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The Park Ridge Center

Bulletin



Organizational
Ethics

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The Poison Doctor Tests the Limits of "Professional Courtesy," Pg. 6

Issue Number Three
FEBRUARY/
MARCH
1998

The Organizational Ethics Dilemma

By Philip J. Boyle

Because the study of organizational ethics is in its infancy compared to other areas of healthcare ethics, discussions about it often seem like hot air with no palpable payoff.

The term "organizational ethics" might even strike people as sleep inducing, elusive, and potentially incoherent. If the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) did not require that healthcare institutions address "organizational ethics," it is unlikely that healthcare professionals would care. This issue of the *Bulletin* enters the discussion without a unified theory or a story about the exact payoff for exploring organizational ethics — except that others might avoid the obstacles that the Park Ridge Center's project on the topic has encountered, and by doing so advance the discussion.

Our project's chief frustration has been to identify and describe the moral characters and dilemmas in organizational ethics. When healthcare ethics began some thirty years ago, people interested in the issues could follow the lead of Marlin Perkins of TV's *Animal Kingdom* fame — they could simply observe healthcare workers in their natural habitats, witnessing first hand the obstacles to informed consent, termination of treatment, and allocation of resources. In contrast, those who want to understand and address organizational ethics are quickly hampered in attempts to scrutinize or define the landscape. Unlike the doctor-patient relationship of traditional bioethics, it has no one focal point (the entire

interesting because it is as much about the failures of organizations as it is a mystery thriller. But our use of the Swango case raises a reasonable question: If the ethical problems in organizations have such potentially serious outcomes, why have the issues not been seen and discussed before? They have, but not as organizational problems. While conflicts in organizational ethics rarely result in such deadly consequences as Swango's deeds, they are publicized, for example, in coverage of some tragic healthcare utilization management decisions (especially denial of services). Beyond organizational decisions that contribute to bad patient outcomes, organizational ethics issues surface in other ways: in conflicts over human relations in areas such as hiring, promotion, and employee termination; in the lack of checks and balances that result in abuse of employees' discretionary power, for example, when people in organizations substitute their mission for the organization's mission.

To complicate our story on organizational ethics, our research project and this *Bulletin* add another layer of questions: What moral problems, if any, are unique or different for faith-based organizations? In our Media Rx column we examine one case in which press coverage of faith-based health care reports a classic religious tension between the gospel and wealth. In that column we consider whether the *Wall Street Journal* report on the Daughters of Charity National Health System

" . . . many of the ethical issues in organizations will be 'hidden in the woodwork,' refractory to moral analysis, exciting to explore because they are so fresh in the ethics conversation and have such potentially significant consequences."

organization needs scrutiny, which complicates any study). Once anyone starts observing an organization, additional obstacles and questions arise. For example, what counts as a problem or dilemma in organizational ethics? How can these problems be distinguished, if at all, from other areas of applied ethics including bioethics, business ethics, and professional ethics? Does it make any sense to speak of the moral responsibility of an organization when it is individuals or groups who make choices and act? And, what benefits are likely to flow from scrutinizing the underbelly of an organization?

To tell this story in all its complexity, the *Bulletin* has chosen a most unlikely focus: the case of Michael Swango, physician allegedly turned killer. The choice is odd because most organizational ethics issues do not result in such obvious lethal outcomes, but this case is

is overly simplistic, and suggest what a public conversation needs to address. Our "Connect the dots" column, which reviews notable articles on organizational ethics, also considers how the religious perspective adds to moral analysis of organizations.

The public conversation about organizational ethics is intensifying. The research that is emerging from our own project suggests that many of the ethical issues in organizations will be "hidden in the woodwork," refractory to moral analysis, exciting to explore because they are so fresh in the ethics conversation and have such potentially significant consequences. We hope that this issue will stir your moral imagination and motivate you to share your perspectives with us.



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Bulletin

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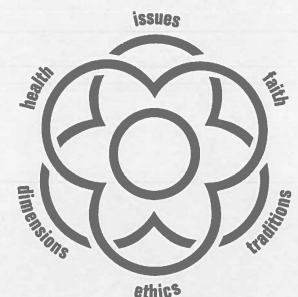
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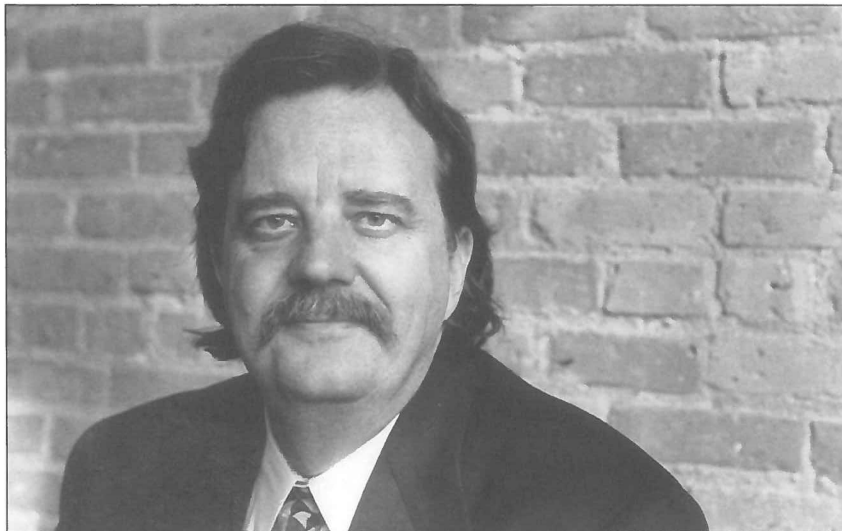
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The Park Ridge Center's six-foil portrays the unending and many faceted interaction which takes place among three major areas of human endeavor: health, faith and ethics.

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People's Theologian Joins Center Staff



John J. (Jack) Shea

Photo by Jean Clough

"My interest has always been in how people integrate their deeper beliefs and values into their work and personal lives" says John J. (Jack) Shea, religious scholar, teacher and writer, who joins the Center staff this year as the Advocate Health Care Senior Scholar-in-Residence. Shea, who also serves as a research professor for the Institute of Pastoral Studies at Chicago's Loyola University, has been hard at work on *Advocate 2000*, a ground-breaking project which will shape the future of Advocate Health Care.

"*Advocate 2000* is an attempt to formulate the faith-based, values-driven nature of Advocate Health Care," says Shea, "and to implement these values throughout the Advocate system." A 200-site, not-for-profit healthcare provider network including eight hospitals and more than 3,800 physicians, Advocate was formed in the recent merger of hospitals and sites of care affiliated with the United Church of Christ, the Evangelical Lutheran Church in America, or no religious body at all. The *Advocate 2000* team has been concentrating on a qualitative study of how faith and values work together in the day-to-day operations of Advocate Health Care.

Shea has also been involved in the Center's *Retrieving Spiritual Traditions* project, which brings the resources of major world religious traditions to bear on questions of aging in long-term care facilities. "My on-going concern is how professionals develop spir-

itually as they engage in the complex tasks of assisting people in their struggles for health," Shea says.

John Shea is the author of the recently published *Gospel Light: Jesus' Stories for Spiritual Consciousness*, and other books, including the well-known *Stories of God* and *Stories of Faith*, and numerous articles. He has taught theology at Mundelein Seminary, the University of Notre Dame, Loyola University, and Boston College.

RECENT GRANTS

The Fetzer Institute of Kalamazoo, Michigan will fund **Spiritual Interventions and Health Outcomes**, a Park Ridge Center research initiative. The project aims to refine our understanding of spirituality and spiritual interventions as they relate to health outcomes. The project's long-term goal is the development of measurement tools to demonstrate the effect of spirituality on health.



Home and Community-Based Services for Elders: An Ethics Resource for Healthcare Providers is being funded by the **Retirement Research Foundation of Chicago**. The Park Ridge Center project aims to improve the ability of professional and paraprofessional healthcare providers to address ethical problems that arise in home and community health care.



THE PARK RIDGE CENTER

The Park Ridge Center will hold a series of intensive courses on a variety of topics in the bioethics field:

July 20-24	Clinical Healthcare Ethics	Chicago
	Starting and Sustaining Ethics Mechanisms in Healthcare Institutions	
October 12-16	Clinical Healthcare Ethics	Naples, FL
	Starting and Sustaining Ethics Mechanisms in Healthcare Institutions	
October 16-17	Theological Reflection in Faith-Based Healthcare Institutions (With Jack Shea)	Chicago
October 23-24	Health Care as a Spiritual Path (With Jack Shea)	Chicago
October 26-30	Organizational Ethics	Chicago
November 9-11	Sexual Issues in the Clinic: Ethical and Religious Challenges	Chicago
December 4,5,6	Ethical Issues in Long-Term Care	Chicago

For more information contact Bernice Chantos at The Park Ridge Center:
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Deciding When to Speak Up

How to Influence the Ethical Use of Management Power

It has been a trying year for the five nursing homes in the extended-care division of Engulf Health Care. Engulf has brought in a management team to restructure, lay off last-hired employees, and set up new policies and procedures.

“We promise to perform some action that will guard the secret — to keep silent at least, and perhaps to do more.”

Steve, a member of the management team, approaches Bob, the division's chaplain, and reports that a number of positions will be eliminated. The division CEO, a hard-driving businesswoman, has assigned responsibility for the downsizing to Steve, who fears news about layoffs will harm employee morale and lower residents' quality of care. Trust between employees and the organization is already shaky. After criticizing management for greed and insensitivity, Steve tells Bob their conversation is confidential.

This is a bad situation that could get worse. Upset, Bob wants to tell the division CEO that staff morale is suffering and employees should be told about the upcoming layoffs. Moreover, Bob wants to address the residents' anxieties. As chair of the extended care division's ethics committee, Bob considers bringing the matter up in that forum but is afraid of violating confidentiality.

Health care has always been a business, involving at a fundamental level the exchange of money for goods and services. The era of managed care has brought about a wave of mergers and restructurings and heightened the concern over conflicts between patients' welfare and the business side of health care.

Maintaining staff morale — and quality patient care — amid change is a challenge for managers. The Engulf Health Care scenario raises several ethical concerns in the chaplain's relationship with the CEO, his colleague Steve, and his obligations to

his fellow employees and to the residents. Trust and confidentiality, in this setting, compete against the company's financial health, the employees' well-being, and the residents' quality of care.

The chaplain, Bob, is troubled by the staff's anxieties and their distrust of the organization's leadership. He is worried that employees will feel

betrayal, anger, and resentment when the news breaks. He does not like how Engulf is handling the business.

It is easy to understand Bob's distrust and his own instinct for self-preservation. At cost-cutting time, pastoral care programs are not immune. At the same time, Bob takes his responsibility as a pastoral care provider seriously. His religious tradition values the pastor's prophetic role. Perhaps Steve saw him as an advocate who could speak for those

“With a sound and sensitive plan in place — kept informed of developments and reasonably notified of upcoming cuts — employees could come to understand that the necessary downsizing will be handled as fairly as possible.”

less powerful. As chaplain, what are Bob's responsibilities to the organization, its employees, and the people whom they serve?

A competing claim is Bob's need to respect his co-worker's confidence. According to philosopher Sissela Bok in her 1982 book, *Secrets*, the pledge of secrecy alters our freedom of action. We promise to perform some action that will guard the secret — to keep silent at least, and perhaps to do more. While his co-worker's comments were not made in the context of the confessional, Bob nonetheless feels an obligation to sustain his promise to him. But, by faithfulness to the one, does he sacrifice the good of the many?

By Edwin R. DuBose

In nursing literature, Bob's dilemma is known as “moral distress,” namely the powerlessness felt by those forced to adopt courses of action with which they are not entirely comfortable. If Bob approaches the CEO, he perhaps risks acting without full knowledge of the situation, and he would clearly violate the confidentiality of his talk with Steve. If he doesn't speak with the CEO, he is perhaps perpetuating a style of management-employee relations characterized by distrust and poor morale. Is there an option between violation of confidence and submission?

Bob considers approaching the CEO to comment only on his perceptions of morale. In this context, the CEO might even mention the layoffs. But would this strategy be duplicitous, fostering the very distrust and deception that Bob wants to dispel?

The attitudes of managers and clergy often seem diametrically opposed. In a 1988 study by Walter Benjamin of clergy/business executive relations, a pastor says: “Business has no moral vision. It is not interested in

the common good. It wants only to maximize profit, destroy the power of labor, and dehumanize its workers.” To this pastor, the dominant business virtue is greed. On the other hand, a CEO reported that “my clergyman doesn't understand the world of trade-offs. There is no ‘free lunch.’” From the business side of the picture, when there is no (profit) margin, in time there will be no mission.

Business ethics and healthcare ethics are not necessarily incompatible. The question is how fiscal efficiency and responsibility (and profit) can be accomplished in a spirit that will make for the best outcome

— continued on Pg.15



What's in a Name?

Are They the Daughters of Charity (or Currency)?

A recent article in The Wall Street Journal on the Daughters of Charity, founded by St. Vincent DePaul in 1633 to minister to the poor, reports that the order is now being dubbed "the Daughters of Currency." According to the article, the Daughters, who each live on \$40 per month, back a nation-wide system of 49 hospitals with a \$2 billion investment fund. But hospitals, says the article "are playing second fiddle to the sisters' investments." Sister Irene Kraus, former president of the Daughters of Charity National Health System, is quoted delivering what purports to be the order's motto: "No margin, no mission."

The WSJ piece raises some interesting questions between the lines. Though the article focuses narrowly on the Daughters of Charity, it also touches on an issue that is central to the healthcare debate that currently rages in this country, the notion that it is somehow morally suspect for hospitals and other healthcare providers to make money, to be, in other words, businesses.

The article is somewhat selective in its use of facts, providing examples of financial acumen on the Daughters' part, augmented by quotes from people who feel the sisters have fallen short in their charitable mission by being too concerned about that "black bottomline." A cursory overview of the WSJ article on the Daughters could easily result in the inference that the order has made growing its portfolio at least as high a priority as providing healthcare services to the poor. The article states that, in fact, many Daughters of Charity hospitals are in affluent suburban areas. The Daughters have divested 11 money-losing hospitals in the past five years, in at least one case leaving a community without Catholic in-patient care. And they treat fewer Medicaid patients than the national average (6 to 8% v. 14%). The WSJ article

points out that the Daughters of Charity today derive most of their income from their portfolio, as opposed to hospital operations.

In fairness, the article also reveals that the Daughters spend 86 cents out of every dollar in earnings on charity care and community work. Their Providence Hospital in Washington, D.C., which serves mostly black and Hispanic patients, gives five free admissions each month to Health Care for the Homeless, a local non-profit.

"Public skepticism about profit in health care is strong and probably based on the idea that it is wrong to benefit from the suffering of another. And rightly or wrongly, the public believes that the path to profit is paved by denying access to services and procedures."

But is it enough? The perception created by the article is that the Daughters' financial acumen is coming under growing fire, that what Sister Carol Keehan, who runs Providence Hospital, calls the "clinking cash register" in her brain dominates the other side that asks "what's the right thing to do?"

Public skepticism about profit in health care is strong and probably based on the idea that it is wrong to benefit from the suffering of another. And rightly or wrongly, the public

"The key question here is, does the money support the mission? Or is the reverse now true?"

believes that the path to profit is paved by denying access to services and procedures. But is that really what the Daughters of Charity have done?

Historically, the Daughters of Charity are noted for adhering to St. Vincent's legacy of responsible stewardship. According to WSJ, they were among the first to create bold financing projects much like today's man-

aged-care contracts. And they continue to think of themselves as missionaries who do good by doing well.

To find out more about how the Daughters of Charity go about pursuing their mission in the 20th century, we contacted Monsignor Charles Fahey, who serves on the Daughters of Charity National Health System board, and asked him about some of the things reported in the WSJ article. Monsignor Fahey told us that the closed Daughters' hospitals have been in "over-bedded communities." He

pointed out that where the Daughters have closed hospitals, they have substituted outpatient healthcare services needed by the community "to strengthen local systems by taking the redundancy out of them."

Fahey also took issue with the article's emphasis on the size and strength of the Daughters' portfolio. "None of this money is owned by the Daughters of Charity," Fahey asserts. "They can't care for old nuns or put in stained glass windows with this money. It exists to back up health care."

So is the Daughters' belief in "no margin, no mission" a statement of greed? Or is it actually a commitment to surviving in the real world? The key question is, does the money support the mission? Or is the reverse now true?

No margin, no mission. True enough. But how is that margin produced? And how does it affect the mission? Of course it's possible that too much attention to the margin could result in no mission after all. But for today, all we can say for certain is that, without that dollar in profit, the Daughters of Charity wouldn't have 86 cents to take care of the poor.



THE POISON DOCTOR TESTS THE LIMITS OF "PROFESSIONAL COURTESY"

Dr. Michael Swango, also known as "the poison doctor," is believed to be one of the most prolific serial killers in American history.

Michael Swango's story is unique in the annals of serial murderers because he often found his victims in their hospital beds, where he came to them dressed in a white coat, disguised as one who would give them care. Though he had served nearly two years in prison for poisoning, Swango was licensed to practice medicine. Despite the trail of violence he left in his wake, no hospital was willing to participate in a thoroughgoing investigation of his activities. The number of Swango's alleged victims is astonishing, but equally surprising is the number of hospital administrators and doctors who entrusted the care of patients to a convicted felon, and who, thereby, allowed him to continue his killing spree.

Of course Swango, as an alleged serial killer, is an anomaly. But isn't it also true that some of those whose job it was to ensure the safety of patients demonstrated negligence?

The article below is excerpted from The New Yorker magazine (November 24, 1997) article by James B. Stewart. Stewart will publish a full treatment of the case in book form next year. We have selected a section of The New Yorker article that details matters of most concern to us, as medical ethicists. It relates primarily to events that took place prior to Dr. Swango's 1985 conviction, when he was a medical resi-

dent at Ohio State University Hospitals.

Following the excerpt from The New Yorker are three opinions, from PRC staff member Philip J. Boyle, who writes from the bioethics perspective; from Ralph Muller of the University of Chicago Hospitals and Health System, who writes as the chief executive of a major healthcare provider; and from Dr. Joan Lang, director of residency training at the University of Texas Medical Branch, who writes both as a psychiatrist and as one responsible for evaluating the backgrounds and performance of resident physicians.

Our three respondents will try to answer some of the nagging questions raised by this sensational case: What should have been done by medical professionals, both administrators and clinicians, to stop Michael Swango? What are the moral obligations in a case like this, and who bears them? Does the fear of litigation on the part of healthcare providers release them from responsibility as moral agents? Our respondents take on these questions, in the hope that the case of Michael Swango is the last of its kind.

We invite our readers to address these questions as well. We welcome your cases for inclusion in a book PRC staff is preparing on organizational ethics to be published by the American Hospital Association. And we welcome your letters on the Swango case and our respondents' opinions, as well as your views on how to provide quality health care within an ethical organization.

PROFESSIONAL COURTESY

BY JAMES B. STEWART

Professional Courtesy (an excerpt from The New Yorker, November 24, 1997)

Edward Morgan, in the course of his investigation..., learned that during the week after Mrs. Cooper's mysterious respiratory arrest the Ohio State University hospitals held three meetings to review Dr. Swango's performance and the Cooper case. The ad-hoc inquiry group included several administrators and doctors, the hospital's lawyer, and an assistant Ohio attorney general assigned to the university, but only one nurse — Jan Dickson, a supervisory nurse, who had demanded the review. One of the physicians, Michael Whitcomb, the hospital's medical director, was assigned the task of reviewing the information, and told the group that he believed that Mrs. Cooper, far from being injected with an anesthetic or poison, had suffered a grand-mal seizure and had been paralyzed immediately afterward. However, a later

internal report by the hospital revealed that had the group spoken with a trained anesthesiologist or toxicologist its members would have learned that Mrs. Cooper's symptoms were consistent with the injection of either curare or anectine into her I.V.

Swango was asked by three doctors if he had injected anything into Mrs. Cooper's I.V. He said no, but offered a different explanation to each of them. To one he said that he was never in Mrs. Cooper's room; to another he said that he entered her room at either her or her roommate's request to retrieve some slippers; and to the third he said that he had entered the room to draw blood. He was never asked about these inconsistencies. Nor did anyone ask about the empty syringe that the nurses had preserved after Mrs. Cooper's respiratory failure. About six months later, the head nurse threw the syringe away. "No one ever collected it from me," she later told university-police inves-

tigators, "and I asked somebody, 'Do you think it's O.K.?' They said, 'Well, sure, it's gone now. It's over with.' So I threw it away."

Morgan was nearly beside himself on learning about the loss of such crucial physical evidence. "It was incredibly frustrating," he told me recently. "If we had been contacted at the time, there was a lot of evidence that would have been available. Instead, the evidence had disappeared." He was astounded, he later noted in his report, that the members of the hospital group investigating Swango "failed to call the actual witnesses before them for statements," and "did not interview any of the nurses, [Mrs. Cooper], her roommate, or Dr. Swango." Morgan recently told me, "I can only arrive at one conclusion — they didn't want to know. They just wanted him out of the hospital."

Legal issues appear to have figured prominently in the group's discussions. Dr. Whitcomb later said, "...we pre-



sented the information we had to the lawyer who was providing us advice. Based on the information that was available, it was his opinion that there were no grounds for us to take any action against Dr. Swango and that there was no other investigation that needed to be carried forward." But when the lawyer was asked by Morgan about that advice, he insisted that it was the doctors who, after hearing the report by Dr. Whitcomb, "indicated there would be no further in-house investigation or further inquiry." In any event, on February 14th, the ad-hoc inquiry group concluded that Dr. Swango should be permitted to return to patient care immediately, but with greater supervision.

When Mrs. Cooper was released from the hospital, the discharge summary on her chart contained a suggestion that her suspicions about someone's tampering with her I.V. was a paranoid delusion.

Ohio State did not renew Swango's appointment for the following year, notifying him of the fact in a letter that gave no reason for the decision, but Dr. Jerry Carey, the chair-

man of the department of surgery, recommended that Swango be licensed to practice medicine in the state of Ohio that March, albeit with "reservations." When the State Medical Board asked for details, Dr. Carey focused on Swango's general performance as an intern. He mentioned the investigation but said that Swango had been "exonerated." Ohio state doctors subsequently recommended that he be licensed to practice medicine in Illinois. When Dr. Carey was later questioned at the behest of Quincy authorities about Dr. Swango's background, he again said only that Swango had been accused of tampering with a

patient's I.V. but had been completely cleared of any wrongdoing. Morgan and the police officials spent ...months investigating Swango. "We were in over our heads," Morgan told me. "Your usual prosecutor is comparable with weapons, guns, beatings. But when it comes to poison we need professional help..." The professional help that Morgan said he needed was not forthcoming from the university hospitals. Morgan said that from a law-enforcement perspective

afterward asked him to delete the names of the patients and the doctors and hospital officials involved. The doctors and administrators of the university hospitals "greatly resent the intrusion of law enforcement in their affairs," Morgan told me. "From Day One, they resented us. They never truly cooperated, or it was grudging cooperation, it was on the surface. ...It's all done under the rubric of patient care. They said, 'We can't have police running around the hospital. It would upset the patients.' ...They were petrified of lawsuits." Morgan reluctantly concluded that he could not prosecute Dr. Swango without at least some corroborating physical evidence, such as syringes, blood tests, or hair samples, but none of these had been retained by the hospitals. "The circumstantial evidence was not enough," Morgan said. His anger at the Ohio State doctors and administrators still audible in his voice, he told me, "They covered it up, that's what it was."

Robert Holder, a lawyer for Ohio State who participated in the Swango inquiry at the time, strongly denies that. "Naturally, our review was criticized by others after the fact," he said. But "you don't come to a meeting thinking someone is a complicated psychopathic killer." Emphasizing that no one knew then of any blemish on Swango's character, he said, "This complaint was taken very seriously and was considered by a distinguished group" that "did a more extensive review than my subsequent experiences tells me that a lot of places would do." He added that "the con-

"When Mrs. Cooper was released from the hospital, the discharge summary on her chart contained a suggestion that her suspicions about someone's tampering with her I.V. was a paranoid delusion."

the hospitals' internal investigation was shockingly inadequate, and stated in his report that doctors, administrators, and lawyers appeared to coordinate their responses to his investigation, closely monitoring its progress. Morgan's boss, the Franklin County Prosecutor, requested that he submit a statement of his report to the president of Ohio State University and

cern of the group at the time was to be even-handed," and denied that potential liability was a factor. Still, he acknowledged that "we could have done better — there's no doubt about that. If we had some of the evidence that was later produced, this would have been an easy decision." He said that the university has since taken steps to improve relations between

the police and the hospitals.

...[In the fall of 1991], Dr. Anthony Salem, the head of the residents' program at the University of South Dakota, in Sioux Falls, had received a letter from an applicant living in Virginia. The applicant seemed to have a solid academic record: he'd completed a distinguished internship at Ohio State, and he'd devoted himself to emergency medicine as a paramedic. But he had not practiced as a doctor for some time, and there was a gap in his resume; he indicated that he'd been convicted of battery after an incident "unrelated to medicine."

...A series of letters ensued. Dr. Salem sent Swango an application and, mystified by the ...unexplained legal trouble, subsequently invited him for a personal interview. Like so many people who have met Swango, Dr. Salem was immediately taken with the earnest young man. Swango was also remarkably forthcoming about his past legal trouble, telling Dr. Salem that he had been charged with and convicted of poisoning his fellow-paramedics in Quincy. He even disclosed that in the past he had lied about his conviction, describing it as arising out of a barroom brawl, but had now concluded that it was better to be honest about it. He maintained that he was innocent of the charges, that he had been convicted on the basis of flawed evidence from a discredited crime lab, and that he had expected to be exonerated on appeal but the appeals court had looked only at procedural issues, and that the whole thing had been a gross miscarriage of justice. "He was very convincing," Dr. Salem said. "I wasn't experienced in dealing with people with this sort of record. I didn't even think about calling the prosecuting attorney, or the parole officer, or getting the records. I thought he had got a bad deal."

Still, Salem would not admit medical students who couldn't be qualified to practice in the state, and he assumed that a felony conviction was such a disqualification. But Swango explained that South Dakota was one of a "handful" of states in which, if a doctor showed that he'd "turned his life around," he could be licensed to

practice medicine.

Dr. Salem, who is also in charge of accrediting physicians hired at the local veterans' hospital for the university, told me that Swango was subjected to a lengthy hiring process. He was interviewed by other doctors in the internal-medicine department, and they found him acceptable. Salem obtained Swango's medical-school records, and they proved to be positive except for the problem with the OB/GYN course. He then called the State Medical Board of Ohio, and it reported that Swango's license had been suspended. Salem was not surprised, since Swango had already told him that his licenses had been suspended in Ohio and Illinois as a result of his conviction. The Federation of State Medical Boards told Dr. Salem that Dr. Swango had experienced "problems." Dr. Salem assumed that that, too, referred to the conviction.

Dr. Salem had his secretary write to Ohio State University to request verification of Swango's records, and in reply he received a letter saying that both Swango and the University of South Dakota would first have to sign a number of legal waivers. "I thought this was strange," Dr. Salem recalled. "But I didn't even know who our lawyers were. I didn't know whom to contact. We've never had to deal with lawyers." In any event, he thought he knew what Ohio State was talking about — the same "problems" that the medical boards had mentioned, which he'd already learned of from Swango himself. So Dr. Salem put the letter in Swango's file and forgot about it. Anyway, Michael Swango had begun his residency a few weeks earlier. "He did fine," Dr. Salem recalled. "He was very popular with the staff. He worked hard. He was ingratiating, nice, intelligent."

...[Last] September, Swango was arraigned in federal district court on Long Island. He pleaded not guilty, and he remains in custody at the Metropolitan Detention Center. He has refused my requests for an interview. Meanwhile, the F.B.I. and the United States Attorney's office continue to search for evidence to elevate the current charges against him. (In

particular, they are hoping that he kept a journal.) To the single charge of misrepresentation, they recently added five counts of gaining possession of controlled substances — hospital medications — by means of deception. Swango's trial is scheduled to begin on January 5th. The V.A. hospital on Long Island has reopened its investigation. Despite the earlier finding that no patient had been harmed by Swango, an investigator there now says, "We just don't know. Clearly, he was doing his thing."

RESPONSE

By Philip Boyle
The Park Ridge Center

ORGANIZATIONAL TEFLON: MAKING SURE THE CASE DOESN'T STICK

At first glance, Michael Swango's case may look more like a healthcare provider turned serial killer than a problem in organizational ethics. It's easy to interpret the moral story as one man's malevolence toward his patients and co-workers, not bureaucratic bumbling. Further moral analysis might seem pointless, in part because other moral issues are oblique and difficult to identify — there are many moral actors (doctors, nurses, administrators, and lawyers) and choices. Compared to poisoning and murder, other moral issues in this story seem like peccadilloes, hardly deserving serious critical attention and unrelated to the tragic outcomes.

The tragic events in the Swango case may well be extreme but they are as much the consequence of organizational failure as they are the actions of a deranged individual.

The New Yorker report captures the context of social interactions, most of them predictable and seemingly benign, that set the stage for Swango's misdeeds.

In fact, James Stewart's article highlights many of the problems of organizational ethics. First everyday mistake: fear of litigation becomes the excuse for inaction. Appropriately

“The tragic events in the Swango case may well be extreme but they are as much the consequence of organizational failure as they are the actions of a deranged individual.”

placed decision makers in the organization had enough evidence to move against Swango, but believed that legal *inaction* was the prudent course. While many organizational ethics problems do not have such untoward results, that this case had gotten to the brink of criminal investigation should have suggested to organization leaders that alternative grounds for action were mandated. Instead, after the internal investigation, two other suspicious but less well-documented incidents occurred and the chairman of the department nonetheless recommended that Swango be licensed to practice medicine in Ohio.

Second everyday mistake: subtle obstruction. The physicians and administrators resented the checks and balances provided by law enforcement, and they told investigators what they thought the investigators wanted to hear. Passive opposition and misleading information became deadly obstruction. An all too common problem of organizational ethics is the lack, evasion, or even obstruction of checks and balances. The division of labor required in complex organizations and the professional discretion afforded healthcare workers requires all organizations to have checks and balances. The internal professional regulation that served as the checks and balances in this case were insufficient for a complex organization; in fact the hospital group investigating Swango “failed to call the actual witnesses before them for statements.” As healthcare organizations rapidly transform into even more complex sets of interactions, professional oversight will offer only one part of the needed checks and balances.

Third commonplace mistake: moral blindness. One physician who reviewed the case stated, “You don’t come to a meeting thinking someone is a complicated psychopathic killer.” Is this evidence of the personal trait of always wanting to presume the best about people? Is it a professional cour-

tesy of expected reciprocity among professionals? Or, is it an understandable desire to avoid negative publicity for the organization? Certainly the simplest explanation of this blindness is to place the responsibility on the moral weakness of individuals or on the common practice of protection professionals afford each other. Yet about this blindness an investigator stated: “I can only arrive at one conclusion—they didn’t want to know. They just wanted him out of the hospital.” Pinning the blindness on the organization seems futile, except that it has a greater responsibility. Organizations gain their advantage by a division of labor. Dispersion and coordination of work characterize bureaucratic organization. By necessity, organizations must have oversight and be vigilant, especially where patient welfare is at stake.

It would be easy to miss the organizational ethics problems in this case. Those other than Swango could be exonerated; there was little or nothing they could do from their distance, and why should they be held responsible for the aggregation of infractions committed by a deranged individual? But organizational distance among moral actors and choices and a non-stick moral responsibility approach are features of organizations that must be addressed if there is to be movement in organizational ethics.

RESPONSE

By Ralph Muller
President and CEO
University of Chicago
Hospitals and Health System

A HOSPITAL ADMINISTRATOR RESPONDS: YES, SWANGO COULD GO UNDETECTED

The story of Dr. Michael Swango is guaranteed to frighten the medical profession. Confronted with the facts of this case, those of us who work in hospitals are forced, at a minimum, to acknowledge that a determined and clever psychopath could harm our

patients before being detected.

According to James Stewart, Michael Swango is a calculated killer who entered several medical training programs before anyone sounded an alarm at the terrorist in their midst. Journalist Stewart labels Swango’s allegedly murderous course through American medicine “professional courtesy,” which suggests that hospitals and doctors grant a kind of latitude to fellow physicians that in turn yields this situation. Is there a defect in the medical profes-

“A large hospital treating seriously ill patients with life-threatening illnesses may have at least one death every day. Quality of care reviews are rarely able to pinpoint the exact cause.”

sion that allows a Swango to operate unchecked?

Stewart’s article suggests that only a considerable defect in the medical profession’s ability to screen for and eliminate deviants could account for Swango’s ability to escape detection. At any rate, reading Stewart’s article, it’s easy to arrive at that conclusion. To more fully comprehend the facts requires an understanding of the nature and circumstances of the *medical* errors that occur in hospitals. Infrequently, bad things happen to patients even when excellent care is provided. Problems also occur when there are accidental deviations from the standard of care that cause significant harm, e.g., when a patient is administered a drug to which he is allergic. More alarming is when negligence is not accidental but occurs because the physician or nurse is impaired, e.g., under the influence of alcohol or drugs. Still worse, and fortunately quite rare, is the situation in which a physician or nurse intentionally harms patients.

True, hospitals have systems to deter errors and negligence. Over the





last decade, continuous quality improvement processes, reviews by the Joint Commission on Accreditation of Healthcare Organizations and government regulators, as well as malpractice legislation,

have improved the quality of patient care and overall medical outcomes. These processes for measuring outcomes should capture any significant variances from the standard of care. But a further complication occurs when a patient has the kind of critical illness that frequently results in death. A large hospital treating seriously ill patients with life-threatening illnesses may have at least one death every day. Quality of care reviews are rarely able to pinpoint the exact cause.

Suspicious behavior may be the only clue to hospital staffers that a killer could be in their midst. A medical setting provides many opportunities to disguise behavior that might appear very suspicious under the circumstances of a normal business. Therefore, it's not completely surprising that it was only at Swango's third medical training program that his supervisors dismissed him and warned other medical schools of his background.

Clearly, hospitals and medical schools need to cooperate more fully in sharing information about deviant and negligent physicians. But we should be careful not to expect immediate improvements in detection of Swango-like conduct. We must continue to improve the ways in which patient outcomes are measured and share that information with the public. These improvements represent an opportunity for greater public understanding of the variation in medical care that does exist in this country. For now, we need to rely on vigilant staff and courageous behavior to catch a Swango. All of us in hospitals are indebted to the few decisive individuals in New York and Illinois who stood up and identified Swango.



RESPONSE

By Dr. Joan Lang
Professor and Director of Residency
Training, Department of Psychiatry
University of Texas Medical Branch

SWANGO: THE VIEW FROM THE COUCH

From the point of view of a psychiatrist, Michael Swango's story could serve as a textbook illustration of a psychopath or sociopath, in current terminology (The Diagnostic and Statistic Manual of Mental Disorders of the American Psychiatric Association), Antisocial Personality Disorder, or ASPD. Such individuals are characterized by displaying a pervasive pattern of disregard for and violation of the rights of others, failing to conform to social norms, deceitfulness, reckless disregard for safety of self or others, consistent irresponsibility, and lack of remorse. Often their own self appraisal is arrogant and inflated. Yet, most amazingly, despite this list of unlikeable character traits, individuals with ASPD may be charming

ing that Dr. Alan Miller, the psychiatry department's residency training director who hired him at Stonybrook, was a former New York State mental-hygiene commissioner who is still described by the dean who reluctantly accepted his resignation over this affair as "experienced and highly respected...a trainer of young people." Dr. Miller acknowledges responsibility for having apparently succumbed to Swango's "singularly persuasive [manner] at his personal interview." Yet, says Dean Cohen: "There would have been no way a skillful psychiatrist would detect any deviant behavior or lack of truthfulness. Any of us would be taken in, given how charming and bright and effective he was."

I do not agree that this complicated story supports the conclusion that "some physicians seem willing to take the word of almost any doctor rather than accept the rulings of the courts." Rather the problem seems to be one of getting the "ruling of the court" into the public record in such a form as to be unalterable by the smooth explanations, forgeries, or obscurities that a Swango can introduce.

Certainly a national data bank that tracks convictions, together with-

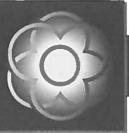
"I do not agree that this complicated story supports the conclusion that 'some physicians seem willing to take the word of almost any doctor rather than accept the rulings of the courts.'"

(if glib). It is remarkably easy to be seduced by the seeming sincerity and engaging charm of the sociopath.

Speaking as a training director who screens applications and interviews applicants, I fervently hope that I would have spotted the holes in such a young man's resume, looked beyond his charm and the superficial plausibility of his explanations, investigated thoroughly to get the entire and true picture of his convictions, heard directly from colleagues at his various institutions of the "between-the-lines" suspicions that they might not dare commit to writing, and had the correct instinct to refuse him. Yet I cannot help but be sobered by learn-

appropriate incentives to check it, will help. So too would providing state licensing boards with greater license to refuse credentials when the record is troubled to the extent that Swango's was. Perhaps the lesson for those who must screen applications is that no document submitted by any applicant can be fully trusted. In a world where anyone has access to xerox, laser printer, and fine paper, the most convincing forgeries can be easily generated. And one's own instincts for sizing up another and detecting honesty, one's own sense of fair play, can fall victim to psychopathy.





The American Way of Death: Gallup Poll Results

By Laurence J. O'Connell

After several decades of bearing witness to the indignities sometimes associated with high-tech death, Americans have begun to insist that dying is more than a clinical event. "The American people want to reclaim and reassert the spiritual dimensions of dying," said George H. Gallup, Jr., chairman of the George H. Gallup International Institute, of his organization's recent national survey, *Spiritual Beliefs and the Dying Process*. The Park Ridge Center hosted the first of three national gatherings to discuss key findings of the survey, which was commissioned by the Nathan Cummings Foundation and the Fetzer Institute.

The survey, based on telephone interviews with 1200 adults 18 and older, explored three clusters of attitudes and behaviors: 1) how people find comfort in their dying days; 2) things that worry people when they think about their own death; and 3) how people plan for disability or death, including the possibility of physician-assisted suicide. The study also considered factors that might account for variations in these attitudes and behaviors, namely, life situations, demographic characteristics, and spiritual beliefs.

The survey emphasized the importance of human contact as a source of both spiritual and emotional support at the time of death. People look to family (81%) or close friends (61%) to provide this support. A minority of Americans sees the clergy as capable of providing broad spiritual support. Only 36% believe members of the

"Americans split down the middle on the question of whether they can envision a situation in which they would request physician-assisted suicide for themselves."

clergy could effectively comfort them. This statistic gives credibility to a recent statement by Charles Halpern, president of the Nathan Cummings Foundation: "Seminaries and major religious groups need to acknowledge the needs of the dying, and then find

ways to devote more theological and practical training to spiritual needs at the end of life."

George Gallup, during his visit to the Center, was even more direct. The survey, he said, "is a wake-up call for the clergy."

The Gallup study listed 24 different matters that might worry respondents as they think about their own deaths. Although medical concerns—such as suffering great pain or living in a vegetative state—are prominent among all age groups, specifically spiritual concerns were most pronounced among younger adults. For example, 72% of the 18 to 24 year-olds worried about not being forgiven by God, and 63% of them feared

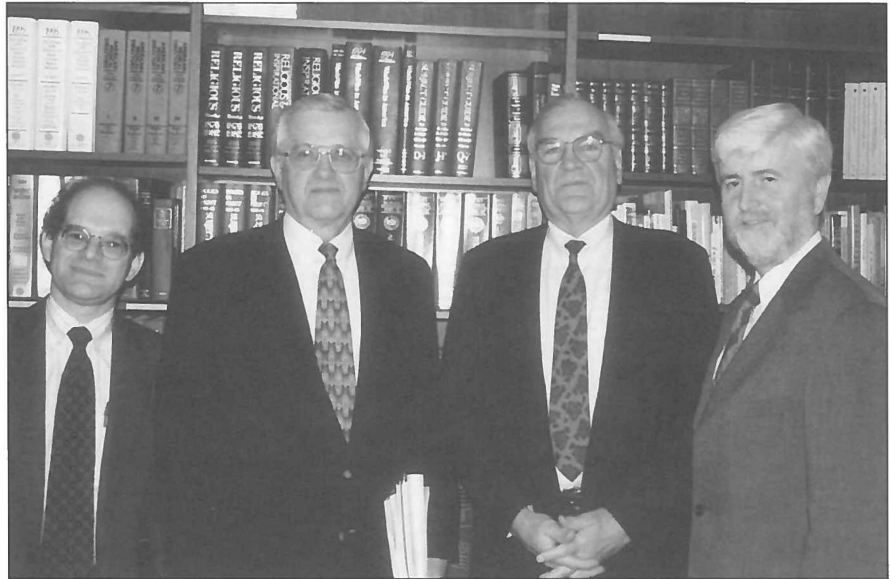
dying cut off from God or a higher power. One might surmise that younger people are still struggling with the shape of their personal spirituality and thus feel less confident about facing ultimate questions.

The question of physician-assist-

ed suicide continues to elicit divided opinions. For example, 33% support making it legal under a wide variety of conditions, while 32% support making it legal in a few cases and 31% oppose making it legal for any reason. Minorities and those over 55 are more likely to oppose physician-assisted suicide. Those who identify closely with a particular faith are most likely to oppose it.

But Americans split down the middle on the question of whether they can envision a situation in which they would request physician-assisted suicide for themselves. Fifty percent said they would, and 47% said they would not. Younger people were more likely to support physician-assisted suicide and to see it as a personal option.

When asked if they would consider very painful treatment if given a 50/50 chance of survival, a majority of Americans said they would opt for the treatment. When the odds became one in four, 70% chose easing pain rather than extending life. One might expect those with the strongest religious faith to be more willing to accept death. But those who said that their religious faith was the most important thing in their lives and that

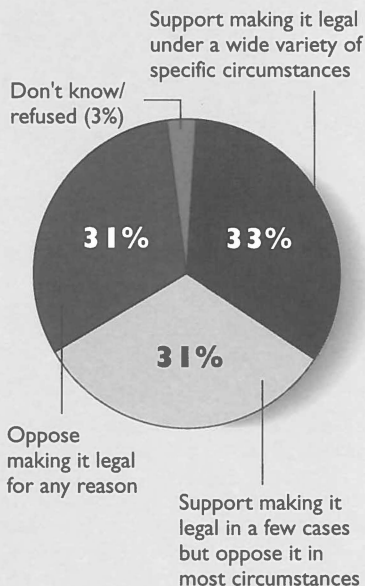


From left to right: Robert N. Mayer of the Nathan Cummings Foundation; Charles Willis of the Fetzer Institute; George Gallup Jr.; and Laurence J. O'Connell of the Park Ridge Center.



PHYSICIAN-ASSISTED SUICIDE

Americans are divided on the question of physician-assisted suicide. Minorities and those over 55 are more likely to oppose physician-assisted suicide.



their lives belonged to God were more likely to choose extending them, even at the cost of significant pain and with greatly reduced odds. Does religious faith somehow engender a deeper appreciation of life's value? Does it sometimes bestow a sense of stewardship that celebrates the preciousness of every moment of life no matter how diminished or painful?

Only 28% of Americans have signed any type of legal document that either appoints someone to make medical decisions for them or describes the type of care they would want. Those most likely to have signed such documents are the elderly (40% of those over 65), college graduates (36%), and the widowed (50%). And of those who have signed such documents, 82% have told a family member, but only 15% have informed a lawyer or medical professional.

This national survey comes at a time when the public and the media seem more receptive than ever to frank discussion of the way we die in America. The findings deserve wide dissemination and serious attention.



GALLUP CONCLUSIONS

George Gallup, Jr. concluded his remarks at the Park Ridge Center by underscoring the strong messages the survey carries for those who bear special responsibility for shepherding the dying process:

■ **THE CLERGY:** The survey is a wake up call for the clergy. Not many see the clergy as capable of providing broad spiritual support.

■ **THE FAMILY:** Throughout the study, the family emerged as a central source of comfort and support. This suggests a strong need, in turn, to support the family. Hospice care is one important means of supporting the family.

■ **YOUNG ADULTS:** The survey uncovers a strong need among younger people to understand what lies ahead. The level and breadth of the concern young people expressed about death calls for a response from those who care about and work with them.

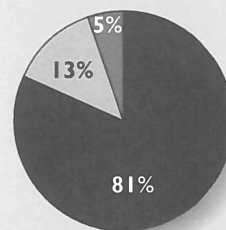
■ **THE MEDICAL PROFESSION:** The study suggests that medical education should prepare physicians to engage the human, spiritual dimensions of the dying process as well as its clinical realities; and, overall, to understand and integrate the spiritual beliefs that so often guide their patients.

WHO WOULD BE COMFORTING?

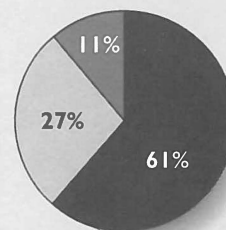
The Gallup survey found that the vast majority of respondents want to be comforted at the end of life by the presence of family or close friends. Only 36 percent chose a member of the clergy.

How many ways? ■ Many ■ Some ■ Very few, if any

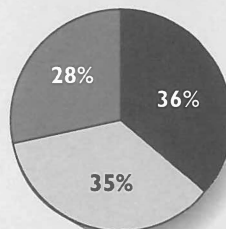
A MEMBER OF YOUR FAMILY



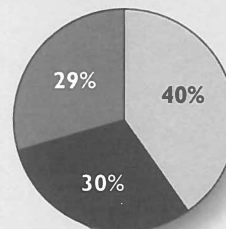
A CLOSE FRIEND



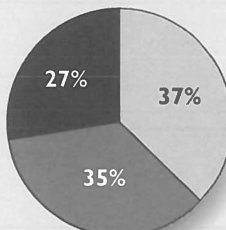
A MEMBER OF THE CLERGY



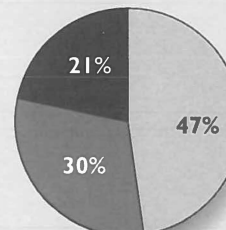
A DOCTOR



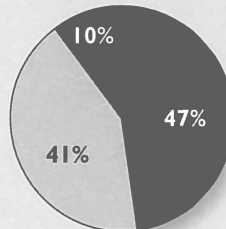
A LAY PERSON WITH RELIGIOUS EXPERIENCE



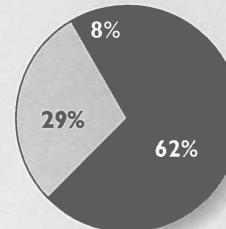
A NURSE



A HOSPITAL VOLUNTEER



A COUNSELOR OR SOCIAL WORKER



The Humanities and Health, Faith, and Ethics

By Martin E. Marty

(Editor's note: A recent reception at the Center celebrated the awarding by the White House of the National Humanities Medal [see the Bulletin for Nov/Dec 1997] to Martin E. Marty. As the George B. Caldwell senior scholar-in-residence at a center for the study of "health, faith, and ethics," Marty talked about the humanities, and its connection with the faith and health themes. The following is a condensed version of his remarks.)

When the U.S. Congress set up the National Endowment for the Humanities it listed the disciplines that make up the humanities. The legislators named all the familiar list-leaders such as literature, history, and philosophy. But they also included "comparative" religion and ethics, precisely the disciplines that, from day one, this Center has set out to relate to all aspects of health. So there should be no need to justify or explain the connections.

Still, more citizens recognize the arts — also honored with a National Medal for the Arts — than the humanities. In describing what the humanities do, as set forth by the National Humanities Commission of which I was privileged to be a part, we can make the connections to health themes more obvious and clear.

When the Center was founded, I began to get invitations to speak regularly on "medical ethics." I turned them down, explaining that I was "neither medical nor ethical." (That sounds a bit lighthearted, but, then, President Clinton's citation mentioned that I was "playful," so playful we must be.) I meant that I had no formal disciplinary training in medicine or ethics. So what was I doing here at such a center?

The answer becomes clear to anyone who watches our staff and consultants in action. We are "doing" the humanities every day, which means we are humanists. Some religious people dismiss humanists as being secular and godless. Not at all. Philosopher Ernest Gellner explains the confusion of terms. The term "humanist," according to Gellner, survives from the days when a con-

"Whenever sacred literature is read to a sick person in order to promote well-being . . . we are putting the humanities to work or, better in this context, into play."



Martin E. Marty

The humanities mirror our own image and our image of the world. Through the humanities we reflect on the fundamental question, what does it mean to be human? The humanities offer clues but never a complete answer. They reveal how people have tried to make moral, spiritual, and intellectual sense of a world in which irrationality, despair, loneliness, and death are as conspicuous as birth, friendship, hope, and reason.

We learn how individuals or societies define the moral life and try to attain it, attempt to reconcile freedom and the responsibilities of citizenship, and express themselves artistically . . . By awakening a sense of what it might be like to be someone else or to live in another time or culture, they tell us about ourselves, stretch our imagination, and enrich our experience. They increase our distinctively human potential.

— Martin Marty

cern with mundane, "human" literature was primarily distinguished not from either illiteracy or science, but from theological, divine concerns. "But 'humanist' concerns now embrace the divine," Gellner says, adding: "Both speak the same language."

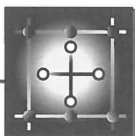
So not only is our ethics work, theological or not — but always stressing the "faith dimension" — directly a part of the humanities, but our "faith" concern itself is humanist in our many interreligious zones of inquiry. Again, however, one asks, what does all this have to do with disease and health, caring and curing, since we are not a generic humanities institute?

Whenever sacred literature is read to a sick person in order to promote well-being, whenever a story works its challenging or soothing effect, whenever what a thinker long ago called "the consolation of philosophy" is offered to help a sufferer make some sense of things, whenever someone is moved by a poem to help find worth in a day of pain, whenever exemplary lives in the fields of medical or ethical inquiry are held before us, we are putting the humanities to work or, better in this context, into play.

In my own case, when I do address what goes by the code name "medical ethics," I act as an historian, philosopher, or theologian who explores past and present in order to address, for example, what "pluralism" in our emergent culture does to moral decision-making. During my years with the Park Ridge Center, I have not known a moment when a topic at hand could not be and was not being informed by what humanists bring to the table.

It is my hope that in the years ahead the Park Ridge Center can make ever more and better contributions to "medical humanities" and parallel fields. And that I can have a part in that work, even as I am grateful to my colleagues for helping me celebrate whatever measure of achievement there has been to date. Thank you.





Organizations and Individuals Need Each Other to be Ethical

By David B. McCurdy

Articles discussed: Paul Schyve, "Patient Rights and Organization Ethics: The Joint Commission Perspective," *Bioethics Forum* 12, no. 2 (Summer 1996): 13-20; Van Rensselaer Potter, "Individuals Bear Responsibility," *Bioethics Forum* 12, no. 2 (Summer 1996): 27-28.

Do organizations have "ethics"? The question may seem to invite a cynical response, but it should be asked in good faith. "Organizational ethics" is not only the ethical buzzword of the '90s, it has also begun to infuse healthcare organizations. The term covers a wide area: the conduct of business affairs; decision-making processes; actual and potential conflicts of interest; appropriate use and allocation of financial and technological resources; human resource questions; and the relation of the organization's actual activities to its stated mission and values.

Proponents of organizational ethics contend that an organization's ethical responsibilities differ in kind from the responsibilities of individuals who work for it or those (such as trustees or non-employed physicians) who are associated with it. Paul Schyve's article emphasizes the responsibility of the organization as a whole for its ethical behavior.

"ORGANIZATION ETHICS": THE JOINT COMMISSION

Schyve, an executive of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), sketches the development of JCAHO standards for "organization ethics." Schyve offers a helpful Cook's tour of the "expanding paradigm" of healthcare ethics. The paradigm's foundation is each practitioner's obligation to the patient, a focus that dominates healthcare ethics from the time of Hippocrates until today. Only recently has a second "source of obligation" arisen with the growing recognition that patients have "rights" in their relationships with healthcare providers. The dual recognition of professionals' obligations and patients' rights fostered a dawning

awareness in Joint Commission statements and standards of the 1970s that organizations had "an obligation to respect patients' rights" (or, perhaps better, to act to support respect for patients' rights).

Schyve does not naively suppose that any structural "fix" will prove a panacea for organizations' ethical challenges. Every "mechanism" for healthcare delivery has its downside; for example, if 1990s managed care promotes "underutilization" of services, the older fee-for-service medicine sponsored "overutilization." On the other hand, simply locating organizational ethics in "the personal ethics of each practitioner and administrator" leaves too much to the vicissitudes of individual character. Organizations have no real choice: they must respond to new ethical challenges.

In line with this perception, the 1995 JCAHO hospital accreditation manual added "organization ethics" standards to existing standards on

Thus, for example, an organization could publicize its "code of business ethics" and its criteria for admitting, transferring, and discharging patients. (It could even, says Schyve, "encourage patients to review their bills"!)

Schyve also outlines distinctive ethical challenges managed care organizations encounter as they respond to enormous cost-containment pressures with cost-control incentives to providers. Recent JCAHO standards have required accredited managed care organizations to "protect the integrity of clinical decision making" and make publicly available their policies on the relationship between incentives and the use of services. (New standards also require hospitals to "protect" clinical decision making against potential adverse effects of financial incentives.) Such standards are more specific than earlier ones in identifying the organizational good to be done and evil to be avoided, both administratively and clinically. In the

"JCAHO . . . standards call for a 'code' of 'ethical' behavior in each accredited organization and identify several areas of activity that the code should address."

patient rights. These standards call for a "code" of "ethical behavior" in each accredited organization and identify several areas of activity that the code should address. However, while the code of behavior should "ensure" that an organization's business and patient care are conducted in "an honest, decent, and proper manner," the burden of specifying the meaning of those terms resides with the organization.

Schyve recognizes that mere compliance with organizational ethics standards does not exhaust the organization's responsibility to make itself "accountable." Organizations should go above and beyond the letter of the law by going public: disclosing ethical risks and their possible effects on patient-customers, identifying safeguards intended to minimize such risks, and actively encouraging patients and the public to raise questions about the at-risk areas.

process they make a critical affirmation: Preserving the integrity of clinical decision making is indispensable to quality patient care.

NO SUBSTITUTE FOR INDIVIDUAL VIRTUE

The Joint Commission emphasizes the development of organizational mechanisms to address ethical problems. Van Rensselaer Potter sounds a prophetic counterpoint by stressing that, even in so-called organizational ethics, "individuals bear the responsibility." Potter, an emeritus oncology professor, is convinced that bioethics must reach into organizations, including corporations and healthcare organizations. But he takes a dim view of any assignment of moral agency and responsibility to the organization itself. Organizational "systems" and "processes," he implies, are

the product of human action, and individuals cannot take moral refuge by laying blame on non-personal systems and processes.

"Every organization . . . has goals and a 'way of doing things' that may appear to us as ethical or unethical." Nevertheless, Potter reminds us that the organization's goals and culture came from somewhere. An organization's leaders and key staff cannot avoid the burden of responsibility for the organization's actions and moral climate. They must be proactive by identifying potential ethical problems, addressing them before they arise and responding appropriately when "the organization' acts unethically."

Potter believes the morally responsible individual can be lost — or can hide — in the current focus on the organization's ethics. Individuals must, instead, speak out of "conviction as to what is right and just" and display the virtues of courage, persistence, and a readiness to speak up "at whatever cost." No organizational fatalism, Potter displays a modest faith in the ability of organizations to change course — if courageous individuals take the necessary risks to initiate the process.

The JCAHO approach, as outlined by Schyve, stresses that "mechanisms" can assure or promote ethical behavior, and implicitly recognizes that an organization can indeed support or hinder individuals in doing good and avoiding evil. Yet the existence of such mechanisms can never eliminate individuals' responsibility to be forthright, persistent, and, yes, courageous in mobilizing an organizational response when ethical concerns arise.

WHAT'S FAITH GOT TO DO WITH IT?

Judaism and Christianity both have perspectives on the question of individual versus corporate agency in organizations. Each tradition recognizes that individuals, particularly those in leadership positions, are

responsible for the moral direction of such collective bodies as the nation and the religious community, yet each tradition also holds such bodies collectively responsible for living out their faith and values.

But the question is not only about ethics but about power. Both traditions attest the experience of forces or "powers" in our common life that have a life of their own. Though humanly created, these realities seem suprahuman in their ability to influence individual and collective behavior. Today the all-consuming market economy and modern bureaucratic organizations — including healthcare

organizations — might count as such "powers."

The traditions see an invisible, "spiritual" dimension in such realities — an unseen but real force that can, for good or ill, affect the spirituality of the individuals who encounter it. Hence it is not only what is explicit, visible, and formalized in organizations that challenges us. It is the spirit of the organization — its climate or "culture," the sum total of collective attitudes and assumptions, its ways of being and doing — which any attempt at organizational ethics must also consider and address.



Common Ground

Deciding When to Speak Up

— continued from Pg. 4

possible over time for the people concerned. Healthcare ethics in its broadest sense concerns the ways that healthcare workers treat patients, families, and one another. Employees have a right to accurate and timely information about developments that affect their jobs.

The chaplain, however, needs to appreciate management's responsibilities and accountabilities. Given the need to cut costs, if other remedies have been tried and layoffs are necessary, the CEO may have understandable concerns about employee morale, a concern that employees will look for other jobs, or that productivity will decline and patient care be affected.

Bob is reluctant to take the downsizing matter before the ethics committee, which serves primarily in an educational and advisory capacity. So what can he do? His best course is to work with Steve to design an ethically sensitive plan for the layoffs. If the organization is to be guided by its mission while recognizing the need to control costs, keeping a focus on the mission could direct the CEO to treat

the employees with respect by acknowledging the tough times and enlisting their aid in finding ways to keep costs down. With a sound and sensitive plan in place — kept informed of developments and reasonably notified of upcoming cuts — employees could come to understand that the necessary downsizing will be handled as fairly as possible. A reasonable severance package and a solid outplacement program would demonstrate organizational concern. Informed of the need for cost-cutting measures, respected as members of the organization with some power to affect the course of events, employees might take a more positive approach. Combined with reassurance for residents and their families, these steps could produce the best outcome possible.

Quality patient care remains the goal. The evolution of healthcare ethics reflects the realization that achieving quality care means making ethics more than just another committee. It means that ethics in health care is fast becoming everybody's business.



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