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Organizational Ethics

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Over the centuries the development of the concept of ethics within medicine focused on the role of the individual practitioner of medicine. The tradition of the solo medical practice and the simple relationship of the individual doctor and patient clearly defined our thinking about ethical issues on both a practical and theoretical basis well into the last century.

The increasing size and complexity of the health care system has led to a delivery system that is dominated by organizations, rather than individual practitioners. In emergency medicine, this starts with the groups of providers that staff an individual emergency department (ED); hospital or multiple group structures that may oversee these single EDs; and associations that represent the interests of emergency physicians and patients on a regional, national, or even international level.

By its very nature, the management of these organizations cannot help but have an influence on both the relationship between practitioners and the relationship between physicians and their patients. Policies and procedures, the design of compensation and incentives, and formal values or

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lack thereof, all impact these relationships and the ethical quality of any decisions that are made within an organization.

Recognition of this simple fact has led to the study and promotion of organizational ethics over the past several decades. This movement, which actually began in the health care sector, has grown to transcend it. In spite of the increasing discussion of business ethics, nowhere more important is the integration of ethics into an organization than it is in health care organizations.

Because emergency patients have sometimes been described as patients without choices, this integration of ethics into practice is even more critical. Unlike the classic doctor-patient relationship, where a thoughtful discussion of risks and benefits occurs in a setting that allows for reflection, family input, and second opinions, the emergency patient is often in a more dependent relationship with the emergency physician or other providers for the clinical care they need [1]. Given this relative decrease in traditional protections to patient autonomy, organizations providing emergency care have an organizational obligation to ensure that providers do not abuse this more dependent relationship, and that patients are protected by other mechanisms. This effectively means that emergency medicine organizations, like hospitalists and others who care for patients in similar ''captive'' situations, must take the lead in providing ethical guidelines and monitoring of practitioners, striving to do so at a higher level than may be necessary in other clinical settings [2–4].

In this chapter, we will discuss the application to the concept of organizational ethics and its application to emergency medicine organizations. These entities include hospital-managed emergency departments, small ED groups, larger emergency medicine corporations, emergency medicine support companies, prehospital emergency medical services (EMS), and specialty organizations.

Definition and principles

Organizational ethics includes both corporate and business ethics, or, put another way, both the corporate values and the financial practices of the organization. They relate to all aspects of the organization including mission, vision, governance, and leadership [5]. Within health care, organizational ethics encompasses the professional and moral codes of the organization's conduct. In the case of a patient care facility or clinical organization, it constitutes the behavior it should follow as it interacts with patients, families, visitors, providers, and staff. In the case of other organizations, it may reflect the conduct toward employees, contractors, or members [6]. Does it treat employees fairly? Are the contracts it signs, including those for patient care reimbursement, morally acceptable? These and similar questions are a step removed from clinical ethics, yet obviously have an impact on patient care [7].

The influence of all of these factors on the patient has lead to a logical and rational argument by scholars that in our current health care environment, health care organizations now practice medicine [8]. In recognition of the significance of this area, in 1996 the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) promulgated an accreditation standard requiring each health care organization to develop and operate under a code of organizational ethics [9].

Much of the recent attention given to organizational ethics in health care has been focused on financial compliance programs. While compliance programs are important, an organizational ethics strategy must be broader than compliance programs that typically focus on legal and regulatory requirements [5].

Because clinical and organizational ethics can overlap, it is sometimes difficult to address one without addressing the other. Clinical topics might include end of life, pain management, organ donation, maternal fetal health, treatment refusal, mental health, and care of vulnerable populations. Organizational issues such as informed consent, research, marketing, access, conflict of interest, financial management, and public policy are embedded into these topics, and provide a means for them to be addressed by individuals within the organization.

Similar to clinical ethics, there are guiding principles that should be used to guide ethical organizational behavior (Box 1). These principles should be considered, implicitly or explicitly, in every decision made by the organization and its representatives.

Although a relatively new concept, organizational ethics actually fits easily into the framework of the traditional ethical principles of respect for persons, beneficence, and justice. Respect is earned by organizational leaders who model ethical behavior, and by staff who replicated these behaviors. Beneficence is achieved by organizations hiring and maintaining ethical staff, developing an ethical culture, and implementing programs in an ethical

Box 1. Principles of organizational ethics [10]

- Duty to individual patients
- Financial incentives
- Quality of care
- Duty to practitioners within the organization
- Due process
- Fairness
- Duty to the community
- Shepherd scarce resources

manner. Justice is demonstrated when action is taken to recognize ethical behaviors, and misconduct is dealt with swiftly and forcefully [10].

Current problems in organizational ethics

Business scandals have been at the top of the headlines over the past decade, and health care organizations have not been exempt. These scandals have caused an ethical crisis in many organizations with a concomitant moral collapse of trust among regulators. Dealing with these concerns is not merely about law, but also about ethics. Just as a focus on business law characterized the emergence of corporations after the industrial revolution 100 years ago, today's challenges call for addressing the more fundamental cause of basic business ethics.

The forfeiture of trust in health care organizations is not merely a result of the flurry of corporate scandals. Rather, it is the result of slow erosion over decades. Several combined causes are to blame, including the increasing role of market forces, such as managed care, and the constant tension that is inherent to access, cost, and quality within the structure of the health care system.

Unfortunately, our nation's organization of the delivery of care often seems to facilitate a fragmentation rather than integration of these important issues. For example, achieving fiscal responsibility entails competing dilemmas; cost reductions may be achieved by constraining services or decreasing access; expanding access typically increases costs whereas lowering costs often entails a reduction of services [5]. Interestingly, it has been shown that large corporations demonstrating a practical commitment to ethical conduct have improved long-term financial performance [11].

The challenge: regaining trust

A crucial role for organizational ethics in health care is to regain lost trust and to recover the confidence of providers, staff, and communities. An organizational commitment to developing and maintaining a foundation of stewardship and integrity should inspire the decision-making processes and standards of conduct for personnel throughout the organization. Of course, while there are examples of health care organizations, including those in emergency medicine, that have lost the trust of some, there are also those whose daily behaviors are already influenced by these principles [5].

Values

Arguably, the only way to create an organization that consistently exhibits ethical behavior is to create a values-driven organization. The management theory behind values-driven organizations is full of hyperbole. The text *Built to Last* written by two researchers from the Stanford

University Graduate School of Business, identified 18 "visionary companies." The primary tenet of these companies was identified as the use of core values, "essential and enduring tenets, not to be compromised for financial gain or short term expediency." Examples are "innovation and absolute integrity" (3M), and "service to the customer above all else" (Nordstrom). The thesis is that these companies with core values and purpose are built to last, and will survive with or without great leaders [12].

Core values should reflect and honor organizational traditions, serve as a bridge between the mission and management decisions, create a unique moral identity, and create organizational pride. Dedication to core values gives organizations strategic focus and provides stability in a crisis. They can and should be the major component of the organizational "soul," and help to both recruit a workforce looking for more than a paycheck, and a client base looking for something beyond basic service provision.

Creating a values-driven health care organization is not necessarily a straightforward task. In clinical organizations, some providers may identify more with the values ascribed to their specific profession, while in professional organizations, other providers may feel more affinity to supporting the values of the clinical organization. Although it is unlikely that the values of these different types of organizations would be in direct conflict, they could be sufficiently disparate to create challenges to achieving uniform buy-in [13].

This is an important issue for emergency medicine organizations and providers that work within the confines of a broader health care entity. Most emergency physicians are not hospital employees, but rather, have a relationship with their hospital though an employment or contractor relationship with a group that contracts with the hospital. While they may have a contractual obligation to abide by that health care organization's ethical policies, they are not members of the organization per se. This creates both opportunities and challenges to the development of organizational ethics for the contracting physician group or emergency medicine support organization. This is especially true if the physician group or organization has relationships with multiple hospitals that have differing ethical values or policies.

Ethical organizations use values to guide all activities of the organization. Core values should promote a culture that promotes the open discussion of ethical dilemmas and the use of a fair process to resolving ethical conflicts. In this regard, organizations must prevent and address ethical mistakes in the same way that they are charged with preventing medical mistakes [13].

Organizations that are not values driven can be fragmented, lacking a unified strategic focus, cohesiveness of purpose, and strong internal social ties, attributes that are lauded by management theorists. Solidarity is a goal and end result of these attributes. Interestingly, solidarity is not necessarily

valued by all of the personality types commonly found in health care organizations. Physicians in particular may value autonomy above solidarity to the extent that presents special challenges to health care organizations attempting to implement a values-driven approach to management [13].

Creating an organizational ethics program

Mission, value, and vision statements

The relative strengths of an organization should be expressed as formal mission, vision, and values statements. The mission statement should express the organization's purpose or reason for existence and describes what they do and for whom. The vision is a broader statement that provides an overall direction or portrait of where the organization sees itself or its interests in the future. The values are the organization's basic philosophy, principles, and ideals. Each of these sets the ethical tone for the organization, and therefore it is critical that ethical principles be incorporated into all three in a substantial and thoughtful way, not just by adding the word "ethics" to the statements. Then, having written these documents, and with continued input and buy-in from stakeholders, everyone must strive to "live them," ensuring that they are the cornerstone of the organization [13].

Most organizations already have mission statements, and many have formal organizational values. Those organizations that have developed a values-driven approach to functioning have a good start to the implementation of an organizational ethics plan. Similarly, organizations that have developed mission statements, values, or philosophy statements have a base from which to start. These documents should be reviewed very early in the process of developing or reviewing the comprehensive organizational plan (COP) to ascertain how well they cover ethical issues, and to determine what sorts of modifications might be necessary to accomplish this goal [13].

The goal should be to create the three basic elements of an organizational ethics program: education, consultation, and policy development/review [14]. Competence in ethics requires moral responsiveness, moral reasoning, and moral leadership. The organizational ethics program provides the structure and processes to develop and maintain this competence. The organizational mission is supported by providing consistency; addressing the multiple loyalties of staff, customers, and governing authorities; and by recognizing priorities and the need for financial stability [14].

Stewardship and integrity are the foundation for organizational ethics in health care. Stewardship first requires that the trust of those served be treasured by the organization as the necessary context for pursuing a prudent use of limited resources. It invites the organization to recall mission as the context that will inspire ethical financing, delivery, and care. In this sense, it fosters commitment, trust, and integrity by abiding to stated

organizational values. While most ethics strategies focus on actual behavior, organizations need to plan and integrate ethical principles corresponding to the mission, fostering a virtuous community with appropriate ethical principles, decision-making processes, and conduct [5].

Infusing ethics into organizational behavior

In the case of established organizations beginning a new organizational ethics program, the effort might begin with a survey of current and past employees about their perceptions of the strengths and weaknesses of the organization. This survey might reveal that improvements are needed in the culture of the organization, improvements in communication or feedback, better expressions of administrative concern for employee well-being, or an overall more positive work environment. Addressing each of these attributes to improve the ethical culture of the environment could result in the resolution of the problems with less expense and effort than would ignoring the problem or addressing the wrong problem [10].

It is the rare organization that can effortlessly exhibit ethical behavior consistently. The best way for an organization to achieve this goal is by integrating the ethical principles of respect, beneficence, and justice found in its mission, values, and vision into the COP. The components of a typical COP are shown in Box 2.

Successful implementation of an ethics plan results in the integration of ethical principles and practices throughout every action of the organization. The competitive, facilities, financial, human resources, information management, and marketing plans all need to be infused with the organization's ethics. Ethics can be incorporated into these plans by considering how the traditional ethical principles of respect for persons, beneficence, and justice, can be addressed in each area. The management of the implementation of these plans should then ensure that actions in all of these areas reflect the organization's ethics as well.

In the competitive arena, an analysis of the opportunities and threats to an organization can have ethical implications. An example might be staffing levels. If staffing levels are inadequate, an organization might choose to

Box 2. Comprehesive organizational plan [10]

- The competitive plan
- The facilities plan
- The financial plan
- The human resources plan
- The information management plan
- The marketing plan

accept this as something beyond their control for economic or practical reasons. Other organizations may seek quick fixes in the form of "locums" or "agency staffing" or new hires without analyzing why the situation has occurred. An ethical organization would go beyond this, not settling for readily apparent causes, but rather studying the situation to find the underlying causes within the organization that have lead to the shortfall.

The facilities plan in the context of emergency services is rarely about brick and mortar. In this context, it constitutes an organizational analysis of the need for the services of an organization and where those services should be located. From an ethical perspective, the ethical dimension of this plan would include performing this function in isolation of any financial considerations. An example would be planning emergency services space and resources designed to meet patient and community resources irrespective of payer mix, rather than having a strategy of intentionally under-resourceing them to discourage use by unfounded patients. The facilities plan would also include establishing relationships with important vendors, and ensuring that those chosen are reputable and known for the quality of their products and services, as well as known for their ethical employment and business practices.

The financial plan can raise numerous ethical issues. From an ethical perspective, it should address the financial needs of the organization while encompassing patient and stakeholder data. For example, while increased funded patient volume is positive, the organization should be committed to increasing admitting volume only when care can be provided safely. Similarly, patients should be discharged or transferred out only when it is in the patient's best interest or the patient's expressed wishes.

Emergency medicine organizations in charitable institutions or institutions serving the poor also have special challenges. The ethical financial plan should be to provide defined basic emergency services needed by the population served, with innovations focused on increasing revenue or donations. The budget should not be balanced on the expense side by creating obstacles to care designed to decrease appropriate use, or to provide evaluation or treatment that does not meet the minimums of the standard of care.

Financial issues internal to the organization are important as well. Are staff being compensated fairly? Is the organization sharing profits or partnership opportunities in an equitable manner? Alternatively, do the organization's financial practices appear to exploit staff, members, or providers?

In negotiating contracts with managed care or other payers, organizations should continue discussions until both parties are satisfied that quality care can be provided for the reimbursement agreed upon. Organizations should not allow negotiations to conclude and later resort to upcoding, understaffing, using poorly qualified providers, or other strategies to gain reimbursement or cut expenses on contracts they feel provide unfair payment. Billing practices should be fair and explained clearly. Clinical practices should reflect that dispositions are made for appropriate care, not profit.

Ethical organizations should be patient focused and care driven in their financial decisions, not resorting to unethical practices to remain viable. Charitable organizations should not use their mission statement or tax status to rationalize questionable behavior. Unethical activities designed to promote an institution with an altruistic mission is still unethical behavior, and should not be promoted or tolerated. The end does not justify the means.

Human resources planning and processes are also critical to the overall ethical performance of the organization. In addition to staffing, the human resources category includes space, equipment, support systems, and the development of internal administrative policies and procedures. Organizations must remember that employees and other associates, including physicians, are more than just a collection of skills and capabilities. Great care must be given to fairness, honest contractual dealings, and due process in dealing with all providers or employees. Promises must be kept to the people in the organization. The people in an organization comprise its culture, more powerful than the administration in regard to the organization's ethics.

Information management planning is another area in which ethics is important. The three broad concerns of information planning are to ensure that effective, accessible systems are in place; that continuous training is offered to employees; and that information systems provide valuable output that can be used to provide real-time benefit to the patients, customers, or members of the organization. Information in health care organizations is particularly subject to ethical concerns. While it is important for employees to have ready access to patient information, these data should be restricted to a "need to know" basis. The ethical organization's model of behavior should reflect this mandate and should supercede the Health Care Insurance Portability and Accountability Act (HIPPA) or other governmental regulations. Such behavior will help increase the overall respect for patient's rights [10,15].

The marketing process differentiates the organization's products and services from those of its competitors. It is an operational manifestation of the organization's goals, connecting the organization's strategies with the operational activities. Marketing includes many components, the most obvious of which is advertising. The ethical organization should ensure that any advertising is truthful and accurate. Advertising or informational materials, and promotional items, should reflect the values, goals, and image of the organization and the concepts behind what the organization stands for.

The marketing plan of an ethical organization does not resort to negative marketing about competitors, but rather focuses on the positive attributes of the organization. Advertising should not be based on unprovoked attacks or comparisons with competitors. Products and services marketed by the organization should be able to pass "the family test," which is commonly described as whether or not organizational leaders could, in good conscience, recommend the same product or services, including physician services, to a family member. If the answer is not clear, then the ethical

organization should take immediate efforts to improve the product or service, and it should not be marketed until such time that the answer is clearly "yes" [10,14]. In the case of emergency services organizations, this may mean replacing physicians or other providers who do not meet quality or credentialing standards.

Following review of the COP to identify opportunities, policy development or updating with an ethical perspective should be the next element of an ethics program. All existing policies should be reviewed from an ethical perspective, and if they do not already exist, policies should be written on topics such as informed consent, withholding/withdrawing treatment, advance directives, surrogacy, do not resuscitate (DNR), medical futility, privacy, confidentiality, organ transplant solicitation, research, conflict of interest, impaired providers, and conscientious objectors. Those responsible for policy development should be ready to respond quickly to requests for guidance.

Leadership

There are an abundance of challenges for health care leaders in the quest for organizational ethics, ranging from the changing and competitive environment, to complex missions and organizational structure, and from increasing fragmentation in care delivery or unclear provider vision. Organizational ethics provides guidance for leaders in these difficult situations and fosters standards of ethical conduct [5].

Leaders who understand that stewardship presents the organization's mission as the context for fiscal responsibility will foster values consistent with the organizational purpose. The values-based vision of these leaders is the focal point that reflects consensus on anticipated scenarios within the organization. This strategic vision, combined with the organizational mission, should drive the accomplishment of goals that are translated from the performance of objective measures of progress [5].

Governance provides another opportunity for the practical contribution of organizational ethics to health care leadership. There are significant changes occurring in regard to the role and functions of health care boards. Corporate boards are expanding the fiduciary-advisory role for shareholders, and nonprofit sector boards often extend community involvement and advocacy to include strategic oversight. This can challenge board members to examine their role with an integrative focus on stewardship, decision-making processes, and standards of conduct [5].

Leadership is particularly important to creating an ethical culture, as a 2003 study showed. Staff in organizations who perceived leaders to be committed to ethical behavior reported having seen unethical conduct only 15% of the time, while a 56% rate of misconduct was observed by the staff of organizations whose leaders were perceived to not be committed to infusing ethics into the organization [16,17].

Provider and employee selection

Given the overriding importance of the human element, it is critical that organizations recruit, select, orient, and educate competent and ethical staff. The best way to ensure ethical behavior is to hire the right people. Ideally this should include ethics testing, in the form of a preemployment decision tree, as part of the hiring process. To support ethical behavior, organizations should have a ''Code of Ethics,'' periodic educational workshops, and policies that encourage the reporting and discussion of ethical concerns. This focus makes long-term outcomes better, and enforcement much easier [10].

Recruitment and orientation are the first opportunity for the organization to provide ethics education, and a brief overview of ethical issues and appropriate responses will introduce topics and promote awareness. This early introduction to the organization's ethics can provide a chance to determine if a potential new staff member is a good ''fit'' into the organization's culture. Culture has a unique relationship to ethics. Culture not only benefits from, it is dependent upon, an ethical management and staff [5,10].

Staff education

In the final analysis, the organization's ethical performance is the sum of collective individual behavior. Ethical behavior begins with education. A foundation in formal bioethics education is essential for those leading the program and providing education or consultation. Ethics education must be ongoing, inclusive, integrated, and organized to avoid fragmentation [14].

Organizations have an obligation to teach ethics to staff and associates at the outset of employment, and on an ongoing basis. Educational organizations in health care have a special obligation to select students who could be predicted to model ethical behavior, and to provide students with the foundation for future study in ethics. Unfortunately, there is currently little research on the reliability and validity of measuring moral reasoning on admission to professional schools in relation to creating ethical providers [18].

This leaves the option of providing effective ethics training during the professional educational process, be it schools of medicine, nursing, or allied health, and any associated internship or residency training. Providers are taught to recognize ethical dilemmas; possess the relevant knowledge of norms, laws, and policies; analyze the situation at hand; and demonstrate the skills to negotiate it. In the clinical education phase, evaluation of ethical performance is also possible.

Content for continuing education in ethics can be based on staff and organizational needs. Values identification is often a good way to start. Explaining the differences in values and ethical approaches, and recognizing the relationship between behaviors and values provides a solid foundation for subsequent training [14,19].

A review of ethics vocabulary is also a good early step to facilitate common understanding. Rights, duties, integrity, humility, kindness, compassion, generosity, community, informed consent, confidentiality, surrogacy, and competency are some examples of words useful in ethics dialog. Particular attention to law, cultural diversity, and gender will ensure a comprehensive educational plan. Topics of importance may include research, financial practices, marketing, and conflict of interest, in addition to clinical topics related to the services offered by the facility, including end of life, treatment refusal, pain management, transplants, and human diversity [14]. Sometimes overlooked is the reality that creating an ethical learning environment, and appropriate role modeling, is critical to the process of educating staff. If this is not done, given the subject matter, all other efforts will be wasted [18].

Ethical decision making/performance

With proper leadership, education of staff, and the development of policies, organizations are positioned to make ethical decisions. This is enhanced by recognition of a formal organizational decision-making processes.

Ethical decision making requires a reliable ethical identification and resolution process. Identification has three steps: recognition of the relevant aspects of the problem, designation of the root problem, and estimation of the cause-and-effect relationships. Resolution also has three steps: clarification of options, determination of the best solution, and implementation of the decision [5].

Ethical behavior entails the development of standards of conduct that will enhance performance improvement throughout the organization. These standards should lead to best practices as benchmarks for ethical behavior at all levels of the organization (Box 3).

Box 3. Ethical Standards of Conflict [5]

Ethics of stewardship
- Developing a virtuous organization that enhances its mission
- Pursuing fiscal responsibility for the community

Ethical decision-making processes
- Identification of the ethical aspects of the problem
- Resolution of the ethical problem

Ethical behavior
- Standards of conduct
- Best practices for ethical behavior

Ethics consultation/committees

Organizations should be prepared to provide consultative services in ethics. Ethics consultation should be assigned to a person or group, such as an ethics committee, with demonstrated competency and skill in this area. Skills required of individuals doing this work are assessment, process, and interpersonal relations.

Traditionally, owing to the emphasis on problem solving in specific clinical cases, the primary focus for ethical issues within health care organizations has been the ethics committee. Whereas the ethics committee absolutely should not be the extent of any organization's efforts in ethics, it is an essential part of any health care organization. Unfortunately, the ethics activities of many organizations are limited to the "institutional ethics committee." Although institutional ethics committees may be responsible for many aspects of the organizational ethics plan, in many institutions the only high-profile activity remains the discussion and disposition of specific individual clinical cases referred to it. This is rarely possible in emergency medicine. A more current, expanded role of clinical ethics consultants and committees should be to move beyond specific "crisis" cases and into a proactive role, attempting to influence the organizational culture to prevent ethical mistakes or misconduct [20].

Depending on the size and mission of the organization, it may also be necessary to constitute a separate conflict of interest committee or subcommittee to supplement the activity of the ethics committee in the area of organizational ethics. In analyzing conflicts of interest, the committee structure should develop and follow clear written policies for oversight and management of all areas of potential institutional conflict. In the case of a service provider, this committee or subcommittee should include both internal and external representatives, and in the case of a membership society, it should include both staff and members, to minimize any potential for subconscious internal bias. Finally, the committee should be charged with pursuing educational efforts to acquaint all staff, members, or other individuals interacting with the organization with the ubiquitous nature of organizational conflicts and strategies for managing these conflicts or minimizing their risk [20].

Ethical issues in health care and emergency medicine

Health care organizations encounter a number of key ethical issues on a regular basis. A study of 4000 nurses identified more than 40 specific types of lapses or potential lapses in organizational ethics [21]. A high level of concern was also found in a nationwide survey of 1500 physician leaders who felt that unethical practices were impacting US health care [22]. A list of representative lapses identified in these surveys is shown in Box 4.

Box 4. Health care organization ethical issues [21,22]

- Organizational economic constraints limiting provision of the highest quality care
- Failure to provide service of a quality consistent with highest professional ethics
- Preferential treatment of persons seen as influential (patients, providers, others)
- Discriminatory treatment of persons
- Employment of incompetent or impaired providers
- Failure to provide honest information about the organization's capabilities to patients or referring providers
- Making disparaging remarks about competitors
- Conflicts of interest: financial, gifts, anti-trust, other
- Willful inaccuracy of records or reports: clinical, financial, billing
- Failure to identify and meet community needs in development of services

Conflicts of interest are a major issue in organizational ethics, and should be addressed in detailed policies that are monitored and enforced in an ongoing way. It is common for the emphasis of these policies to be on discouraging or preventing individuals in decision-making roles to make decisions that could benefit them financially in personal investments or payments, possibly at the expense of the organization. While important, this focus is narrow-minded and misses the point of organizational ethics. Conflicts of interest also include situations in which behavior may provide a direct benefit to the organization, with or without an indirect benefit to the persons exhibiting the unethical behavior.

Examples of such behavior might be a decision to cut staffing to a level at which the quality of care is arguably affected, or encouraging systematic upcoding of bills. This behavior may be intended to increase the profitability of the organization. Those responsible for this decision might benefit from the increased profit in the form of bonuses, raises, promotions, or job stability. In many cases a financial benefit may extend to physicians or others who are actually providing the clinical services. Of course, the potential for this sort of potential conflict of interest is inherent in all management decisions, even in public or charitable settings. It is therefore critical for managers in health care organizations to recognize this conflict, and ensure that all decisions are driven first by the values of the organization, and then by financial or other goals.

Another common example in health care organizations involves research, and much work has been done in this area [23]. Many academic

medical institutions are centered around a research enterprise, and research success translates into grants and funding that often constitute the majority of the organization's budget. The prestige associated with organizational research success translates into increased clinical referrals and patient volume. Individual job security in the form of academic promotions and tenure are usually directly linked to scientific publications and research as well. The sources of financial conflicts of interest are shown in Box 5.

In the absence of strong institutional ethics, a number of incentives exist for systematic research misconduct. The need to enroll large numbers of patients in clinical trials to achieve statistical significance could encourage the enrollment of subjects who may not be good candidates for the study. Proprietary funding sources for pharmaceuticals and medical devices may encourage the design of studies biased to show positive results from their application. Even in the case of governmental or other nonproprietary funding, researchers may be under tremendous pressure to "publish or perish." The phenomenon of publication bias favoring studies that show positive results could therefore encourage data interpretation that results in more ambitious conclusions.

As in other areas, it is essential that organizations participating in research have well-defined policies and procedures to protect patients and the public against potential or real conflicts of interest. Starting with enrollment of subjects, the consent process must clearly acknowledge the ways in which the institution might profit from positive results. When there are potentially direct investment conflicts, the most stringent approach is to preclude the research from occurring at the organization at all, just as an individual researcher would be prohibited from it. Clear firewalls must be established between decision-making committees responsible for investment, technology transfer, and research [23].

Organizational ethics in the emergency care organization that conducts clinical research dictates that the organization do so in a way that protects the rights of subjects, and that the organizational incentives are such that the results published are accurate and unbiased. Particularly challenging to emergency medicine organizations is the concept of informed consent,

Box 5. Potential organizational research financial conflicts of interest [23]

- Royalties from the sale of investigational product
- Any equity interest in a nonpublic sponsor of the research
- Significant ownership or interest in a publicly traded sponsor
- Individuals in the organization have significant financial interest in the sponsor

as much resuscitation research requires waiver of consent by the community or other surrogates for individual patients. Such substitute consent requires the most rigorous possible application of ethical principles in all phases of the design and conduct of experiments [24,25].

Organizations must have policies and audit procedures to ensure that research data are reported accurately. Ethical organizations should create promotions and tenure decisions that reward researchers who conduct studies that are well designed, analyzed, and presented, even if they do not yield positive results and are not published. In creating a culture valuing science over publication, they can promote ethical research behavior while continuing to foster new advances in patient care.

Privacy and confidentiality have been significant ethical tenets since the time of Hippocrates, and are no less so today. Moral codes and legal requirements, most recently HIPPA, require practitioners to guard patient privacy and confidentiality. The practice of emergency medicine, from prehospital locations to the crowded emergency department, presents unique challenges to patient privacy and confidentiality [26].

Patient information on "status boards" in public view, open bays, multipatient treatment areas, and constant traffic in the ED all contribute to the problem. The physical barriers within the ED can be particularly problematic when patients need treatment for conditions that are embarrassing to them, and may not have anywhere else to go for treatment. Similarly, minors may seek care in the ED to avoid telling their parents about their health problem. In all of these cases, the patient is at the mercy of the ED providers [26].

Health care organizations can and should seek to maximize privacy and confidentially within the context of providing high-quality care in the ED. The JCAHO 2003 standards include requirements that organizations implement policies and procedures, physical barriers, and other measures, with particular attention toward the ED and patients informed of these policies on arrival [26].

Respecting both spirituality and individual religious beliefs is an issue for all health care organizations, but can be a particular challenge in emergency medicine. In an emergency, patients may not be able to choose the hospital they are taken to. This could result in a patient being at a facility with a religious sponsor they are not comfortable with, or a nondenominational facility with less emphasis on religious and spiritual support than the hospital of choice [27].

Patient safety is another area that benefits from organizational ethics, by promotion of quality care that results from a dedication to shared mission. Systems should be geared to prevent, detect, and minimize hazards and the likelihood of error affecting care. This safety culture must be a part of all clinical organizations [5].

When patient safety efforts fail, medical errors occur. Communication of medical errors is sometimes considered another ethical dilemma, but in cases where the error is clear, they should not be. Proactive truth telling is another

mark of an ethical organization. Informing patients of medical errors is a clear manifestation of this policy and behavior [28]. These policies have the benefit of allowing for timely and appropriate treatment to correct problems, prevents patients from unnecessary worry, and protects the patient's rights.

Palliative care is another issue that has generated concerns. In our culture, acceptance of death outside of the hospital is often difficult. This results in patients being brought to the emergency department with terminal illnesses in the last days of life. Organizations should ensure that these patients receive palliative care, including adequate pain relief, irrespective of any other concerns. At the same time, no religions or philosophies have ethical precepts that require the provision of futile care. Performance of diagnostic tests or treatments that will not lead to improved comfort or extend life in a manner consistent with the patient's wishes are arguably unethical. Organizations should therefore have clear policies in regard to palliative care, particularly when death is imminent [29].

Physician partnerships with nonphysician health care organizations continue to be a challenge to these organizations. No single model has yet emerged as reliably successful. The pressures of cost containment, declining reimbursements, and evolving needs continue to frustrate the success of these arrangements. Organizational ethics should encourage both sides to initiate due diligence that engages the threefold matrix of stewardship, ethical decision making, and ethical conduct. This behavior should occur as a result of shared mission and desire to improve the delivery of quality patient care. This is generally accomplished when all physicians are clear decision makers in all of the organization's decisions and policies that can affect patient care.

All too often, current models of partnerships encounter difficulties because of their primary focus on legal or financial arrangements in which one partner trumps others in power or prominence, whereas organizational ethics locates fiscal responsibility within the context of a broader mission of stewardship and integrity. A sense of stewardship can enable a partnership to emerge that gives primacy to quality patient care rather than falling into the zero-sum game of economic self-interest. Standards should encourage improved clinical services, increased physician fulfillment, and progressive organizational performance. Over the long term, this should be done by building and maintaining relationships that are based on honesty and trust [5].

Emergency organizations and providers face these and many more ethical challenges, and should have clear policies on how they will be addressed. For organizations developing these policies, reviewing the policies of professional organizations, such as the American College of Emergency Physicians (ACEP), can be illustrative and helpful (Appendix 1) [30,31].

Regardless of the issue, the development and implementation of an organizational ethics program should enhance service excellence both in establishing proper standards of conduct and in fostering best practices. If

a culture of stewardship is fostered, there is a clear benefit to provider and patient satisfaction that will improve the organization's overall performance [5,32].

Case studies in organizational ethics in health care

The M.D. Anderson Cancer Center began a core-values project that was neither on the goals outlined by management theory nor cognizant of the pitfalls that might befall such a project in an academic medical center. At the outset, it was determined that a decades-old code of ethics, while updated regularly and used in teaching, was not used in day-to-day decision making or even in ethics consultation. At the conclusion of the project, the Clinical Ethics Committee came to view the Center as a moral community distinguished from other hospitals by the value placed on its core missions.

The M.D. Anderson project began with a Core Values Task Force, with 5 of 12 slots being held by past or current members of the Clinical Ethics Committee. Other members represented administration, public affairs, human resources, academic affairs, and faculty. First, the Task Force reviewed both the literature on core values and the existing individual documents. They then interviewed past and present leaders, particularly those with a reputation for moral or dedicated service. Those interviewed were asked to identify the core values of the institution, and their responses where correlated into a frequency table used to rank and then distill them into the final list.

The five prior organizational documents were consolidated into a Mission, Vision, and Values Statement. Focus groups chosen to represent a cross-section of employees and patients were gathered to review the drafts, looking for words or phrases that might not communicate what was intended. After several drafts, and 9 months, during which the documents were simplified, the Task Force moved into the implementation phase.

In the introduction phase of implementation, the process hit a roadblock that, based on the literature, should not have been unexpected. Although physicians had been involved throughout the process, when implementation was discussed with physician leadership groups, significant skepticism was expressed. Faculty were concerned that the values would be used to impinge upon their academic freedom. They objected to having their evaluations based on values in addition to their own professional competencies. This required that values be omitted from faculty evaluations except for teaching purposes.

After the physician delay of nearly a year, implementation began simultaneously on several fronts. Potential employees were made aware of the values so they could determine whether the job fit their goals. New employees were trained in the values, and all nonphysician employees where

evaluated by them. Values are used to design institutional policies, processes, and systems. They have become the cornerstone of strategic planning and decision making at the institution [13].

Other published case studies involving clinical organizations include Montefiore Medical Center [33] and HCA Health Care Corporation [34]. These successful examples of integrating ethics into organizational programs are including situations where the organization may have been challenged initially [33,34]. In the case of HCA, the organization is sufficiently large enough to publish high-quality booklets on "Code of Conduct" for all employees and providers, and a "Leader's Handbook" for organizational leaders, clinical and nonclinical, as an enhancement to the program.

Nonclinical organizations need to set ethical tones as well. In medicine, the role of specialty societies and associations is particularly important in modeling and promoting ethical behavior by staff and members. For example, the ACEP has a comprehensive ethics strategy that incorporates a number of concepts.

The recognized specialty society for US emergency medicine, the ACEP has a comprehensive organizational ethics plan for its members and staff. First, ACEP has mission, vision, and values statements that define what the organization does, including why and how [31]. These documents provide the framework for all other policies of the organization, both internal and external.

A centerpiece of ACEP's values-based policies is a policy for members, the "Code of Ethics for Emergency Physicians," which is displayed as Appendix 1 [30]. By acceptance of membership, members are bound to the Code of Ethics for Emergency Physicians. In it, ACEP outlines principles of ethics for emergency physicians, while providing an overview of ethics in emergency medicine and a compendium of policies that offer guidance in common situations that could challenge members. As a proactive measure, The Principles of Ethics for Emergency Physicians are 10 fundamental obligations that should be embraced by all emergency physicians (Box 6).

Member governance processes are intended to be transparent and open to the greatest extent practicable for a large organization.

Concerning it's actions as an association, ACEP has voluntarily adopted Sarbanes-Oxley auditing standards, and has a values- and vision-driven strategic planning process that determines organizational priorities and creates the organizational budget. Human resources policies and procedures emphasize fairness and due process, and management practices are designed to infuse values and a sense of contribution to the mission into every staff member.

Medical societies have a responsibility to motivate members to adherence to the ethical norms of the organization. To accomplish this end, ACEP has a number of policies that are designed to encourage ethical behavior by its members. Expert witness policies are one example of how organizational

Box 6. Principles of Ethics for Emergency Physicians [30]

The basic professional obligation of beneficent service to humanity is expressed in various physicians' oaths. In addition to this general obligation, emergency physicians assume more specific ethical obligations that arise out of the special features of emergency medical practice. The principles listed below express fundamental moral responsibilities of emergency physicians.

Emergency physicians shall:

1. Embrace patient welfare as their primary professional responsibility.
2. Respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
3. Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
4. Communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
5. Respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law.
6. Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired, incompetent, or who engage in fraud or deception.
7. Work cooperatively with others who care for, and about, emergency patients.
8. Engage in continuing study to maintain the knowledge and skills necessary to provide high-quality care for emergency patients.
9. Act as responsible stewards of the health care resources entrusted to them.
10. Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

values and ethics influence the members and potentially the environment in which they are implemented.

Specialty society guidelines on the behavior of expert witnesses, such as the policy of the ACEP, should guide member behavior, and when violated, are a common source of ethics complaints [35]. Given the conflict of interest that is inherent in providing testimony for a fee, and evidence that the source of the case influences the opinion, it is critical that organizations model and enforce ethical behavior in this area. Fortunately, the ability for medical organizations to do so was recently upheld in the landmark case of *Austin v. American Association of Neurological Surgeons (AANS)*. In this case, the AANS suspended the membership of a neurosurgeon whom it determined to have given testimony that was not supported by the medical literature. A lower court found in favor of the AANS, and the verdict was upheld on appeal to the US Court of Appeals for the Seventh Circuit. While Dr Austin had maintained that the AANS was exacting "revenge" on him for testifying against another member, in an attempt to discourage members from testifying on behalf of plaintiffs, the courts found that the policies of the AANS merely encouraged telling the truth [36]. The ACEP policy is similar, and serves as one example of how organizational ethics can simultaneously influence events outside of the organization, and the behavior of its members.

Summary

The development and implementation of an organizational ethics program can benefit emergency medicine organizations, including hospital emergency departments, emergency medicine groups, and entities providing business or professional support to the practice of emergency medicine, or advocacy on behalf of emergency patients. While the frequently complex matrix of responsibilities to multiple organizations can complicate this task, the benefits of navigating the challenges far outweigh the costs. In addition, the professional imperative to do so is compelling, and should be embraced by all emergency care providers, particularly emergency physicians.

Organizational ethics is a relatively new, and rapidly developing area within health care ethics. Given the unique challenges of emergency medicine in providing care to "patients without choices," and within the context of multiple organizations, it is also an area of ethics in which emergency physicians should chart a clear leadership role.

Appendix 1. ACEP Code of Ethics for Emergency Physicians?

I. Principles of Ethics for Emergency Physicians
II. Ethics in Emergency Medicine: An Overview

A. Ethical Foundations of Emergency Medicine

1. Moral pluralism
2. Unique duties of emergency physicians

B. The Emergency Physician-Patient Relationship

1. Beneficence
2. Respect for patient autonomy
3. Fairness
4. Respect for privacy
5. Nonmaleficence
6. Patient's responsibilities

C. The Emergency Physician's Relations with Other Professionals

1. Relationships with other physicians
2. Relationships with nurses and paramedical personnel
3. Impaired or incompetent physicians
4. Relationships with business and administration
5. Relationships with trainees
6. Relationships with the legal system as expert witness
7. Relationships with the research community

D. The Emergency Physician's Relationships with Society

1. The emergency physician and society
2. Resource allocation and health care access: problems of justice
3. Central tenets of the emergency physician's relationship with society:
   a. Access to emergency medical care is a fundamental right
   b. Adequate inhospital and outpatient resources must be available to guard patients' interests
   c. Emergency physicians should promote cost effectiveness without compromising quality
   d. The duty to respond to out-of-hospital emergencies and disasters
   e. The duty to oppose violence
   f. The duty to promote the public health

III. A Compendium of ACEP Policy Statements on Ethical Issues (Approved 1997; Revised 2000; Revised 2001; Revised 2002; Revised 2004)

A. ACEP Business Arrangements
B. Advertising and Publicity of Emergency Medical Care
C. Agreements Restricting the Practice of Emergency Medicine
D. Alcohol Abuse and Motor Vehicle Safety

E. Animal Use in Research
F. Antitrust
G. Appropriate Interhospital Patient Transfer
H. Collective Bargaining, Work Stoppages, and Slowdowns
I. College Board Member and Officer Expert Testimony
J. Conflict of Interest
K. Delivery of Care to Undocumented Persons
L. Disclosure of Medical Errors
M. Discontinuing Resuscitation in the Out-of-Hospital Setting
N. "Do Not Attempt Resuscitation" (DNAR) in the Out-of-Hospital Setting
O. Emergency Physician Contractual Relationships
P. Emergency Physician Rights and Responsibilities
Q. Emergency Physician Stewardship of Finite Resources
R. Emergency Physicians' Patient Care Responsibilities Outside of the Emergency Department
S. Ethical Issues of Resuscitation
T. Expert Witness Guidelines for the Specialty of Emergency Medicine
U. Filming in the Emergency Department
V. Financial Conflicts of Interest in Biomedical Research
W. Gifts to Emergency Physicians from the Biomedical Industry
X. Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients
Y. Law Enforcement Information Gathering in the Emergency Department
Z. Managed Care and Emergency Medical Ethics
AA. Mandatory Reporting of Domestic Violence to Law Enforcement and Clinical Justice Agencies
BB. Nonbeneficial ("Futile") Emergency Medical Interventions
CC. Patient Confidentiality
DD. Positive Promotions
EE. Responsibilities of Acute Care Hospitals to the Community
FF. Universal Health Care Coverage
GG. Use of Patient Restraints

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