
Critical Issues for Healthcare Organizations

Part III moves away from the individual and concentrates on healthcare institutions. It features examples of issues that will be a part of their future in the twenty-first century. Chapter 14 presents a discussion of the differences between ethical issues in a clinical situation and those faced by an organization. It includes the complexities of organizational ethics in the changing healthcare environment. The chapter also shows how organizations must address clinical situations, legislation, and community responsibility and still make money. The author challenges you to think beyond the clinical arena and to consider the broader view held by institutional ethics.

Chapter 15 includes an overview of the institution's response to ethical challenge—the ethics committee. It provides you with an understanding of the function, membership, and future challenges for these committees. The practitioner's view section discusses some challenges that ethics committees face because of financial concerns, technology demands, and scrutiny in end-of-life situations.

Chapter 16 features managed care, an aspect of health care that is challenging for both clinicians and organizations. It begins with a review of the distinctions between the types of managed care organizations (MCOs). It then presents the ethical challenges that are part of such practices, such as utilization review, capitation, and physician incentives. The author also gives examples of forces that will balance the negatives of MCOs and provides a managed care model that includes ethics. This chapter should evoke much thought and discussion among your fellow professionals.

Chapter 17 examines current and future ethical dilemmas for specific types of healthcare organizations—those that deal with prehospital and emergency care. The chapter suggests that emergency departments (EDs) are struggling to be the safety net for the poor, and they might be losing the struggle. It acquaints you with such controversial areas as the need for paternalism, assisted suicides and emergency room practices, and prehospital DNR orders. In addition, the need for security for those who work in the ED, the practice of teaching on the newly dead, and the ability to conduct research on critical patients are presented as ethical concerns that will continue into the future.

Another specific organization that is included in Part III is the home care industry, which will be discussed in Chapter 18. Technology's almost miraculous ability to prolong life has led to an increasing problem for healthcare organizations and individuals. Some patients require care beyond the ordinary, and home health care tries to provide this care. The chapter provides information on the home health model and its history of dealing with medically fragile,

technology-dependent adults and children. Ongoing ethical issues for home health are stressed, and the impact of the aging boomers on its future is included for your consideration.

Chapter 19 introduces a global ethics issue for healthcare organizations. It asks the question, “what is the role of spirituality in a healthcare organization?” The chapter explores the definition of *spirituality* in general, its application to work, and reasons why it will be an issue for healthcare organizations in the twenty-first century. It also includes the effect of the spirit on transition and the ethical theories and principles that support spirituality in the healthcare organization.

Part III does not include every future ethical situation faced by healthcare organizations. However, it does provide a beginning for considering issues that will affect all these organizations. It also gives an overview of some of the quandaries faced by specific healthcare organizations, such as home health and the emergency department. In this part of the text, you will be challenged to “think outside of the clinical box” and consider ethics from the organization’s view.

Healthcare Institutional Ethics: Broader than Clinical Ethics

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OVERVIEW

This chapter provides an examination of the current and future ethics issues that challenge healthcare institutions. They are addressed from several viewpoints, mirroring the model for this text. For example, issues facing individual managers in terms of their need for practicing ethical integrity are presented (individual). Issues involving nonprofit institutions as they struggle with providing care and making payroll and the need for healthcare institutions to provide proactive care are discussed (organizational). Finally, the schizophrenic view of American society about its healthcare system is presented in a matter that fosters understanding of this often complex issue (society). This chapter will greatly increase your understanding of the business side of health care and the ethical issues it faces in its future.

INTRODUCTION

Bioethical problems have dominated the ethical concerns of hospitals and other healthcare institutions for the past 35 years. Clinical issues such as the termination of treatment, patient autonomy, informed consent, confidentiality, advance directives, and other individual case-based issues have occupied center stage. In the late 1980s and early 1990s, the focus of bioethics began to broaden. With the onset of rapid change in the structure of the healthcare delivery system, many institutions began to recognize and address ethical issues inherent in business practices, corporations, and managed care organizations. As managed care took its place as primary mode of healthcare delivery, questions were raised about how to expand bioethics to address institutional structure and the business aspects of health care.

Institutional focus on clinical, business, and ethical matters eventually began to give way to network concerns. Networks comprised of institutions, physician organizations, financing mechanisms, other health businesses, and community organizations began to emerge. This change resulted in new and organizationally complex ethical dilemmas that demanded different analytical frameworks and broader ethical analysis. In the bioethics literature, this area of inquiry has become known as “organizational ethics,” applicable to both individual healthcare institutions (e.g., hospitals) and to the other entities

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that make up the modern healthcare system.¹ Several definitions of organizational ethics have been formulated. Some examples include: it “aims to enhance the overall ethics of an organization with the goal of changing the climate and then the culture of the organization;”² it “deals with an organization’s positions and behavior relative to individuals (including patients, providers, and employees), groups, communities served by the organization, and other organizations;”³ it is described as “the intentional use of values to guide the decisions of a system;”⁴ and it “focuses on the ethical climate of the entire organization...which encompasses and integrates all other ethics resources and activities within an organization.”⁵

Today, healthcare networks and their member institutions constitute complex, interdependent systems of patients, families, professionals, payers, processes, communities, and businesses. These multiple players interact in intricate ways. Their daily activities, missions, institutional values, strategic goals, and their impact on the community and the community’s health status are ethically significant. The bioethical principles of autonomy, beneficence, nonmaleficence, and justice as traditionally formulated may not be sufficient to address the ethical issues that arise. Although these principles have their place, questions of distributive justice demand greater attention and the principles of business ethics, such as “honesty, truthfulness, and keeping promises”⁶ may also be useful.

Since patient care is still the focus of much of an institution’s activity, the need to address clinical bioethical issues remains a priority. These issues are addressed in other chapters of this book. This chapter focuses on the ethical issues that healthcare network and institutional administrators (and sometimes trustees) need to address from a personal, institutional, and communal perspective. These include justice issues (social, distributive, and commutative), the promotion of the common good, the role of the community in the healthcare system, preservation of human resources, the definition of health, the role of law and government regulation, promoting access to quality health care, conflicts of interest, and the allocation of resources, to name a few. This chapter will not outline a comprehensive theory of justice, argue for a process of allocating or rationing resources, or define the concept of health. Rather, it will attempt to outline important considerations and describe potential ethical issues and value conflicts that arise in healthcare networks and institutions at the organizational level.

Healthcare organizations play an important public role in their communities, providing medical care, medical education, and significant employment opportunities. Trustees and managers confront ethical issues that involve clinical matters, corporate and institutional structure, strategic direction, personal and personnel commitments, and the public nature of health care.

MOVING FROM A CLINICAL FOCUS TO INCORPORATE ORGANIZATIONAL CONCERNS

For many years, healthcare institutions have been expected to be attentive to clinical ethics issues that arise in the context of patient care. Some of these expectations are embodied in laws and regulations, for example, the Patient

Self-Determination Act, required education for Medicaid recipients, organ donation request laws, EMTALA (the “anti-patient-dumping” statute), HIPAA (the privacy rule), the Patients’ Bill of Rights, and regulations governing human subjects research. However, independent accreditation bodies also play a role in defining the requirements for institutional ethics activities. In the patient-rights section of its accreditation manual for hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that “the patient or the patient’s designated representative participate in the consideration of ethical issues that arise in the care of the patient.”⁷ Institutions must develop processes that provide patients (or their representatives) access to ethics consultants, an ethics committee, or other procedural mechanism designed to address ethical questions and concerns.

Clinical issues are typically dealt with using traditional ethical principles such as autonomy, beneficence, nonmaleficence, and justice.⁸ The limits of these principles might force healthcare institutions to confront ethical issues that reach beyond the clinical setting (e.g., the limits of the institutional or professional obligation to treat a patient who requests “everything”). Clinical issues often wind up involving questions of community need,⁹ accreditation and government regulation,¹⁰ and organizational structure.¹¹

New clinical ethical issues arise as medicine and technology continue to develop new financial structures that more intimately link hospitals and physicians to financial concerns. These issues also raise organizational questions as to their effects on the provision of appropriate, quality medical care. Examples of the issues raised include: the nature of advocacy in the patient-physician relationship, when physicians are subject to outside influences that might affect care decisions¹²; the potential for financial conflicts of interest¹³; challenges to the traditional fiduciary nature of the physician-patient relationship¹⁴; and the provision of preventative or primary healthcare services to the community for which the institution might not be reimbursed.

In 1995, JCAHO introduced a new accreditation standard in its “Patient Rights and Organizational Ethics” chapter of its accreditation manual, requiring hospitals to “operate according to a code of ethical behavior.”¹⁵ A hospital’s code must address business ethics concerns, including the marketing, billing, admission, transfer, and discharge practices of the hospital and its relationship to “other healthcare providers, educational institutions, and providers.”¹⁶ With this standard, JCAHO expects hospitals to approach these issues in an ethical manner that reflects its moral responsibility to patients and the community they serve.¹⁷ Soon after, the American Society for Bioethics and Humanities Task Force on Standards for Bioethics Consultation acknowledged the growing importance of organizational ethics issues and the need to develop institutional capabilities to address these issues as part of its ethics consultation service or ethics infrastructure.¹⁸

These developments led to a flurry of scholarship in the bioethics literature addressing the emergence of organizational ethics problems, including special journal issues, conferences and symposia, and books on the topic.¹⁹ For example, the American Medical Association’s Institute for Ethics formed an organizational ethics-working group,²⁰ and the American College of Healthcare Executives created a code of ethics setting forth standards to guide the con-

duct of executives.²¹ The discussions focus on questions of what the concept of organizational ethics means for healthcare institutions and how its principles can be successfully implemented and sustained.²²

The following questions have been addressed in these discussions: Are business ethics and healthcare ethics compatible?²³ Can healthcare organizations or corporations be considered morally responsible for their actions?²⁴ Who will do the work, the existing clinical ethics committee, a risk management committee, or a new committee focused solely on organizational issues? What additional education or expertise will ethics consultants need to address ethics on the organizational level? What are the differences and similarities between clinical ethics and organizational ethics consultations?²⁵ What process should be used to address organizational issues?²⁶ How can an organization build an “ethical culture,” and how will the program thrive? How do you ethically negotiate the tension between patient needs and the institution’s financial viability?

Stakeholder theory, defined as “an approach to business ethics that takes into account the rights and interests of the broad range of individuals and organizations who interact with it and are affected by business decision making,”²⁷ is an example of business ethics theory that has been applied in the healthcare arena. Incorporating principles of business ethics into an existing healthcare ethics program implies expertise in an area not traditionally represented on ethics committees. Although some authors suggest that organizational ethics should be viewed as an additional task for the ethics committee, they recognize that new members must be added or existing members must receive additional training.²⁸ To many, the goal of an organizational ethics initiative should be to arrive at a system of “integrated ethics,” one that combines clinical, organizational, and community goals.²⁹

It might be easier to achieve consensus when addressing clinical concerns rather than in the group of issues that involve the network or institution’s work life, its sense of justice, the concept of health, or the definition of a socially accountable healthcare network. Although certainly a challenge, attention to these issues should lead to better design and implementation of healthcare services that are patient focused and morally sound.

HUMAN RESOURCES AND THE INSTITUTIONAL CLIMATE

Usually there is consensus about the organization’s ethical commitments to human resources and personnel issues. An organization’s greatest resource is its human resources, and many would agree that the inappropriate or unethical treatment of the workforce can lead to a collapse of the institution’s mission and its ability to serve the public. A list of ethical principles and rules could be developed that, *prima facie*, seem to be normative. These include treating people as an end, not as a means; providing fair compensation; not being deceitful or manipulative; and instituting mechanisms for participatory decision making and consensus building. They also include ensuring that personnel policies are just and nondiscriminatory; treating employees with dignity and respect; implementing fair disciplinary policies; and protecting against physical or sexual harassment in the workplace.

Surveys of human resources professionals reveal an empirical basis for this normative agreement about what is ethical in the workplace.³⁰ For example, in one survey 22.6 percent of personnel managers indicated that sex discrimination in recruitment and hiring was an ethical issue they confronted. Nearly 31 percent indicated that the hiring, training, or promotion of personnel based on favoritism was an issue.³¹

Clearly, this *prima facie* agreement on normative principles does not ensure that all people in the workplace act ethically. The temptation might be to dismiss unethical practices as aberrant behaviors of unethical managers or employees, but the root cause might lie in the culture of the organization or its inability to address or control the unethical practices of its employees.

Employees of healthcare organizations have diverse professional backgrounds (e.g., medicine, nursing, social work, administrators, etc.), and each individual has a personal sense of what is just or moral, in addition to those values identified in the workplace. Because of this, organizations must focus on building a strong "ethical climate" by identifying core values and beliefs that are visible to both patients and staff, who can then abide by them and expect the organization to live up to them.³² Hospital staff might also benefit from educational programs that focus on organizational ethics, helping them to spot issues as they present themselves on the job.³³

Organizational assistance must be provided to workers to ensure that they are able to assert their rights and act on their values. One way this can be accomplished is providing protection for whistle-blowing actions in the workplace.³⁴ If this protection is not provided, employees who witness unethical behavior will be less likely to come forward, and, if they do, they may suffer negative consequences for speaking up.³⁵ Owners/managers need to make a commitment to the assurance of employee rights and to the inclusion of workers in the process of creating, nurturing, and sustaining the workplace environment.

Trustees or administrators who establish ethical parameters for personnel policies and the managers who implement these policies must think about the factors that contribute to unethical behavior. Furthermore, in order to create an ethical climate they need to carefully consider the content of policy manuals, the design of disciplinary procedures, the organization's mission and strategic goals, and other activities that reflect the ethical commitment of the organization. Furthermore, employers must create an environment where the staff feels comfortable expressing ethical concerns without fear of retaliation or other negative consequences. This attention to ethical matters in personnel policies has to be deliberate, ongoing, and public.

Emerging healthcare networks raise additional concerns. Key among them is a change in an institution's commitment to its workforce. In today's healthcare climate, the ethical question is not necessarily about loyalty, but rather about an organization's commitment to its human resources that enables workers to learn new skills and respond to rapidly changing work environments. Conversely, employees need to be open to change and be willing to learn and take on new challenges.

Work is a means through which human beings express significant aspects of personal life, support the development of family, build community, and create

a culture. Healthcare institutions employ a great number of individuals who view their work as a vocation, a calling, or a ministry. Even workers who perform more routine tasks often characterize their work activity as contributing to a greater end—the care of those in need. Therefore, the ethical challenge for healthcare administrators is to create a work environment in which all employees are able to express their personal dignity, achieve personal fulfillment, and realize their creative possibilities.

Those authors who focus on the question of work, including management-science authors, describe a number of additional “normative” principles that help to create a meaningful work environment. First is the principle of *subsidiary*; that is, that decisions should be made at the level where they have the most impact and involve the owners of work processes. The second principle is that decisions, whenever possible, should be based on consensus. This suggests that people who work together, examining the root causes of problems, and seeking functional and cross-functional solutions, are more likely to find effective solutions and to create a respectful work environment.

Finally, although perhaps not purely an ethical commitment, managers need to think about what management style, technique, or process best helps to build a positive and respectful work environment. Management style will have a direct impact on the type of managers recruited and hired. Furthermore, high-level management must be supportive of creating and affecting the ethical climate of the workplace.³⁶ Management style should be seen as a means to achieve an ethical end—a workplace where employees are respected, are able to assert their rights, and are comfortable expressing their own moral views if they conflict with the practices or policies of the institution.

ORGANIZATIONAL IDENTITY AND STRATEGIC DIRECTION

Another area for ethical reflection for trustees and managers is the mission of the healthcare organization and the means it uses to accomplish this mission. In the late 1980s and early 1990s, issues related to organizational mission came to the forefront when many healthcare institutions saw their nonprofit tax status challenged in state and federal courts.³⁷ The issue was raised to new heights when proprietary organizations, such as Columbia/HCA, questioned the tax status of community nonprofit organizations.

What are the ethical duties owed by a healthcare institution to the community it serves? Potter suggests that the incorporation of organizational and community bioethics “will be a time to recover the social responsibility of healthcare institutions.”³⁸ In part, this responsibility arises out of the commitment to meeting the needs of the community. Ideally, managers lead healthcare organizations in an analysis of community needs and develop and design its strategic directions to meet these needs.

For the purposes of this part of the discussion, the focus will be on nonprofit (voluntary) healthcare organizations. Nonprofit institutions must be financially sound, act as appropriate stewards of resources, and generate excess revenues over expenses. Questions about whether a manager behaves as a responsible steward of these resources or whether the organization acts justly in the “business community” are questions of business ethics. The more spe-

cific question to be addressed here is: What are the organizational ethics concerns of nonprofit healthcare institutions as they provide goods and services to the community?

Paul Starr and Rosemary Stevens each trace the growth of the voluntary healthcare sector.³⁹ According to Stevens' analysis, this growth involved a shift from voluntary hospitals, whose purpose was to mobilize local resources, to a range of disparate institutions that successfully fought government intervention and organized medicine. By the late 1930s, voluntary hospitals exemplified (in ideal cases) "public responsibility without government compulsion" and "private initiatives untainted by selfish gain."⁴⁰

In time, nonprofit institutions lost touch with the principles of that earlier era. Medicine became increasingly more organized, healthcare institutions became more dependent on federal and state funding, and the government had an increasingly larger role in designing healthcare financing and delivery systems. This was especially evident with the growth of Medicare and Medicaid. Healthcare institutions adjusted their practices to survive and grow in the new environment. As a result, some people looking at health care began to see big business rather than public charitable corporations. More recently, the focus has changed again as care has shifted from traditional nonprofit hospitals to community-wide networks that include proprietary insurance companies and physician networks with equity incentives. The values of the "health system," as described by Stevens and Starr, seem to be long gone.

Municipalities, pressed for tax dollars to maintain other community services, began to question the appropriateness of the tax status of healthcare institutions and emerging networks in light of the amount of "charity" care and community benefit they provide. If things have changed so much, and if the organizations look more like businesses, then perhaps they should pay the same taxes and municipal fees that for-profit enterprises are required to pay. Critical focus on the tax-exempt status of nonprofit healthcare organizations and the provision of charity care has only grown over the last 10 years. However, a recent empirical analysis comparing the provision of services by for-profit and nonprofit healthcare organizations finds that, comparatively, nonprofit hospitals provide more "private and public goods in the public interest" and that the focus on tax exemption is misplaced, because it does not constitute a large percentage of overall public spending.⁴¹

Furthermore, U.S. society has a schizophrenic attitude toward its healthcare institutions. On the one hand, communities expect that healthcare institutions will (1) be close to home; (2) be filled with the latest technology; (3) abound in expertise; (4) be efficient, quality, full-service providers; (5) take care of the poor and uninsured; (6) not be concerned about insurance or payment arrangements; and (7) not be prohibitively expensive. Communities expect the costs of providing these services will be covered by income derived from the overall activities of the institutions, free from overdependence on public money. Healthcare institutions should also provide services as needed, without addressing questions of the national healthcare budget or rationing resources. On the other hand, the community expects that healthcare institutions (1) should not be involved in projects that raise money through non-health-related activities (except for philanthropic fund-raising); (2) should be wary of joint

ventures and other business practices; and (3) should compete openly in the marketplace while not looking like a business. Obviously, these conflicting expectations need to be resolved.

This is not to suggest that there are not appropriate limits to a nonprofit institution's use of excess revenue, capitalization of proprietary projects, inurement, or executive compensation. However, at the root of these issues are questions about whether healthcare services are public or private goods, whether competition and the marketplace help or hinder the provision of these goods, and how many tiers of healthcare services society really wants.

No clear policy will resolve every issue. In the absence of a national health plan (and even if there were a national health plan), managers and trustees of voluntary institutions must do their best to create institutions that respond to the needs of the communities they serve. This is not be easy, and strategies differ depending on applicable laws, regulations, and court decisions. Managers and trustees need to develop strategic directions that guide their institutions through the regulatory maze while simultaneously meeting the needs of as many people as possible. This is not only sound business strategy, it is an ethical imperative if one understands health care as a social good.

The ethical components of institutional strategy are definitional and procedural. Definitional concerns include defining *health*: What is health? Is it the optimal functioning of the whole person? Should the definition of health focus on the individual, or should it have a broader community (public health) perspective? What goals is the organization aiming for? Which services benefit individual patients and which address community health? Increasingly, health benefits are measured in terms of both community and individual gain. Consequently, preventive services, community-education programs, primary health care, outreach and advocacy programs, and other activities become part of the institution's mission in the community.⁴²

The procedural aspects of strategy require managers to define the process of the allocation and rationing of healthcare resources. Although there may be no ascertainable national healthcare budget to frame spending, each institution or organization has a general sense of an "annual total budget" available to it through implementation of the strategic/financial planning process, its cash reserves, its charitable funds, and its debt capacity. After determining the health needs of the community, managers must allocate the human and fiscal resources necessary to meet these needs. If all health needs cannot be met, the institution must then ration services based on the revenues it has.

Therefore, the institution must devise a procedure for rationing—the denial of possibly beneficial resources to some or all people—that is publicly defensible, socially accountable, quantitative, and clear.⁴³ Often this is not the case, and rationing is instead surreptitious and secret and not publicly recognized (although managed care organizations can be considered a very public form of rationing).⁴⁴ Managed care rationing often is perceived as a "denial" of treatment by healthcare consumers, consequently weakening public trust in the healthcare system. In the hospital setting it is an uncomfortable reality, but failure to ration care appropriately can lead an institution into fiscal difficulty when services are provided beyond its resources or without full reimbursement.

Not all people agree that rationing is necessary, and some believe that the elimination of inefficiencies and waste could go a long way toward ensuring universal access to cost-effective and quality healthcare services. The ethical challenge for those who believe this is to define appropriate outcomes and cost-efficient practices and then to build a system that allows sound stewardship of available resources.

Other procedural concerns include ensuring that managers exhibit integrity⁴⁵ and behave ethically. For example, financial managers must be honest and must establish mechanisms that are not illegal or unscrupulous. Planners must honestly assess the needs of the community when developing healthcare services and match available financial resources with the institution's commitment to serve that community. Operations personnel must make decisions about services and personnel that are aligned with strategic directions and goals, and the chief executive officer must integrate these activities within the institution and, when necessary, revise them accordingly.

THE PUBLIC NATURE OF THE CORPORATION

A healthcare organization's commitment to service is a public statement. Such a statement is ethically significant because it can contribute to the building of a community. Trustees and executives must ask basic questions such as: How will this network or institution make a difference to the community that it serves in the future? The fiduciary responsibility of trustees can be backward-looking: What was the financial performance of the organization last month (or last year)? How many goals were achieved last year? However, their ethical responsibility is mainly forward-looking: How will this organization make a difference in the world tomorrow? Planning how the ethical obligations of the organization will be met is the work of the board.⁴⁶

Creating tomorrow's vision demands ethical sensitivity to the public nature and service orientation of the organization. Generally, this includes a special concern for the uninsured, disenfranchised, and the poor. The managers and trustees should respond to community, state, or national demands for social justice, consider the social determinants of health, work to ameliorate factors that contribute to poor health, and use their considerable financial and institutional power to help shape the community's future. These ethical concerns often are addressed through community networking, by building partnerships between community entities (businesses, educators, etc.), as well as working with public and elected officials to promote positive changes that will improve the health status of the community.

The preferential tax treatment of most healthcare organizations, their public trust, and their service mission obligates trustees and managers to work for the public good. At times, this obligation requires an institution to challenge the medicalization of social problems and help eradicate the social determinants of health. For example, an organization must take on the causes of lead poisoning (poor housing conditions); the prevalence of malnutrition; abusive treatment of children, the elderly, and other vulnerable populations; the lack of vaccinations; and access to healthcare services and insurance. If healthcare organizational leadership does not address these issues, costs will

rise, people will continue to be harmed, and the health status of the community will deteriorate.

Often, healthcare organizations, whether alone in smaller communities or in groups in larger communities, constitute a leading economic and political force. Leveraging an institution's powerful economic position for community gain is an ethical requirement flowing from the mission of the institution. Moral persuasion might be the tool most often employed in these situations, but a community's trust in and dependence on healthcare institutions or networks gives tremendous ethical power to trustees and managers.

The ethical commitment to the common good has implications for other institutional practices as well. Why would a healthcare institution not be sensitive to environmental issues? In the wake of the increasing costs of cure and care, can healthcare organizations be indifferent to returning people to a polluted or harmful environment? Environmental awareness will lead institutions to consider more closely the appropriate disposal of their wastes and toxins and promote the use of environmentally-friendly products.

Healthcare organizations also need to be self-critical when making strategic decisions. When deciding where to place the newest clinic or professional office building, they need to consider how the location might affect access to care for the poor and uninsured or contribute to the geographic isolation of the sick. What policies or regulations should institutions advocate to increase access, equitable reimbursement, and community support? Sometimes it seems there is a tendency in healthcare organizations to advocate for policies that will ensure their own continued existence, rather than those that benefit patients or the community. With ever-increasing external stresses on the healthcare system, the ethical concern for tomorrow is whether healthcare institutions will advocate for changes that are consonant with patient needs, such as increased outpatient services. Can there be a redistribution of public dollar commitments to address preventive health needs and decrease institutional and technological use? What social structure improvements will prevent illness and increase the health status of the community? There will always be a need for healthcare institutions, but perhaps the most equitable healthcare structure will consist of a new and different alignment of institutions, payers, and providers.

CONCLUSION

Healthcare networks, organizations, and institutions are powerful forces in public and political life. The ethical concerns of health care are broader than those that arise in the clinical context, and they are still being defined. Managers and trustees of healthcare organizations, if faithful to their mission, identity, and public commitment, must systematically address their role in promoting public welfare, protecting employees, creating a better environment for healthy living, influencing the politics and economics of the community, and helping to develop a just public order. Trustees and managers should focus on distinct, but complementary, objectives to achieve these general goals. To accomplish this, there must be a deliberate and systematic approach to address, implement, and monitor the ethical commitments of healthcare organizations.

SUMMARY

Issues in healthcare ethics are not restricted to clinical situations; they are also increasingly difficult for the institutions that address healthcare needs. This chapter presents some of the areas of concern for these institutions and systems including their role in clinical concerns, issues surrounding personnel, and the nature of the work itself. Because of healthcare organizations' unique mission, a discussion concerning organizational identity and obligation to the community is included. Finally, the reader is reminded of the need to be aware of ethical issues and to continue to address them, now and in the future.

QUESTIONS FOR DISCUSSION

1. Why do you think there has been an interest in ethics with respect to the institutional part of health care by organizations such as JCAHO and others?
 2. What is the role of the administrator or manager in institutional ethics?
 3. Why are healthcare businesses interested in being proactive in meeting the community's healthcare needs?
 4. Why do you think Americans are so schizophrenic about their attitude toward health care?
 5. What principles of ethics would be most important to institutions as they consider their ethics actions in the future?
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NOTES

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29. R. L. Potter, "On Our Way to Integrated Bioethics: Clinical, Organizational, Communal," *Journal of Clinical Ethics* 10, no. 3 (Fall 1999): 171; C. R. Seeley and S. L. Goldberger, "Integrated Ethics: Synecdoche in Healthcare," *Journal of Clinical Ethics* 10, no. 3 (Fall 1999): 202.
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