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AN ETHICS DISCUSSION SERIES FOR HOSPITAL ADMINISTRATORS

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The complexity of healthcare provision has increased dramatically during the past several decades in the United States. That complexity is a function of numerous interrelated factors, including advances in medical technology, increasing roles for non-physician providers of medical services, growing expenditures for healthcare, establishment of new entities for health care delivery (including managed care organizations), and a chaotic array of multiple medical insurers. A distinct element of change is the corporatization of medicine and the dominant role of institutions in health care delivery systems. Indeed one might argue that institutions are now practicing medicine (1).

These developments have spawned a growing administrative infrastructure, and administrators of healthcare institutions - many of them non-physicians - are now pivotal decisionmakers in the medical enterprise.

Many of those decisions have moral dimensions, with implications not only for individual patients, but also for people who work in healthcare institutions and for the larger community. Thus, it seems logical that healthcare institutions should consider ways to promote explicit ethical reflection by administrators (2)(3).

Surprisingly, however, the literature on healthcare institutional ethics is rather sparse, with very few specific descriptions of initiatives in ethics for heathcare administrators. One example described by Reiser is "administrative case rounds" at the University of Texas Health Science Center in Houston (3)(4). At these conferences, modeled after traditional clinical case conferences, administrators and other members of the institutional community meet to discuss specific problematic cases involving institutional policy. Depending on the case, some of these conferences are open to the entire institutional community, while others are limited to constituents of a specific administrative unit.

Another author proposes a "corporate ethics committee," and describes the early planning stages for such a committee in a Chicago health system (5). This committee would address issues in business and organizational ethics, and would be composed of representatives of both the administration and the medical and nursing staff. It would remain separate from the existing hospital ethics committee (HEC), which would continue to focus on traditional patient care ethics. In contrast, others have suggested that corporate or business decisionmaking should be on the agenda of traditional HECs, arguing that "there is no bright line between patient care decisions and broader policy decisions" (6). For example, one author has suggested that traditional HECs review hospital marketing practices, because of the effect of marketing on the expectations of patients (7).

We recently initiated a project in hospital administrative ethics that differs from those described above. We theorized that top-level hospital administrators might value a regularly scheduled opportunity to meet by themselves for informal discussions devoted to the ethical issues they faced routinely in their professional lives. These sessions ideally would foster a more personal exchange of ideas that might not be possible or desirable in the larger and more public "case rounds" format, or in the more formal - and thus presumably more task-oriented - format of a "corporate ethics committee."

In this paper, we report the initial phase of our project. First, we describe the local context and logistics of the project. Second, we review some of the cases and issues discussed by the group during its first two years. And finally, we explore in preliminary fashion some of the potentially generalizable insights about hospital administrative ethics that have emerged from the project.

Background

In 1994, a new interdisciplinary Center for Bioethics was established at the University of South Carolina. The establishment of the Center was a cooperative effort involving the School of Medicine, the university's Institute of Public Affairs, and Richland Memorial Hospital. Richland Memorial Hospital, a county-owned hospital and the largest of four hospitals in greater Columbia, SC, is the principal teaching institution for the School of Medicine, and has provided substantial funding for the Center. The hospital provides primary care services for the local

community, including a larger proportion of indigent care than other local institutions; it is also a tertiary-care referral center for central South Carolina.

In 1995, two of the authors conceived the idea of a project in institutional ethics for administrators at Richland Memorial Hospital. One (JIR) was the hospital's Senior Vice President for Education and Research and an active emergency medicine physician; the other (DES) was the director of the new university Center for Bioethics and a clinically active academic cardiologist. Their idea was endorsed by the hospital's board of trustees, allowing the project to begin in early 1996.

The initial plan was rather simple: The top level administration at Richland Memorial Hospital, including the Chief Executive Officer, Chief Financial Officer, and 18 vice presidents, would meet monthly for a 1½ hour lunchtime discussion/meeting. This group would be joined by three of the core faculty members at the Center for Bioethics (DES, the director; ASB, an internist and faculty member in the School of Medicine; and GK, a philosopher on the University faculty).

The inaugural meeting of the group included an open-ended discussion of participants' expectations. Two key points emerged from the discussion. First, the administrators noted that their day-to-day work lives are overwhelmingly "task-oriented," with inadequate opportunities for more philosophical reflection about administrative decision-making; this forum could provide a venue for such reflection. And second, the group could test the "conscience of the organization," by examining concordance between the organization's actions and its alleged values.

The group also brainstormed about the agenda for the coming year. Suggested items for discussion included cases (both past and concurrent) with ethically problematic dimensions, as well as more general topics not rooted in any particular case.

The topics addressed during the first two years of the project included the following:

- ethical issues in "re-engineering," including "downsizing" of the hospital staff;
- distinctions between for-profit vs. not-for-profit hospitals;
- ethical issues in advertising by the hospital;
- fairness in the hospital's negotiations with nurses from different units;
- truthfulness in performance evaluations of employees by super-

visors,

- African-American attitudes toward advance directives;
- end-of-life decisionmaking: Retrospective discussion of a case in the hospital;
- a decision by a competing area hospital (recently purchased by a for-profit national company) to build a new facility;
- a recently announced proposal for an alliance between Richland Memorial Hospital and another local hospital;
- relationship of the hospital's mission statement to institutional values;
- a local hospital's widely publicized dismissal of two salaried primary care physicians said to be "excellent doctors" but not sufficiently productive, and
- a role-play exercise (conducted by a local acting group) on weighing productivity vs. personal character in the decision to fire an employee.

Some of these topics emerged from specific cases with which the administration was dealing contemporaneously. For example, Richland Memorial Hospital (a secular institution) was studying a merger or alliance with a neighboring hospital with a religious affiliation; the group discussed whether these differing traditions could pose serious obstacles to the alliance. Another example - a discussion of fairness in treatment of employees - derived from a situation in which the institution provided additional financial compensation to retain intensive care nurses, who were in short supply; that policy was considered unfair by equally experienced nurses from non-intensive-care areas of the hospital.

In contrast, other sessions were not tied to specific cases, but rather to more generic ethical issues faced frequently by the administration. For example, the session on evaluations of employees emerged from a desire to discuss obstacles to truthfulness and honesty when supervisors provide feedback to employees.

Only rarely were there "didactic" presentations by the participants from the Center for Bioethics. For example, on one occasion a Center faculty member made a brief presentation of theoretical models of accountability in medicine and medical institutions; on another occasion, there was a short presentation on theories of truth, since discussions of truthfulness and deception arose in several different sessions. But these sorts of presentations were the exception and not the rule. More

commonly, the faculty from the Center for Bioethics simply contributed to discussion when appropriate.

A discussion of hospital advertising exemplifies one of the more successful sessions in the series. During the previous few years, Richland Memorial Hospital and another local hospital had engaged in competitive advertising regarding their open-heart surgery programs. In our discussion, it was apparent that the hospital administrators had varying perspectives on the appropriate design of this particular advertising campaign, and on advertising by health care institutions in general. While the group did not achieve consensus on these issues, it did proceed to delineate the following list of characteristics by which future advertising ideas should be judged: *Trustworthy* (i.e., confident that we can deliver what the advertising promotes); *fair* (i.e., avoiding deception); *accurate* (i.e., well-researched and factual content); *pragmatic* (i.e., reflecting a realistic appraisal of the hospital's position and needs in the competitive environment); *positive* (i.e., emphasizing positive aspects of Richland Memorial Hospital, rather than negative aspects of other hospitals); and *informative* (i.e., providing information of value to the target audience).

Evaluation

It is difficult to evaluate the impact of any project like this one in its earliest phase. Nevertheless, we recently conducted a brief structured interview with five regular participants among the hospital administration. All considered the series to be valuable; representative comments included the following:

- "It helped me understand my fellow administrators better";
- "I have more insight now into how some of the other vice presidents think about issues";
- "It was a good forum for expressing thoughts openly. We don't always get the chance to do this";
- "The participation of members of the Ethics Center was extremely helpful";
- "The conferences helped me personally explore some issues which I hadn't thought about before in any detail";
- "It helped me put into perspective my struggle with my own beliefs and those of the organization";
- "I got the opportunity to express my thoughts without fear of

reprisal"; and

- "It has made me more sensitive to the views of others."

These comments, along with other informal feedback, suggest that the series has accomplished three things. First, it seems to have provided an opportunity for administrators to exchange ideas and reflect upon certain sensitive issues that might otherwise not be addressed during "business as usual." Second, some participants believe that the discussions have fostered introspection and self-understanding. And third, the discussions have enhanced participants' understanding of the views of their colleagues. Consistent with these generally positive comments, the group has enthusiastically endorsed continuation of the series.

Two respondents voiced specific concerns. One believed that the group did not adequately confront issues of race and diversity because they were probably "too sensitive." Another stated, "Rather than just talk, the sessions should lead to policy changes within the hospital." Ongoing feedback and evaluation will be necessary to determine whether the group will ultimately address these concerns, or other issues that may not yet have surfaced.

Discussion

The ethics of hospital administration occupies a unique position at the intersection of traditional patient-centered medical ethics and business ethics. On the one hand, the raison-d'etre of health care institutions is to provide a service to patients. It therefore follows that the ethics of administrative decisionmaking must account for the impact of administrative decisions on patient care. On the other hand, the day-to-day operation of healthcare institutions is similar to that of many large non-medical businesses. The literature and language of business ethics, with its emphasis on moral problems in economic transactions and in the relationships between employers, employees, and consumers, would seem more germane to the latter aspects of a healthcare organization than traditional medical ethics.

The tension between the moral perspectives of medicine and business has become a common theme in both the professional literature and the public media (8)(9)(10). An underlying question in these discussions is whether the moral rules and values governing the professions of medicine and business - once considered distinct but now

inextricably intertwined - can be reconciled with each other. For example, a frequently recurring theme is whether the pursuit of profit can coexist in a neutral or positive way with the traditional "service-first" ethic of medical practice.

These debates are particularly germane to hospital administrators, who simultaneously assume the roles of business-person and healthcare provider. Both the medical and business underpinnings of hospital administrative ethics are recognized in the Code of Ethics of the American College of Health care Executives (11). The preamble emphasizes responsibilities to patients: "The fundamental objectives of the health care management profession are to enhance overall quality of life, dignity, and well-being of every individual needing health care services." But the body of the Code of Ethics emphasizes administrative responsibilities that are not directly related to patient care. These are primarily responsibilities to the organization (e.g., use of sound business practices, truthfulness in organizational communication, etc.), and responsibilities to employees (e.g., creating a work environment free from discrimination or harassment, and attending to the safety of employees).

Following the distinctions noted above, the issues addressed by hospital administrative ethics might fall roughly into two groups that overlap considerably. One group deals largely with the institutional perspective on matters that have, until recently, been discussed primarily within the framework of the isolated patient-physician relationship (12). For example, confidentiality is a traditional concern in encounters between patients and physicians, but it is now a growing problem for relationships between patients and institutions. Other examples might include institutional policies and procedures for withdrawing life-sustaining treatment or writing do-not-resuscitate orders for hospitalized patients.

Another group of issues is closer to the business end of the spectrum. It includes administrative activities that at first glance are not obviously related, or are only indirectly related, to the care of specific patients. Advertising, decisions to merge with other institutions, downsizing, and relationships between administrators and other hospital employees are examples in this domain. Because these activities occur in any large business, administrators may be tempted to analyze their moral dimensions with minimal reference to patient care. Yet most of these so-called business activities ultimately have some sort of impact on patient care. For example, advertising that stretches the limits of truthfulness may be justified as "necessary" to compete for a fair market share. But the

analysis would be incomplete without considering the effects of persuasive advertising on the expectations of specific patients who choose that institution in response to the advertisement (7)(13).

These traditional business concerns might "trickle down" to patient care in yet another way. For example, if hospital administrators create an institutional tone that is dominated by impersonal or callous treatment of employees, those employees may unwittingly adopt the same demeanor in providing hands-on treatment of patients. Or, deceptive public statements by a hospital might create a cynical institutional atmosphere, which in turn might have a detrimental effect on patient care.

It is obvious from the previous listing of topics in our series that ethical issues on the "business" end of the spectrum were the topics favored for discussion by our administration. However, most of the participants appeared to view their business decisions - as well as the administrative ethos of the hospital - as having morally relevant consequences for patients, even when there was no direct impact on patient care at first glance.

In conclusion, we believe that a regularly scheduled discussion group, constituted by a small number of high-level administrators and several persons with formal training in clinical and philosophical ethics, is a promising way for hospital management to address ethical concerns. Obviously this is not the only possible way, and other models described earlier in this paper might be better suited to achieve certain goals. For example, the more formal "corporate ethics committee" described by Schneider-O 'Connell might be better suited to make institutional policy, while the "administrative case rounds" described by Reiser allows for input from a wider audience (4)(5).

In fact, a comprehensive institutional ethics program might well incorporate more than one of these models. But the ultimate bottom line - whether these forums make a positive impact on patient care and the working environment - remains to be seen.

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