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8 Seeing the Forest Beyond the Trees: A Holistic Approach to Health-Care Organizational Ethics

8.1 Introduction

With the growing body of research concerning organizational ethics of health care over the past 2 decades (Barina 2014; Gallagher and Goodstein 2002; Hall 2000; Khushf 1998; Magill and Prybil 2004; Potter 1996; Rorty et al. 2004; Werhane 2000), ethicists have turned their attention to the way in which organizational contexts have a direct influence on the practice of health care (Bean 2011; Førde and Hansen 2014; Khushf 1998; Spencer et al. 2000). Against the background of continuous transformations in the way health-care organizations (HCOs) operate, contextual aspects, such as financial pressure, time efficiency, or reporting to supervisory bodies, are often underlined as influencing medical decisions made by physicians and staff (Austin 2007; Carney 2011; Wesorick 2002), sometimes to the detriment of patients' needs (Hart 2005). Ongoing moral concerns over institutional processes may potentially lead to structural tensions and conflicts among staff (Barina 2014; Gibson 2012), or even inappropriate medical outcomes (Chen et al. 2007), suggesting that there is still room to further develop organizational health-care ethics.

Despite the focus on organizational level of moral issues, contextual features of HCOs are still approached in a dichotomous manner. One prominent example concerns compliance versus integrity, often understood as a rules *or* values approach to organizational ethics and translated into conflicting and disconnected ethics programs within HCO practice (Boyle et al. 2000; Magill and Prybil 2004; Mills and Spencer 2001; Silverman 2000). This could negatively influence future development of the field, leading to fragmentation and lack of consistency. I argue that, if we want to advance research on organizational ethics and gain more explanatory power, we need to approach such dichotomies holistically, in a manner that is integrative instead of antithetical. To that end, I argue that compliance and integrity should be seen as complementary approaches to ethical issues occurring at the organizational level and that they respond to and mirror two organizational dimensions that require better alignment: the organizational informal culture and formal structure. Both are needed to make ethics work in HCOs[1].

1 Throughout this paper, by health-care organizations (HCOs), I refer to "medium- and large-sized provider organizations that have a defined management structure" (Werhane 2000, 170) and whose focus is on maximizing the healing and well-being of patient population (Wall 2007; Werhane 2000).

To address this issue, I use normative insights from research in business ethics. First, I make a brief overview of organizational ethics in health care and point out its analogous counterpart in business ethics – ethics management. Second, I argue against the common dichotomy between integrity and compliance in HCOs, by referring to a normative model of integrated ethics management advanced in business ethics research. Third, I explore how an optimal alignment between organizational culture and structure can better embed ethics at an organizational level in health-care settings. I end with suggestions for future research, highlighting the need for closer collaboration between research in HCO ethics and business ethics.

8.2 Organizational ethics in health care

Since its emergence as a field in the mid-1990s, organizational ethics in health care has been interpreted in various ways, all of them anchored in the idea that HCOs *per se* are responsible for the outcomes of their operations at a distinct level from their constitutive members (Spencer et al. 2000). Research on organizational ethics therefore acknowledges that the medical act is influenced by the way work is framed in the health-care setting (Carney 2011; Fox et al. 2012; Rorty et al. 2004). This is especially relevant when the ethical quality of clinical care is at stake (Førde and Hansen, 2014), given that practitioners often cannot control the policies and procedures of their respective institutions (Emanuel 1995; Gallagher and Goodstein 2002; Reiser 1994).

As a result, organizational ethics, unlike bioethics or clinical ethics that deal with specific ethical issues occurring in medical practice, is concerned with "all aspects of the operation of the HCO so that positive ethical climate can be developed and maintained" (Spencer et al. 2000, 5). It consists of various "processes to address ethical issues associated with the business, financial, and management areas of health care organizations (HCOs), as well as with professional, educational, and contractual relationships affecting the operation of the HCO" (Spencer et al. 2000, 212). As such, organizational ethics refers to the overarching framework by which processes, procedures, and policies are designed to ensure that organizational performance is in line with its ethical foundations (Phillips and Margolis 1999). To that end, HCOs are required to work toward defining key values, while also striking an optimal balance between conflicting values and stakeholder expectations.

Briefly put, three definitional aspects may be delineated to elucidate the meaning of organizational ethics: (1) issues pertaining to management and governance of HCOs; (2) implications of organizational decisions on stakeholders (practitioners, staff, patients, regulatory bodies, the industry, and so on); and (3) complexities of balancing key organizational goals, such as quality of patient care, financial sustainability, staff management, medical research, and public accountability (Gibson 2012; Gibson et al. 2000; Hall 2000; Spencer et al. 2000).

This understanding of HCO ethics is synonymous to the notion of "ethics management" used in business ethics. Kaptein (1998, 42) defines ethics management as "the systematic and coherent development of activities and the taking of measures in order to realize the fundamental and justified expectations of stakeholders and to balance conflicting expectations of stakeholders in an adequate way". For Jeurissen[2] (2004, 11), ethics management is centered on the question "how do you manage ethics in organizations?" and "aims at improving the decision-making processes, the procedures and structures in an organization, so that the operations of the organization are more geared towards ethical principles". To that end, organizations use instruments such as codes of ethics, ethical audits, ethical trainings, or ethics hotline.

The focus on ethical issues at the organizational level has marked a shift in business ethics from a bad apples to a bad barrels paradigm (Treviño and Youngblood, 1990), in a move forward that has resulted in more emphasis being put on "the characteristics of the organizational context within which unethical behaviour occurs" (Kaptein 2011, 844) than on "the personal characteristics of individual transgressors" (Idem). *Mutatis mutandis*, we need to acknowledge that errors in HCOs often reflect faulty systems rather than practitioner errors (Austin 2007) and that HCOs need "an ethics *of* the system rather than ethics *in* the system" (Wall 2007, 228). However, the question remains as to how should ethical issues pertaining to the HCO context be best approached?

8.3 Compliance versus integrity: an apparent dichotomy

Research about managing ethics at the organizational level in health care proposes one apparent dichotomy between compliance and integrity (Mills and Spencer 2001; Silverman 2000), with organizational ethics being equated with the latter. Overall, a rules-centered or compliance approach is interpreted as focusing only on legal, regulatory, or administrative norms, whether externally or internally imposed, and on how to effectively enforce these guidelines. Instead, a values-centered or integrity-based approach is seen as focused on educating and guiding ethical judgments and behavior of organization members, usually by rewarding excellence (Boyle et al. 2000; Magill and Prybil 2004; Weaver and Treviño 1999).

2 In the business ethics context, Jeurissen uses the notion of organizational ethics to refer to the type of applied ethics aimed at "analysing specific ethical problem types in organizations, in order to provide normative clarification and guidance" (2004, 11), with examples such as advertising ethics, the ethics of insider trading, or the ethics of company restructuring. Translated to health care, this characterization is rather synonymous to clinical ethics. Therefore, I take common understanding of organizational ethics in health care to be rather synonymous to what business ethicists call "ethics management".

This theoretical dichotomy was supported in health-care practice by the way the two types of programs were introduced at the same time in the USA (Mills and Spencer 2001). On the one hand, government agencies such as the Department of Justice (DOJ) focused on reducing fraud and abuse in health care, imposing specific compliance programs that HCOs could easily implement to meet the specific requirements of the Federal Sentencing Guidelines for Organizations. On the other hand, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) started, in 1996, to focus on the effect of organizational context on medical performance. To meet accreditation requirements, HCOs needed to develop a process that integrates ethical issues pertaining to various departments and protects the integrity of clinical decision-making, a process they named organizational ethics.

In practice, this resulted in organizations implementing compliance programs on a large scale, but with implementation of fewer integrity programs (Mills and Spencer 2001). Sometimes, compliance programs are implemented as a substitute for, or even a competitor to, integrity or organizational ethics programs (Boyle et al. 2000). In other cases, HCOs have developed two compartmentalized programs (Mills and Spencer 2001), one targeted toward government compliance and the other involving more diffuse ethics activities. While compliance programs emphasize interdictions, integrity programs highlight what should be done in order to strive for moral excellence (Boyle et al. 2000; Silverman 2000). In this context, some have already indicated that organizational ethics strategy must go beyond compliance programs (Magill and Prybil 2004), while others point to an integration of the two (Mills and Spencer 2001) within the existing infrastructure of compliance programs. However, there is still a paucity of normative research concerning the integration of compliance and integrity in HCO ethics.

Developments in normative grounding may be found in the business ethics interpretation of ethics management, where the polarization between rules and values used to be the dominant interpretative view (Jeurissen 2004). However, business ethics has evolved to a more refined approach, in which an integrative view is favored against the former antithetic approach. Organizational ethics in health care could adopt this holistic approach, leading to a more comprehensive perspective of compliance and integrity issues at the organizational level.

Instead of being opposites, these two approaches differ only by their *degree of moral complexity* (Jeurissen 2004). Issues pertaining to compliance and integrity are placed on a continuum of increased moral complexity, without being mutually exclusive. Namely, Jeurissen (2004) posits rules-based and values-based approaches as the first two stages of moral development in an integrated four-level model of ethics management. Depending on the moral complexity of the situation, we may rely on one possible approach. This largely depends on two main coordinates of the situation: the action context and the normative context. While the first refers to the complexity of the issue under moral evaluation, the latter pertains to the complexity of the overall stakeholder framework. Both the action and the normative context

involve a low and a high level of complexity: the higher the complexity, the broader the instruments of ethics management that need to be used to address increasingly diverse stakeholder groups. This combination finally results in four approaches or levels of ethics management that respond to the increase of situational moral complexity in organizations.

The four levels move from simple to complex. First is a rules-based approach, adequate when basic moral criteria need to be applied to standard cases. Second involves a values-based approach, relevant when creative solutions are needed for new ethical problems. Third comprises a stakeholder dialogue approach, required when there is moral disagreement among stakeholders. Fourth and last is a social dialogue approach for occasions when moral disagreement involves larger societal spheres and issues. As Jeurissen (2004) puts it, these levels are caught in a contingent and evolutionary relationship. This means that while all four approaches reinforce and sustain one another, each retains its own unique relevance to ethical matters in organizations. On the other hand, this also means that they evolve from simple to complex issues, but at the same time, none is "better" than its predecessor because in practice, each of these approaches "can be an adequate solution to specific types of ethical problems, depending of situational characteristics" (Jeurissen 2004, 16).

The model may be easily translated to health care. HCOs display several characteristics that differentiate them from other types of organizations (Werhane 2000). Boyle et al. (2000, 10) identify four such characteristics: (1) their mission to alleviate pain and suffering and restore health; (2) the complex, highly regulated environment – internal and external – in which they operate; (3) professional cultures (physicians, nurses, health care managers); and (4) the rapidly changing health care market. Based on these characteristics, we could say that HCOs operate under all four levels of moral development as identified by Jeurissen (2004). First, a HCO includes multiple routinized activities, which allow it to "function efficiently and effectively and also enable its stakeholders to understand it and rely on it" (Wall 2007), given the predictability of the medical protocols. Routine organizational situations should be captured by a rules-based strategy, efficient when clear and unequivocal guidelines are needed (Jeurissen 2004). Instead, more complex issues require a value-based strategy, for instance, aspects such as providing care to the uninsured, research funding for new treatments, or staffing policies. Other situations require HCOs to address moral issues, as well as societal concerns (e.g., new medicine testing or genetic modification), thus yielding an even higher level of complexity.

This model provides some relevant normative guidance to dissolve the dichotomy between compliance and integrity in HCO ethics. The next question is this: what does this mean for how organizations operate?

8.4 Embedding ethics in HCOs: optimal alignment between culture and structure

Once we overcome the apparent antithesis between rules and values, and capture the broader picture of organizational ethics, we can explore how this may be reflected in the way HCOs function. With both compliance and integrity sharing a common goal, namely, to improve the ethical climate and relationship with key stakeholders, we need to research how they may be integrated in the organizational context.

To achieve organizational integrity, one has to combine two operational components: the informal culture – values, expectations, and unwritten norms – and the formal structure – processes, procedures, and rules (Constantinescu and Kaptein 2015b; Kaptein and Wempe 2002; Silverman 2000). Both form the overall context in which the medical act takes place and together build up the organizational practices that "are *actually* expressed in the actions of organizational members" (Kaptein and Wempe 2002, 146–9). Therefore, organizational ethics is focused on the actual behavior occurring in health-care settings as a result of the organizational context (Magill and Prybil 2004).

The complementary relationship between compliance and integrity is reflected in the relationship between the formal structure and informal culture. While compliance is linked to the organization's formal structure, integrity is more useful for dealing with aspects of the informal culture. The formal structure determines what constitutes ethical behavior (Kaptein 2008), while the informal culture stimulates ethical conduct (Weaver and Treviño 1999). There is a certain reciprocity between organizational ethical principles and ethical conduct: ethical principles adopted at the organizational level inspire ethical behavior, and ethical behavior reinforces the organizational ethical principles (Magill and Prybil 2004). This could potentially lead to a mutually enhancing relationship between an individual's ethical behavior and organizational ethical practices. The more the individuals behave ethically, the more the organizational practices become ethical, and in turn, stimulate individuals to act even more ethically. Individual and organizational practices build off each other in a cycle, analogous to an upward double-helix relationship (Constantinescu and Kaptein 2015a).

Given this interdependence, research on both business ethics and organizational ethics highlights the need to have consistent formal policies and informal culture within an organization, as well as to balance "what is formally expected and the ways things really get done" (Boyle et al. 2000). For formal procedures and policies to be effective, they need to be linked to the informal organizational culture (Chen et al. 2007; Treviño et al. 1999; Weaver and Treviño 1999). When formal procedures state one thing, and informal culture recommends the opposite, organizations display a lack of alignment (Treviño et al. 1999; Weaver & Treviño 1999) and send mixed signals to employees regarding desired ethical behavior (Constantinescu and Kaptein 2015a).

Organizational values are thus applied inconsistently, creating disconnect between espoused and enacted values (Silverman 2000).

To respond to these challenges in practice, HCOs should have integrated ethics departments that manage both the implementation of ethical rules that ensure organizational compliance and the development of an ethical culture that promotes organizational integrity. Such a department would integrate and balance stakeholder concerns and expectations within the organizational environment, including rules and values. In doing this, attention should be paid to the fact that the organizational formal structure is designed independently of the individuals fulfilling specific job functions, while the informal culture is dependent on the personal characteristics of individuals (Boyle et al. 2000). From a normative stance, this means that the integrated ethics department may be approached based on different theories. On the one hand, a rational systems approach is appropriate for matters pertaining to the organizational structure, stressing that written policies and procedures are needed to support employees' ethical behavior. On the other hand, a natural or open systems approach is more appropriate for issues related to the organizational informal culture, highlighting that ethical conduct also needs moral guidance based on values. Such a systems perspective allows us to picture organizational ethics as managing the network of structured and informal relationships among multiple parties, thus "acknowledging the interdependence of all the stakeholders in the organization, internal and external: the clinicians and administration, the board, the patients and the community" (Rorty et al. 2004, 86).

A normative evaluation of the way ethics is managed at the organizational level thus becomes synonymous to the way "the actual corporate context stimulates and facilitates employees to realize the justified and fundamental expectations of stakeholders and to balance conflicting expectations in a responsible way" (Kaptein 1998, 58). This means taking into account not only the way the organization fosters ethical relations between its own members, but also the broader societal context of managing ethical issues. For HCOs, this translates into the way optimal alignment is achieved between formal medical protocols and general norms that govern clinical practice, nonmedical operations, and informal practices. Furthermore, the quality of this alignment determines the HCO's success in finding the optimal balance between expectations from multiple stakeholders.

8.5 Conclusion and suggestions for future research

Ongoing changes in the way HCOs operate have raised new issues about contextual pressures that individual members face, such as time constraints, cost efficiency, and staffing reductions (Austin 2007; Carney 2011; Wesorick 2002). This often leads to the moral distress of physicians and staff in cases when individuals can hardly live up to moral standards because of contextual issues (Austin 2007; Jameton 1993).

Professionals working in HCOs report difficulties dealing with cases that present a lack of consistency between patients' needs and organizational contextual requirements (Hart 2005). Therefore, more emphasis is needed on the HCO itself.

This article has suggested a possible means to dissolve the apparent antithesis between compliance and integrity approaches to ethical issues in HCOs operating especially in European and North American countries. I have argued that an integrative view, where compliance and integrity are on the same continuum of moral complexity, offers more explanatory power and is better able to advance research in HCO ethics. Moreover, I have emphasized that this complementary relationship mirrors two organizational dimensions: the informal culture and formal structure. HCOs must work to better align these two dimensions if they want to promote integrity in handling both internal and external stakeholder legitimate requests.

Currently, the main challenge for HCOs is to "maintain and if possible to improve the quality of care in the face of cost containment" (Rorty 2000, 59) because of the separation between cost management and clinical management, often translated into the rivalry between cost and quality. To resist the temptation to sacrifice the quality of care in favor of cost reduction, HCOs should take all efforts to make compliance and integrity complementary, thus aligning organizational culture and structure. Indeed, to be able to optimally balance legitimate stakeholder concerns related to cost and quality, organizational ethics "needs to embrace both substance and form, substance driving form, meaningfully informed by context" (Bean 2011, 325).

The need for substantive organizational ethics programs is even more urgent today given that HCOs cannot rely only on imposed legal regulations to integrate moral concerns of its multiple stakeholders. Morality goes beyond legal requirements (Constantinescu and Kaptein 2015a; Jeurissen 2004; Paine 1994) because the law addresses the minimum moral standards to be obeyed, without necessarily driving excellence or virtue. The organizational context needs to receive the importance it deserves in health care, given that formal structure and informal culture influence employee morality (Kaptein and Wempe 2002). Given that an ethical climate improves both the quality of medical care and the overall organizational performance (Suhonen 2011), research and implementation of organizational ethics in health care become utterly relevant.

Future research on HCO ethics should take a closer look at and collaborate with business ethics research. The field of ethics management could provide additional normative insights that would advance research on organizational ethics. To that end, the first suggestion for future research is to explore the full implications of the integrated model developed by Jeurissen (2004) and discuss how the moral complexity continuum may be applied to realistic health-care situations. Second, future research must analyze the implications of the lack of alignment between culture and structure on the medical act performed in HCOs and synthesize possible remedies. For instance, one such remedy proposed in business ethics research that could be applied to HCO ethics concerns the degree to which HCOs integrate ethical

virtues, such as those proposed by the Corporate Ethical Virtues Model advanced by Kaptein (1998, 2008). Third, it would be critical to discuss moral criteria to ascribe blame and praise at the individual and also group levels in HCOs. In this vein, one possible line of research would be to explore the interaction between various levels of moral responsibility in HCOs and see under what circumstances this interaction may lead to a mutually enhancing responsibility (Constantinescu and Kaptein 2015a). Equally important, future research would need to explore normative and empirical methods of evaluating the way ethics is managed at the organizational level in health care. Finally, more attention should be paid to the philosophical underpinnings of organizational ethics. Developments of virtue-based ethics approaches to business ethics (Kaptein 1998, 2008; Moore 2012, 2015; Solomon 1992, 2004) could potentially offer a relevant anchor of understanding moral issues at the organizational level in health-care settings.

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