CASE STUDIES IN HEALTH ADMINISTRATION
VOLUME FOUR:

ETHICS FOR HEALTH SERVICES MANAGERS

Kurt Darr JD ScD FACHA
Editor

Foundation of the
American College of Hospital Administrators
Chicago, Illinois

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For

Emma Hoff Darr and Johannes Kurt Darr

FOREWORD

This casebook has been edited by Professor Kurt Darr, an educator and a Fellow in the American College of Hospital Administrators (ACHA). The volume has several features that make it especially useful to the reader. The introductory chapter describes various moral frameworks and derivative principles useful for guiding health services managers in moral decision making. It also presents a problem-solving process for identifying and resolving ethical issues. Cases run the gamut of biomedical and administrative issues and are representative of the kinds of issues confronting health services managers on a regular basis. In particular, Professor Darr's comments concerning operative principles and the need to develop a personal ethic challenge those in leadership positions to find ethically acceptable ways of meeting the needs of their communities and maintaining the integrity of their organizations.

"Ethics for Health Services Managers" is the fourth in a series published by the ACHA. Volumes one and two, edited by James O. Hepner, addressed the topics of planning for multi-hospital systems, and hospital administrator-physician relations, respectively. Volume three is entitled "Strategic Planning for Hospitals" and was edited by Philip N. Reeves, D.B.A., FACHA. All cases in these volumes were written by Members of the College as evidence of their ability to define management problems and evaluate solutions and were submitted in partial fulfillment of requirements for advancement to the status of Fellow in the College.

The College is proud to use the experience and knowledge of its affiliates to educate others in the field. It is our hope the cases will assist in making the management of health services organizations more effective.

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PREFACE

Ethics have commanded greater attention from the health services field during the past decade, and the most drama has occurred in biomedical ethics. Mechanical hearts, liver and heart transplants, and babies doe make headlines grabbing the public's attention, and we find all of society fascinated with medicine's ability to save and extend life and improve its quality. Little has been said about the manager's role in biomedical ethics. Yet, there is no doubt we must be involved, and participate with clinicians as they seek to deliver efficacious patient care in this era of limited resources.

In addition to the regrettable inattention to the manager's role in biomedical ethical issues, there is a problem of insufficient consideration to the administrative ethical issues which confront managers. Issues such as conflicts of interest, consent, and resource allocation are common and have likely affected every manager in a health services organization. Although the literature and professional meetings have given some consideration to these issues, the profession itself has paid them scant attention. If managers are to function effectively they must recognize and deal with ethical issues of both types.

Of the several hundred cases reviewed in developing this casebook, few focused on administrative or biomedical ethical problems. In addition, health services management literature infrequently addresses problems of administrative ethics. Since we know ethical problems occur with significant frequency we must ask why there is such a paucity of cases describing them. Managers may feel uncomfortable dealing with biomedical ethical problems and surrender the solution exclusively to physicians and other caregivers. For both clinical and administrative ethics they may fail to recognize them in certain guises or manifestations. It may be they consider them unimportant. Whatever the reason, it is hoped this casebook will help fill that void.

This casebook is the fourth in a series published by the American College of Hospital Administrators (ACHA). It utilizes cases developed by ACHA Members seeking advancement to Fellow who granted permission for use of their cases. Because the cases often contain information of a sensitive nature they are not attributed to specific authors. Alphabetically, the Fellows are:

G. Kent Ballantyne
Larry O. Barton

John P. Brozovich
James G. Coller
Garrett E. Colquette
Samuel Duane Draper, Jr.
Frank R. Gabor
Stephen J. Kelleher, Jr.
John W. Logue
William L. Meyer
Paul E. Raczkiewicz
Dan L. Rex
James J. Sexton
Barry J. Solomon
Thomas J. G. Tighe, Jr.

The editor is grateful to them for granting permission to use their cases as well as their willingness to review final edited versions.

In preparing this volume I have been assisted by Peter A. Weil, Ph.D., ACHA Director of Research and Development. Dr. Weil encouraged me to propose a casebook on ethics to the College and was instrumental in obtaining permission to proceed with this volume. He gave enthusiastically of his time throughout the process. Jonathan D. Moreno, Ph.D., Department of Philosophy of The George Washington University, offered constructive criticism about the moral frameworks. Shelby Higgins provided excellent clerical support. Stephen Messinger effectively researched numerous topics. Edna Dick assisted with technical and proofreading help on the cases and interstitial material. I am grateful for the assistance of each.

It is hoped the College will continue to publish collections of Fellows' cases. Such an effort makes available the experience of others and benefits affiliates, others in the field, and students. While experience may not always be the best teacher, there is much to be learned from those who have successfully, or unsuccessfully, worked to solve management problems. We owe the casewriters a debt for sharing their experiences.

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INTRODUCTION

Background

This casebook is about ethics as they affect health services managers. It takes little effort to find ethical dimensions in most management decision making, especially if the manager has been sensitized to administrative and biomedical issues. Sensitization was a primary motivation for preparing this collection. In addition, the book proposes a problem solving process to facilitate the manager's ability to formulate and implement solutions. A final purpose is to develop organized means to assist in minimizing the potential for occurrence of ethical problems and maximizing the probability of solving them.

This Introduction contains three segments: summaries of moral philosophies and derivative principles, knowledge of which is essential to understanding the context of administrative and biomedical ethics; description of problem solving which is applicable to ethical problems; and discussion of techniques that assist the manager in preventing ethical problems, or facilitating their solution. Each is preceded by a concise discussion of issues raised and special considerations.

Although necessarily brief, it is hoped this introductory material and the cases will whet the reader's appetite to explore further the increasingly available and high quality literature in the field. A bibliography has been included to assist in doing so.

Moral Philosophies

Western moral thought has been influenced by hundreds of philosophers and thinkers. We consider only a few here. Even a brief overview allows the nub of their ideas to be presented and to suggest how applying them can affect management decision making in health services organizations. Among the most important are Kantian deontology, utilitarian teleology, natural law as developed by Thomas Aquinas, and the work of a contemporary American, John Rawls. These moral philosophies will be the basis for formulating the ethical principles useful in understanding ethical issues and in developing a personal ethic. The principles are autonomy, beneficence, nonmaleficence, and justice.

Deontology. The combination of the Greek words deon, meaning duty, and logos, meaning the study of, results in the word deontology--literally the study of duty. Immanuel Kant was an 18th century philosopher who stressed the duty each of us

owes another as moral agents. This duty has to arise solely from the good will, not from other motives. For Kant, good will is the only thing that is good without qualification. To learn the proper scope and content of that duty, we are to test actions taken in light of it in a special fashion. This test was termed the formulation of a categorical imperative. The categorical imperative requires us to universalize the actions we are considering. That is, we take a principle of action that we think may be appropriate and determine whether it can be consistently applied to all persons in all places at all times. No exceptions are made, nor are any allowances permitted for special circumstances. Each person is treated as equal to any other. If the principle of action meets this test we can accept it as a duty. It fails to meet the test if it is contradictory to the overriding principle that all persons must be treated as moral equals and are, therefore, entitled to respect.

If, for example, we want to permit physicians to deceive their patients because this makes medical treatment more efficient, we would have to apply a rule stating "Physicians may deceive their patients when they consider it necessary to speed delivery of treatment." It is obvious such a policy would cause chaos in patient care. Patients would know it is acceptable for physicians to lie when it aids efficiency. However, patients would not know <u>when</u> their physicians are lying or telling the truth, and trust would be lacking. This is contradictory, and destructive of the physician-patient relationship. Because they are being deceived it fails to treat patients as moral equals. Therefore, it does not meet the test of the categorical imperative. The duty to tell the truth must be respected without exception, regardless of consequences. The rule "Always tell the truth," satisfies the categorical imperative. A one-sentence summary of Kantian deontology states the golden rule: do unto others as you would have them do unto you.

<u>Teleology</u>. Derived from the Greek root <u>telos</u>, which means result or end, teleology is literally the study of ends. One type of teleology is utilitarianism. It focuses on the consequences of taking a certain action. Utilitarianism's roots lie in hedonism (epicurianism) which measures morality by the amount of pleasure obtained by an act or rule. This theory was refined by two 19th century philosophers, Jeremy Bentham and John Stuart Mill. Its most complete elaboration was achieved by Mill who, unlike Bentham, distinguished the various types of results and treated them differently. Mill argued there are gradations of happiness and these must be taken into account in attempts to measure various "ends" (results) brought into being.

In judging morality, utilitarians ignore the <u>means</u> by which results are achieved and look only at the end result--the amount of good produced or its opposite avoided. In some forms of utilitarianism, therefore, it is moral to enslave a

minority of the population since the happiness produced for the majority exceeds the minority's unhappiness. However, in On Liberty Mill stresses liberty as requisite to producing happiness, and this makes it unacceptable to infringe to this degree the privacy of any group or individual. Utilitarian philosophy permits a balancing of results produced, and in an effort to have the "greatest good for the greatest number," many decision-makers weigh the alternatives.

There are rule utilitarians and act utilitarians. Rule utilitarians develop a general rule that meets the test of utility--balancing the pleasure and pain produced by an action--and use it until reassessment proves the rule should be changed. Conversely, act utilitarians do not develop a frame of reference, but determine only the consequences of a particular act. Some economists and managers use utilitarian theory in cost-benefit analysis activities. A somewhat harsh but nonetheless accurate statement of utilitarian philosophy is that "the ends justify the means." Act utilitarianism is not compatible with the derivative ethical principles to be developed and will not be considered further.

Natural Law. The third important theory is natural law. It derives from writings of the 13th century church theologian St. Thomas Aquinas, who based his work on Aristotle. The Roman thinker Cicero was also a natural law theorist, but not from a theological standpoint. Natural law is very different from utilitarianism, even though they are both teleological. It also rejects Kantian deontology.

Natural law views each living thing as having function and purpose--a natural potential. It is grounded in concern for the "good" of human beings, and this good is revealed by man's ability to reason. This ability enables us to know at least part of God's divine plan, and we are guided by it in doing what is right. For example, natural lawyers often argue that homosexuality and all sexual "perversions" are immoral precisely because they violate the natural order of sexual relations revealed to us by reasoned inspection of the biological world.

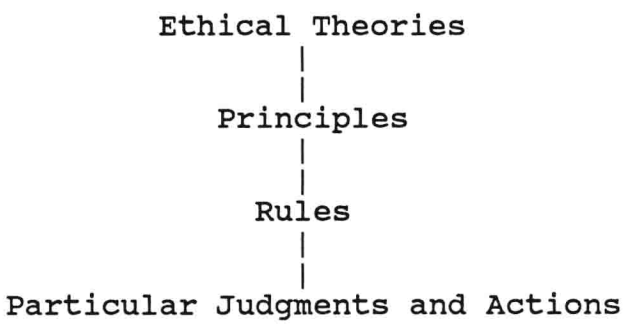
To implement natural law theologians have developed numerous subsidiary principles. Several are useful in biomedical ethics. They include the concepts of extraordinary and ordinary care and the principle of double effect. These concepts will be described in Part III below. A shorthand statement of natural law is "do good and avoid evil."

Rawlsian Theory. A contemporary philosopher, John Rawls, has developed a theory applicable to allocation and delivery of health services. He begins with a hypothetical construct that places persons who remain rational and self-interested in an original position under a veil of ignorance. It means they do not know who they are, their talents or deficiencies, and their economic position or social class.

It is important to stress that Rawls's strategy permits these persons to carry the very human trait of self-interest, but since they are not biased by knowledge about themselves, he suggests they will adopt certain moral principles to govern a just society. This society will have (1) the greatest individual freedom for each person consistent with the same level of freedom for all [liberty principle]; and (2) social and economic inequalities will be arranged so that they are {a} reasonably expected to be to everyone's advantage, and {b} attached to positions and offices open to all [difference principle]. For Rawls, the liberty principle which governs political rights is much more important and precedes the difference principle which governs distributive rights. He argues that persons in an original position and under a veil of ignorance will agree to distribute social and economic primary goods (presumably including health services) equally; but if that is not done, any distribution is expected to meet requirements of the difference principle. Rawls would permit groups of providers, such as administrators and physicians, to be economically and socially advantaged if that inequality is reasonably expected to be to everyone's benefit.

Operative Principles

Link to Moral Philosophies. Beauchamp and Childress have developed a useful graphic presentation of the relationship between ethical theories (moral philosophies) and actions (implementing decisions):[1]



Ethical theories are necessarily abstract and general. But from them can be developed principles, rules, and particular judgments and actions. It should not be assumed that ethical theories invariably conflict. In fact, diverse philosophies may reach the same conclusion, albeit through different reasoning or assumptions, by various constructs, or through applying divergent theories, e.g., the utilitarian's ends versus the deontologist's duty.

The link between ethical theories and derivative principles decreases the level of abstraction and develops usable guidelines for the health services manager. To aid that

process, this discussion suggests principles for managing in the health services field. These principles are supported by the moral philosophies discussed earlier. They are basic to delivery of health services, and one would expect to see them reflected both in the philosophy of the organization and the personal ethic of health services managers. These principles are autonomy, beneficence, nonmaleficence, and justice. Some treat utility as a distinct principle; however, this may be confusing and it is included in the principle of beneficence.

Autonomy. Both Mill (utilitarian) and Kant (deontologist), though for different reasons, reach the conclusion that autonomy is an important principle. It requires that persons be self-governing. They must be rational and uncoerced--able to choose and pursue a course of action. A correlate of self-governance is that an individual is entitled to respect, the respect given an autonomous agent. For the health services manager this means a duty to be truthful. Autonomy also requires that every effort be made to treat patients and others in the organization and those with whom it has contact in a fashion that furthers the principle of autonomy. There are situations in which patients are or become nonautonomous, e.g., the physically or mentally incapacitated and infants, and special requirements are neeeded to deal with them. The principle of autonomy is especially applicable in obtaining consent for treatment and in the general way the organization views and interacts with patients and staff.

Beneficence. A dictionary definition of beneficence means to act with charity and kindness. Applied as a principle in the health services field, it has a similar but much broader definition and has roots in all ethical theories described above, as well as in Hippocratic tradition. It is a positive duty, compared to the principle of nonmaleficence, which requires us to refrain from actions that aggravate a problem or cause other negative results. However, beneficence has other dimensions. Beauchamp and Childress divide it into (1) providing benefits and (2) balancing benefits and harms.[2] Conferring benefits is a firmly established tradition in medicine, and failure to provide them when in a position to do so violates the professional duties of both clinician and administrator. Balancing benefits and harms is part of the principle of beneficence and provides a philosophical basis for cost-benefit analysis, as well as other considerations of risks balanced against benefits. This principle will be of increasing significance in the environment of prospective payment. However, it is not meant here to be applied in such a fashion that the rights of individuals or groups may be violated to gain maximum utility.

Nonmaleficence. The third principle is nonmaleficence. Like beneficence, it is rooted in the moral philosophies discussed earlier. Nonmaleficence means in effect primum non nocere or above all, do no harm. This is an ancient dictum for guiding physicians' actions, but is applicable to health services

managers. Beauchamp and Childress note that although this principle gives rise to specific moral rules, neither the principle nor the derivative rules can be absolute because it is often appropriate (with the patient's consent) to inflict harm to avoid worse harm or prevent more harmful situations from occurring.[3] Nonmaleficence also leads to management and clinical decisions to avoid risk, unless the potential results are such as to justify them.

Justice. The fourth principle, justice, is important in several areas of administrative decision making--for example how health services resources should be allocated. But it has application in how employees are treated, e.g., personnel policies and decision making about them. What is justice and how does one know when it has been achieved? Rawls defines justice as fairness--each person gets his just reward or his due. This helps, but leaves us to define fairness and just reward. A principle of equity is that equals are treated equally; unequals unequally. This is also of assistance, but it does not solve all problems of definition and opinion. This makes justice a difficult principle to apply. Macro- and microallocation of resources are increasingly important problems, and at a mimimum clinicians and administrators act justly when they consistently apply clear criteria in their decision processes.

The foregoing brief descriptions of moral philosophies and derivative principles provide background and a framework in developing a personal ethic or assessing another's ethic. Managers are unlikely to agree fully with a specific moral philosophy and most will be eclectic as they work to solve ethical problems. However, principles such as these should be acceptable to all health services organizations and those who manage in the health services field. Not all will be needed in each situation, nor will they be given equal weight when they are applied, but they should be considered basic in our efforts to solve administrative and biomedical ethical problems.

Developing a Personal Ethic

Background. Managers of health services organizations begin careers as mature adults who, even though inexperienced, have already developed a personal code of morals which governs their conduct. They have a sense of right and wrong which may be more or less specific and clearly developed. What is it that managers use as they formulate a personal ethical code?

An adult's morality is a product of environment, education, moral or religious training, and experience. Education for health services administration at post-secondary and graduate levels has the important collateral task of socializing the student to various roles and activities of health services

management. Some programs include study of administrative and biomedical ethics. And they may provide information about professional codes of ethics such as those of the American College of Hospital Administrators (ACHA), American Medical Association (AMA), American Hospital Association (AHA), and the American College of Health Care Administrators (ACHCA) (long term care). These special codes identify concerns unique to the health services field and assist in providing information and an additional context for the manager's personal ethic.

Biomedical Ethical Issues. No administrative code provides useful guidance on biomedical ethics. These professional groups may have membership too diverse to allow development of biomedical ethical guidelines. One indication of the diversity problem is the reference in the institutional code developed by the AHA, "Guidelines on Ethical Conduct and Relationships for Health Care Institutions." It directs health care institutions to ensure respect and consideration for the dignity and individuality of patients, employees, physicians, and others "wherever possible and consistent with (its) ethical commitments." Thus, ethical precepts of the organization govern, and patients are to be given services consistent with its philosophy.

The lack of assistance puts the manager somewhat adrift when working to solve biomedical ethical problems. And this necessitates better grounding in the moral philosophies and principles discussed earlier, more attention to nuances and specialized situations, and deliberate efforts to become knowledgeable about decision making and developments in the field. An important aspect of identifying and analyzing biomedical ethical issues is simply to understand the options available. A major role of the manager is to develop the systems and procedures by which effective biomedical ethical decision making can take place. Means of assistance in reaching these decisions are discussed below.

Administrative Ethical Issues. The ACHA "Code of Ethics" is the most comprehensive code for health services managers and provides useful and detailed guidance on administrative ethics. Last revised in 1973, it contains nonspecific and limited guidance on biomedical ethical issues, however. (See Appendix A). It is useful in administrative ethics and has more detail than any other administrative professional code, especially with regard to conflicts of interest. Codes developed by other administrative groups in the field are very general and provide little guidance for health services managers.

The ACHA considers code enforcement an important function and has a committee on ethics that meets to hear any complaints against affiliates and then recommends action to the ACHA's governing body. The most stringent penalty it can levy is to terminate an affiliate's relationship. The lack of licensing