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# Hospital Organizational Ethics

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## Abstract

Hospital organizational ethics refers to the corpus of principles, codes, beliefs and organizational values by which one can evaluate and regulate the actions of the medical personnel. This study presents a series of applicative frameworks of organizational ethics: organization classification from the ethical point of view, ethical issues in hospital activity, sources of organizational ethics (virtue approach, common good, honesty and justice, duty, utilitarianism), stages in the elaboration and implementation of the ethical codes' system, aspects of the hospital ethical committees' organization and functioning (personnel component, activities, results). Finally, some of the effects of the application of hospital organizational ethics are presented: the ethical climate (concern, legislation, codes, rules, instruments, and independence), immoral practice prevention, the solving of cla-

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ssical ethical problems (e.g. inequality, patient rights). The authors would like to highlight the fact that the ethical committees' activity should be an integrative component of hospital activities, authorized to solve ethical problems wherever these might occur. This activity should not be regarded as a sporadic one, initiated only when a specific incident or situation require a solution.

*Keywords:* organizational ethics, ethical committee, hospital, management, community.

## Introduction

Organizational ethics (OE) is in itself an aspect of the organizational culture, a means of evaluating and regulating employee activities through the framework of principles, codes, beliefs and organizational values. It is a concept leading to the examination of moral life, connected with the actions and decisions taken by the organization members during their workplace daily activities (Appelbaum, Soltero, & Neville, 2005). It also refers to the corpus of rules and standards which govern employee relationships, in respect of the needs and desires of all parties involved (Frederick, 1999). Ethics presents itself as a systematic reflection over the moral consequences of decisions, which may cause damages inside the organization, to its personnel, as well as to the persons outside the organization (Johns, 1998).

From an ethical perspective, the organizations are divided as follows (Nica & Iftimescu, 2003): (1) ethical organizations whose objectives maintain a real equilibrium between responsibility and profit. In this case, ethical values lie at the fundament of employee daily behavior and the decisions taken are correct ones (Lupu *et al.*, 2017); (2) organizations oriented towards respecting ethical principles, interested in finding and promoting equilibrium between responsibility and profit and creating an ethical climate; (3) responsible organizations which promote the idea of social responsibility, mainly out of the need to change the negative image created by certain unethical practices of the past; it is a fact that organizations once affected by unethical behavior turn out to be strong supporters of ethics; (4) organizations oriented towards respecting legal provisions, interested more in avoiding punishment rather than ethics, their main objective being profit achievement (Ciubara *et al*., 2016); (5) immoral organizations characterized by lack of respect towards ethical or legislative norms, exclusive pursuit of profit and the absence of ethical codes (Bulgaru Iliescu *et al.*, 2015).

The ethics as science requested formal or informal tools for managing and calibrating of moral issues in certain contexts. The management of ethics defines and includes such elements, as are the ethical committees, the codes of ethics, specific policies and procedures, ethical audit, training programs in ethics. The

new technologies brought up to the table new extensions of the ethical debate such as the virtual ethics. The virtual actions are often considered out of the legal frame while the long term effects on the real world are considerable. Applications as simulations, analysis (Hnatiuc & Iov, 2014), mimics, modelling and the telemedicine, the top level of the virtual applications in medicine (Hnatiuc & Iov, 2005; Hnatiuc & Iov, 2013) are put in shadow by virtual crimes, offenses, illegal activities. Medical ethics developed in the '60s, both as an academic discipline, as well as a practice of medical institutions (Bulgaru Iliescu, 2012). Their promotions are due to the successful medical research intended towards finding new medicines, treatments and diagnose technologies (Damian, Mihai, & Damian, 2008). Taking into account the fact that several types of new treatments were highly expensive, the initial ethical issues referred to the way of paying for these benefits and how to prevent from these benefits those persons incapable of covering the costs themselves (Johnson, 2006). Later on, more and more medical and organizational practices came under the incidence of ethical studies.

In the case of Romania, organizational ethics has always been supported by health practitioners. Paradoxically, some unethical situations have been encouraged by the very system management (Ciurea *et al.*, 2007). For instance, some came to the point of not being able to practice in the best ethical and procedural conditions on account of the lack of resources (Carausu E.M. *et al.*, 2017) and regulations. The ethics of health resource distribution has always been a neuralgic point of the system. Some errors showed lack of respect towards both procedure as well as ethics: human products resulted from various laboratories and stored in improper locations, irregularities concerning the rights of intellectual property, lack of communication between the media and the medical institutions (the craving for sensational led to the violation of deontological norms of the two professions, by media presentation of certain cases, filming without patient consent). Critics recorded ethical inconveniences at the leadership level: corruption accusations, incompetence, and authority misuse. The ethics of professional relations was highly jeopardized in certain cases. The medical press indicated that the medical staff was confronted with tensions, accusations, complicity in the drawing of some of the patients' complaints, conflicts etc. The malpractice cases were exaggeratedly debated in the media. It was stated that the presence of errors in statistics is highly encouraged; however, their interpretation could be different, as they might reflect the too small a number compared to the number of procedures, as well as the lack of population awareness – people do not know their rights and consequently do not denounce the errors (Ciurea *et al.*, 2009; 2011).

## Sources of organizational ethics

There are at least five different sources of hospital ethical standards (Popescu, 2008):

1. *The virtues' approach*: it is a current version of Aristotle's ideas from the *Nicomachean Ethics – it describes the ethical action as the one in need to be in compliance with the ideal virtues that will completely develop human nature*. These virtues are customs or dispositions that allow one to act towards achieving full personal potential, based on values such as: justice, beauty, honesty, courage, compassion, tolerance, integrity etc. (Bulgaru Iliescu, *et al*., 2014). The moral question present here is the following: "What kind of a person would this action turn me into?". These *virtues* allow one to approach an *ideal* which would become one's own and would allow one to reflect upon its own decisions and actions;
2. *The common good approach*: originates in the writings of Plato, Aristotle, Cicero and more recently, Rawls, and is commonly associated with the concept of "common good for everyone's equal benefit". At the basis of this approach lies the assumption that society is made up of individuals whose well-being and happiness are connected to community well-being, and community members are forced to pursue common values and objectives. The operative framework of this approach leads one to reflect on its own actions that need to comply with the *common objectives* of the community one is part of;
3. *The honesty and justice approach*: originates in Aristotle's philosophy while its operative principle is as follows: "Equals must be treated equally, and those unequal must be treated unequally". The moral questions arising here are: "How fair is my action?", "Do I treat everyone equally, or do I discriminate?". Nowadays, these ethical ideas are put into practice through the activity that does not discriminate those affected, and , in case there are *discriminations*, they have to be fair and just and be based on certain standards that can be easily verified;
4. *The duty ethics approach*: Immanuel Kant (18th century) suggested that an action is an ethical one if it protects and respects the moral rights of those affected by it. According to this approach, what differentiates humans from other beings is their dignity given by their ability to choose what to do with their life. The corresponding principle is the following: "People need to be treated as purposes, not as means". The main (natural) human rights are the following: the right to make decisions, to know the truth, the right to dignity. Another central idea of Kant's ethics is that the main guidance of one's deeds is the rational judgment translated into an imperative: "Behave in such a manner that an activity in the given circumstances becomes a

behavior rule for all those dealing with the same circumstances". The operative framework of decisions is given by the following question: "Does our action respect the moral rights of others?" In case the answer is negative, then, the respective action is not an ethical one;

5. *The utilitarian approach*: part of the teleological philosophy, it was developed in the 19th century, mainly by Jeremy Bentham and John Stuart Mill, its aim being to help legislators pass the best moral laws. It is focused on the consequences of actions and politics over those affected directly by them. The basic principle is the following: "The action that produces the most or the least harming welfare is an ethical action". The unethical behavior is that in which personal gains are founded on the loss of others or of society. The analysis framework of our actions becomes operative through the acknowledgement of all possibilities of actions as well as of all those affected. Taking into account these variables, one can take an ethical decision that will generate more welfare for a higher number of persons involved.

All these sources of various philosophical approaches produce standards based on which an individual can judge its own decisions, intentions and behavior. Moreover, there approaches generate different assumptions, based on which these actions could be interpreted by the other participants of the medical organizational environment (Popescu, 2008).

## Applications of ethics in healthcare

### *Ethical codes*

The ethical codes help specify the general ethical rules through which an organization will translate its intended values in a concrete, behavioral manner (Nanu *et al.*, 2015).

McNamara (1999) showed that organizations can implement ethical codes at various stages as follows: (1) As far as large organizations are concerned (such as hospitals) it is highly recommended to develop first an ethical code for the whole institution and then several other codes for each clinic/department; (2) Not only human resources and the legal departments have to develop ethical codes, but as many employees as possible should be involved in this activity. It is insufficient to develop ethical codes which ensure only formally that ethical and legal practices are registered. Most companies using such a code consider it "useful, but insufficient" (Popescu, 2008). Without top management support and sanctions for unethical behavior, the efficiency of such codes is limited; (3) The identification of main values that will become priorities for the organization is done at several stages:

As many necessary values as possible will be enumerated in order to support the existing laws and regulations. Those values that will benefit the hospital in aligning itself to the existing regulations need to be defined and detailed (operationalization): (1) The values that can develop the most important features for those services considered successful and ethical (confidence, respect etc.) will be overviewed; (2) The values that support the ethical climate of the organization will be identified. Further on, descriptions of the existing behaviors and an evaluation of their ethic value will be gathered – thus, one identifies the values that generate the intended behaviors; (3) The results of the hospital strategic planning will be reviewed. For instance, if the SWOT analysis had been already performed, one can evaluate the values that generate those behaviors supporting the strong features and the opportunities and reduce the weak features or protect the hospital from potential threats; (4) Those values and behaviors appreciated by employees, clients, suppliers, community members need to be overviewed; (5) Examples of values need to be given: respect, responsibility, trust, civic virtue; (6) The drawing of the ethical code, by associating each value with several examples of behaviors that the respective value reflects; (7) Patterns need to be added which clarify employees that they are expected to comply with this ethical code and answers are to be prepared for possible questions; (8) The ethical code is to be presented to the members of the organization in order to receive feedback; (9) The ethical code is to be distributed among employees and listed on a notice board; (10) This code needs to be updated each year. What is more important that the very existence of this code is its development process, through which employees become aware of the ethical aspects (Popescu, 2008).

### *Ethical committees*

Throughout the world, hospitals generally have an ethical committee (EC). It has been documented lately that their influence has been a beneficial one over the quality of healthcare. In 1983, almost 1% of American hospitals had ethical committees, which grew to 60% in 1989. Starting with 1998, this percentage stepped over 90% (Johnson, 2006). In 1992, the Commission on Accreditation of Healthcare Organizations (CAHO) of the United States of America demanded from institutions to implement certain mechanisms dedicated to ethical issues (McGee *et al,* 2001).

There are *two main functions* of the ethical committee:

- Acts in order to be compatible with the official regulations of the state and connected agencies;
- Offers a consultancy environment for ethically complicated situations which may occur either during patient treatment, or during medical research (Johnson, 2006). Thus, such a medical ethics' committee has several attributions: (1) Investigates the complaints with respect to the violation of

professional deontology; (2) Prepares the file for disciplinary investigation; (3) Supports the disciplinary action in front of the disciplinary commission (Johnson, 2006).

The task of this committee is to "make efforts in order to achieve a *mutual understanding* towards commonly stating a set of norms expressed in common life vocabulary". There are also *professional deontology and ethics' commissions*, whose status is similar to ethics' commissions, encompassing the following attributions: (1) Making sure that doctors respect the Deontological Code; (2) Analyses the evolution of deontological norms in European and international practice; (3) Suggests changes to the Medical Deontological Code (Johnson, 2006). In the case of disciplinary deviations, their investigation is to be done bearing in mind the legal framework, the Professional Deontology Code, medical units' internal regulations and the job description, in order to insure a highly professional morality inside the medical staff. In the event of actions that affect the professional honor of the medical staff, a "professional jurisdiction commission" will interfere, firmly asking for the withdrawal or the correction of such actions (Johnson, 2006).

Hospital ECs are founded on the principle of "several voices speaking", meaning that when gathering together specialists from various fields of practice and with different life approaches, an ethical problem is very likely to be solved in various ways, taking into account different perspectives. These differing specialists that might put together this ethical committee are chosen on no specific rules saying which group should be represented and which not. However, doctors and medical assistants are indispensable in forming ethical committees, due to their professional experience. For instance, such a committee could also include a lawyer, a social worker, a priest, a hospital administrator, and academic of the local community (preferably one trained as far as medical ethics is concerned) and at least one member of the community. The solutions to ethical issues are often obtained through a consensus-oriented process, mutual understanding and the introduction of several norms. Each of the prospective solutions of a problem shall be explained by its representative through an easily accessible language to the other members of the committee. As a result, the language and communication abilities of committee members are always a challenge (Johnson, 2006).

It has been ascertained that 87% of ECs play an important part in clinical decisions throughout the ethical and clinical consultations they imply. Although, 4.5% of these committees elaborate policies on planned healthcare, 50% of the EC personnel consider themselves insufficiently trained to deal with this matter (McGee *et al*, 2001). The aim of these ethical committees all over a nation in elaborating clinical healthcare policies is higher than estimated, as they have an important role in debating and solving medical and clinical policies and cases.

McGee *et al.* (2001) conducted a research on American hospitals' ethical committees (1998-1999). The average age of ECs was approximately 7 years old,

with an average number of 14 members – around 4 doctors, 3 medical assistants, an administrator, a manager, a human resources' worker, and another member of a different background. The activities the members of the EC deal with range from domains such as: education (the training of the EC personnel), rules (forms and policy and treatment evaluations) and consultation (consultation on specific cases and their revision). As far as planned healthcare policy is concerned, this topic took almost 4.5% of the time of committee discussion, but 50% of the EC members reported not to feel capacitated enough in order to deal with such issues. Of the active members, 86% reported to have been involved in consultation cases (only clinical cases presented on an official basis in front of the commission, leaving aside informal, unofficial consultations asked by fellow colleagues). Almost 5% of commissions dealt with decisions of an obligatory nature. The results of consultations consisted of recommendations towards personnel and communication relations with the families of patients. Most communications focused on patient autonomy, competence and means to improve communication. In general, all persons dealing with patients – doctors, medical assistants, family members etc., have the possibility to ask for consultancy on ethical issues.

The activity of ECs has a series of pragmatic implications: recommendations towards doctors and management, patient/family communication, obligatory decisions, arbitration, consultancy as far as risk management is concerned, publishing of case studies, documentation of medical activities, administering and enlarging hospital budgets, patient advantages, patient autonomy and adaptive competences, research, technical endowing, communication improvement, clinical competences, end of life issues. Surprisingly, the issue of terminally-ill patients was not an important point on the ECs' agenda. Later on, EC members assigned around 23% of their time to the formulation and evaluation of specific policies concerning the rules of putting an end to medical care (brain death, children with encephalic pathologies, organ donations etc.). Some ECs restrict access to ethical consultations in order to insure prudency (when faced with possibility of doctor manipulation of such a committee) and larger respect for the issued recommendations. Some ethical commissions deal with financial issues, as ethical consultancies resulted in financial growth for hospitals and patients. Many of the EC policies refer to important aspects of medical policies, which apply not only to institutions, but also to taxpayers, patients and society.

All in all, ECs play an important part in the medical system and are an essential feature of hospital efforts to control complex ethical problems (McGee *et al.*, 2001).

## Discussions

In order to make the applications of organizational ethics work, it is highly necessary that personnel policies and procedure include the following aspects (McNamara, 1999): (1) Ways of solving ethical dilemmas; (2) The framework for developing ethics – oriented trainings; (3) Ways of repaying ethical behaviors; (4) Consequences of violation ethical principles; (5) Ways to solve employee complaints; (6) The implementation of a hotline used to report anonymously suspicious unethical activities; (7) Activities to promote hospital organizational ethics contribute to the creation of an ethical climate.

Considered as a subtype of organizational climate, the ethical climate has been defined as "the sum of psychological descriptions of relatively stable organizational characteristics, given by the current practices and procedures which have an ethical content" (Victor & Cullen, 1988). There are at least five types of ethical climate (Victor & Cullen, 1988): (1) *The comfort climate* – contains aspects of "goodwill": "Everyone's welfare is highly important in our hospital", "In this organization, people take care that everyone feels well"; (2) *The law and code climate* – refers to aspects of principle: "In this organization, we expect people to strictly respect professional laws and standards"; (3) *The rules' climate* – includes items such as: "Successful people of our organization respect rules and procedures" or "People of our organization obey the organization rules and procedures"; (4) *The instrumental climate* (Local/individual egotism): "In this organization, people protect their own interests, above all", "We expect people to do everything for hospital benefit, no matter what"; (5) *The independence climate* – best described by statements such as: "in this institution, we expect people to follow their own ethical principles"; "Each person decides for himself/herself what is good or bad".

## Conclusions

Employees of organizations endowed with ethical codes consider that morals contribute to maintaining public confidence, supporting professionalism and rule respect, but also prevent immoral practices from occurring (Sims, 2003). What is more, organizational ethics leads to solving classical ethical debates such as: common morality and moral dilemmas (Olaru, 2010), death and mortality approach in patient-doctor relationship (Poanta, 2010), inequality in medical care (Oprea, 2010), illness responsibility (Hurzum, 2010), patient rights (Guvercin & Arda, 2010) etc. Taking into consideration the fact that we have lately witnessed important progresses in medical technology, the structure of medical care, as well as in the social and political climate, one might ask the following question: How can hospital ethical committees, with their traditional structure, solve new ethical

problems? Thus, it is necessary to examine both the internal proceedings of such committees, as well as their configuration inside the international context. The activity of the ethical committee can no longer be seen as a "satellite-operation" – initiated only when a specific incident or situation need solving. On the contrary, this activity needs to be perceived as an integrative component of hospital operations, authorized to solve ethical issues wherever these might occur (Johnson, 2006).

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