Whistle Blowing in Healthcare: An Organizational Failure in Ethics and Leadership

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Citation

Abstract

Ethical behavior, decision-making and leadership are becoming increasingly important in the healthcare environment where the traditional "service orientation" is being replaced by an almost exclusive "profit orientation." This fixation on the profit oriented business model has ominous implications for the ethical provision of healthcare services. Healthcare organizations have been in the process of restructuring for over a decade and practitioners, patients and society are questioning unethical practices in managed care including gag rules, lack of full disclosure and compensation plans that reward withholding of healthcare services. There has been very little information published about organizational and administrative ethics in the healthcare literature.Individuals employed by healthcare organizations have a very large diversity in moral ideology reflective of society at large. Under these circumstances it is necessary for the HCO to identify basic and common core values and beliefs. It is from this perspective that we will examine an organization's responsibility to create, define, and manage ethical behavior for the organization.Key Words: Ethics, ethical decision making, health care administration, institutional leadership, managerial ethics, organizational culture, organizational ethics, health care workers and organizational values.

INTRODUCTION

I would like to start this article by citing Ralph Nader in response to the recent deceptive and unethical accounting practices at large companies such as Enron and World Com. "What amazes me is that there were thousands of people who could have been whistle-blowers, from employees to the boards of directors to corporate insiders to the accounting firms to the lawyers working for these firms to the credit-rating agencies. All these people! Would a despotic dictatorship have been more effective in silencing them and producing the perverse incentives for them all to keep quiet? The system is so efficient that there is total silence. I mean, at least the Soviet Union had enough dissidents to fill Gulags."[1]

Nader's comparison of these organizations to a despotic dictatorial regime is quite applicable and accurate. Essentially the mentality keeping "all those people" from reporting illegal, immoral and unethical behavior is the same mentality that prevented people from speaking up as dictatorial regimes such as Nazi Germany and Soviet Russia swept across the world stage oppressing millions. "For evil to triumph it is only necessary for good men to remain silent."[2]

And so, in silence, the cancer of moral depravity eats away at corporate America. Some examples from this cancer in the healthcare industry include:

The Allegheny Health, Education and Research Foundation (AHERF) declared bankruptcy and its former CEO was sentenced to prison for using restricted assets to keep the not-for-profit organization afloat.[1]

Columbia/HCA paid more than $840 million in criminal fines and civil penalties and damages after a whistle-blower brought allegations of unlawful billing practices to the attention of the federal government.[1]

HealthSouth officers have been charged with accounting fraud and conspiracy to commit wire and securities fraud. The company agreed to pay the government $7.9 million to settle allegations of Medicare fraud. The company faces shareholder lawsuits.[1]

These examples in healthcare can be added to those from the "business world" like Enron, WorldCom and others. What is glaringly apparent is that corporate America is suffering from a "moral meltdown". Good men and women in these organizations are remaining silent in droves. Many employees have a misplaced loyalty to their organization.

They fail to see the hidden costs of their inaction and the organizations lack of reciprocal loyalty to the employee. These organizations have created an environment of fear, intimidation, punishment and retaliation so effective that it prevents almost anyone from speaking out when illegal, immoral or unethical behavior is observed in the organization. This "culture" created and fostered by these organizations is a living testimony to the failure of these organizations to provide ethical and morally responsible leadership. These organizations have lost their way.

Ethics is defined as: "A systematic process of reflection in which issues of what one morally ought to do are analyzed, decided, and evaluated through moral reasoning that encompasses, but is not limited to, ethical principles and theories."[3] Ethical behavior, decision- making and leadership are becoming increasingly important in the healthcare environment where the traditional "service orientation" is being or has been replaced by an almost exclusive "profit orientation." This fixation on the profit oriented business model has ominous implications for the ethical provision of healthcare services. "Ethical work environments are both multidimensional and multi-determined. There is variance in the ethical climate within organizations by position, tenure, and workgroup membership and significant differences both across and within firms."[4] "For employees to engage in ethical behavior, Brown (1990) proposed that conditions of power, trust, inclusion, role flexibility, and inquiry must be present."[5] "Workers should have the right to receive relevant information (inclusion), to be free to say what is needed to be said about an issue (power), and to be free to disagree with one another in order to increase their understanding of issues (trust)."[6]

Often individuals are identified as the source of ethical failure. However, one of the most important aspects of creating ethical behavior is the culture and environment of the organization in which these individuals function. "Managerial ethics assume a position of profound consequence here in the form of organizational policies and processes, culture, espoused vs. enacted values, leadership behavior, rewards and punishments, social networks, and treatment of employees."[7-15] Organizational policies and procedures dictate actions that may have ethical content.[16] Organizational cultures create in employees a perception of the levels and limits of trust and integrity, two domains nearly synonymous with ethics.[6,8,9,17-22]

Through organizational socialization, employees learn what constitutes acceptable behavior. The ethical conduct of leaders -- or lack thereof -- has a subtle but profound influence on the behaviors of all employees.[23-27]

Much of the literature on business ethics considers situations of relatively blatant and consequential misconduct, e.g. unsafe conditions for patients,[28] or retribution for whistleblowers.[29,30] In some cases, the organization may be dependent upon the wrongdoing as was the case with Columbia HCA falling into a pattern of fraudulent billing.

The most prevalent sources of ethical action, however, are the little everyday actions of managers, which though of no immediately visible consequence, build to create the ethical climate. There may be acts of commission or omission, or enactment of organizational standards that are inconsistent and place employees in a bind.[31,32]

It is from this perspective that we will examine an organizations responsibility to create, define, implement and manage ethical behavior for the organization and all employees and associates under its control. This is a leadership role that cannot be discounted or minimized if an organization is to maintain its integrity and foster a culture based on ethical behavior and moral values. This ethical behavior and values are especially critical in the healthcare environment where profit motive does not excuse illegal, immoral or unethical behavior.

CASE STUDY

In 2007, Philip Rolland, a registered pharmacist (RPh) with a bachelor's degree in pharmacy (B.S.Pharm.), a doctor of pharmacy degree (Pharm.D.) and an ASHP-Accredited Pharmacy Practice Residency was working as the Director of Pharmacy for a contract pharmacy management company at a small, rural hospital in De Soto Parish, Louisiana.

During his tenure he discovered an Interim Director of Pharmacy had documented extensive lack of compliance with the conditions of participation for Medicare and Medicaid by the previous pharmacy management company and a continued refusal by the hospital to address any of these previously identified issues in a meaningful way.

These deficiencies confirmed by the Louisiana Department of Health included: (1) The governing body did not ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted service. (2)

The Pharmacy Department did not participate in the hospital's Continuous Quality Performance Improvement program relative to pharmacy services. (3)Pharmacy services provided were not assessed to ensure the services were provided in accordance with acceptable standards of practice, (according to a service contract agreement services shall include but are not limited to: maintenance of an intravenous admixture program, participation in medication use evaluations, patient therapy reviews, and antibiotic surveys, continuous drug interaction monitoring and adverse drug reaction programs).(4) Failure to conduct annual performance evaluations related to pharmacy services provided by contract.(5) The governing body did not ensure that the services performed are provided in a safe and effective manner.(6) The hospital did not maintain a list of all contracted services, including the scope and nature of the services provided.(7) The hospital did not measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.(8) The hospital's governing body (or organized group of individuals who assume full legal authority and operating responsibility for operations of the hospital) medical staff and administrative officials responsible were not accountable for ensuring that an ongoing program for quality improvement is defined, implemented, and maintained.(9) The hospital did not have an organized nursing services that provides 24-hour nursing services. The nursing services were not provided or supervised by a registered nurse.(10) Drugs and biologicals were not prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under section 482.12(c)and accepted standards of practice.(11) There was not a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.(12) The hospital did not have pharmaceutical services that meet the needs of the patients. The institution did not have a pharmacy directed by a registered pharmacist or drug storage area under competent supervision. The medical staff did not take responsibility for developing policies and procedures that minimize drug errors. (This function may be delegated to the hospital's organized pharmaceutical service.) (13) Current and accurate records were not kept of the receipt and distribution of all scheduled drugs.(14) All compounding, packaging and dispensing of drugs and biologicals was not under the supervision of a pharmacist nor performed consistent with State and Federal laws.(15) When a pharmacist is not available, drugs and biologicals were not removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with State and Federal Law.(16) Drug administration errors, adverse drug reactions and incompatibilities were not immediately reported to the attending physician and, if appropriate, to the hospital-wide quality assurance program.[33] (Department of Health and Human Services Centers for Medicare and Medicaid Services Statement of Deficiencies Survey 02/29/08).

Philip confirmed these deficiencies and brought them to the attention of the Interim CEO/CFO (his reporting official at the hospital), the RDO (his reporting official at the management company), the medical staff of the hospital, the Chief of Staff and the Chairman of the Board of Directors for the hospital. Philip continued to document these and other deficiencies, prioritized them and created an action plan for correcting all of the identified deficiencies within a reasonable time frame. Despite his attempts to correct these deficiencies both the hospital and management company instructed him not to mention these issues again. His reporting official was changed from the CFO to the CNE and additional problems surfaced after this change was made. Philip was ordered to give the CFO and CNE a key to the pharmacy and not report missing cocaine powder discovered during a random controlled drug audit.

Additionally, Philip was informed that he was going to train a group of nurses to enter the pharmacy, compound and dispense chemotherapy medications for regularly scheduled chemotherapy patients. He was informed that this was being done in order to keep up with the demand for services and in conjunction with an anticipated $1,000,000.00 expansion in chemotherapy services for the hospital.

Philip contacted the Board of Nursing, Board of Pharmacy and Director of Regulatory Affairs for the contract pharmacy management company to determine whether the proposed training could be conducted. All three sources confirmed in writing that this activity would be outside of the scope of practice for both nursing and pharmacy and that training nurses to practice outside of their scope of practice was illegal. All three sources provided written directives citing Board of Nursing, Board of Pharmacy and Department of Health regulations and prohibitions with instructions not to proceed with the planned training.

Philip relayed this information to the CEO, CFO, CNE, DON and RDO who all insisted that, despite the written

directives to the contrary from these regulatory agencies, he would be expected to move forward with this training concurrently with the expansion in outpatient chemotherapy services.

Philip refused to participate in this training program and was terminated by the hospital and contract pharmacy management service. However, before being terminated he was severely harassed, threatened and intimidated for months. His mental health, reputation and integrity were brought into question. His character was attacked and he was isolated and humiliated. An action plan was created to correct so-called "deficiencies in performance".

After relaying information from the Board of Nursing, Board of Pharmacy and the Director of Regulatory Affairs regarding the illegal nature of the proposed activities, his performance and behavior received excessively close scrutiny and observation. This excessively close scrutiny was even to the point of being told what he could include in emails and whom he could speak with inside and outside of the organization.

He was directly ordered not to communicate with the management company's Director of Regulatory Affairs or other regulatory bodies including the DEA, Board of Nursing and Board of Pharmacy. He was even offered a severance package if he agreed not to disclose any of the activities and events that took place during his employment. After his departure, another doctoral level and residency trained pharmacy director was terminated for refusing to participate in the same programs. Prior to his tenure the facility had changed pharmacy directors a total four times within four months including his tenure as Director of Pharmacy. As of February 2008 the facility has had a total of seven changes in Director of Pharmacy within fourteen months. The previous CEO had a two-month tenure and an Interim CFO is acting as the Interim CEO and CFO.

DISCUSSION

Although there are many precedents and references for law, medicine and ethics in clinical medicine there are much fewer precedents and references for ethics in healthcare organizations and a well-documented paucity of literature on ethics in pharmacy.[34]

Despite the fact that this case study took place most specifically in the pharmacy all of the dynamics involved relate much more broadly to nursing services, hospital administration, the medical staff, the hospital's governing body and a contract pharmacy management company. For these reasons the discussion will focus on ethical implications within the organizational framework of the hospital.

In an ethically responsible healthcare organization whistleblowing would not have to occur because there would be sufficient policies and procedures in place to appropriately address legitimate concerns of hospital staff. This is a leadership responsibility of the governing board and institutional management i.e., the CEO.

A failure in ethics may underlie an organizational failure in leadership. This is an unnecessary tragedy because with minimal effort any organization can create, define, implement and maintain a coherent, intelligent, logical and ethically and morally defensible Code of Ethics. No Code could ever cover all possible scenarios. However, the overall process for identifying an ethical problem, defining the facts and issues and resolving organizational, interpersonal and professional conflicts that arise are instrumental in giving organizations ethical leadership credibility. When a system fails to adequately address legitimate employee concerns whistleblowing may occur.

Whistleblowing "refers to a warning issued by a member or former member of an organization to the public about a serious wrongdoing or danger created or concealed within the organization."[35] In this case study example the whistleblower unsuccessfully utilized all appropriate channels within the organization to correct the perceived deficiencies. This definition is in keeping with a study conducted by Sellin, 1995 on patient advocacy within organizations that distinguish whistleblowing from reporting. According to Sellin, "participants tended to view whistleblowing as an external action to an unresponsive organization and reporting as an internal process done through organizational channels."[36]

This type of action may be viewed as a "back-against-the-wall", "final-straw", "last-ditch" type of behavior where every appropriate channel for a satisfactory resolution has been exhausted and there is no choice but to appeal to an outside source for some type of resolution. In this regard, when an employee has exhausted all internal mechanisms to address the problem, whistleblowing may be considered an organizational failure in leadership since the organization failed to reach a satisfactory resolution to whatever source of conflict was present. Once again, this is an organizational failure with numerous negative consequences both within

and outside of the organization.

One author describes organizational responses that may be expected when this type of event occurs: (1) broken promises to do something about the unethical practice, (2) isolation and humiliation, (3) formation of an "anti-you" group, (4) organizational stonewalling, (5) questioning of one's mental health, (6) unusually close observations of what one does and says, (7) vindictive tactics to make one's work more difficult or insignificant, (8) talk about so-called generous severance packages, (9) assassination of one's character, (10) disciplinary action or hearings before one has had a chance to address identified concerns, (11) suspension and (12) termination.[37]

Another author includes the unfortunate and tragic experience of those who commit suicide because they tried to do what was morally right but could not survive the harassment and threats.[30] According to Fletcher "the preceding tactics and situations are the result of an organization that has profoundly lost its moral compass and has been ethically tainted to its core."[30]

There are self-evident external conflicts involved in whistleblowing because many times this event puts an organization in an adversarial position against patients, employees, regulatory agencies or accrediting bodies. However, there are internal conflicts involved as well. In reaching a decision to "cry out for help" a person must consider his own integrity, loyalty to patients and loyalty to an organization.

"Personal integrity means that one is consistently true to one's moral ideals and value system and is able to demonstrate this consistency in how one lives his daily life."[30] While loyalty means "that one is steadfast in allegiance to others and does not desert or betray others in their time of need." "Loyalty also suggests other virtues such as mutual respect, promise keeping, and the ability to keep confidences."[30]

A person who chooses to go outside of an organizational entity to effect a satisfactory resolution to ethical problems or dilemmas is keeping his personal integrity intact. If corrective measures are needed that an organization refuses to address then this person is also being loyal to both patients and the organization. He or she is in effect seeking to remedy an "internal illness" of the organization. There has been an organizational failure in ethics and leadership that may be corrected with assistance from outside the

organization.

Fletcher (1998) outlines several moral justifications for whistleblowing: (1) The reason the whistleblower is blowing the whistle is because he sees a grave injustice or wrongdoing occurring in his organization that has not been resolved despite using all appropriate channels within the organization, (2) The whistleblower morally justifies his course of action by appeals to ethical theories, principles or other components of ethics, as well as relevant facts, (3) The whistleblower thoroughly investigates the situation and is confident that the facts are as he understands them, (4) The whistleblower understands that his primary loyalty is to the patient(s) unless other compelling moral reasons override this, (5) The whistleblower ascertains that blowing the whistle most likely will cause more good than harm to the organization and (6) The whitleblower understands the seriousness of his actions and is ready to assume responsibility for them.[30] Several authors concur that whistleblowing is an institutional failure in ethics and leadership. Hunt (1995) calls whistleblowing a "multilayed breakdown in accountability." The common welfare of citizens is a primary responsibility of healthcare workers and accountability surrounding this responsibility is the core issue of whistleblowing.

There are many different accountable entities involved with different levels of responsibility. Among those with recognized responsibilities are: (1) The governing body of the healthcare organization, (2) The medical staff (3) The administrative leadership, (4) Department Managers and (4) Individual healthcare professionals i.e., non-medical staff.

We will examine some of the professional codes, regulations and accrediting agency standards that relate to accountability and responsibility in the healthcare organization.

The first and foremost entity within a healthcare organization with responsibility for providing leadership is the governing body. In addition to the ethical, fiduciary and legal responsibility the Board of Directors has to their stockholders (or stakeholders) they have additional responsibilities to regulatory agencies and accrediting bodies.

This responsibility is explicitly described in the Medicare/Medicaid Conditions of Participation. In our case study almost every deficiency cited by the Department of Health and Human Services started with the phrase: "The governing body (or organized group or individual who

assumes full legal authority and responsibility for operations of the hospital), medical staff and administrative officials are responsible and accountable for ensuring...". It is absolutely clear from these statements that the Department of Health and Human Services holds the governing body, medical staff and administrative officials responsible and accountable as leaders of the healthcare organization.

This responsibility cannot be "farmed out" to others in order to place the blame outside the organization when failures occur. Once again according to our case study: "The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services." These Conditions of Participation do not allow a Board of Directors to "scapegoat" or place the blame for failures on organizations and entities outside of the healthcare organization. Overall operational responsibility of the HCO rests squarely on the shoulders of the Board of Directors.

In addition to the regulatory accountability of State and Federal agencies there are standards created by accrediting bodies such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). The key standards of organizational ethics identified by JCAHO are: 1. The hospital operates according to a code of ethical behavior. 2. The code addresses marketing, admissions, transfer and discharge and billing and resolution of conflicts associated with patient billing. 3. The code addresses the relationship of the hospital and its staff members to other health care providers, educational institutions and payers. 4. The hospital's code of ethical business and professional behavior protects the integrity of clinical decision making, regardless of how the hospital compensates or shares financial risk with its leaders, managers, clinical staff and licensed independent practitioners.[38]

These areas address very broad organizational areas. Unfortunately they do not address what an HCO's responsibility is relating to disagreements about clinical practice and they do not ensure the protection and professional integrity of the parties to the dispute. This is very unfortunate given that "HCO workers are reluctant to report what they know, especially if the person about whom they would report is a supervisor or someone perceived to have greater standing."[39] In addition, "Even when negative

consequences are not anticipated, moral agency in healthcare organizations can be difficult because 'medical settings do not encourage understanding and acting upon ethical issues as social and organizational in nature.'"[39] Nevertheless JCAHO at least recognizes that a healthcare organization should operate with a code of ethical behavior.

These regulatory and accrediting body standards address the responsibility of the governing body and medical staff. What about the administrative leadership and individual healthcare practitioners?

According to the American College of Health Care Executives (ACHE): "The Code of Ethics incorporates standards of ethical behavior governing individual behavior, particularly when that conduct directly relates to the role and identity of healthcare executives...being a model means that decisions and actions will reflect personal integrity and ethical leadership that others will seek to emulate."[40] The CEO is the Board of Director's choice for administrative and executive leadership of a healthcare organization and must embody and demonstrate the highest level of ethical, legal and moral behavior. The CEO is responsible for "putting into effect" the governing body's ethical, legal and moral "code". This person creates, defines, implements and maintains any culture of ethical, legal and moral behavior that exists within the organization. Of all the individuals within the healthcare organization it is the CEO that is the "face" of the organization more than any other. This "face" must project the ethical, legal and moral values of the organization. If the CEO is perceived as an ethical and moral person the organization is likely to be perceived in the same manner.

The ACHE identifies six specific areas that relate to the Healthcare Executive's (CEO's or HCE's) responsibility.

In regard to the CEO's responsibility to the healthcare management profession ACHE states: "The healthcare executive shall conduct professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon the profession AND will comply with all laws and regulations pertaining to healthcare management in the jurisdictions in which the healthcare executive is located or conducts professional activities."[40]

In regard to the CEO's responsibility to patients ACHE states: "The healthcare executive shall work to ensure the existence of a process to evaluate the quality of care or service rendered AND demonstrate zero tolerance for any

abuse of power that compromises patients."[40]

In regard to the HCE's responsibility to the organization ACHE states: 1."The HCE will lead the organization in the use and improvement of standards of management and sound business practices" 2. "Be truthful in all forms of professional and organizational communication and to avoid disseminating information that is false, misleading or deceptive" 3. "Implement an organizational code of ethics and monitor compliance and provide ethics resources to staff to address organizational and clinical issues."[40]

In regard to the HCE's responsibility to employees the ACHE states: 1. "The HCE shall create a work environment that promotes ethical conduct by employees; providing a work environment that encourages free expression of ethical concerns and provides mechanisms for discussing and addressing such concerns." 2. "Establishing appropriate grievance and appeal mechanisms."[40]

Finally in regard to the HCE's responsibility to the community and society ACHE states: 1. "The HCE shall work to encourage and participate in public dialogue on healthcare policy and issues and advocate solutions that will improve health status and promote quality healthcare." 2. "Provide prospective patients and others with adequate and accurate information, enabling them to make enlightened decisions regarding services."[40] (ACHE Code of Ethics March 2007) These quotes are extensive but not comprehensive and sum up the HCE's responsibilities to: (1) the healthcare management profession, (2) patients, (3) the organization, (4) the employees and (5) the community.

The next level of responsibility for ethical, legal and moral behavior rests with the Department Heads. This is composed of individual healthcare professionals. We will examine aspects of the professional code of ethics for nurses and pharmacists since the case study involved nursing and pharmacy and the Department of Health and Human Services cited lack of compliance in nursing and pharmaceutical services as a deficiency in the organization.

In 1950 the American Nurses Association adopted an official code of ethics. The code evolved adapting to changes in the societal role of nursing. The current Code of Ethics no longer views the nurse as a passive employee of an organization but rather as an active, independent practitioner whose primary duty is to the patient. This responsibility to the patient over and above any responsibility to the physician or organization is cited again in the 1985 Code for Nurses with Interpretive Statements: "The nurse acts to safeguard the client and the public when healthcare and safety are affected by the incompetent, unethical or illegal practice of any person."[41]

In the case study a "cohort" of nurses acted illegally and unethically even submitting false statements to the Board of Nursing. These nurses were caught in their untruthful statements by additional inquiries from the Department of Health. However, imagine the damage to patient care a large cohort of health professionals could inflict by stating and standing by false and/or malicious statements. Fletcher (1998) argues that changes are needed within the organization to develop and maintain an ethical climate. This would ensure that nurses and other healthcare professionals who file complaints or express concerns about unethical practices within the organization can expect both that these will be taken seriously and that procedures will be in place to arbitrate an issue."[30]

In 1993 the American College of Clinical Pharmacy (ACCP) published Pharmacists and the Pharmaceutical Industry – Guidelines for Ethical Interactions with the caveat "Because ethical considerations are not limited to one industry sector, the following guidelines should be applicable to any situation."[42] Despite this statement their guidelines are very narrowly defined and there is a broader Code of Ethics for Pharmacists published by the American Pharmaceutical Association.

However, in an attempt to incorporate guidelines from related industries ACCP recognized several organizational ethical guidelines including: 1. The Pharmaceutical Research and Manufacturers of America (PhRMA) Code on Interactions with Healthcare Professionals, 2. The United States Department of Health and Human Services Office of Inspector General's Compliance Program Guidance for Pharmaceutical Manufacturers, 3. The Standards for Commercial Support from the Accreditation Council for Continuing Medical Education (ACCME) and 4. The Accreditation Council on Pharmaceutical Education (ACPE).[42]

The American Pharmacists Association's Code of Ethics for Pharmacists is very broad and very vague and was adopted October 27, 1994. According to the APhA Code of Ethics for Pharmacists:

1. A pharmacist respects the covenantal relationship between the patient and pharmacist.

2. A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner.

3. A pharmacist respects the autonomy and dignity of each patient.

4. A pharmacist acts with honesty and integrity in professional relationship.

5. A pharmacist maintains professional competence.

6. A pharmacist respects the values and abilities of colleagues and other health professionals.

7. A pharmacist serves individual, community and societal needs.

8. A pharmacist seeks justice in the distribution of health resources.[43]

For purposes of our discussion the first and most broad guideline by ACCP includes recognition of the pharmacist's primary responsibility: "As healthcare professionals responsible for managing drug therapy, the welfare of patients should be the pharmacist's primary concern in all aspects of pharmacy practice."[42]

Thus Pharmacy, like the Nursing profession, now identifies the patient's welfare rather than loyalty to the physician or healthcare organization as their primary responsibility. These patient-centric ethical guidelines signal a recognition of the increase in professional autonomy and independent decision making capacity away from the rigid, hierarchical, physician-dominated and archaic mentality of the past. There is a societal recognition that non-physician healthcare providers should be considered just as much an autonomous, independent professional as the physician and the same high level of ethical, legal and moral responsibility is expected of them.

Some proponents argue that ethical standards must be sufficiently diluted and vague in order for most members of society to accept the standards. However, I would argue that in the healthcare profession a higher than average standard is warranted due to the impact healthcare has in the lives of individuals, family members and others who are affected by the action or inaction of healthcare providers. Many times these are life and death decisions that cannot be taken back or reconsidered at some later point in time.

What can healthcare organization do to create a culture of ethical behavior? According to Rest (1986) there is a four-step process for individual ethical decision making: 1. recognize a moral issue, 2. make a moral judgment, 3. resolve to place moral concerns ahead of other concerns and 4. act on the moral concern.[44] This is such a straightforward and simplistic model it would seem to be self-evident that organizations would not have ethical failures if all individuals acted according to this model.

However, in the real world healthcare individuals employed by HCO's have a very large diversity in moral ideology reflective of society at large. Under these circumstances it is necessary for the HCO to identify basic and common core values and beliefs. According to Fletcher (1998) "It is the HCO's responsibility to articulate the organization's ethical climate as distinct from the individual beliefs held by staff members."[30]

According to Grosenick (1994) "Values and ethics are not only central to organizational culture but also to positive organizational performance."[45] This is a group approach rather than individually oriented. i.e., all persons within an organization must share common positive values and beliefs to create an effective ethical culture.

Under this "shared system of positive values and beliefs" organizational leadership is paramount but insufficient alone to ensure success of an ethical culture. According to Grosenick (1994) "Strong moral corporate leadership in and of itself was unable to change the existing morally deviant value structure of an organization."[45] This necessity is obvious in the case of a "dirty hands" situation. "A crucial component of a dirty hands situation is 'creating situations' that necessitate and justify acting with dirty hands."[46]

This was the situation in our case study where Nursing attempted to force a "dirty hands" situation in the pharmacy by demanding training outside the scope of practice for nurses to compound and dispense chemotherapy based on "institutional needs." There was a large expansion planned in outpatient chemotherapy services and the organization thought it would be more cost-effective to train a group of nurses to compound chemotherapy rather than to hire another pharmacist and bring the sterile compounding room up to standards. There was absolutely no regard for the fact that they were asking the Pharmacy Director to perform illegal activities that would place his personal license in jeopardy and create a process that would place patients at unnecessary risk.

Healthcare organizations have been in the process of restructuring for over a decade and practitioners, patients and society at large are questioning unethical practices in managed care including gag rules, lack of full disclosure and compensation plans that reward withholding of healthcare services.[47]

There has been very little information published about organizational and administrative ethics in the healthcare literature. This may be due, in part, to the fact that organizational ethics are much broader than clinical ethics and the number of stakeholders involved makes it a very unwieldy process.[48]

It is important to realize that "institutions have ethical lives and characters just as their individual members do."[49] According to Mohr and Mahon (1996) "Survival of healthcare providers in morally deviant organizations may mean doing what the organization requests of them or losing their jobs."[46] This was certainly true in our case study where refusal to provide blatantly illegal services resulted in termination of more than one pharmacy director.

In creating an ethical organizational culture Renz and Eddy (1996) suggest a four-step process: 1. Conduct a formal process to clarify and articulate the organization's values and link them to the mission and vision statements. 2. Facilitate communication and learning about ethics and ethical issues, including values clarification and reflection on their link to practice. 3. Create structures that encourage and support the ethical culture and 4. Create processes to monitor and offer feedback on ethical performance.[50]

For an in-depth case study of how these four processes may be implemented in a practical manner I will refer you to an article by Mary Cipriano Ph.D., Organizational and Administrative Ethics in Health Care: An Ethics Gap. This article discusses a very impressive case study where a nurse was able to change an ethically tainted organization into an ethically responsible organization by implementing these four recommendations to create a change in the organization's ethics infrastructure.

I would like to quote her summary regarding implications for healthcare. "Too often persons in healthcare leadership positions tend to micromanage or ignore ethical issues or to allow legal concerns to override ethical decisions. When executives micromanage, they are unable to see their organizations as a whole. Consequently, they are unable to see the necessity for an ethics infrastructure that not only includes their own departments but also all other departments within an organization. When healthcare executives are blinded to ethical issues, they are prone to act with insufficient knowledge and insight, often resulting in inadequate decision making. A common example is the allocation of scare resources. If a healthcare executives view such allocation only as a fiscal decision, the executive is blinded to the fact that all allocation of scarce resource decisions are, ultimately, ethical in nature. And, lastly, when healthcare executives allow legal principles to override ethical principles, the executives are often operating at a minimum, rather than a maximum, standard of practice."[51]

In addition, Dr. Silva makes four recommendations for healthcare executives: 1. Extend their horizons by taking classes or seminars in organizational ethics. 2. Read business journals or books on ethics and organizational structure. 3. Understand that behind many decisions there is an ethical issue waiting to be explored. 4. Believe that ethics should override law in executive decision making and act on this belief.[51]

In the final analysis "Ethically justifiable behavior...consists of morally correct decisions and actions in which the interests of the society take the degree of precedence that is 'right'...'just'...'fair' over the interests of the individual. It is 'good' for society according to the ethical principles of normative philosophy, not according to the moral standards of a given group or culture."[52] This is ultimately a call to a higher not a lower standard for healthcare organizations. This is the standard that our patients deserve.

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