functions of the organization into one value vision of making ethics as important for health care decisions as clinical data, financial concerns, and legal issues.

Three Attitudes Necessary for an Integrated Ethics Program

There are three primary attitudes that must be cultivated in order to actualize an integrated ethics program: a missionary mentality, conviction of the centrality of values, and a dedication to systems thinking.

A transformed organizational ethic is the environment in which clinical ethics can complete its goal of raising the patient into full partnership in health care decisions.

The missionary mentality believes that spreading the word throughout the organization is a demand to which we must respond. A sense that leadership is servanthood to a mission is critical to success. This sense of servanthood will be supported by passionate engagement in the project of integrating clinical and corporate ethics.

Conviction that values are central to human action is central to success. To trust that ethics grounds all human action creates the power to thrust ethics into the core of all clinical and corporate decision making. Believing that values drive all decisions makes value sensitivity the most important characteristic of a virtuous organization (Keeney 1992).

To persist at systems thinking will allow a "learning" organization to discover the decisional

pressure points where ethics must be raised to consciousness. Six decisional pressure points have been defined by the 1996 standards of the Joint Commission on Accreditation of Healthcare Organizations: admission, transfer and discharge of patients, marketing, billing, and the conflict of interest, which can exist particularly at the board of trustee level. The attitude of a learning organization will enlist everyone in understanding the subtle dynamics of corporate decision making and seek out opportunities to introduce moral reflection at the right moment of that process (Singe 1990).

Health care managers ultimately solve organizational problems by clarifying the web of connections between the good of the patient and the good of the system. A missionary mentality, a conviction of the centrality of values, and a dedication to systems thinking will clarify the connections between the clinical and the corporate.

The Goal of an Integrated Ethics Program Is To Create an Ethical Corporate Culture

It is essential for health care organizations to emphasize ethical concerns by formally integrating ethics into quality improvement. It is essential because it is good and right to do; it will moderate the distorting pressure of health care competition; it is healthy for business to do so; and accreditors demand it.

Unified ethical action can create a morally healthy environment for health care. When individual clinical and collective corporate levels of behavior act out of the same value/vision, the best possible outcome for each patient can be balanced with the justifiable needs of the larger community of persons who make up the health care organization. To create such a supportive ethical environment organizations should

1. Adopt and honor a vision/values statement which supports an ethical corporate culture;
2. Develop and maintain a culture where ethical considerations are integrated into decision making at all levels and are as important as clinical data, financial considerations and legal concerns;
3. Create a "moral space" in which thoughtful reflection about decisions is an expected standard;
4. Define integrity as the central management virtue;
5. Encourage trust among employees through open and effective communication at all levels of organization;
6. Educate employees about ethical issues they will encounter;
7. Have policies in place to provide guidance for employees confronted with ethical issues;
8. Develop formalized methods for managing ethical conflicts and dilemmas (Biblo 1995).

A transformed organizational ethic is the environment in which clinical ethics can complete its goal of raising the patient into full partnership in health care decisions.

Conclusion

Health care organizations are changing. It is prudent for the bioethics movement to adjust to the change. The direction of the adjustment is to become bi-focused on both clinical and organizational ethics as the matrix for moral reflection and action. The proposed move to an integrated ethics program is not a break with the past but a continuing evolution of the original vision of bioethics to thrust moral values into the core of health care decisions.

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