The Rashomon Effect: Organization Ethics in Health Care
Rorty, Mary V;Werhane, Patricia H;Mills, Ann E
HEC Forum; Jun 2004; 16, 2; ProQuest
pg. 75

H E C FORUM
2004; 16(2): 75-94.

© 2004 Kluwer Academic Publishers.
Printed in The Netherlands.

THE *RASHOMON* EFFECT: ORGANIZATION ETHICS IN HEALTH CARE*

Mary V. Rorty, Ph.D., Patricia H. Werhane, Ph.D.,

and Ann E. Mills, M.sc. (Econ), M.B.A.

The Academy-Award winning 1950 Japanese movie *Rashomon* depicts an incident involving an outlaw, a rape or seduction of a woman, and a murder or suicide of her husband. A passer-by, who is also the narrator, explains how the story is told to officials from four different perspectives: that of the outlaw, the woman, the husband and himself. The four narratives agree that the outlaw, wandering through the forest, came upon the woman on a horse being led by her husband; the outlaw tied up the husband, sex took place between the woman and the outlaw in front of the bound husband, and the husband was found dead. The narratives do not agree on how these events occurred or who killed the husband. The outlaw contends that consensual sex occurred between him and the wife, and he claims to have killed the husband. The wife depicts the sex as rape and claims that because of her disgrace she killed her husband. The husband, through a medium, says that the sexual act began as rape and ended in consent, and that in shame, after being untied by the outlaw he killed himself. The passer-by's story agrees with the husband's account of the sex and the bandit's account of the murder. Because the passer-by is also the narrator of the film, we tend to believe his version. But what actually took place is never resolved.

Introduction

In her book, *Moral Imagination and Management Decision-Making*, Patricia Werhane describes what she terms the "Rashomon effect." Referring to the 1950 award-winning Japanese movie *Rashomon*, Werhane maintains that, "...all experience is framed and interpreted through sets of conceptual schemes or mental models. The ways we present or re-present a story, the narratives we employ, and the conceptual framing of that story, affect its content, its moral analysis and its subsequent evaluation" (1, p. 70). Because different participants in the same event may apply to it different mental models, interpretations of a given situation or event by persons, groups or societies may differ greatly from

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

each other. In this paper, we apply the insights of this analysis to a problem of ethics in contemporary health care institutions. An organizational decision impacts a number of different stakeholders in that organization, and each may see a different aspect of the decision, and see the organization in a different light because of it.

Although there are several traditional perspectives on ethics in health care that have been applied to health care delivery, changes in the structure of health care delivery have set the stage for new conflicts, as well as bringing to the forefront old conflicts in new guises. Over the course of the last century health care delivery has become increasingly multi-disciplinary and increasingly institutionalized. Although retaining the primary responsibility for patient care, the physician is one of several clinicians at the bedside, and many treatment decisions are influenced by other health care professionals. Institutional constraints influence care decisions as well, and the complex contemporary hospital is the site of intersection of multiple actors, including administrators, lawyers, and patient care representatives as well as physicians and nurses, simultaneously pursuing such divergent objectives as individual patient care, population health and cost control. Biomedical ethics, a social movement of the mid-20th century, supplemented the professional ethics of physicians and nurses with clinical ethics, focused on patient rights rather than professional prerogatives and concerned with the ethics of multidisciplinary clinical practice and problems which arise in the care of particular patients (2). Clinical ethics programs are designed to address some of the ethical problems associated with the increasing complexity of multi-disciplinary practice, but may require modification or expansion to deal with organization level ethical issues (3). Until recently, issues of business ethics were largely considered irrelevant to the delivery of care. But competition, with its attendant tensions and temptations, has entered the industry and with the "corporatization" of health care in recent decades health care organizations have been subjected to the same kind of ethical and legal scrutiny as corporations in other institutional sectors. As concerns have grown over reimbursement, business ethics has joined issues of clinical and professional ethics as a perspective on ethical crises in contemporary health care delivery (3).

In what follows, we create a hypothetical case and tell four "narratives" of the situation as understood from the perspectives of different participants. We ask whether professional ethics, clinical ethics, or business ethics taken separately can illuminate our case. We argue that none of these three predominant approaches to ethics are adequate in themselves. We adopt a "systems" perspective on institutional decision making, and illustrate how decisions made on one level affect relationships throughout the organization. We propose an organization ethics framework for thinking about ethical issues

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

which may meet the challenge of reconciling the diverging values in the four narratives in a way which can acknowledge the participants' different roles in the health care institution.

The Case: Blood and Trust

A 64-year old man has a prostatectomy for cancer at Twinville Community Hospital. During surgery he receives two units of packed red blood cells. One month following the surgery, the patient calls his physician with a question concerning the bill for the transfusions ($670 per unit "processing charge"). He states he has been a frequent blood donor to the Red Cross and has been happy to do this because of his understanding that the blood would be available at cost for everybody. He reports that his neighbor had recently received blood at a nearby hospital and had been charged only $625 per unit.

The physician, a member of a physician practice associated with the hospital, contacts the administrator of the hospital blood bank. The administrator tells him that there had been a change in suppliers, from the Red Cross to an independent, who charges more per unit. Although he admits he has no evidence, he speculates that the change had been made because of a close relationship between the president of that company and two members of the hospital board.

The troubled physician contacts the hospital's Chief Executive Officer. He is told to tell the patient that the costs from the supplier have recently increased, requiring an increase in the charges. The CEO points out that the increase in expense of this product remains within the range compensated by most payers. The physician says he has heard a rumor that the supplier had been changed. The CEO says that as an inducement to make the switch, the new supplier agreed to provide laboratory services to the hospital for the uninsured-costs that the hospital has not been able fully to reclaim from state or federal agencies.

When questioned about the rumor of a relationship between the two board members and the president of the independent supplier, she responds that yes, there is a close relationship between the three but the change of suppliers has been calculated to be in the best financial interest of the organization, and the personal relationship did not influence their decision. The CEO notes that this latter arrangement must remain in confidence. If word got out about this agreement, the supplier would have to back out of the arrangement because some of the company's other customers would demand the same concession. She reminds the physician that the contract between the hospital and his practice association contains this clause: "Neither party to this contract will make any statements to other persons that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

could adversely affect the management and/or financial position of the hospital or association."

A. *The CEO's Narrative*

"The price went up. It happens. There was nothing at all wrong or unethical about the decision to change suppliers. In making the switch the board contracted with a dependable blood supplier who has agreed to provide needed laboratory services to our uninsured patients as well. I am sorry that there was any misperception on anyone's part about the relationships of two of our members of our board and our supplier – but as far as I am concerned their relationship is irrelevant. This change will be good for both the hospital and our community."

The CEO emphasizes the overall positive financial effects of the switch in suppliers – coverage of currently unreimbursed lab costs and the associated benefit to the hospital and to portions of the community – and minimizes the impact on other community members, including the patient whose concerns prompted the physician's question. From her perspective the benefit to the community's uninsured and to the hospital outweighs the relatively minor cost to insured patients and well-off uninsured patients. She is not overly concerned about the personal relationship between the supplier and the Board members – indeed, she may approve of it, if she feels that the only reason the change occurred was *because* of that relationship. We do not know whether there is in fact any impropriety in the new arrangement due to the relationship. The CEO makes clear that she does not think there is, or that this represents a conflict of interest. Does this hospital have a mission statement or code of ethics that addresses such issues as disclosure, conflicts of interest, relation to other organizations, responsibilities to the community, or the proper relation of cost and quality? If so, the CEO is responsible to that code.

She also makes it clear that she does not think this is anyone else's business, and has no interest in opening that discussion to a wider range of participants. She may not like secrecy but she has responsibility for the hospital's reputation and knows that talk of relationships that might appear to be improper could damage the reputation of the hospital. For the sake of protecting that reputation she emphasizes the doctor's obligations to the institution, minimizing his obligations to his patient and recommending stonewalling over disclosure. She also must try to limit any discussion of an agreement which benefits the hospital over some other organizations in the community. Her priorities add up to a business decision. She is unsure that the physician understands the importance of keeping quiet, so she makes a veiled threat that is backed up by a clause in the physician's contract that requires him to protect the hospital in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

which he practices. In the course of their conversation the CEO, made conscious of the difficulties of her position by the doctor's questions, has shown her discomfort by become increasingly defensive and aggressive.

B. The Blood Bank Administrator's Narrative

"What can I do? I provide the blood, but I don't make the contracts. This appears to be a Board decision to change suppliers and it probably was made for financial reasons. Everyone knows how close a couple of the board members are with the president of our new supplier – but that's none of my business. I only care that our supplier is reliable."

The effect upon the reputation of the blood bank manager is relatively benign so long as the blood, although more expensive, is as reliable and as readily available as it was through the previous supplier; but he seems to be unhappy about the change. Was he a party to the decision? If not, it may be his feelings of frustration at not having been consulted that lead him to offer the physician his speculations about the reason for the change. He seems to assume that the decision to change suppliers is the result of the relationship of the board members to the president of the new supplier. He may find that inappropriate, or worse, he may expect such partisan decisions. His attitude suggests, "It happens all the time. So what?" If this reaction is an indication of what some stakeholders believe about the institution, that personal interest is dominant in contractual relationships, it serves as a barometer of the institution's culture and suggests a negative ethical climate.

C. The Patient's Narrative: "Tell me, doctor, why the difference?"

The patient presents an external perspective on the hospital, representing the community which the hospital serves. His main contact with the hospital is through his physician, with whom he has an ongoing relationship, and through whom he entered this hospital, rather than the hospital down the road to which his neighbor was admitted. He feels, with considerable justification, that the person to whom any questions should be addressed is his physician. He has, after all, told the doctor frankly about the symptoms, which led to the exploratory and his eventual diagnosis. He has been warned, equally frankly, about possible side effects of the operation and necessary post-operative care. With this degree of intimacy and disclosure, of trust and reciprocity of information, it is the doctor, rather than a billing clerk or the blood bank director, from whom he can expect an honest answer; and as the person responsible for putting him in the position of being charged this higher fee, it is the doctor who is the appropriate person to question.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Whatever the physician tells the patient – that the increase in price is the result of a board decision; that it is a business decision; that it is the result of providing necessary services for the uninsured – the patient can and perhaps should respond, "What has that got to do with me, Doc? You're the person responsible for my care. When I donated my blood for free, it was not a business transaction; and I am not responsible for the costs of the uninsured." Will the patient's trust in the organization, and through him, perhaps, the larger community's trust, be eroded? What obligation does the organization have to inform the members of the community it serves of decisions that impact that service?

D. The Physician's Narrative: "Where do my loyalties lie?"

Can the physician tell his patient any more than, as the administrator said, "costs from the supplier have recently increased?" Is it his responsibility to make the more explicit reply, "We no longer buy from the Red Cross," which might lead to further questions? ("Why not, doctor? Do you know something about the Red Cross that I don't know?") Is it his responsibility now to tell his patient what he knows about the arrangement – that it was made between close friends with the knowledge and full approval of the board because of the benefit to both the hospital and the community's uninsured? Should he take the risk of divulging why the decision was made, knowing that he is risking both his contractual relationship with the hospital which may involve his colleagues and his staff, and an arrangement that could benefit his other patients?

The physician's loyalty to the institution is in explicit conflict with his loyalty to his patient, his loyalty to his own practice, as well as his loyalty and concern for his other patients, both insured and not. The threat of the CEO makes it clear that it is not in his self-interest to encourage the patient to continue to discuss the price increase and so he is frustrated and angry with the CEO of the health care organization for putting him into a conflicted situation – one that he feels powerless to control. It is as if he has become responsible, in the eyes of his patient, for a decision of which he had no notice, and in which he had no say. Responsibility without power of influence is one of the most troubling aspects of health care delivery under contemporary conditions.

If the physician feels compromised by the CEO's demand for secrecy or doubtful about the legitimacy of the justification for change of suppliers, he may reconsider signing with that hospital in the future, thus weakening the position of the hospital in the community by the loss of an able practitioner. Or in some communities he may not have that option. That hospital may be the only one in town, or the only one with adequate facilities for his specialty practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Three Lenses

There is trouble in Twinville Community Hospital, as reflected in the discomfort of each of the narrators in our hypothetical scenario. Our story does not suggest an explanation; instead it is a story of how one organizational decision impacted four stakeholders with different roles in that organization. We are less concerned with what "really" happened than with how this complex organization could more adequately meet the challenge of judgment from so many diverse but equally valid perspectives. Can professional ethics, clinical ethics or business ethics, separately or severally, meet this challenge?

Professional Ethics

Physicians, nurses and hospital administrators all operate under professional codes which are "Hippocratic." The American Medical Association, The American Nurses Association and the American College of Hospital Executives codes all acknowledge the primacy of the welfare of the patient as the governing value of their functions. The same is true of other health professionals, and Board members too agree to serve on the assumption that they are acting in the best interests of the organization. There is no commonly agreed upon definition of a profession or a professional. For our purposes we want to focus on health care professionals and distinguish these learned and highly specialized professional practitioners from the more generic classification. Orr writes:

> In the classic sense being a professional implies a publicly declared vow of dedication or devotion to a way of life. It implies a special knowledge not available to the average person; it is an unequal relationship. But with that special knowledge comes a special responsibility. It is thus a fiduciary relationship in that the possessor of knowledge has a responsibility of altruism, and the recipient of the special knowledge may thus trust the professional. In other words a professional is a trustworthy trustee (4, p. 1).

Health care organizations and the professionals employed or contracted with them have generally relied on professional or clinical ethics to provide guidance for difficult decisions. In addition to spelling out the appropriate treatment of patients, every professional code directs attention to the dangers of conflicts of interest to professional integrity. A conflict of interest occurs when one's professional judgment or code is in conflict with other demands or

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

influences that if acted upon would compromise professional judgment (5).

The board members seem to have a conflict of interest via the personal relation with a contractor. But the CEO, privileged with information to which the other narrators do not have access, claims that the board did not act inappropriately. Although she is concerned for secrecy, that may have as much to do with reputation as with protecting an advantageous financial arrangement. Whatever the case with respect to the Board, the CEO's veiled threat has created a conflict for the physician, putting him in a position where his personal or professional well being may be threatened if he is frank with his patient.

The patient's question and the CEO's response raise another professional problem for the physician. The situation that the physician finds himself in represents what Werhane and Doering call a "conflict of commitment." "Conflicts of commitment are those sets of role expectations where competing obligations prevent honoring both commitments or honoring them both adequately" (6, p. 47). The physician is ethically responsible to the institution to which he is contracted, he is ethically responsible to his practice association, and he is ethically responsible to his other patients—both insured, underinsured, and uninsured – so the dictum to put his patient above all else is compromised because by so doing he may risk the welfare of this institution, his colleagues and staff, as well as the welfare of some of his other patients.

Werhane and Doering have argued that an ethically acceptable response to conflicts of commitments or conflicts of interest is disclosure and publicity (6). But there are two intertwined issues in this case – the relationships of two of the Board members and the president of the independent supplier, and the arrangement between the hospital and the independent supplier that allows blood per unit prices to increase while eliminating the costs of laboratory services to the uninsured. The Board apparently knows of the relationship and has factored it into their decision to switch suppliers. But further discussion or disclosure of the *appearance* of a conflict of interest because of the relationship might unfairly damage the hospital's reputation while publicity about the arrangement between the hospital and the blood supplier might cause an advantageous arrangement to be cancelled.

Another recommended recourse by Werhane and Doering is to perform "triage" on commitments, prioritizing them in terms of who is least harmed or most benefited, which demands are necessary for professional excellence, which least violate one's other role commitments, and which can be put aside (5). But we cannot frame the question this way because we do not know the net effects of harms and benefits. The physician cannot maintain his role as patient advocate, where trust and reciprocity are essential, without risking other commitments.

Professional ethics focuses attention on the integrity of the individual and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

his actions. But it strains the concept of professional ethics to apply it to collective or organizational decisions. In complex organizations, decisions are made by groups with mixed professional affiliations, and individual professionals may serve in a variety of functional roles, some of which may require different ordering of priorities or involve interests other than their professional ones, generating various conflicts. If professional ethics were the physician's only recourse for understanding and if possible improving the situation in Twinville Community Hospital, he might be moved to courses of action that would on balance damage, more than improve its ethical climate.

Clinical Ethics

Clinical ethics is premised on the assumption that people with a variety of professional (or personal) perspectives have an equal moral stake in patient care, and need to have their voices heard in making treatment decisions in conflicted or ethically complex cases. Health care in the last few decades in the United States has increasingly been delivered through a team model in complex institutions (7). When numerous clinicians and hospital personnel are directly involved in patient care, cases can arise where inadequate communication, conflicts between caregivers or differences between family members about appropriate treatments can create impediments or interruptions in the implementation of plans of care for individual patients. Clinical ethics, a patient-centered application of biomedical ethics, has developed for dispute resolution and mediation in clinical settings (8). But rather than focusing on the obligations of the physician to her patient it focuses on the rights of the individual patient. Discussions of these individual clinical cases may involve informed consent issues, life and death decision making, pain and suffering and the uses of power in clinical settings, as well as such issues as communication, disclosure and truth telling. Clinical ethics does focus on making differing perspectives explicit and working toward agreement on the proper priority of shared values. But it does so within a limited range.

The limitations of clinical ethics for adequately addressing this case lie in its clinical focus. This case would never come before a clinical ethics committee. There was little harm to the patient, and the individuals more likely to claim harm, the doctor or the blood bank administrator who was left out of the decision, do not have a claim on their attention. Although clinical ethics committees are available for resolution of disputes arising in patient care and are a vehicle for formation and review of policies governing patient care, wider considerations such as the obligations of the organization to its community of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

stakeholders are not within their purview as currently constituted. Further, although when properly done, clinical ethics can involve root-cause analysis to figure out how to prevent recurrences of the same kind of problem, clinical ethics is typically reactive, rather than proactive, in focus. Some of its procedures might be useful if applied more broadly, but the problem in Twinville is an organizational, not a clinical, problem. This case does not present clinical ethical issues as such. Although the existence of ethics committees and ethics consultation within a health care organization is a useful model for a mechanism for ethical review, clinical ethics committees will have to develop a wider perspective before the resources they offer—mediation, negotiation or education—can be helpful in cases like this one (9).

Business Ethics

As normative applied ethics, business ethics evaluates business practice and decision making in light of standards and codes. It develops rules and codes appropriate to the context of commerce, and it offers a framework of moral reasoning to think through recommendations and solutions to particular ethical dilemmas in business. As evaluative, business ethics seeks to develop and use sets of normative rules of conduct, codes, standards, or principles that recommend what one ought to do in contexts where the well-being, rights, or integrity of individuals are at stake.

Health care is, and to some extent has always been, a business. But the kind of business it is has changed over the decades, and by now the individual artisan or craftsman model of medicine and the small business model of the private or group practice have been joined by the organizational structure model of hospitals, and more recently by the model of corporation or conglomerate. Business ethics has developed in connection with rather different corporate or organizational models than those that characterize health care. Business models and the range of things scrutinized in business ethics are extremely useful in considering our case. Issues like the treatment of employees, obligations to other organizations, honesty in financial dealings, regulatory considerations, grievance procedures and job protection are commonplaces in business ethics (10), although not necessarily taken into consideration in either professional or clinical ethics.

Stakeholder theory has been a particularly useful contribution of business ethics to the study of ethical decision making in health care. It takes into account the roles, obligations, and reciprocal relationships of each of the many individuals that are affected and thus have a moral stake in, health care decision making. By calling attention to the variety of roles that can be occupied by individuals, all of whom have a moral stake in the organization, stakeholder

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

theory can help provide a framework for explicating conflicts of value, of loyalty, of commitment, and of interests (11). Examining the purpose and mission of the organization allows us to rank stakeholders in terms of their legitimate and appropriate claims on the organization.

A business ethics approach, while providing us with insights about the roles and responsibilities of each stakeholder, may be complicated in its application to health care as opposed to a more common garden variety of corporation. The limitations of business ethics have to do with the applicability of some of its canonical principles to health care. Consider the principle of fairness of choice, for instance, that is central to consumerism. Compare our patient's relation with Twinville Community Hospital with his relation to Proctor and Gamble, maker of a variety of cosmetic products. Proctor and Gamble's products are available on the open market in competition with other comparable products. The purchaser of the product, although possibly influenced in the first purchase by persuasive, funny and omnipresent TV ads, remains in a position to evaluate the quality and suitability of the soap in question, and to decide whether to re-purchase from the same company or to change brands.

Is the patient in Twinville Community Hospital's operating room in the same position? Yes and no. The prostate patient in our case was there because his physician was a member (under contract) of the PHO agreement. He may have had some choice of physician, and may even have asked for a second opinion or sought for referrals and recommendations. But once the decision to have the operation is made, the patient is delivered to the hospital by a process in which he has little say.

There is some element of choice on "re-purchase." It may be that on the basis of his discomfort with the unexplained higher cost of the blood that he will request a different hospital for future admissions, choose a different doctor, or complain to his insurer. These possibilities are very much on the mind of both the administrator and the physician in the case we described, and very much to the disadvantage of both. But not every patient is in the position to make decisions of that sort.

The "customer," the patient, is often – most typically – in the hospital because he is SICK: weak, often desperate, terrified, confused, and helpless. It is because medicine is concerned with the ill, about as close to a pure vulnerable population that you can find, that it is a business with social welfare status, unlike Proctor and Gamble's marketing of soap. Moreover, there is some ambiguity about who is the customer of the hospital – the payer or the patient (12, p. 5).

In standard businesses, the customer is both the consumer of and payer for the product or service offered by a business. In health care, the recipient of care may not be the payer, and the interests of those different stakeholders may

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

conflict. And although both are important, different components of the health care organization may choose to prioritize the interests of those two differently. At best, this structural anomaly interjects a third-party into a straightforward analysis of the roles and relationships of the hospital's stakeholders. At worst, it forces attention away from the patient as the primary stakeholder of the hospital (13). If business ethics broadens the range of issues and interests to be appropriately considered in the operations of the organization, professional and clinical ethics conduce to a focus on the social function of the health care organization, its role in caring for the sick.

Blending the Perspectives: A Systems Approach to Organization Ethics

Where do we go from here? The perspective of each participant in our case is different, dependent as they are on the roles and responsibilities of each. Each of the four narrators is affected by, and thus has a moral stake in the way Twinville Community Hospital is operating, and each is troubled by what he or she sees. Each perspective is legitimate, although no one of the four is in a position to see the situation from the position of any other narrator. This case is damaging to the cohesiveness and morale of the institution, and its relationship to its community. An element of defensiveness and wariness has entered the CEO's relationship with the physician. The physician is in an uncomfortable relationship with his patient, his pool of patients, the hospital, and his colleagues and staff. The blood bank administrator's belief that something is wrong in the institution looks like it will be confirmed, and the patient is wondering why a forthright question is taking so long to answer. The stage has been set for distrust between doctor and patient, and doctor and institution. The pride, commitment to mission and confidence appropriate for an institution with an important social function may be replaced by apathy, mistrust and demoralization. It will be bad if this incident creates a crisis in the organization. It will be even worse if the attitude of the blood bank administrator is accepted: "That's just the way things are done around here."

But if we believe that each participant has a legitimate interest in the consequences of the change of suppliers, what ethical approach can overcome the disruptive effect of their partial perceptions? The three lenses through which we have examined our case each have something crucial to contribute, but each is inadequate as it stands. A different approach is needed. This is an organization ethics problem, which needs to be approached in a way that acknowledges the interdependence of all the stakeholders in the organization, internal and external: the clinicians and administration, the board, the patients and the community.

The health care organization from this perspective is seen as consisting of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

a network of structured and informal relations between various individuals. It is one component of a larger web of organizations in the institutional sector of health care, playing an important social role and structured by a legal and regulatory matrix. Adopting a systems approach to organization ethics allows us to contextualize the organization in its relation to both the individuals that constitute it and to the larger social context in which it functions.

A "system" has been defined as "a complex of interacting components together with the relationships among them that permit the identification of a boundary-maintaining entity or process" (14, p. 51). Systems are connected in ways that enhance the fulfillment of one or more goals or purposes. Systems may be micro (small, self-contained with few interconnections) or macro (large, complex, consisting of a large number of interconnections and purposes). A system may be rigid and function mechanically, or it may be what Paul Plsek calls an "adaptive system," because it consists of individuals and organizations that have the liberty to interact with, respond to, and change the system (15). While employing some mechanical systems (in their billing procedures, for instance), hospitals are usefully seen as examples of complex adaptive systems – a view that has been endorsed by the prestigious Institute of Medicine (14). Sorting out these networks of relationships requires what Mitroff and Linstone call a "multiple perspectives" approach (16).

While it is never possible to take into account all the networks of relationships involved in a particular system, especially given that these systems interact and change over time, a multiple perspectives approach forces us to think more broadly, and to look at particular systems or problems from different points of view, which reveals insights not in principle attainable from only one focus. Such an approach is valuable if we are to understand the purpose of the system, the different priorities of values of different stakeholders of the system, and the consequences of decisions made at any level of the system. Being clear about these relationships, and how each individual and each element of the system are or should be accountable to each other helps to clarify where decisions go wrong (17). If we approach organizations as organic, interdependent webs of relationships between individuals, other organizations and the wider society, it becomes less puzzling that a decision on the part of one functional component, in this case the board, can have ripple effects throughout the organization, magnifying its effects in unpredictable ways.

The complexities of ethical issues within health care organizations have been recognized in a recommendation by the Joint Commission for Accreditation of Health care Organizations. In 1995 JCAHO added a section

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

called "organization ethics" to its standards for patient rights and ethics. It requires that the health care organization operate according to a code of ethical behavior, and develop a process within the organization to facilitate this. Such a process should encourage, protect and integrate business ethics, professional ethics and clinical ethics. It specifically requires a process to examine ethical issues in marketing, admissions, discharge, billing, and relationships with third-party payers and managed care plans, while protecting the integrity of clinical decision making (18).

In our case, each of our narrators – the patient, the doctor, the blood bank administrator and the CEO – is feeling that something is not quite right. There is some question whether the blood bank administrator is correct in suspecting inappropriate influence on the decision to shift suppliers, or even honest in suggesting it, if his motive is anger at not being consulted. There is no question that the suspicion of wrongdoing is damaging both to trust and reputation, and the CEO is correct in judging that a false belief to that effect can do as much damage as a true one. Her reaction, to protect, deny and threaten, heightens the discomfort rather than reducing it. A misunderstanding or misjudgment threatens to become a public relations nightmare.

How can Twinville Community Hospital act to prevent or mitigate distrust and disaffection among its internal and external stakeholders? What approach might best address this rapid cascade of unfavorable impressions of the way the hospital is operating? One way is to set up a process in which different perspectives can be brought to bear on the problem – and then work it through.

Focus on the Goals

In the case we are examining, the various internal and external stakeholders whose interactions and relations constitute the health care organization are united by a common purpose of delivering care of good quality for a reasonable cost to the population for which they are responsible. To meet that goal the organization must support the expertise and efficiency of its clinicians, managers and administrators, deliver care of good quality, and remain economically viable. These values implicitly or explicitly define the mission of the organization.

In our case, we can assume that all our narrators shared a working consensus on these values. Their discomfort stems from a fear that the decision to change suppliers might not have been made in conformity with those values. Did that decision support, or undermine that mission?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Acknowledge Different Roles

The various participants have different relations to those shared values. Some are more salient to each narrator's function than others. The patient has no obligation to the care of other patients, although he may hope for them care as excellent as that he has received. The board members may be predominantly non-clinicians, and thus give little direct attention to individual patient care, although very aware that their service area includes uninsured potential patients among the population. The role of the CEO is primarily focused on the delivery of quality care to populations of patients, the needs of those populations, as well as the financial health of the hospital. She is not focused on the individual encounter – which is the focus of the physician. The physician believes that trust and reciprocity are essential to the delivery of quality care, and while the CEO may well agree with the physician, she has not understood that the hospital's change of blood suppliers, as well as the secrecy that must surround that contractual relationship, has put an impediment in the physician-patient relationship, and that this impediment is eroding the quality of care as defined by both the physician and patient. But the better informed each person is about the range of obligation and values, the less likely each is to be limited by a perspective deriving from restricted roles.

Adopt Appropriate Procedures

Let's imagine that Twinville Community Hospital had an organization ethics process of the sort envisaged by JCAHO, charged with working out business decisions and procedures while protecting clinical decision making. It provides a forum to which the physician could take his conflict between responsibility to his patients and loyalty to his institution. Instead of confrontations with one person, or even a series of persons, who may be no more able to change the situation than he, he might be able to discuss it, in appropriate confidentiality, with a group of equally concerned and affected professional, clinical and administrative colleagues and devise ways of altering the decision or minimizing its impact.

Evaluating the system's purpose and its concomitant distributed responsibilities gives us the necessary parameters within which to address this case. The hospital is responsible to the community to provide good care at a reasonable cost. In order to provide quality care the health care organization must preserve the physician-patient relationship, for without the physician-patient relationship, and the trust and reciprocity it implies, professional excellence is compromised to the detriment of both the professional and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patient. Furthermore, this relationship must be preserved within a context of ethical and legal propriety and economic viability. Somehow, we must remove the impediment from the physician's relationship with his patient and prevent this particular situation from reoccurring; and, at the same time, we must not compromise the interests of other patients, the organization, or external stakeholders.

Working It Out

Consider the following scenario: within the non-threatening space provided by the organization ethics process, the CEO meets with the physician, who tells her of the conflicts that he is experiencing because of the switch. The CEO, instead of reacting defensively, promises to rethink the problem in a way that can preserve the physician-patient relationship. She asks the physician and other members of the organization ethics process if it will be enough to insulate the patient (and other patients) from the switch, and the physician and other members agree. If the patient is paying the same amount as his neighbor is paying, the patient is as well off as before the switch, so the patient no longer has a problem. If the patient continues to worry about the switch, then the physician, without feeling compromised by conflicting interests and loyalties, can reply that the hospital has come to a confidential arrangement with the new supplier that he is contractually bound not to comment on. However, he can honestly point out that the same standards of quality are being met and that the patient is not incurring additional costs. Since there is no harm to the patient, he can endorse the switch in good conscience.

The CEO asks the hospital's chief accountant to construct a model that has the hospital paying the difference between the costs of the Red Cross and the new supplier offset by the savings the hospital will make by allowing laboratory services to be provided to the uninsured. If that number is positive, the hospital will continue to reap the benefits of the switch, though not by as much as originally envisioned. If it is equal or only marginally different, she believes that she can still persuade the Board to pay the difference, as it will generate substantial good will from the physicians, who will see that the their concerns about professional excellence are being taken into account by the hospital. She can point out that this good will can be used later, possibly at a more critical time for the hospital. It is only if a large loss will be incurred by the hospital that she will have to rethink a solution to the problem (perhaps she can persuade the Board to renegotiate the terms of the contract with new supplier) – but she does not think that will be the case. In this possible solution, obviously, some stakeholders win more than others but no one is left worse off than before the switch. This is a solution that could not have

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

been formulated without a multi-perspective view of the problem – and an understanding of the limits of the three bodies of ethics that have hitherto guided decision making in health care.

Secrecy still surrounds the conditions of the agreement of the hospital with the supplier, in order to protect the special concessions the hospital has received. Assuming that this arrangement is legal and breaches no regulations, the agreement represents a competitive advantage to the hospital that it is well advised to protect in the current competitive environment. At the same time, the administration might re-think any institutional practices of secrecy and unilateral action. Since it is inevitable that the change of suppliers will become known, it would have been reasonable to discuss the coming change with the bloodbank administrator and announce it to the physicians. Many organizations have found that involving people in decisions that will affect them prevents problems of this sort arising—good preventative ethics (19).

Conclusion: Systems, Ethics, and Moral Imagination

Something has gone wrong at Twinville Community Hospital in the scenario described by our case. But separately, none of our available lenses – those of business ethics, clinical ethics or professional ethics – can focus widely enough on the problem to make clear what needs to be done to fix what has gone awry, or more importantly, how to prevent the reoccurrence of similar trust-destroying incidents in the future.

In art, the tension generated by unresolved differences in perspective can be exciting, provocative and creative. In organizations dealing with practical problems, failure to acknowledge and address differences in perspective can be confusing and demoralizing. In complex health care organizations, decisions made at one level can have unanticipated consequences that threaten the values or priorities of other levels. Ethical issues in health care organizations need to be approached in a way that accommodates different roles in the organization, while acknowledging the values definitive of its mission. Structuring communication and feedback mechanisms into everyday operations in the way system thinking requires can help an organization respond flexibly and positively to necessary changes.

Differing narratives may all represent legitimate points of view. Professionals and administrators from different parts of an organization may prioritize differing but often equally legitimate values, all of which need to be acknowledged and openly discussed. Patient perceptions need to be clarified, corrected, or validated. In an organization collaborating with multiple professions and external stakeholders to deliver health care to a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

community, there are many possible occasions for conflict between different ethical perspectives and demands associated with different roles in the institution. Of course we all expect of others and ourselves behavior to the highest professional and personal ethical standards. But if our obligations are themselves conflicting, or if our perceptions are mistaken, trying harder for individual moral perfection cannot help. It is realistic and appropriate to accept the possibility of legitimate conflicts of roles and expectations. A positive ethical climate in health care organizations requires that we build in structures and processes that can deal directly with such conflicts. These structures and processes are the object of organization ethics programs.[1]

NOTES

*This work was supported by a grant from the Batten Institute of the Darden Graduate School of Business Administration at the University of Virginia.

[1] There are many examples of how such programs can be formulated. See A.E. Mills, E.M. Spencer, and P.H. Werhane eds., *Developing organization ethics in healthcare: A case-based approach to policy, practice and compliance* (20), J. West and E. White, "The development of the Sentara Healthcare System's ethics program" (21), C. Myser, P. Donehower, and C. Frank, "Bridging the gap between clinical and organizational ethics in a newly merged healthcare organization" (22), and J. Gallagher and J. Goodstein, "Fulfilling institutional responsibilities in healthcare: Organizational ethics and the role of mission discernment" (23).

REFERENCES

1. Werhane PH. *Moral imagination and management decision making.* New York: Oxford University Press; 1999.
2. Fletcher JC, Lombardo PA, Marshall MF, Miller F; eds. *Introduction to clinical ethics,* 2nd ed. Frederick, MD: University Publishing Group; 1997.
3. Spencer EM, Mills AM, Rorty MV, and Werhane PH. *Organization ethics in health care.* New York: Oxford University Press; 2000.
4. Orr RD. Personal and professional integrity in clinical medicine. *Update*, 1992; 8(4): 1-3.
5. Spencer E. Professional ethics. In: Fletcher JC, Lombardo PA, Marshall MF, Miller F; eds. *Introduction to clinical ethics.* 2nd ed. Frederick, MD: University Publishing Group; 1997: 287-300.
6. Werhane P, and Doering J. Conflicts of interest and conflicts of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

commitment. *Professional ethics*, 1995; 4: 47-82.

7. Starr P. *The social transformation of American medicine.* New York: Basic Books Publishing; 1982.
8. Siegler M, Pellegrino, ED, and Singer PA. Clinical medical ethics. *Journal of Clinical Ethics*, 1990;1(1): 5-9.
9. Society for Health and Human Values-Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. Core competencies for health care ethics consultation. Glenview, IL: American Society for Bioethics and Humanities; 1998.
10. Donaldson T. and Werhane PH; eds. *Ethical issues in business.* 7th ed. Upper Saddle River, NJ: Prentice-Hall; 2002.
11. Evan W, and Freeman RE. A stakeholder theory of the modern corporation: Kantian capitalism. In: T. Beauchamp and N. Bowie; eds. *Ethical theory and business.* 3rd ed. Englewood Cliffs: Prentice Hall; 1993: 101-105.
12. Morreim EH. *Balancing act: The New medical ethics of medicine's new economics.*_Washington, DC: Georgetown Press; 1955.
13. Mills AM and Rorty MV. Total quality management and the silent patient. *Business Ethics Quarterly*, 2002; 12 (4): 481-504.
14. Laszlo A, and Krippner S. Systems theories: Their origins, foundations and development. In: Scott J; ed. *Systems theories and a priori aspects of perception.* Amsterdam: Elsevier; 1988.
15. Plsek P. Redesigning health care with insights from the science of complex adaptive systems. In: *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press; 2001: 310-333.
16. Mitroff II and Linstone H. *The unbounded mind.* New York: Oxford University Press; 1993.
17. Werhane PH. Moral imagination and systems thinking. *Journal of Business Ethics*, 2002; 38: 33-42.
18. Joint Commission on Accreditation on Healthcare Organizations. Patient rights and organizational ethics: Standards for organizational ethics. *Comprehensive manual for hospitals.* Oakbrook Terrace, IL: Joint Commission on Accreditation on Healthcare Organizations; 1996: 95-97.
19. Collins J, and Porras J. *Built to last: Successful habits of visionary companies.* New York: Harper Collins Publishers; 1994.
20. Mills AE, Spencer, EM, and Werhane, PH; eds. *Developing organization ethics in healthcare: A case-based approach to policy, practice and compliance.* Frederick, MD: University Publishing Group; 2001.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

21. West J and White E. The development of the Sentara Healthcare System's ethics program. In: Mills AE, Spencer EM and Werhane PH; eds. *Developing organization ethics in healthcare: A case-based approach to policy, practice and compliance.* Frederick, MD: University Publishing Group; 2001: Appendix C.
22. Myser C, Donehower P and Frank C. Bridging the gap between clinical and organizational ethics in a newly merged healthcare organization. In: Mills AE, Spencer EM and Werhane PH; eds. *Developing organization ethics in healthcare: A case-based approach to policy, practice and compliance.* Frederick, MD: University Publishing Group, 2001; Appendix D.
23. Gallagher J and Goodstein J. Fulfilling institutional responsibilities in healthcare: Organizational ethics and the role of mission discernment. In: Mills AE, Spencer EM and Werhane PH; eds. *Developing organization ethics in healthcare: A case-based approach to policy, practice and compliance.* Frederick, MD: University Publishing Group, 2001; Appendix E.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.