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III Mrs. Gomez is an undocumented person from Colombia. Since coming to this country in 1976, she has been employed as a housekeeper. Because she has no health care coverage, she has received all of her care in the emergency rooms of various local hospitals.

Last week Mrs. Gomez came to General Medical Center quite ill and was admitted to the medical unit, where she was found to be in kidney failure. She was begun on dialysis and remained in the hospital for three days, until she had been dialyzed twice. When she was ready for discharge, the medical resident in charge of her care inquired whether she would be eligible for Medicare support for her future dialysis under the end-stage renal disease program. He was told that, although Mrs. Gomez's in-patient costs might be covered by Medicaid—something that still needed to be determined—she was clearly not eligible for Medicare.

The medical resident, not to be defeated in his pursuit of care for his patient, asked the ER staff what is usually done when a patient in kidney failure who needs dialysis comes to the ER. He was told that, under an arrangement between the ER and the dialysis unit, these patients are transferred directly to the unit for emergency dialysis treatment. The medical resident told Mrs. Gomez to come to the ER three times a week so she could have the dialysis

she needs. When this plan was discovered, the director of the ER exploded and said that this could break the budget for his service. He also pointed out that a nearby city hospital with a dialysis unit is designed to take care of poor people with no insurance.

If the topics in this chapter—access to health care, justice, resource allocation, organizational ethics—seem abstract and unrelated to your committee's function, stay tuned. From its beginnings, the scope of bioethical inquiry has encompassed both clinical matters and the therapeutic relationship *and* the broader questions of social justice and the distribution of health care. While the preceding chapters have focused on the former issues, this chapter takes up the latter.

Let's begin by acknowledging a difficult truth: the ethical principles and concepts that we have been discussing can seem almost impossible to apply in an environment that makes health care available in an unjust manner. "But wait," you say. "Even if the nation's health care delivery system needs work, we can't be expected to take on those huge problems. We have enough to worry about right here in our own health care facility." Precisely. As the local arbiter of moral reasoning and ethical practice, your committee's responsibilities include monitoring and guiding the way organizational decisions are made and how they affect the delivery of health care in your institution. So, let's look at the big picture as background and then see how it applies to what you do.

ACCESS TO HEALTH CARE IN THE UNITED STATES

Any discussion of health care entitlement should begin by distinguishing between a *moral* right and a *legal* right: a moral right might exist even if it is not recognized by law. Health care in the United States, with some exceptions, is not a legal right. If, however, it is a moral right, then disparities in access to care that exist in our society may be criticized as unjust.

The following overview examines the extent to which there is a *legal* right to health care in the United States. Since World War II, most health insurance in this country has been private, a fringe benefit of employment. Employers provided health insurance, often for the individual employee and his dependents; later, the employee contributed as well. Such a system of providing health insurance is extremely vulnerable to fluctuations in the economy and job market. Those who are not wealthy enough to either purchase outright all the health care they want or buy enough insurance to cover their needs depend on their employers for coverage. In periods of economic downturn, unemployment rises and many employers cut back on the benefits they provide their employees.

The two main public insurance programs in the United States are Medicaid (a joint federal and state program, mainly for the poor) and Medicare (a federal program mainly for the elderly, but also for persons with end-stage renal disease and some disabilities). Enormous variation exists in the percentage of poor people covered by state-run Medi-

caid programs, and states are free to restrict the range of "optional" services and the number of allowable hospital days for Medicaid patients. Moreover, Medicaid is often an entitlement in name only. Physicians often refuse to treat Medicaid patients because of low reimbursements, and hospitals that treat a predominantly Medicaid population are sorely understaffed and undersupplied.

Medicare, by contrast, has been an enormously successful program. It provides universal access to generally high-quality health care for those over 65 and has also reduced poverty in that population. Concerns have been raised, however, about the adequacy of coverage. For example, despite the passage of legislation that provides modest drug coverage under Medicare, the high cost of medication places an increasingly large financial burden on the elderly. In addition, in recent years Medicare reimbursements for care have been cut back. Larger premiums and co-payments have meant that affluent Medicare patients experience fewer problems when they need medical care than do the less prosperous elderly, who find the required out-of-pocket expenditures, especially for increasingly expensive drugs, very burdensome. The new Medicare Part D prescription drug benefit, which went into effect in 2006, covers cumulative drug expenses up to \$2,250, but not between \$2,251 and \$5,100. The result is a \$2,850 "doughnut hole" in coverage where it is likely that beneficiaries will have to cut back on even essential medications.

Despite widespread coverage, existing forms of health insurance do not reach many people. The estimate usually cited by year is that more than 44 million people in this country are without any form of health insurance coverage, either public or private. This figure, however, reflects the number of uninsured during a twelve-month period. According to some estimates, far more people are without coverage for at least some portion of the year (Rhoades, 2005). During the two-year period 2001–2, almost one-third of people under 65 (79.8 million) were without insurance for at least one month (Nichols, 2004). The uninsured population includes those who are not poor enough to qualify for Medicaid and yet are unable to afford private health insurance. They are the working poor, as well as many in the middle class and self-employed persons who cannot pay high health insurance premiums. In addition, there are many more millions in our society who are underinsured.

Private hospitals and academic medical centers have long assumed some of the responsibility for providing uncompensated care to the poor and indigent, but their budgets are steadily shrinking. This trend is due largely to the extension of prospective payment, spurred by the adoption of diagnosis-related groups (DRGs) for hospitalized Medicare patients. Likewise, preferred provider arrangements have eliminated cross-subsidies through which hospitals have covered the costs of providing uncompensated "charity" care by increasing charges for insured patients and those who pay directly out of pocket. Most managed care plans negotiate payment to the lowest level, making such cross-subsidies difficult.

Public hospitals continue to provide access to health care for those who cannot

otherwise afford it but, under the pressure of fiscal crises, local and state governments have found such institutions burdensome to maintain. Both because of the resources available to them and the insurance status of their clientele, these institutions may be inferior to hospitals in the voluntary, not-for-profit sector.

Two other pockets in our health care system guarantee access to care in specific circumstances. Under the federal "antidumping" law, the Emergency Medical Treatment and Active Labor Act (EMTALA), patients who arrive at an emergency room must be assessed and stabilized before they can be transferred. Prisoners also have guaranteed rights to health care under rulings of the U.S. Supreme Court, although the quality of that care is regularly challenged in federal courts.

Mrs. Gomez's case illustrates the issues raised in a system that denies some people access to health care that it makes available to others. Health care institutions, especially those in poor or minority communities, are often considered to have a special obligation to provide health care to residents. When patients are uninsured or underinsured, staff sometimes feel the need to get around the rules by "gaming the system" in order to provide necessary care. In this case, the solution blurs the distinction between two types of care. Emergency care is limited to traumatic, unanticipated, often life-threatening injuries and illnesses that require immediate treatment. In contrast, clinic care is planned, routine primary care, including the monitoring and treatment of chronic conditions. Because emergency care is episodic, it does not provide the continuity, comprehensiveness, and multidisciplinary resources so important in the ongoing treatment of chronic illnesses, such as renal disease.

Mrs. Gomez clearly needs care that the institution can and would provide under other circumstances. Because her renal failure has been corrected in the hospital, she no longer requires emergency care. Her condition could be managed on an outpatient basis as long as she receives regular dialysis. Without it, her condition will again become unstable and she will eventually need urgent care. Her undocumented status, however, means that she is uninsured, making her ineligible for clinic care. Given this set of circumstances, the staff feels compelled to search for creative ways to ensure that she continues to receive needed treatment.

Gaming the system in this way heightens the tension between the organization's ethical obligation to benefit one patient and the obligation to steward resources responsibly to benefit all patients. Undocumented persons who require sustained treatment, such as dialysis, should not be denied care because they are unable to pay. Nevertheless, the fiscal realities prevent institutions like General Medical Center from providing all services to all those who need them, regardless of cost. However well intended the staff's motives, it is reasonable to question whether the *predictable need* for emergency care justifies a practice of using the resource *preventively*. The routine proactive use of emergency resources may well impair the hospital's ability to provide care for true emergencies. Because the public hospitals have historically covered care for the uninsured, the doctors can refer Mrs. Gomez to a city hospital for treatment. Given the

increasing financial drain, however, even the municipal system may not be able to continue providing uncompensated care indefinitely.

The literature also reveals racial and ethnic disparities in health care, including diagnostic, curative, life-sustaining, and palliative care interventions (Post, forthcoming; Wolf, 2004; Epstein and Ayania, 2001; Phillips et al., 1996). These reports are of special concern because of what they reveal about both effect and cause. The health consequences of disparate care are reflected in the reported underuse among nonwhite patients of diagnostic and therapeutic interventions projected to improve clinical outcomes. Moreover, these disparities have remained relatively unchanged for decades in the United States, as has the average life expectancy of blacks, which is six years shorter than that of whites (Epstein and Ayania, 2001; Freeman and Payne, 2000). According to one estimate, compared to the vast sums dedicated to improving medical technology in an effort to save lives, five times as many deaths could be averted if the disparities in health care were corrected (Woolf, 2004).

Racial disparities in medical services suggest possible discrimination or bias, either deliberate or unintentional, by health care providers, including physicians and institutions. It is argued that the causes of the inequities implicate health care systems rather than just individual providers, and will need to be addressed systemically (Epstein and Ayania, 2001; Freeman and Payne, 2000). Although the disparities in health care tend to fall along racial and ethnic lines, commentators caution against viewing the problem as stemming only from patients' cultural values and provider discrimination. Rather, it has been suggested that the overarching problems are the socioeconomic conditions of marginalized populations and the societal priorities that do not have as a goal a "common standard of wellness." What is lacking, then, may not be the national resources to create a just health care system, but the national resolve (Woolf, 2004, p. 54).

As this brief review makes clear, there is no universal legally protected right to health care in the United States. Everyone in this country is legally free to seek health care and, when the proper arrangements are made, to receive it. But, with the noted exceptions, there is no recognized societal *obligation* to provide it. Instead, our society permits access to health care to depend on one's ability to pay or the source of one's health insurance. As a result, health care is not equally available to all those who need it. This is an especially serious problem for the many uninsured in our nation, because health status is to a large extent dependent on access to health care. The socially sanctioned inequality of opportunity that deprives some people of the health required to realize their potential fully is a moral abdication that rises to the level of true injustice.

A RIGHT TO HEALTH CARE?

Given the limited legal right to health care in this country, is there at least a moral claim that can be supported? The President's Commission for the Study of Ethical Problems in

Medicine and Biomedical and Behavioral Research confronted this issue in its influential 1983 report entitled *An Ethical Framework for Access to Health Care*. According to the commissioners, health care is different from other consumer goods, such as televisions and automobiles, because it is crucially related to the length and quality of life. Moreover, like education, health care is necessary to achieve equal opportunity in society. Without decent access to care, health status is likely to suffer and poor health status prevents people from enjoying the range of opportunities that would otherwise be available.

Because the nation's health care needs are vast, sometimes unpredictable, and extremely costly, the President's Commission concluded that the free market alone cannot meet them adequately and society has an obligation to assume part of the burden. The commissioners cautioned, however, that this societal obligation is not unlimited; it must be constrained by the balance of costs and benefits to the population. Moreover, they argued, the fact that society is morally obligated to provide *some* care does not mean that everyone is entitled to an equal amount or quality of health care. In other words, not all *inequalities* in access to health care amount to *inequities* in access, and it is only the latter that justice requires us to eliminate. As long as everyone is guaranteed access to an *acceptable* or *decent* level of health care, the report maintains, society will have fulfilled its moral obligation.

It is worth noting that the President's Commission self-consciously chose not to use the language of "rights" to frame its notion of a social duty. Yet many bioethicists, using the same arguments presented in the commission's report, have concluded that each citizen has a moral right, as distinguished from a legal right, against the government to a decent level of health care.

THEORIES OF JUSTICE

Answers to questions about allocation and access presuppose some views on the nature of individual rights, social obligations, and notions of fairness, even if they are not articulated. If there is a *moral* right to health care, it must be grounded in and justified by some more general theory about the nature of social justice. Generally speaking, a person is treated justly if he is treated according to what is fair, due, or owed. The specific term *distributive justice* refers to fair, equitable, and appropriate distribution of the benefits and burdens of social cooperation. Here we refer to the equitable distribution of the benefits and burdens of health care resources. Three theories of distributive justice—libertarian, utilitarian, and egalitarian—dominate current thinking, and each has very different implications for the right to health care.

In the libertarian theory of justice, espoused most prominently by Robert Nozick and Tristram Engelhardt, individuals have moral rights to life, liberty, and property, which a just society must recognize and respect. In this view, the sole function of

government is to prevent these rights from being interfered with and to protect the individual's life, liberty, and property against force and fraud. Everything else in society is a matter of individual, not societal or governmental, responsibility. For the libertarian, there is no moral right to health care and no societal obligation to provide it.

The utilitarian theory of justice, articulated by John Stuart Mill and Jeremy Bentham, is committed to maximizing the common good. Acts, practices, and rules are to be judged better or worse, right or wrong, according to how effectively they promote this goal. Whereas libertarians stress freedom from government interference, utilitarians are more disposed to government welfare programs because these may be necessary to promote the good of society as a whole. For utilitarians, there is a moral right to health care insofar as its provision contributes to the overall good of society's members.

The egalitarian theories of justice reject libertarianism because it fails to include what egalitarians perceive as a fundamental moral concern: those who have more than enough should help those in need. Egalitarians reject utilitarianism because it fails to provide sufficiently strong support for individual moral rights. A leading twentieth-century egalitarian theorist, John Rawls, maintained that inequalities in the distribution of "primary social goods" (e.g., income, opportunities) are justified only if they benefit the least-well-off members of society. Egalitarians, such as Norman Daniels, generally embrace some notion of a moral right to health care.

RATIONING

It is hard to deny that individuals in this country are not equal with respect to the availability of health care. Beyond concerns about the costliness and inefficiency of the nation's health care system, disparities in access to care raise fundamental questions about whether the system is fair and just. Given the number of competing goods that require the investment of societal resources, such as housing, jobs, education, and defense, it appears that guaranteeing all citizens access to health care is not in the immediate future. Accordingly, it is necessary to confront the challenge of health care rationing and recognize that, while some forms of rationing are morally justifiable, others are not.

Rationing Defined

In the ongoing debate about health care, *rationing* has become a highly charged term with moral overtones. The basic ethical problem is how to structure our health care system so that it *fairly* distributes limited resources and provides *equitable* access to health care at *manageable cost*. To accomplish these various and sometimes conflicting tasks, many now call for the adoption of some explicit form of societal rationing or limit setting. As noted earlier, much of the U.S. health care system already involves a kind of implicit or covert rationing—that is, rationing by ability to pay and level of

personal resources. Rationing on this basis is objectionable because of the special nature and importance of the good of health care, making its deprivation an injustice. The notion of rationing has several meanings, according to Daniel Wikler:

- Trimming: "cutting back on services that few people want and no one needs" (e.g., targeting inefficient and ineffective care)
- Cutting: "refusing genuinely needed and wanted care on the grounds that the cost is 'too high'" (e.g., a provider's decision not to provide a nonexperimental organ transplant to a medically suitable candidate based on a payer's refusal to reimburse for it)
- Tailoring: "eliminates care which is (1) of questionable effectiveness, even though it may be popular or even standard, or which has marginal effectiveness relative to risk; or (2) care which prolongs conditions which are marginally endurable" (e.g., using expensive medical technology to sustain patients who are in a persistent vegetative state or have an extremely poor quality of life) (Wikler, 1992, p. 399).

Cutting, that is, withholding care expected to be of net benefit to the patient, is the most ethically troubling form of rationing and the one that both proponents and opponents of rationing chiefly have in mind. Commentators disagree about whether cutting is really necessary, except in special circumstances. Trimming and tailoring, some optimistically argue, will for the most part eliminate the need for this more problematic form of rationing. Others disagree, arguing that the aging of the population, the onward march of medical progress, and the limits of societal resources make the more extreme form of rationing imperative.

Societal versus Bedside Rationing

Rationing health care can be done on a societal or community level, through a process of public deliberation leading to general guidelines for limit setting as a means of cost containment. This approach is known as macroallocating resources. Alternatively, it can be done "at the bedside," by individual physicians making decisions to deny particular interventions to particular patients as a means of controlling health care costs. This process is known as microallocating.

An example of macroallocating, or societal rationing, is the Oregon Health Plan, officially enacted in February 1994. The Oregon plan originated in a choice faced by the state legislature in 1987, when it decided to invest its limited health care dollars in prenatal care for thousands of uninsured poor women rather than fund organ transplants of questionable efficacy for a relatively small handful of patients. The Oregon program involves the following elements: an attempt to guarantee universal access to health care through the expansion of the state Medicaid program to include everyone officially defined as poor; recognition of the necessity of limits in the care that is pro-

vided to everyone on Medicaid, these limits to be determined by how much money the state can afford to spend on health care in any given year; and an open and democratic process for making these difficult decisions about limit setting.

The Oregon plan has been criticized on the grounds that it achieves the goal of cost control solely at the expense of those who are already disadvantaged, namely, poor women and children. The plan has been praised for making a social commitment to guaranteeing some level of health care for all poor people in the state and for relying on an open and publicly accountable system for making rationing decisions.

Microallocating is highly controversial. On the one hand, it is argued that bedside rationing is inevitable and that it is the responsibility of physicians to participate in cost containment in morally credible ways. Physicians, in this view, are the stewards of health care resources at the site of use and in the best position to assess both clinical and cost effectiveness. On the other hand, bedside rationing is criticized on several grounds: physicians may allow their personal biases to influence their decisions about which interventions are not worth the cost; variability from physician to physician means that there will be no uniform standards for limit setting; and physicians cannot be both agents of cost containment and advocates for the best interests of their patients. A middle ground would see some modest form of rationing as appropriate, and possibly obligatory, for physicians.

HEALTH CARE ORGANIZATIONAL ETHICS

III The asthma control program at Gotham Medical Center was started by the group physician practice (GPP) in 2000. The GPP is an example of a mixed economic model. Rather than a fully capitated practice, it participates in a health maintenance organization (HMO), but also provides care on a fee-for-service basis.

The asthma program was directed by a nurse administrator who was hired by the GPP and to whom referrals were made by physicians in the group. Her role was to work with patients to enhance their understanding and management of their medical conditions. Information was provided by phone and in person to both children and adults about symptoms, appropriate medications and when to take them, and how to manage asthma attacks without having to go to the emergency room for care. The asthma program seemed to have been clinically effective, based on the decreased number of ER visits for asthma treatment and the reports of improved patient and family satisfaction. The program had also been an important health care resource for the community.

Despite its benefits, however, controversy had arisen about the asthma program's financial implications. On one hand, the program's administrative costs had been borne by the GPP. In addition, the program's clinical success had resulted in fewer patient visits to physicians' offices and less frequent hospital admissions, decreases that had cut into the GPP's revenues. From the standpoint of the HMO, however, reducing physician and ER visits and hospital

admissions had kept medical costs down, which was one of the HMO's primary missions. In 2002, the GPP decided to terminate the asthma program, based on the increased administrative costs and the decreased revenues.

What interests are in tension when organizations consider which health care services to provide? Do health care organizations have ethical, as well as financial and business, obligations that inform their decisions? What role can ethics committees play in organizational matters?

From Bioethics to Health Care Organizational Ethics

In the ever-widening scope of concerns addressed by health care ethics committees, organizational ethics is a relatively new consideration. Until a few years ago, the study of ethical issues in health care focused on the moral conflicts in the clinical setting that have been addressed in the preceding chapters of this handbook. Increasingly, however, clinicians and administrators have come to recognize that how a health care organization makes decisions directly affects the quality of the care it delivers. For your ethics committee to address both organizational and clinical issues, it is important to appreciate the relationship between the two areas of concern.

Largely as a result of efforts to limit the rapid and uncontrolled rise in health care costs, the care delivery system has changed radically during the past twenty-five years. New and often competing scientific, economic, and political imperatives demand attention. The physician-patient relationship no longer controls the clinical dynamic; managers and administrators make and enforce policies that restrict the available options and the ability of physicians and patients to make choices about them. New analytic frameworks are necessary to meet current challenges in allocating health care resources and decision-making authority.

The response to skyrocketing health care costs has been a new environment in which medical practice is managed by organizations that impose economic discipline on clinical decision making. While fiscal concerns remain significant in the changing health care system, other factors, including heightened interest in the quality of care, have also promoted greater organizational control of clinical decision making. As a result, the increasingly prominent mechanisms of quality assurance and measures of clinical effectiveness have been motivated by both economic considerations and concern to improve clinical practice.

Organizational ethics introduces an *intermediate* level of analysis between the narrower set of clinical concerns and the broader societal policy issues. Health care organizations—hospitals, nursing homes, visiting nurse agencies—make daily decisions about resource allocation, clinical priorities, conflicting interests, and community responsibilities, all of which have ethical implications. In this analytic perspective, the organization as health care provider assumes ethical rights and responsibilities similar to but distinct from those of individual health care professionals. Of central importance in

distinguishing clinical from organizational ethics is the notion of moral agency. Traditionally, bioethics has examined the actions of *individual* agents—clinicians, patients, family members—and has held them accountable in light of ethical principles, norms, and obligations. In the intermediate analysis, the locus of moral agency differs from that of clinical ethics and the *organization* itself is seen as having obligations to adhere to certain norms of ethical behavior.

This perspective has particular relevance to ethics committees, which have traditionally functioned as their health care institutions' analytic and consultative resource on moral issues and conflicts. This handbook argues that the committee's role should not be limited to considering the ethical aspects of individual clinical interactions, but should encompass scrutiny of how the organization creates an environment in which quality care is provided because ethically sound decisions are made.

Moral Responsibilities of Health Care Organizations

III Central Hospital is considering some innovations in an effort to make its operation more efficient. In the process, it is confronting a conflict between its role as a health care delivery system and its role as a risk-bearing entity. For example, one of the suggestions under consideration is the establishment of an observation suite in or near the ER. Sometimes when patients come to the ER, their presenting symptoms (chest pain, shortness of breath, abdominal pain, asthma) do not make it clinically apparent whether they need to be hospitalized. An observation suite would provide a place where they could be observed closely for up to twenty-four hours while their condition either stabilizes or changes and their medical needs become clearer.

From the risk perspective, the advantage is the opportunity for twenty-four hours of monitoring, which is much less expensive than a hospitalization. From the hospital's viewpoint, however, such a resource may not be economically advantageous because it would drive up the cost of an ER visit without generating additional revenue to offset the cost. Because most patients are not in the risk category, the hospital would only be entitled to reimbursement for an ER visit.

Organizational ethics draws its core notions from the disciplines of both business and health care ethics. Traditional bioethics views organizations merely as settings for encounters between individual patients and individual clinicians. Its focus on the ethics of professions, including medicine, nursing, psychology, and social work, neglects the organizational climate that promotes or impedes the ethical delivery of health care. Business ethics recognizes medicine as a business enterprise but fails to appreciate the distinctive nature of health care as a good and the special quality of the provider-patient relationship. What distinguishes organizational ethics is the notion that organizations are more than aggregates of individuals with their own roles and responsibilities. As we have argued at greater length elsewhere (Blustein et al., 2004; Blustein et al., 2001), organizations can usefully be thought of as moral agents with

interests, values, and obligations that inform their goals and the means they use to achieve them.

How these matters are considered not only has philosophical significance, but enormous practical significance as well, especially for health care ethics committees. If organizations are moral agents, they should be expected to develop a sense of what is morally acceptable and unacceptable practice and to manifest that sense in their policies and procedures. If they are only powerful economic entities, they cannot be expected to exercise moral responsibility and society would be well advised not to trust them to be self-regulating.

It would be naïve to suggest that health care organizations can be guided only by their moral codes. Like other business entities, they have a parallel and often competing responsibility to remain fiscally sound to meet their obligations to patients, employees, and the communities they serve. Central Hospital's decision about establishing an observation suite, for example, pits the benefits of risk reduction and improved clinical care against the economic burden of creating an expensive and under-reimbursed service. Because hospitals have fixed budgets, the analysis will require a balancing of goods, considering the worth of this unit in relation to other programs that may have to be delayed, downsized, or eliminated altogether.

In an analogy to the clinical setting, it might be asked whether organizations have the *capacity* for morally responsible conduct or whether, like individuals who lack this capacity, they can only be kept in line by external regulation, such as compliance requirements. We argue that organizations can be motivated not only by economic self-interest, but by a capacity to regulate their actions according to a set of moral imperatives. This position has important implications for ethics committees in determining the scope of their involvement in the goals, policies, and procedures of the institutions they advise.

Health care organizations can act in morally responsible ways only if they have a clear sense of their core values in relation to other organizational goals. These values, typically articulated in the organizational mission statement and code of ethics, become an essential part of an organization's identity. As an example of how an institution might express its governing moral philosophy, part V offers a sample code of organizational and clinical ethics. This code was developed by the Montefiore Medical Center Bioethics Committee, endorsed by the administration, and formally adopted by the board of trustees.

But neither a mission statement nor a code of ethics is worth much if executives do not appreciate the need for monitoring and evaluating performance to determine the organization's effectiveness in light of its values and goals. The organization can only act as a moral agent through individuals who use the mission of the organization as a benchmark for assessing organizational behaviors. Although the mission should be taken seriously at all levels of the organization, executives play a special leadership role in ensuring that organizational activities reflect its stated goals and values.

Organizational Ethics and Compliance

Recognizing that the transformation from fee-for-service to managed care presents ethical problems in addition to those that arise in clinical care, in 1995 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) changed the name of its standards chapter from Patient Rights to Patient Rights and Organization Ethics. The new standards require health care organizations to develop and operate according to a code of ethical behavior that addresses "marketing, admission, transfer and discharge, and billing practices" and "the relationship of the hospital and its staff to other health care providers, educational institutions, and payers" (Joint Commission on Accreditation of Healthcare Organizations 1998a:55–56, Standards RI.4.1 and RI.4.2).

Although JCAHO refers to its new standards as "organizational ethics," we use the term to distinguish a normative reach beyond the minimum required for adherence to laws and regulations. A separate but related area of organizational scrutiny, compliance, focuses on those obligations whose nonfulfillment amounts to fraud and abuse, while organizational ethics is concerned with obligations whose nonfulfillment provokes specifically moral condemnation. Organizational ethics recognizes that organizations confront many ethical problems for which no applicable laws and regulations exist; in other words, unethical conduct may not be illegal. Moreover, because ethical problems often resist neat and easy solutions, they may demand a more nuanced analysis than the determination of whether compliance has or has not occurred.

Hospitals and other health care organizations have responded to legal and regulatory requirements by appointing people whose responsibility is monitoring institutional compliance. Working with the offices of risk management and legal counsel, compliance officers are charged with ensuring that institutional policies and procedures meet or exceed specified governmental standards. Your institution likely has an office of compliance, dedicated to this effort. In contrast, your ethics committee's function is to provide the principled analyses and recommendations that will promote ethically sound organizational decisions and actions.

Ethics and the Allocation of Resources

III City Hospital has a fifteen-bed intensive care unit and, as usual, tonight the unit is fully occupied. When the ICU is full and the ER has also reached its limit, this hospital, like others in the region, typically closes its ER to ambulances because it cannot accommodate additional patients. Ambulances that would normally bring patients to this hospital are diverted to the nearest hospital with an open ER. On this night, all area hospitals have closed their ERs because they are filled to capacity. Patients picked up by the emergency medical service (EMS) must be taken somewhere, however, so City Hospital must admit a patient despite its saturation.

The last patient admitted to the ICU is a 45-year-old chronic schizophrenic man with a high fever and overwhelming infections who has been brought in from one of the city's state-

operated psychiatric facilities. Another bed is already occupied by a 96-year-old woman brought to the ER from a nursing home, where she had been found unresponsive. Efforts to restore her to consciousness have so far been unsuccessful.

A third patient in the unit is a 23-year-old woman, an IV drug user with two children, who presented in the ER with symptoms of *Pneumocystis carinii* pneumonia (PCP). Because of her pulmonary disease, she is in respiratory distress and needs to be stabilized before starting antiretroviral therapy. The remaining ICU beds are occupied by patients whose average age is 75 and for whom continued ICU treatment has been deemed essential.

The patient who has just been brought to the ER is a 63-year-old professor of internal medicine who has just had a heart attack. The university where the professor teaches recently endowed a new wing of the hospital.

Which patient, if any, should be removed from the ICU to make room for the professor? What criteria should be used in determining eligibility for ICU care? In what way do decisions about allocating ICU beds involve issues of justice?

Questions about resource allocation are among the most common and important in organizational ethics. Allocation decisions are trade-offs, necessitated by the fact that health care resources and the economic assets needed for their provision are limited. Sometimes the trade-offs involve hard choices between doing things that would improve the health of a population in serious need and doing what is necessary to preserve the fiscal integrity of the organization and, thereby, its long-term ability to continue serving the needs of the community. More commonly, the trade-off is not between some needed program and institutional survival, but between a new program and those that are already in place meeting other needs.

Resource allocation decisions often have to balance and rank a number of competing considerations. For example, resources devoted to very costly cutting edge treatments and technologies that might benefit a few patients diminish what is available for less expensive care that can benefit a larger number. Investing in large-scale marketing campaigns to attract more patients may result in less being spent on providing care to those who are already patients. A growing problem for organizations is determining how to budget for the care of undocumented persons, as well as citizens who are uninsured or underinsured.

In these and similar cases, the central questions are: who wins, who loses, and what alternatives do the losers have for getting their needs met? Because resource allocation decisions confer benefits on some (the winners) at the cost of not conferring benefits on others (the losers), they raise issues of distributive justice. The distribution of the benefits and burdens inherent in resource allocation decisions should be done in a way that is fair to all concerned and does not discriminate against any group or individuals.

One distinction is between expensive and scarce resources. For example, in City Hospital, ICU beds are an *expensive* resource that is made into a *scarce* resource by an organizational decision limiting the number of beds. If the institutional budget

permitted ICU expansion, more beds could be made available. In contrast, solid organs, such as hearts, are from the outset a scarce resource because of their finite supply. Because ICU beds are expensive and limited, not all persons who could potentially benefit from critical care can receive it in the ICU.

Another useful distinction is between rationing and triage. Rationing, discussed above, is setting limits on spending to allocate limited resources among competing care and treatment needs, thereby denying beneficial care to some. Triage, the approach used in most ERs and ICUs, is determining the order in which care is provided, using as criteria the urgency of the care needs and the likelihood of benefit. Generally accepted medical criteria exclude from the ICU patients considered unlikely to benefit from critical care because it would be physiologically futile, patients who are in PVS, or those who have met the criteria for brain death. Priorities are established and patients with a greater likelihood of benefiting from ICU care are given preference over those who are less likely to benefit from care in that setting. The alternative to this approach is to increase the ICU census by admitting more patients and potentially decrease the quality of care.

Decisions regarding the allocation of limited resources in City Hospital should be based on sound medical and ethical criteria. It is reasonable to question whether giving the ICU bed to the professor, simply because his university has endowed a new wing of the hospital, is fair to the other patients who are already benefiting from ICU care. This might well be seen as an unjustified form of favoritism that has little to do with medical criteria, clinical benefit, or distributive justice. The ethics committee role in reviewing institutional policies would contribute a principled analysis to the guidelines for ICU admission, focusing on the just and clinically indicated allocation of a limited resource.

Ethics Committees and Organizational Issues

III The Atlas Hospital medical director has brought the following issue to the Atlas Bioethics Committee for consideration. Especially during protracted hospitalizations, patients' conditions and, therefore, their medical needs change. Often patients who were admitted to one medical or surgical service subsequently need to be transferred one or more times to a different service for continued care. In each instance, the process requires the medical team on the first service to communicate with the medical team on the second service, explaining why the patient would benefit from the transfer. Depending on its evaluation of the patient's condition and its own clinical burdens, the second service has the option of accepting or rejecting the transfer. It has come to the medical director's attention that clinical services are avoiding accepting transfers for reasons other than clinical indication.

Atlas Hospital is also working to promote clinical efficiency and discourage unnecessarily long hospitalizations. Accordingly, when a patient either leaves the hospital or dies, the length of stay (the number of hospital days) is credited to the discharge service, not the admitting or transferring service. That means that, if a patient spends sixty days on a surgical service and is transferred to a medicine service for two days prior to discharge, the entire sixty-two-day

length of stay will be credited to the medicine service. Because the costs incurred during a hospitalization are applied to the clinical service caring for the patient, it is in each service's interest to minimize lengths of stay. Under this system, it is also unsurprising that services are not eager to accept patients who have or are likely to have long lengths of stay.

The organization's ethics committee serves a vital function by monitoring the consistency of the institutional mission and goals with the policies and procedures that guide them, and the administrative decisions that realize them. Its effectiveness requires the recognition that ethical issues arising in health care cannot be neatly compartmentalized and addressed separately from other institutional matters. Because clinical and business concerns are interrelated, decisions about them must be grounded in or consistent with the ethical principles and values that inform the institutional mission. The committee's composition and agenda should be expanded to reflect this broader scope. The membership should include both clinicians and administrators, and the issues it considers should include clinical and organizational priorities and decisions.

The interservice transfer issue is a good example of how ethics committees can influence organizational decision making and, thereby, promote better clinical decision making. The Atlas committee analyzed the situation in terms of the conflict between the obligation to promote patient best interest and the obligation to be responsible stewards of institutional resources. Patients are benefited by transfer if their treatment needs can be met more effectively in another clinical setting. Transfer burdens them if they are deprived of the clinical judgment, skill, and continuity of care on which they rely. The committee also recognized that even physicians who intend to act in their patients' best interests will be reluctant to make medically appropriate decisions that appear to disadvantage their clinical services. Organizational involvement and support are essential to developing solutions that are medically and ethically sound. The committee's ethical principles and suggested guidelines for interservice transfer appear in part III.

Your ethics committee's utility as an analytic and advisory resource, however, is only as good as its access to and active involvement in organizational planning and decision making. Genuine integration of the ethics perspective in the formulation and execution of institutional activities requires a fundamental and often difficult culture change. The significant differences between the clinical and organizational cultures challenge both ethics committees and institutional leadership seeking meaningful collaboration. Transparent and inclusive decision making, which is central to ethical process, may be seen by financial and business management as intrusive and inhibiting. Administrators may need the reassurance of sustained demonstration that ethical analysis and recommendation can enhance the efficacy and validity of organizational decision making without compromising its efficiency or security. These issues, as well as strategies for addressing them, are discussed at considerably greater length in *Ethics for Health Care Organizations: Theory, Case Studies, and Tools* (Blustein, Post, and Dubler, 2002).

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PART II

Clinical Ethics Consultation

This is the part that you've been waiting for—where ethical theory meets clinical reality. A key function of ethics committees is providing clinicians with an analytic framework for identifying and resolving ethical dilemmas that arise in the clinical setting. As discussed in part I, these challenges usually reflect the inherent tensions between and among the ethical obligations incumbent upon health care professionals. Sometimes the situations are matters of life and death, with elements of high drama. More often, they concern the rights and responsibilities of patients, families, and caregivers as they struggle to make decisions that are clinically, ethically, and legally valid. In that process, the perspective of the ethics committee is an invaluable resource.

Whether ethics committees assume responsibility for conducting clinical consultations on an ad hoc or rotating basis or periodically review the work done by a dedicated consultation service, members need a foundation in ethical analysis and a sense of why similar cases invoke certain reasoning. While consultation considers each case individually, the ethical concepts and principles that inform the process, presented in part I, provide analytic clarity and consistency. Part II begins with a discussion of the fundamentals of clinical ethics consultation, including the goals and descriptions of two different approaches that committees might adopt. Committees also may find it useful to compile a library of cases that can serve as analytic models. So, in addition to the case examples in part I, this section includes sample cases with the type of analyses they might receive in clinical ethics consultations.