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### e-Ethics, 2000 January

Advocate Aurora Health

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## Organization-wide Responsibility

**E**ight years ago a hospital built a new family waiting room by enlisting wide community philanthropic support from individuals and businesses. Clinical Manager X, a volunteer community leader for the campaign, overheard that, due to rapid hospital expansion, the new administration wanted to eliminate the waiting room. She approached her superiors, who confirmed this. Her superiors also requested confidentiality because administration would proceed without public announcement. Manager X is involved with church and civic groups who donated money for the room. She feels obliged to inform them, and even galvanize community protest. What are her options?

When facing clinical moral dilemmas Manager X, like most staff, turns to the ethics committees. In organizational ethics cases like this one however, staff are unsure how to voice concern. Before acting it is best to understand both the range of, and the moral responsibility for, the dilemmas. Among the issues in this case are conflict of interest, confidentiality, and promise-keeping.

We regularly balance competing interests between family and work, but rarely does meeting a professional obligation simultaneously jeopardize civic obligations. How can Manager X resolve the competing interests between obli-

**This newsletter is available on the cc:Mail system as a bulletin board called e-ethics. Watch for monthly postings.**

gations to her work and community? First, it is important to examine whether any clear moral directive informs either moral obligation. For instance, when physicians experience competing moral obligations between patients' welfare and business, they often prioritize obligations by relying on a clear professional dictum to "do no harm." Manager X has to ask herself if she made any explicit commitments in her work contract not to divulge management plans or in her volunteer fundraising to be vigilant in the stewardship of the gift that might help prioritize the competing obligations.

The issue of confidentiality is straightforward in this case—her superiors asked her to keep a confidence and it was not immediately evident that the request was an immoral one. Simple fairness ("do unto others") dictates that we keep confidences because we, in turn, want our confidences held sacred. Even if Manager X's superiors had not requested silence on the matter, her job would most

likely require prudent use of sensitive management information. From an organizational—ethics stance it is important to examine whether the organization in its job descriptions, policies, and training—explicitly reinforced its expectations about confidentiality.

Aside from the practical moral problem of alienating donors who support the mission of the hospital, what commitments has the hospital made to the donors? Moral evaluation of the hospital's promise-keeping would have to include examination of what the donors explicitly requested, what development professionals promised, and whether administration knew about its potential stewardship of the gift.

Plainly, the problems cut across the organization. Manager X's challenges include how she could be a catalyst for administration to rethink its decision. Other groups, such as administration and development, must rethink how the commitments of predecessors will be honored. As hospitals move to address organizational ethics, they must not only identify and examine the problems, but also imagine where they are best resolved, for no one locus will be sufficient.



# e-Ethics

## Must We Do Everything? Heroic Measures Reconsidered

**W**hen medical interventions were few, "doing everything" was rarely questioned. But new technologies have patients and medical professionals asking if "everything" promotes patient well-being. Medical, legal, and ethical consensus provides that competent adults may refuse treatment, and that appropriately withholding and withdrawing therapy constitutes neither homicide nor suicide. Although no ethical distinction exists between withholding and withdrawing, powerful symbolic and emotional differences may create ethical confusion.

Defining and clearly communicating goals of care remain critical to deliberation. In order to make informed choices, patients should understand the ultimate purpose of recommended treatment. Team members must comprehend treatment goals in order to recommend appropriate care (palliation, for example, rather than cure).

When genuine uncertainty exists about treatment benefit, we should err on the side of preserving life. However, it does not follow that once begun, treatment can never be withdrawn. Treatment trials should be initiated, the patient closely monitored, and benefit assessed at appropriate intervals. Implementation of treatment trials provides reassurance that physiologic data will not overshadow patient well-being.

No treatment is intrinsically "ordinary" or "extraordinary," and using such terms may confuse. "Ordinary" therapy in one setting may be "extraordinary" in another. Medical staff often use "heroic measures" to mean "low likelihood of success," but lay people frequently equate "heroic" with "lifesaving."

Rather than using vague expressions (including "doing everything," or "doing nothing"), each therapy's purpose should be discussed relative to the patient's condition. Treatment effects must be distinguished from benefits, since therapy producing physiological effects may not improve the patient's prognosis.

Determining whether treatment burdens are proportionate to benefits must include the patient perspective. "Routine" therapy (only minimally painful or intrusive) may be disproportionate to benefits if the prognosis is poor and therapy impedes other patient goals.

When it is clear that therapy is not beneficial, withdrawal is ethically permissible. However, the machinery of medicine—such as heart monitors and ventilators—provides visual symbols of "caring." When removed, the unspoken feeling may be that "Nothing is being done." Aggressive palliation, informing family about symptom management, and including them in appropriate aspects of care, can overcome unintended messages.

### Calendar of Events Jan. – Feb.

all events take place  
at the Park Ridge Center except where  
noted

#### Ethics for Lunch

Lutheran General Hospital

January 18:

Ethics and Aging

February 1:

Physician Responsibility to the  
Dying Patient

February 15:

System Wide Policies

#### Ethics for Lunch

South Suburban Hospital

January 28:

Advance Directives:

Raising the Subject

February 25:

TBA



**e-Ethics** provides discussion of important ethical issues in clinical care and organizational life. In specific cases, fuller ethical analysis may be required, in addition to consideration of hospital policy and legal standards.

**To register** or obtain more information about Park Ridge Center events, contact Bernice Chantos at (312) 266-2222 ext. 255, fax (312) 266-6086, or e-mail [bmc@prchfe.org](mailto:bmc@prchfe.org)

**To list** an event in this calendar, contact Mary Ann Clemens at ext. 240 or [mac@prchfe.org](mailto:mac@prchfe.org)





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