Ethical Issues in Health Care Management

Proceedings of the Seventeenth Annual Symposium on Hospital Affairs
April 1975

Conducted by the Graduate Program in Hospital Administration and Center for Health Administration Studies, Graduate School of Business, University of Chicago.

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Introductory Remarks

J. JOEL MAY

Each year the faculty of the Program in Hospital Administration of the University of Chicago and the Executive Council of the Alumni Association are charged with the task of choosing a subject. Three criteria are applied in the selection process. for the Annual Symposium on Hospital Affairs. First, does the topic deal with a subject of general current interest and importance to managers of hospitals and health care institutions? Next, is it addressable from a sound scientific or intellectual perspective rather than a how-to-do-it focus? And finally, can the chosen topic be cast in a framework which makes it of immediate relevance and usefulness to the registrants?

The subject we have chosen this year is "Ethical Issues in Health Care Management," and I believe it is one that meets all three of these criteria admirably.

Those of you who follow the literature in the field need not be reminded of the breadth of this subject area.

It ranges all the way from, on the one hand, the question of the purchasing agent receiving gifts from the supplier at Christmastime and other sorts of issues that Ed Pellegrino says have nothing to do with *ethics,* but rather with *etiquette;* all the way at the other extreme to the kind of colloquies that go on between theologians and ethicists and between both these groups and research physicians. Typically, these deal with questions of life and death, euthanasia, gene manipulation, and other "earth-shaking" and (not incidentally) press-coverage-producing topics.

To give focus to our particular deliberations at this symposium, I want to limit our discussions, if I can, to what one might call the *institutional implications* of the answers being suggested as a result of these discussions.

We won't deal with questions of who shall live and who shall die. Neither will we deal with questions of the funeral director bringing candy to the emergency room nurses. We are not interested in dealing with questions of conflict of interest because they have been very adequately dealt with in other kinds of meetings and in the literature.

What we would like to address are those day-to-day decisions made by health care managers which, while individually apparently insignificant, taken together represent or reflect a set of ethical judgments which shape and mold the institution and the way health services are delivered.

An important example of this sort of decision

The Seventeenth Annual Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration of the Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on the University of Chicago's campus on April 25–26, 1975. Chairman for this Symposium was J. Joel May, Director of the Program in Hospital Administration and Associate Director of the Center for Health Administration Studies.

These Symposia explore current issues in the field of health care management. Because the subject of this Symposium, "Ethical Issues in Health Care Management" is one of importance and, because of the dearth of literature in the area, these proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

Special thanks are due Mrs. Margarita O'Connell, Mrs. June Veenstra and Mrs. Evelyn Friedman who not only staffed the Symposium, but also are in large part responsible for these proceedings.

is that which involves the allocation of limited resources among competing purposes in an institution. How should the manager set priorities for such allocations? All such decisions represent a complex, interesting, and unique combination of the facts of the case, the politics of the situation, and the individual decision-maker's prejudices, beliefs, and ethics.

When competing groups are arguing about the desirability of a range of programs, whose arguments should be given the most weight? Should the scarce resources with which we are working in our institutions be devoted to improving preventive care services or devoted to crisis intervention and exotic treatments? Should they be expended for present purposes or should they be withheld from present needs in order to insure organization survival in the future or be able to meet needs which we don't now perceive. To the extent that different income, racial or religious groups exhibit different sets of medical and health care needs and advocate different sets of priorities in meeting them, how shall the resources be allocated among or across the groups? Who shall make the decision?

These questions cannot be answered solely on political grounds, nor do the economic issues provide all the clues needed to resolve them. The administrator of a health care agency or a hospital plays the role of a redistributor of income, a "Robin Hood," taking from people who have and giving to people who have not. He decides which persons or groups to take from and which to give to—a very weighty responsibility and one fraught with ethical issues.

Health care managers are frequently caught on the horns of a dilemma, one horn of which is labeled equality and the other horn labeled equity. Equality means equal amounts for everybody. Equity means fairness or justice. They aren't necessarily the same. When faced with a choice between the two, how does the manager behave?

I have raised a lot of issues. I have tried, by raising those issues, not so much to introduce them as topics for discussion as to focus the discussion down on these nitty-gritty, day-to-day snap judgment kinds of decisions which we are all making and which do have major ethical implications.

Over the next day and a half we will address these and related issues. We will hear from persons representing the fields of ethics, general management, medicine, academia, hospital administration and hospital trusteeship.

As I became more and more involved in the program planning and development of the program for this Symposium, I became more and more excited about the topic. I hope that, when we finish, you will be equally excited.

Morality in Management

DANIEL CALLAHAN, Ph.D.

CHAIRMAN MAY: We are fortunate in having as our first speaker Dr. Daniel Callahan who is the Founder and Director of the Institute of Society, Ethics and the Life Sciences. Dr. Callahan holds a degree from Yale University, a Master in Philosophy from Georgetown and a Ph.D. in Philosophy from Harvard.

Prior to founding the Institute of Society, Ethics and the Life Sciences in 1969, Dr. Callahan was a staff associate at the Population Council and was Executive Editor of *Commonweal* magazine.

He has served as Visiting Professor at Brown University, the University of Pennsylvania, Temple University and the Union Theological Seminary.

An author of 14 books and over 100 articles, he was chosen as one of the 200 outstanding leaders in the United States by *Time* magazine in 1974. His book on abortion won the Thomas More Medal recently.

The title he has chosen for his presentation is "Morality in Management."

DR. DANIEL CALLAHAN: I come to this topic with a great deal of trepidation. Obviously, there are problems of morality and management. Unfortunately, I could discover no literature on the topic of morality and health care management. In fact, all I can really bring to this task are my own reflections on the very large topic of managing people, and I hope with enough specific references to hospital management to be of some help to you.

This is a topic, despite the three criteria laid down, which does not lend itself all that well to finding an adequate scientific basis.

It seems to me that when we begin talking about matters of morality and ethics, we rapidly move out of what would narrowly be called science, and are forced back to some very basic and fundamental questions. The test in the end is not scientific validity, which seems to me an inappropriate norm, but rather rational validity. How can one think through ethical problems in ways which meet the standard of rationality, coherence, consistency; and thus in the end make some sense of the world in which we live.

Until a few years ago I spent most of my time writing and doing scholarly research. And I had the typical attitude of such people toward all administrators, namely, that administration was the easy way out, that the real work of the world was research and scholarship, and surely the most difficult kind of work in the world.

For the past six years, I have been an administrator. I have discovered I was absolutely wrong in my early attitudes. It is far more difficult running things than thinking about things, and I hope some day to retreat back into looking for the truth, with a big T—a very pleasant task compared with being an administrator.

What I would like primarily to do is to see if I can provide you with at least a framework for sorting out some of the issues. It will, of necessity, have to be a rather general framework, but what I have found most lacking in discussions of the general subject of morality and management is some kind of coherent way of even organizing the topic or deciding how one ought to approach it in the first place.

I want to talk about two aspects of the problem of morality and management: on the one hand, that of the obligations of the manager or the administrator; and on the other hand, the kinds of virtues, to use an old term, which I think ought to mark the administrator.

The essence of the work of the manager or administrator is to serve simultaneously many causes, values and interests. It is almost by definition the task of the administrator to make groups work, to make things run, to keep people functioning together in some effective and hopefully progressive fashion.

In the case of the health administrator, specifically the hospital administrator, it seems to me that one can separate out a great range of obligations. Certainly there will be obligations toward hospital trustees, or more broadly toward those by whom one has been hired. People are normally taken on to do certain jobs. They are given assign-

ments. They are given a kind of stewardship, and one could easily say that there is an obligation toward those for whom one works, namely, one's superiors.

There is certainly an obligation toward other professional groups. One must respect the values of the different professional groups which one tries to organize and administer. One must recognize that members of those groups have obligations of their own, that there are duties which they must perform as part of being simply what they are. Thus, the physician, the nurse, the paramedical person, even the custodial staff, all have certain kinds of duties which go with their particular roles. The administrator has obligations to respect their particular duties.

A third obvious area is obligation toward patients. That, after all, is what the whole system is about. Perhaps the most peculiar thing about obligation toward patients is they are by definition, sick, ill, weak, or debilitated. They are not in possession of their full powers while under the sway of people in health administration or under the sway of physicians and nurses. They are, in short, in a weakened, dependent position. One surely has obligations toward them.

There are also in our society very fundamental obligations to government, to state and federal laws and regulations. One might like to set them aside. In many cases they will be exasperating and troublesome, but nevertheless, one is obliged to recognize them.

Finally, there is an obligation toward the general welfare of society. That is a very broad sweeping kind of obligation but, nonetheless, all health facilities in this country certainly make the claim that they exist for the common welfare. That is certainly one of their claims when they go about seeking money. For just that reason, if no other, they have taken on an obligation to the general welfare.

I am assuming, in using the word "obligation," that one has obligations to all of these different groups. They, in turn, have certain rights; there are claims they do make upon you and claims they legitimately can make upon you. Surely the patient can say that you owe him or her something. Surely the government can. Surely the trustee or the higher health authority can as well.

The essence of the moral problem of health management is how to balance and deal with all of these obligations.

The claims that one can readily and with some agreement from others dismiss as invalid will really pose no problems. They may pose political problems or simply be annoying, but it seems to me the moral problems arise when one recognizes that indeed one does owe something to different and diverse groups. How in the world is one to discharge a variety of obligations to different groups with different needs and different claims, and, to make matters worse, often discharge them at exactly the same time? It is the nature of any moral dilemma that one finds certain fundamental rights or obligations coming in conflict with each other, and initially, at least, one sees no very clear way of resolving the conflicting claims.

I might mention parenthetically that, in talking about rights and obligations, from what I can observe no one has ever very clearly pointed out what the rights of the administrator are. All other groups are very articulate about their rights over against the administrator. I assume that everyone working in management or administration assumes that they, too, have rights. But, strikingly, as a group they have not tried to articulate the claims they can make upon others. This is made all the worse by the fact that the administrator seems to be in the peculiar position of trying to serve everyone else's rights, meeting all the demands of others, without clearly in the eyes of those others having very well-defined rights of his or her own.

In philosophy, there are a variety of ways of trying to resolve conflicts between and among obligations. One very standard way is to attempt to rank priorities. There may be, for instance, eight or nine sets of obligations to be discharged in a situation; but perhaps some are more important than others, and if one can decide which are relatively more and which are relatively less important, then perhaps most concrete issues can be resolved. Thus one might well make a case that one's primary obligation is to those for whom one works, the trustees, or other authorities. They are the ones who have hired one. They are the ones who have set the conditions of employment. One might thus claim that in all cases their demands should take precedence, and that, if there is any conflict between the demands of those authorities and the demands of other groups, then the authorities come first.

But certainly a very good counterclaim could be entered, particularly in the health services delivery area, that one's highest obligation is finally toward the patient, toward the ill person, the person in need, since that is why the whole system exists. Without the patient, there would be no system. The system claims and is presumably thought to exist to serve the patient. It does not exist to serve

trustees or the government. It exists to serve people, sick people. Shouldn't their needs take precedence over those of trustees, or superiors?

However, professional staffs and professional groups who work under one or at least are coordinated by one, might well claim that it is not the direct task of the administrator to serve patients. That is what doctors, nurses, and paramedical personnel are for. They might well claim that it is the task of the administrator only to establish those working conditions, those psychological, economic, physical conditions, which allow them to carry out their duties to the patient. These duties are far more direct because of their particular skill and training than are the duties of the administrator.

One could go on, I think, pointing out how different counterclaims could be put forward. My point is only that while it sounds easy to talk in terms of trying to establish some kind of hierarchy of obligations, which would enable one to make very clean and neat decisions, it turns out to be enormously complicated in practice.

I doubt that in the area of health administration one could clearly come up with a very simple kind of hierarchy with which one could, in some mechanical fashion, sort out all issues and make, at least, the kind of decisions that one could say were morally correct decisions.

Let me turn then to another way of trying to resolve large issues. That is the principle of doing the greatest good for the greatest number, a very common principle in our society, and I suppose the most commonly used shorthand ethic available.

It is a very attractive kind of principle, particularly for the administrator who, by definition, is not working in a one-to-one relationship as a physician might with a patient, but almost by definition is administering a large group of people.

One might then say that, if one runs into problems, particularly moral dilemmas, or even administrative dilemmas with large groups of people, that one's aim should be to serve the most people. If one can meet the interest and the demands of the largest number of people, then one has made presumably the right kind of decision, using that kind of ethical formula.

The problem, though, is that there are certain paradoxes in the health system if one really attempts to push that all the way.

First of all, the people in the minority in the health system—if one includes adminstrators, staff, patients—the people in the minority are probably going to be the sickest and most desperately ill patients. The people in the minority in most hospitals, I presume, will be, say, the *dying* patients. The majority will be people who are there for one reason or another, one illness or another, but who will normally be discharged, who are going to get out of the place. The people who are not going to get out are the terminal patients, and they will constitute probably the smallest group, if one thinks of all the people involved in the delivery of health care.

Now if one's principle is to do "the greatest good for the greatest number," then by definition one is saying that the numerical minority loses, and in that case, one gets the very odd result that the people most desperately in need of care, most desperately in need of resources and comfort, will, by definition, be left out of the system.

The difficulty with using a utilitarian calculus of the greatest good for the greatest number is that we simply will have to confront the problem of rights. It may well be that what is conducive to the greatest good for the greatest number can only be achieved by doing great harm or injustice to a few. Perhaps some people can live with that and are willing to sacrifice a few to achieve some overall benefit for the many. But it seems to me that we will have very serious moral problems on our hands if we always end up with a result which deliberately, or at least by default, sacrifices individuals for some larger good.

The problem of justice comes up very clearly here. Is it just to sacrifice a few in order that many will benefit? Do we as health care managers have the right to choose some people to be the victims, those who must personally and privately bear the weight of the benefits to be handed out to the many?

One probably could go on indefinitely talking about a conflict of obligations, and talking about what kinds of general moral principles one wants to use to deal with these conflicting obligations.

But I think there is quite a different way of going at the issue, one which, if it raises as many problems, may provide a somewhat more illuminating perspective. That is to talk, not in terms of the obligations of the administrator or the manager, but rather in terms of what ought to be the virtues possessed by such a person.

There are a number of virtues which can be pointed to, virtues which strike me, at least, as rather fundamental.

Surely, there is the virtue of efficiency. The virtue, that is to say, of managing the resources at one's disposal in some effective, rational and expe-

ditious way. One might speak here, in general, of possessing good and well-developed managerial skills.

There is certainly also the virtue of perceptiveness, by which is meant the capacity to perceive, and emphasize, and respond to the needs of the great number of different and usually very disparate groups with whom one has to deal, trying to understand what their problems are, getting under their skin, getting some sense of the way they look at the world. When one works in professional systems, there is a fundamental need to perceive how different professions organize, recognize, and try and perform their duties. What do they see as their obligations? What do they see as the particular sorts of tasks that they are supposed to be doing? What do they see as the particular sensitivities of theirs which others ought to recognize and be well aware of?

One also needs the virtue of genuinely respecting the rights of others, recognizing that people do have rights, that we owe other human beings something, that human beings are not simply items to be manipulated by us.

Finally, I would mention a kind of skill in the allocation of resources, a skill which is not simply that of being a good manager, but something which transcends that; a kind of skill in allocating resources while, at the same time, recognizing that perhaps justice requires that not all skills be allocated equally, across the board, that different groups may have different and disparate needs, and one skill may be required in not only figuring mechanically, so to speak, how to do it, but also somehow take account of varying needs in the process.

Finally, it seems to me an enormously important virtue for the administrator to be a negotiator, one who can deal with a variety of conflicting forces at the same time, a variety of competing claims, and can somehow coolly, and yet at the same time sensitively, deal with all of them in a way which even if some are not left happy, they will at least say that they have been treated with fairness and with some sensitivity.

But when one begins talking of virtues, one runs into some of the same problems as in talking about obligations.

What does "efficiency" mean? All that is economically efficient in a health system is not necessarily efficient in terms of human needs. The cheapest way to run a hospital, the most cost-effective way, may not be the way which is most responsive to the needs of patients or staff.

It is a peculiar situation that in medical care, psychological comfort provided the patient can often be as important as physical remedy.

This means that one is often forced to deal with the very difficult problem of how do you somehow build intangible kinds of benefits, intangible kinds of values into a system, over against very hard items such as dollar figures. How much efficiency ought one to sacrifice in the name of comfort and warmth? What does one do when one is trying as an administrator to develop very tight schedules to make sure that everyone is working efficiently and effectively, that resources are not being squandered? What does one do in situations where all of those goals may be actually antithetical to providing a great deal of warmth, having one's staff give time to patients, and in the end most painfully recognizing that the sick patient is often a person in extraordinarily great need. They are in the hospitals in what is for most people rather critical situations psychologically, where their needs are not going to be predictable. Their needs are not going to be simple. They are, in short, going to present problems which fly in the face of the efficiency which the administrator would like to maintain.

One can talk at great length about cost-benefit analysis. It seems to me the main thing which is known about cost-benefit analysis is that it is much easier to specify benefits than it is to specify costs. We can all think of the gains of a certain line of action. We can to some extent even put a dollar value on some of the costs, but it becomes very difficult if one is particularly thinking of patient care in dealing with the *psychological* cost to patient, the *psychological* cost to families who visit patients.

How are we to put any kind of figure on considerations of that kind? Cost-benefit analysis works only if one is able very radically to narrow the scope of both the cost and the benefits and normally to narrow them by trying to give a dollar value to them.

But if one knows anything about human reality, and anything about managing any organization, hospitals included, there are many things that one simply can't quantify. If there is to be a balance of cost and benefits, an awful lot of intangible, but nonetheless very fundamental, values have to be taken into account.

Another trap in trying to think of some of the difficulties in looking at the administrator from the viewpoint of the virtues is what Erving Goffman has called the very common trap in our society of "people work." That is, the assumption that if one's job is ultimately directed to the welfare of

people, that one is by definition doing good, that one is by definition a warm, sensitive, serving, sympathetic human being.

Goffman, however, particularly in his work on asylums, found that it is very common for people whose job it is to serve other people to begin looking at those they serve very much as objects of manipulation. Moreover, they often persuade themselves that it is all right to so look at people because in the end they are so doing good, that if they decide that they don't want to be involved with their patients, or don't want to be involved with their staff, don't want to be sympathetic toward them, that is legitimate, (a) because it may lead to greater efficiency, and (b) because in the end the very nature of one's work is to do good for people. Therefore, it doesn't matter very much along the way whether one happens to be doing good for any *individual* person. One has to take very serious account of the fact that, in large bureaucratic organizations, those organizations after a while begin existing for the people who run them, not for the people whom they are meant to serve. This is a special possibility in the hospital setting, where the patient after all is the transient, the one who comes and goes, while the staff is permanent.

It is very easy in that kind of situation to really begin worrying about those who are permanent in an institution, to be much more concerned with their needs, their problems, the obligations that one has to them than with those transients who come and go as patients.

The question in such a setting is: How is someone to achieve a good balance between the inevitable tendency to worry about those with whom one has to live day-in and day-out over a period of years as distinguished from those who will be just passing through?

In the end, whether one goes to the problem of management in terms of trying to sort out obligations or in terms of trying to specify virtues, or perhaps in terms of trying to develop a way of combining both of these, one can never hope that there are going to be any very clear and any very happy resolutions.

The very essence of trying to balance a variety of competing obligations is that one will never find the perfect balance, that one will always have to do some injustice to somebody. The world is not a perfect moral universe, and there are very few moral situations, particularly those involving large numbers of people with different needs, where perfect solutions can be found.

We can certainly learn a lot about the needs of different groups, about patients, about the needs of professions, by looking at some of the sociological literature. We can certainly learn something about the cost of running institutions by looking at budget sheets; but the peculiar problem in the end with making moral decisions is that one is finally forced to go beyond the data. One can collect data. One can collect observations; but in the end one is going to be forced to make the prudential judgments, and often to make them midst a great deal of ambiguity and uncertainty.

What one has to strive for and hope for is not the perfect solution which often simply can't be found, but instead, that solution which first of all is imbued with some notion of *principle*—that decisions are not simply ad hoc, self-centered, arbitrary and capricious, that there are some articulated sets of moral principles and values at stake, and that if one is asked to justify a decision, one is able to justify it in terms of the articulated values.

I don't think it is the case that every moral decision is utterly unique, so different that one can develop no general operating rules of principle at all.

On the other hand, I think it is very hazardous to try to develop one simple rule, namely, greatest good of greatest number, and hope that is going to do the trick. It will simply break down in practice.

There is a middle ground, though, where one begins getting a sense, first of all, of one's obligation, a sense that perhaps some obligations are more critical than others; where one also gets a sense of the kinds of virtues required. In the final analysis one recognizes that there is an enormously sensitive balancing act required here, a balancing which is going to require that one understand whatever facts are relevant, that one is going to understand the kinds of claims and interest at stake, and finally, that one must have some understanding of one's self.

Do we as people really know how we operate and think? Do we know what our values are? Have we thought them through? A very difficult task, it seems to me not only because if we think some of our values through, we may find ourselves rather appalled by some of their implications, but also a difficult task because one can't usually come to any terribly happy resolution. For that reason people run away from such things.

One of the very largest problems in our society, and one which all of you are sensitive to and aware

of, is the very difficult question of how we are to handle large bureaucracies and systems.

The size and complexity of our society requires that there be systems and these systems will, in fact, have to manage people, and unfortunately, in some ways will often end up willy-nilly manipulating people.

The peculiar fact of hospital management, or health care management more generally, is that one is dealing with some of the weakest, most dependent people in our society. One might say the real test of any system is whether it can deal with large numbers of people in sensitive and humane ways. It is almost inevitable that large bureaucratic structures and systems push away from concern for the individual, push to some higher abstract level of thinking about people, push, in short, in the direction of simply more and more efficiency even at the cost of more and more sensitivity.

I wish I could offer you a lot of neat, tidy formulas for dealing with morality in management. I can't.

The most I can offer is the plea (or challenge) that each of you develop a framework for your thinking in this area, a set of tools for addressing your problems, and further, that each of you take a very careful look at the ways in which moral language is used.

We all talk the language of goodness, virtue and righteousness, or at least we like to think we do. We certainly do on public platforms, but what do we mean by all those terms? Have we thought them through?

I would say finally that most of us, regardless of what we do, have rarely unearthed the structure of our own moral thought. Most of us do, in fact, behaviorally operate with some set of ethical values. Have we tried to make them consistent? Are they the values in the end that we want to have? That, I think, is a life-time task, not something done just once. It is a life-time task, and it seems to me that it will be the life-time task of the administrator to grapple with moral issues.

The administrator, however he or she is labeled, is still going to be making fundamental moral choices. They will be disguised very often as technical choices or as administrative decisions, but nonetheless, since they affect the lives of other people, since they will reflect some notion of what is good for societies or hospitals or health care systems, they will, in fact, be moral decisions.

The point, I think, is to recognize that, to ponder it, to then go on to the much more difficult task of developing those principles and rules of conduct which will make that moral task a viable one and hopefully one productive and helpful to others.

Some Ethical Implications of Management Styles

LEONARD DUCE, Ph.D.

CHAIRMAN MAY: The second speaker this morning is Dr. Leonard Duce.

Len is the President of Texas Military Institute. He is a graduate of McMaster University in Hamilton, Ontario, holds a degree in Sacred Theology from Andover Newton Theological School and a Ph.D. from Yale.

His career, his professional work, his writing and his speaking have been primarily in the areas of administration.

He has been addressing the Interagency Institute for Federal Hospital Administrators for a number of years now on this topic (and will become Director of that Institute on July 1 of this year). I have heard him speak and he is an extremely articulate, extremely thoughtful individual and knows a lot about the hospital field and the management field.

His title is, "Some Ethical Implications of Management Styles."

DR. LEONARD DUCE: When Mr. May invited me to participate in this symposium, I was impressed by his description of what he hoped would be the central themes of our discussion during these two days. I hope he won't mind my quoting from his letter:

> In planning this year's symposium we explicitly rejected consideration of a legalistic, "conflict of interest" approach to the subjects as well as consideration of "fuzzy" issues such as genetic manipulation, psycho-surgery, euthanasia, etc. We want to focus on the ethical or value content of management decisions dealing with resource allocations, programs of service development, capital investment, etc. As a group, health care administrators are quite capable of arriving at "rational" decisions in these areas after having taken into account all of the relevant financial considerations.
>
> But such decisions are inextricably involved with human values such as the "right" to health care and those value systems are not universally agreed upon (or even understood). Hence, there is a large subjective component in any such decision which transcends or (perhaps) undermines its "rationality."
>
> In the Symposium, we want to address this aspect of the decision process and to (hopefully) cause the participants to introspect on the question as well as to develop an empathy for the attitudes of others involved in a given situation.
>
> The opening presentation will be by an ethicist who will attempt to build a conceptual bridge from the science of ethics to the practice of management. I hope you, as the second speaker on the program, will be able to complete that bridge . . . building from the management side.

There are two terms which fascinate me in Mr. May's instructions. The first is "a conceptual bridge." This metaphor is especially intriguing when it is envisioned as a two-lane span between an evaluation of human conduct in general and an evaluation of a segment of human conduct in particular. To put it in another way, one lane represents the imperatives of an ethical interpretation of human conduct upon a particular segment of conduct, while the other lane represents the normative implications arising out of the nature of that particular segment—in this case, "management" or administration. Unlike the usual bridge however, the two lanes of the conceptual span we are discussing may not be parallel, may not be separated by a median which also unites them, and may not be coterminous at either or both ends. The fact that the general ethical imperatives of a society and the particular ethical codes of parts of that society, e.g., professionals, do not always agree is sufficient evidence of this fact. Of course, there is a mutual influence of general ethical judgments and particular ethical codes upon one another but at times they appear to be either contradictory or unrelated. Is it not true that for a long time in our industrial society, the demands of management efficiency were often at loggerheads with the general ethical imperatives to which that society supposedly subscribed? *Caveat emptor* and "the public be damned" are just two examples of such contradictions.

The other word which intrigued and frightened me was the word "complete." While a great deal of intellectual and practical traffic has travelled the lane from ethics to management, the other lane has not been as adequately constructed or as thoroughly used. The reason for this fact is not hard to find. In spite of all the intellectual effort that has gone into the study of management in recent years, it cannot compare in scope or depth with the effort of ethicists for thousands of years. Indeed when one looks at what Koontz has called "the manage-

ment theory jungle" he is tempted to agree with C. West Churchman who wrote in his *The Challenge to Reason:*

> Now managing is a type of behavior, and since it's a very important type of behavior, you might expect that we know a great deal about it. But we don't at all. We could also explore the many ways in which managers often think they manage, but observers of their behavior often differ from them quite radically. The manager is frequently astonished to hear a sociologist's description of his activities, which he believes he knows so well, and he resents the inclination on the part of the "detached" scientist to try to describe the activity that he performs. . . .
>
> The whole activity of managing, important as it is for the human race, is still largely an unknown aspect of the natural world. When man detaches himself and tries to observe what kind of living animal he is, he finds that he knows very little about his role as a decision-maker. Few managers are capable of describing how they reach their decisions in a way that someone else can understand; few can tell us how they feel about the decisions once they have been made. Of course, despite our ignorance about managerial phenomena, a great deal is written on the subject. . . . It appears that the less we know about a subject, the more we are inclined to write extensively about it with great conviction.

However, the relevant point for our discussion is that except for a few efforts by McGregor, Selekman, Golembiewski, Burske, and their ilk, neither the various theories nor the actual practices of management have been examined with any thoroughness to discover what normative problems they raise and what normative implications they entail. Of course, most management literature recognizes that there are moral problems and obligations in managerial practice but for the most part it deals with them from a legal rather than an ethical point of view. The confusion of the ethical and the legal in our time is vast and deep, as Watergate has shown us. The ethical analysis of management—as compared to its legal analysis—is in its infancy, so that any claim on my part to *complete* the bridge from management to ethics would be sheer presumption.

A final introductory word of explanation! I have chosen to discuss "the ethical implications of management styles" rather than "the ethical implications of management theories" because of the essential truth of Churchman's remarks. Whatever ethical or normative implications arise out of management, their source is more the practice than the theory of managing. For this reason also, I am using the word "style" to refer to the basic *motif* or over-all type of managerial activity. Of course conscious theory and rational form contribute to style, but other factors are equally important. No matter how scientific management becomes it remains essentially an art, so that the manager's value system, his attitude to himself, his way of relating to his superiors, peers, and subordinates, his aspirations for himself and his organization, and his moral standards determine how he manages as much as his intellectual grasp and his technical mastery of what he does. While we may argue endlessly whether "style" is a cause or consequent within the totality of management activity, I am using the term to characterize that totality in a fairly definite way.

I.

Before beginning the speculative process of building the bridge to ethics from the management side, it is only right that I state fairly clearly my assumptions about the other lane of our conceptual bridge. Whether these assumptions accord with what we have just heard from Dr. Callahan I leave for you to decide.

1. My first assumption is that there are some general ethical imperatives—that is, some judgments about values and obligations in human conduct to which our society, and, I suspect, most of us give verbal and ideational—if not always practical—allegiance. We believe that man is a moral being and that he judges his conduct in terms of the difference between what it is and what it ought to be.

2. These general ethical imperatives are interpreted in many and varied ways. Differences in interpretation result from cultural changes, from modifications of life styles, and from ideological revolutions. Moreover, the ultimate sources of these general ethical imperatives, as well as their accepted authorities, are different. Some are transcendentally derived from religious faith, some deduced from intuited or self-evident principles, and some from processes of philosophical analysis and synthesis. Perhaps nothing is more confusing to the layman than the divergence between equally competent ethicists concerning basic moral imperatives.

3. General ethical principles, whatever their source or form, are difficult to apply to particular situations. If the "why" of an ethical imperative is difficult to delineate, the "how" is often much harder. So much so that one is tempted to agree with Joseph McGuire,

> . . . I feel somewhat skeptical of the virtues of codes of ethics. Past experience with such codes has led me to adopt the attitude reflected in the beatitude. Blessed are those who expect nothing, for they shall not be disappointed. There is an old dilemma which surrounds busi-

ness theorizing, whether it is concerned with ethical codes in business or other occupations. Such codes either impose a dogmatic rigidity upon people or institutions and cause them to act unnaturally amidst the complexities of the real world, or are written in such indefinite, misty, and grandiose terms that they are meaningless.

We are always caught between the Scylla of endless casuistry or the Charybdis of emotional generality. However, this difficulty of applying ethical principles to one-time situations does not relieve us of either the need or the impulse to generalize and to particularize in each and every decisive human situation.

4. My fourth assumption is that we can reduce to *four* these general ethical imperatives without doing an injustice to their multiplicity and complexity. Briefly stated, they are:

(a) Every human being has a moral obligation to be as intelligent as he is capable of being. To be intelligent is not *merely* to be logical in some coldly formal and objective way, important as this quality of human behavior is, but also to be sensitive to the complexities of the situations in which he finds himself, to give as much rational form as he can to those situations, to distinguish between objective fact and subjective feeling while recognizing the importance of both, and to be always open to new experiences and new ideas.

(b) Every human being has a moral obligation to act deliberatively and to assume responsibility for his actions. Of course, much of human conduct is reflexive and habitual—but the mark of *homo sapiens* is that he can make decisions, that he can initiate action, and that he can be held accountable for both his decisions and his actions.

(c) Every human being has an obligation to respect human personality, whether his own or others'. He must acknowledge the right of every human being to be a genuine self and therefore, to some degree, the determiner of his own destiny. Perhaps this obligation is best summed up in the command, "love thy neighbor as thyself."

(d) Every human being has a moral obligation to contribute to the general good of mankind while at the same time fulfilling the potential of his own personality and life. As Bertrand Russell put it, "Without civic morality communities perish; without personal morality their survival has no value." This imperative arises out of man's inevitable participation in human life beyond his own individuality.

The specification of these general ethical imperatives in the various areas of human activity is a never-ending task—and I for one am most grateful for thinkers like Dr. Callahan who direct the traffic along this lane of our bridge between ethics and management.

If we are to build the other lane we must recognize that these, or similar, general imperatives describe the goal or *terminus ad quem* to which the valid normative implications of our management practice should point. Otherwise, we do not have a bridge at all but two projections over the unknown which either collide destructively or miss each other altogether. No one has recognized this fact more clearly than Golembiewski who believed that until our ethical principles and our management practices are *both* reinterpreted so that they meet where men can and must travel, there is only tragedy ahead in our post-industrial society.

II.

In the limited time at our disposal, we cannot examine every style of management. In one sense, there are as many styles as there are managers, but in another sense, management styles tend to group themselves around certain common characteristics. Therefore, this morning, I shall confine myself to three of them. At the risk of getting into semantic trouble I shall designate them (1) autocratic, (2) idealistic and (3) realistic. These do not correspond to the usual categories of style, e.g. as developed by Blake and Mouton or by McGregor, but they will serve to illustrate the ethical problems and implications of different managerial styles. Let me remind you again that I am thinking primarily in terms of managerial activity rather than in terms of the theory which may be used to explain or defend that activity.

1. *The Autocratic Style*

This is the oldest and unfortunately the most venerated management style. Its basic *motif* is that the administrator is at the top of the organization and that power within the organization always flows in one direction, namely from the top down. While this style may be camouflaged, as in paternalism or pseudoparticipative management, its theme is always that the administrator: (1) knows best; (2) makes all the really important decisions; (3) demands complete loyalty; and (4) maintains the organizational structure as close to its formal model as possible—except where it threatens his authority, in which case he does not hesitate to change it. The autocratic style involves a strong ego image

and at the same time a cynical depreciation of other persons. The autocratic manager believes not only that "the buck stops here" but also that "the buck must *always* stop here." He expects his decisions to be obeyed unquestioningly and he values submissiveness in his employees above creativity and, too often, above competence. The organizational structure is an instrument not only of his authority and power but also of his will. Lest anyone believe I am drawing an exaggerated picture here let him think seriously about the literature on management and organization until very recently. Even with the change in the theoretical approach to management style now under way, the qualities I have described break through in the typical managerial reaction to developments in labor relations, governmental regulations, social expectations, and social control mechanisms. The real issue for many managers is not whether these forces are good or bad in themselves but whether they threaten the manager's powers and prerogatives. Every Wednesday at Rotary, I am subjected to endless, nostalgic complaints about not being the boss anymore.

What normative implications does this management style have for its disciples?

First, it implies that in the work situation—and even beyond it—most men are not only unintelligent but are incapable within themselves of attaining any real semblance of intelligence. It is the manager's job to impose his intelligence upon them. "Theirs is not to reason why; theirs is but to do or die." In our kind of world this imperative for the manager goes beyond his relation to the managed; it extends to other men everywhere—in similar organizations, whether cooperating or competing, in the community, in the economic, social, and political worlds, and in society in general. When, however, the autocratic syndrome moves to its logical conclusion, it contradicts itself, for its perpetrator is himself no longer truly intelligent as we defined that quality a few moments ago. He is not sensitive to the complexities of situations; he is not open to new experiences and new ideas. In attempting to supersede the obligation to be intelligent which devolves upon his fellow men, he fails to fulfil that obligation in himself. Of course, every administrator should know more about his own job than non-administrators, but he may very well know much less about the jobs of others who work for and with him. Much of the publicized conflict between administrators and professionals stems not from their comparative intelligence but from the residual autocratic syndrome to which each is so often subject. This imperative of autocratic management is thus self-contradictory and cannot serve to help build the second lane of our bridge between management and ethics.

Second, autocratic management style does imply that the administrator should act deliberatively and assume responsibility for his action. At first glance it would appear that this style suggests a successful building of the bridge from management practice to ethics. The problem arises, however, when we ask what kind of deliberative action and to whom the administrator is responsible for his actions. The autocratic administrator ultimately consults himself and is responsible to himself. But the world in which the contemporary administrator lives is not conducive to such an egocentric expression of an ethical imperative. As the *Atlantic Monthly* put it some years ago, "Everyone is someone else's peon" in our world. The manager's deliberations must take into account the opinions of others as well as his own best thought; ultimately he must take responsibility for his actions but that responsibility has its reference to his board, his consumers, his peers, and eventually society itself. No matter how much he resents it he is responsible for his decisions and actions not only to himself but to all those persons and organizations that his decisions and actions affect.

Third, autocratic management style implies that the administrator must view those who work for and with him not as determiners of their own destiny but as objects of his and his organization's manipulations. Their skills—not to say their persons—are only commodities which he commands and not also instruments for their own personal fulfillment. It is one thing to recognize with Selekman and Golembiewski that "administrators cannot realistically and morally discharge their responsibilities until they recognize that they monitor power systems" and another to "claim a kind of divine right to monopolize power, and feel morally justified in doing so."

Fourth, autocratic management style implies that workers are "social isolates," to use Golembiewski's term, and that they have to be forced into social cooperation by some kind of regimentation or external reward. The former runs completely counter to the moral obligation to contribute to the common good while the latter ultimately vitiates the organization's effort. We may laugh at or with Robert Townsend, but at times he comes close to the hub of this aspect of managerial style when he says,

> And look at the rewards we're offering our people today; higher wages, medical benefits, vacations, pensions, profit

sharing, bowling and basketball teams. *Not one can be enjoyed on the job.* You've got to leave work, get sick, or retire first. No wonder people aren't having fun on the job.

Simply, then, the normative implications of the autocratic managerial style are diametrically opposed to those general ethical principles we have suggested as characteristic of our society. Whatever virtue there may have been in this style in the past, it cannot serve as the abutment on which to build our lane from management practice to ethics today. By failing to recognize this fact, we are not only creating obvious managerial difficulties for ourselves, but we are exacerbating a conflict between our fundamental moral values and obligations and the implied values and obligations of our management position.

2. *The Idealistic Style*

At the opposite end of the managerial spectrum is the style which has been given names such as "theory Y," *laissez-faire,* democratic, fully participative, or as I prefer to call it, idealistic management. The manager, so conceived, is first among equals, not so much at the top as out in front. Power does not flow from him to others, but it permeates the whole structure of the organization almost like alternating current in an electric wire. Its theme is that the administrator: (1) may sometimes know best but usually knows less than the group of people who work *with* him rather than *for* him; (2) makes very few decisions on his own and still fewer major decisions, (3) bestows loyalty. rather than demanding it from others; and (4) subordinates the organizational structure to people. In spite of some indications to the contrary, perhaps no writer on management and organization has so thoroughly manifested in both his writing and his practice these qualities of the idealistic style as Robert Townsend. Borrowing from McGregor, Townsend insists that people are the key to managerial and organizational success. Speaking of organization charts as *rigor mortis,* he says

> . . . draw them in pencil. Never formalize, print, and circulate them. Good organizations are living bodies that grow new muscles to meet challenges. A chart demoralizes people. Nobody thinks of himself as *below* other people. And in a good company he isn't. Yet on paper there it is. If you have to circulate something, use a loose-leaf table of organization (like a magazine masthead) instead of a diagram with the people in little boxes. Use alphabetical order by name and by function wherever possible.
>
> In the best organizations people see themselves working in a circle as if around one table. One of the positions is designated chief executive officer, because somebody has to make all those tactical decisions that enable an organization to keep working. In this circular organization, leadership passes from one to another depending on the particular task being attacked—without any hang-ups.

The normative implications of this managerial style are quite different from those of the autocratic style.

First, the idealistic style implies that men are naturally intelligent and that the imperative to be intelligent is unnecessary. The imperative for the administrator is to create those conditions in which intelligent men and women, in the words of "Annie Get Your Gun," do "what comes naturally." The difficulty here is that "the moral obligation to be intelligent" in our general ethical culture has no significance if man cannot be intelligent or if he is naturally intelligent. The idealist implication veers away from the lane from ethics to management as much as the autocratic implication. Golembiewski has demonstrated that social ethics with its idealism is as false to the ethical nature of man as is Protestant ethics with its cynicism.

Second, the idealistic managerial style implies that human beings just naturally act deliberatively and are willing to take responsibility for their actions, so that the imperative for the administrator is again to set up the conditions for his people to be themselves. If you will pardon another reference to Townsend and his egocentricity, he states this position most forcefully in his reference to his experience at Avis:

> In 1972 after thirteen years Avis had never made a profit. Three years later the company had grown internally (not by acquisitions) from $30 million sales to $75 million sales, and had made successive annual profits of $1 million, $3 million, and $5 million. If I had anything to do with this, I ascribe it all to my application of Theory Y. And a faltering, stumbling, groping, mistake-ridden application it was.
>
> You want proof? I can't give it to you. But let me tell you a story. When I became head of Avis I was assured that no one at headquarters was any good, and that my first job was to start recruiting a whole new team. Three years later, Hal Geneen, the President of ITT (which had just acquired Avis), after meeting everybody and listening to them in action for a day, said, "I've never seen such depth of management; why, I've already spotted three chief executive officers!" You guessed it. Same people. I'd brought in only two new people, a lawyer and an accountant.

The problem comes when we ask what the conditions should be and how they can be created. All the attempts to answer these questions are

either too general and infinite or too particular and finite. But again, if there is an ethical imperative to act deliberatively and to take responsibility for one's actions, this must be because persons do not always obey such injunctions, even though we can admit with the idealist—contradictory to the cynical autocrat—that they can do it. And again, the lane from practice to ethics is not necessarily complementary to the lane from ethics to practice.

Third, the idealistic, managerial style contains the obligation to recognize persons as ends and self-determiners of their destiny. It agrees with the general ethical obligation to respect human personality wherever it is found. But in doing so it overlooks the finitude of human personality, which includes the possibility of both *being*, and making others *to be means* instead of *ends*. Otherwise, no ethical obligation to respect personality would ever have arisen out of human social life. Moreover, it forgets that in management situations we are faced with limited purposes, circumscribed relationships, and conflicting human values.

Fourth, the idealistic managerial style implies that to contribute to the common good is to fulfil oneself. There is no more truth in this implication than in the supposition of the traditionalists that to fulfill oneself is to assure the common good. At this point the cynical and idealist ideologies—like most opposites taken to their logical conclusion—seem to merge. The utilitarian, "greatest good for the greatest number," does not really solve the problem either, since we *may* know what "greatest" means when it modifies "number" but we *do not* know what it means when it modifies "good."

At least, the idealist style is positive about human nature in a way in which the autocratic style is not—but it cannot serve as the logical abutment of our bridge from practice to ethics since it really affirms that ethical imperatives are not truly meaningful because they are not needed. If the implications of the autocratic style collide with our general ethics, the implications of the idealistic style make our general ethics superfluous. To quote Socrates, "Which is worse, only God knows."

3. *The Realist Style*

Up to this point I have deliberately dealt with my subject from the philosophical and the general management viewpoint. It seems to me that the descriptions of the normative implications of the autocratic and the idealistic styles apply with equal force to management in whatever institution it is performed; moreover, it is not difficult to specify these descriptions to every management field. In dealing with the third managerial style, which might be called, "realistic," I shall endeavor to relate it specifically to the health care field. My reason for doing so is both philosophical and practical. While there is a fundamental core of management theory and practice applicable more or less alike in different institutions, the nature of the institution in which the manager operates also has an effect on the style of that operation. It is not *realistic* to believe that exactly the same attitudes and actions will be effective in such varying organizations as a factory and a hospital. While the quantitative and scientific procedures may obey the same objective laws, the more human activities will be influenced by the different goals, structures, processes, and evaluations in varying institutions. A realistic style of management is specific in a way not characteristic of either the autocratic or idealistic style. It can only be described adequately in terms of a specific environment. And, of course, in this symposium our practical concern is health care administration and its organizations.

The hospital—like the university or the preparatory school—shares many characteristics with business organizations. But there is a difference. Recently an article by Al Nash in *Personnel Journal* (December 1973) pointed out that there had been much less conflict in hospitals than in other organizations. Let me quote his explanation:

> A major reason for this state of affairs is that the value system of the hospital is less conducive to conflict than the value systems of profit-making or of other large-scale organizations. . . . The core of the value system is patient care which draws employees together, integrates the structure and helps overcome many of the problems present in the hospital. The result is an orientation to the sick that is built in the roles of many employees including blue-collar workers, and takes the form of a desire by the employee to play a constructive role in patient care.
>
> Along with the master value of patient care is the use of persuasion and education which is part of the social climate of the hospital. The use of persuasion and education is consistent with the presence of a high number of professionals who play the major role in the hospital.

As I think of the hospitals I have known it is ironic that those persons furthest removed from the master value of patient care have often been the members of the administration. However, Nash's point is well made, as we shall see in a moment.

The realistic style of management is based upon a recognition that manager and managed are finite human beings and that they operate together in finite situations. (1) The manager may often know better but sometimes may know less than the people

who work for and with him. (2) He makes many decisions but not all of them; and most of the decisions he makes are the result of combing through inputs from many sources and levels in the organization. (3) He expects loyalty but he knows that he must merit it; he also bestows loyalty whenever and wherever he can. (4) He sees the organization as both a formal structure and a society of persons in dynamic relationship with each other and with the objectives for which they exist. He is neither confined by the first nor submerged in the second. But most of all his style is that of the low road rather than the high road—to use Golembiewski's terms. He does not allow ideology, whether conservative or liberal, to prejudice his decisions in particular situations. "He confronts individual issues on their individual merits," which, as Bell says, the ideologist, whether cynical or idealistic never does. Perhaps most of all the realist style of management puts the manager not so much on top or out in front, although at times he will take each of these positions, but rather in the middle where the action is.

What then are the normative implications of the realist style as exemplified in the hospital or health institution administrator?

First, it implies that what is needed is a kind of intelligence which can combine structure and process, the scientific and the human, the rational and the subjective, as it deals with the problems that arise in the hospital. In our "age of reason" it is easier to master structure, whether organizational, fiscal, quantitative, technological, or even procedural, than it is to guide the human processes which give the structures life and purpose and value. I recently had a rather startling experience of this comparison in a large and complex mental health organization on whose board I serve. The executive director—a graduate of an H.A. program—discovered in January, a month after his appointment, that the deficit for his budget year was likely to be $140,000.00. For two board meetings we heard lengthy plans—very rational ones at that—to eradicate the possibility of the deficit. It was apparent to all of us on the Board that the executive director felt that his managerial life and reputation were at stake as well as the viability of the whole organization in the community. Suddenly, without warning, he had a rebellion on his hands. The director of one of our important programs, a psychiatrist of some note, asked to appear before the Board. His complaint was that he could not work with an executive director whose only concern was a budget deficit. Programs, he said, were the reasons for budgets in the first place—should not they, rather than fancy arithmetic, be the basis for adjustments to the budget. Instead of subtracting numbers, should not the executive and the board be discovering ways of saving money by making the programs qualitatively more efficient and effective? The most startled person in that session of the Board was the executive director himself! I am happy to say that he was intelligent enough to get the point—and the Board was intelligent enough to let them clear it up on the management level, refusing to enter the conflict at the board level. The hospital administrator's life is full of the need to be sensitive as well as rational, to be open as well as decisive, since he deals constantly with other people. And their subjectivities are nearly as difficult to understand as his own!

The realist manager recognizes that to be intelligent in his job, he must be continually aware of the objectives of his health care institution. It is not enough to mouth words like "quality patient care" or "we pamper patients" or "your health is our aim." The objectives of a hospital are complex, many layered, and constantly enlarging. They may center in the patient but they include in one way or another the good of everyone who works in the hospital, the well-being of the constituency which supports it, and the enrichment of the community for which it is now an integral rather than a residual institution.

Second, the realistic style of management implies both deliberativeness and responsibility. But it is a deliberativeness which is qualified by the recognition of the unknown, by the necessity of taking a risk, and by the willingness to act before all the evidence is in. The administrator of a hospital lives in an atmosphere of knowledge and of risk far too complicated to characterize here. His actions are predicated not only on his own thoughtful awareness of the situation but also on his appreciation of the professionals' expertise in other aspects of the situation. But neither his knowledge nor theirs is perfect or certain. To be deliberative is not to be omniscient, but it is to be careful, to seek advice, to be honest with oneself, with one's staff, with one's constituency, and above all, to keep the patient at the center of his deliberation.

In a complex situation like the hospital, it is easy for the administrator to try to avoid accepting responsibility for his actions. He can blame the doctors, the nurses, the agents of government, the members of his board, the lack of legislation or

too much of it, the economy, and even his assistants —but in the long run, he fools no one but himself! He may be able to delegate authority, but he cannot delegate responsibility. Many people are horrified today that liability for malpractice is now a burden for the administrator as well as for the doctor. In fact it has reached the board member—frankly I have not recovered from the discovery that the board of a hospital on which I serve has insured me for $1,000,000.00, and the board as a whole for $10,000,000.00. (I still find it anomalous that a lowly educator might be sued for that amount.) While this trend troubles me—if for no other reason than its materialistic *motif*—it indicates something far more important, the undoubted accountability of the executive in a modern hospital for his own and all other actions that go on in it. This implication of the realistic style obviously moves toward the direction from which ethics speaks to the manager.

Third, the realistic style implies respect for but not worship of human personality. The manager must inevitably think of persons as *means* sometimes, but if he is properly realistic, he must also remember that it is only part of them that he can ever use as means to his or his organization's needs. Their skill, their professional expertise, their capacity to work—these, not their integral selves, are instruments in his employ. He can use, evaluate, even eliminate these qualities from his presence—but he should never go beyond that. Perhaps no lesson has been harder to learn in our highly organized society than that even the lowliest person has a right to be the determiner of his own selfhood. Much has been written by the psychologists of management on the greater productivity of workers when they are recognized as individuals with ideas of their own and are allowed to contribute individually to the working of the institution. For this we can rejoice, but there is something more important in the facts upon which this conclusion is based—namely, that there is a value—a genuinely ethical value—in people being themselves as genuinely in their work situation as in the other areas of their life.

I served for awhile on the advisory board of a hospital which had an autocratic administrator. The time came when I had to have an operation in that hospital; for some reason the administrator was not informed when I was admitted. About three days after the operation, he rushed into my room, almost falling over a Mexican girl who was cleaning the floor, and grabbed my hand and apologized for not having come sooner. In the confusion, I noticed the girl rush from the room. Some time after the administrator left, she came back. I asked her why she had disappeared so suddenly. I have never forgotten her answer. "I cannot stand to be in a room with someone who never sees me. In the last few months he has almost fallen over me several times but has never, by a word or a glance, let on that I was there."

In the hospital, which after all is a place of crisis, where patients and family members are often threatened at the core of their life, the manager has a special responsibility to respect persons. To lack that respect anywhere in the organization sooner or later affects the ambience necessary for personal healing and perhaps survival. Such respect is not some kind of emotionalism or even some exotic "I-thou" relation praised by certain sensitivity fanatics, but rather a realistic acknowledgement that while we sometimes must use each other's skills we never abuse each other's person. The difference is infinite. The realist manager knows that he must combine order and freedom if the kind of teamwork necessary in a hospital is to be realized—and that demands genuine respect for persons at every level.

Fourth, the realistic style of management must take into account the common good as well as personal fulfillment. No institution is more beset by conflict concerning "the common good" than the hospital. In the contemporary morass of cynicism and idealism, the hospital administrator is bombarded from both sides. The cynic says, "everyone is entitled to as much health care as he can pay for"; the idealist insists, "health care is the right of every person regardless of economic status." The former yells, "down with the welfare state; damn socialized medicine." The latter shouts, "up with government health insurance; break the doctors' hold on medical care." The realist health care administrator is aware that this ideological battle will likely go on for a long while—just as did a similar battle in education—but he is also aware that he must do his job in a finite situation. He cannot escape fall-out from the contemporary predicament nor can he desist from acting until the social conflict has ceased. And like everyone else he has a right to enter the lists for what he believes to be the right. But he must live today—not yesterday or tomorrow—and he cannot allow the warring ideologies to detract him from that imperative. His job demands that he recognize the situational demands of right now!

The word "common" may be misunderstood as "equal" or "ideal" or "average" or even "human."

The common good has to be decided in each particular situation, not in some purely relative way, but in the light of a creative tension between the ideal and the possible. The realist manager recognizes that he and the situation in which he finds himself are both finite. His special ethical dilemma is that he often must choose not the best over the worst or even the good over the bad, but the better over the good or the bad over the worst. By the same token, the truly normative implication of the realistic style is that the manager *must* make the choice, with the best help he can get from his team, even when he knows that the end of his action will not be either as common or as good as it should be. He must decide and act! This imperative overrides many times other possible normative judgments on the quality of his decision and action.

Perhaps it is too much to say, but I believe that the realistic style of management has normative implications that can help to complete the bridge from ethics to management and from management to ethics. Moreover, if there are such things as ethical imperatives on the one hand and management imperatives on the other, surely the most relevant place to bring them together is in the hospital where human values are ultimately both the *end* and the *means* of all that we do.

DISCUSSION

with Daniel Callahan and Leonard Duce

MEMBER: I wonder if the speakers could talk a little bit about the difference between those ethical decisions that are clearcut in all circumstances (the manager, for example, shouldn't embezzle), and those ethical decisions that are situational in which no ground rules exist and in which decisions have to be made on a day-to-day basis.

The manager is faced with both kinds, and the extremes may be easy to decide, but it is the questions in the center with which one has to wrestle with himself as to which way to go.

DR. CALLAHAN: Let me begin by observing that I doubt that any such situation is really utterly and totally unique. It seems to me that the problem is that one finds unusual combinations of factors and this combination doesn't seem to lend itself to easy resolution.

Here I like to think in terms of general moral policy. 'Policy" in the sense that one has no fixed rules of conduct for every single situation (much as a foreign policy can't say what will happen in every conceivable situation), but by and large has established a kind of bias toward working something out, a bias which one feels one can legitimate and justify—which pushes one in one direction rather than another. As a practical point one has to decide, in those very unique, strange kinds of situations, what are the highest values one is trying to serve, and take that particular course of action which seems best to serve them, recognizing that what makes the situation very difficult is that you are not even clear what the values are. In fact, there are a variety of values, all of which you would like to serve simultaneously.

DR. DUCE: I think the question is a most interesting one, and very, very difficult to answer.

With regard to the first kind of decisions to which you suggest the answers are clearcut, your own illustration has something to tell us. You used the illustration of embezzlement.

There have been philosophers who thought ethics dealt solely with what you shouldn't do. Santayana was very close to this. In this framework the negatives are often far clearer than the positives. In other words, we have definitely decided that some things aren't moral, and we don't do them. In the past, the negative side has been much more definitely defined than the positive. But lest we think that is absolute, the new morality today is indicating that some of the negative things we thought we were sure of are no longer exclusively defined as negative.

The second thing I want to say is I think that in the ordinary decisions that Joel was talking about in his introduction, we are very seldom in a clearcut ethical situation: "If you do this you are bad; if you do that you are good."

As McGuire said in his book on business ethics, the tragedy of ethics in management or business is that I always have to choose not between the bad and the good but between the better and the good or the worse and the bad, and I wish this weren't the case, but I would have to say that it stems from the fact that we are finite human beings.

One statement we cannot make is there are no absolutes. That happens to be a self-contradictory statement because if it is true, it is false, and if it is false, it is true. On the other hand, whenever we try to describe those absolutes, we find ourselves in difficulty.

I have a feeling that the important thing is that the manager ought to be intelligent in the sense that I have described. He shouldn't merely allow others, whether it be based on the ideology of his group or that of the total culture, to determine which way he acts. He has a responsibility for deciding.

We have not, as such, defined "ethics" this morning. I am sure that no single definition of ethics would satisfy any group of philosophers that I know or any group of pragmatic people that I know, and the reason for this is that the system of ethics under which our society is operating de facto has its source in many places historically.

In the first place, of course, the primary source of our ethical insights, or ethical beliefs, is religion, and particularly in our Western society, the Judeo-Christian religious tradition.

The second source of our ethics has been naturalism, scientific naturalism, which has pretty well dominated our thinking for the last three hundred or four hundred years about nearly everything. Knowledge is a tremendously important ingredient in any ethical system, and particularly when you attempt to apply it to situations.

I think there is another strand, namely, the humanist: the recognition beginning with the Greeks of the tremendous significance of human nature, not just as understood scientifically, but as understood in its totality. That ground for ethics received a tremendous boost in the Renaissance.

Another source throughout history has been hedonism, and this seems to be very much a part of human nature also. Namely, that is good which is conducive to happiness, and that is bad which is conducive to pain or unhappiness, and almost all of the great ethicists including the scriptural ethicists recognize this source.

In our modern world another source has been pragmatism, and I am talking now about the source of ethics that has risen out of our Industrial Revolution, our Scientific Revolution. What has worked has come to be what is good.

Then finally, especially since Kierkegaard, there has been a strand of existentialism which has been a source of ethics. In other words, where you stand in the situation is the criterion.

When you put all these together you have a very complicated system of ethics. If I were to define it, I would define it very simply as this: It is the way in which we judge human conduct with reference to its being right or wrong, good or bad.

By the time we reach our occupational status as managers of whatever form of organization, we already possess, as human beings, a highly complicated system of ethics or, said another way, a highly complicated system of morality which we have not fully made into an ethic.

Ethics, as philosophers have pointed out for a long time, exist on different levels in human experience. Personal morality is perhaps the first and the deepest within human nature, then institutional morality. All the various institutions—families as well as corporations—have their own systems of ethics, but they are never quite the same.

Finally, there is social ethics, a great deal of which has been promulgated in our century, perhaps more than any other century.

The question which is raised is, of course, "What are the judgments about values and the obligations imposed by the social ethics onto the institutional ethics, and subsequently onto personal ethics? It is this question which managers of health care enterprises—indeed managers in all organizations—must ultimately answer for themselves.

MEMBER: I would like to ask Dr. Callahan to comment on the use of negotiated compromise as a means of defining the good.

DR. CALLAHAN: I think one often runs into the situation where there is a basic conflict between the ethical and the political issues involved in a decision.

The whole point of negotiation is to find a process to resolve very fundamental differences, and it seems to me it is a rational, almost self-evident kind of procedure to use. This is particularly true when there are very strong fundamental conflicts among people for which there seems to be no course other than negotiating, seeing what kinds of tradeoffs can be arranged, what people will be willing to give up in turn for something else.

The problem is that many people, when forced into a compromise situation, feel that they are going to be betrayed in the process, that they are going to be forced to give up something good.

Often the fundamental value is that the welfare of the organization is at stake. People realize that somehow the organization must go on and must continue functioning, and that becomes a higher

value than the individual principles of particular people involved in dispute.

Now if people are unwilling to enter into negotiation, if they are unwilling to say there is a higher good perhaps than my holding on to this or that value, then, of course, negotiation can't take place. All of us get in situations where we are forced to give up some of our convictions or modify them or alter them in order to adapt to other people's convictions. This is obviously very difficult. It depends on how much is at stake, of course, in terms of our values, but by and large, I don't see how organizations can operate at all unless people are willing to enter into that kind of political process, a political process which I think can be seen as a moral process if one is interested in preserving an institution.

MEMBER: Idealistically, should or can a manager enjoy the luxury of letting his own moral values or idealistic ethics interfere with the decision process in the organization for which he is working? In situations where his own moral or ethical conviction may not be shared by others should he not "step back" from the decision process to avoid imposing his values or "biases" on it?

DR. CALLAHAN: That is always the first luxury we allow ourselves, I think.

It seems to me that it is impossible for people to give up their own values. They can conceal them from themselves. They can hide them. But it makes no sense to talk of somebody "giving up his values." They are going to come out in one form or another. Either the person will have no conscience at all, in which case one would be wary of having that kind of administrator around, or the person does have a set of values. They will inevitably come out, if not in explicit statements, then in the behavior patterns of the person.

It seems to me if one takes the administrative role as peculiarly that of the negotiator, the bargainer, the balancer, the one who has to arrange many forces, then certainly one virtue should be the ability to step back and ask objectively, "Well, which team am I on, and what are my particular values here?" Yet, at the same time, I don't think that one ought to make that such a radical ideal that somehow one is talking about a disembodied person who is nothing more than a detached, rational automaton. When anybody says, in some very critical situation, "I am objective about this," one tends not to believe him.

Perhaps the most difficult problem facing the manager is precisely in this area: how to preserve objectivity and rationality without doing violence to one's values—or vice versa.

DR. DUCE: If I may, I would like to comment. There is probably a point at which the decision or issue at stake affects what might be called the top priority of one's ethical value system. At this point one has to take a stand, like Socrates took a stand and other people down through history have taken a stand.

But I often think that stands are sometimes taken on what I would call secondary or even tertiary moral priorities, and the long-range values that are involved in the situation are lost sight of. This doesn't mean that a person will usually compromise his ideals. I think what it does mean is this: that if he has a genuine system of values, he is going to make darn sure that he doesn't damage or short-change the organization unless it is for the most important of those values. I am sure that such a confrontation occurs seldom in a manager's life.

I have seen once or twice where a manager put his job on the line because of his moral principles, and I admired him for doing so because it happened to be dealing with one of his highest values, not some of the secondary considerations.

CHAIRMAN MAY: But, if you had disagreed with his moral position, would you not have thought he was a darned fool for doing so?

DR. DUCE: Well, I am not sure I agreed with Socrates. I am not sure that I would have done what Socrates did in that particular issue, but I admire him for having done it. The friend of mine I was thinking about who did this had priorities quite different from mine. In fact, I kind of thought that he was dumb for having those priorities. But I still had to admire him for living by them.

You see, what was at stake here was his own integrity, and how often is one's own integrity at stake? That is the real question to ask. If I can violate a moral principle without destroying my integrity, it couldn't have been a very important principle. But if it is very important, and it is at the very core of my value system, then I do nothing but destroy my personality and my self-respect by not standing up.

Managerial Ethics in Practice: I. An Administrator's View

DAVID H. HITT

CHAIRMAN MAY: The next segment of our program will be devoted to an examination of the application (or, perhaps, applicability) of the concepts of ethics in health care management. We have asked the speakers—a hospital administrator, a physician, and a hospital trustee—to speak from their own experience about the relevance or irrelevance of these concepts in their professional lives and roles. The administrator's view will be presented by David Hitt.

Dave, as most of you know, is the Executive Director of Baylor University Medical Center. He has been with the Medical Center since June 1st, 1952, has been a hospital administrator since '47. He has a degree in Hospital Administration from the University of Minnesota. He is a recipient of the Earl M. Collier Award for Distinguished Hospital Administration from the Texas Hospital Association. He is currently Chairman of the Regional Advisory Board of the American Hospital Association and a member of their Board of Trustees; he is also on the Administrative Board of the Council of Teaching Hospitals for the AAMC and a member of their Committee on Graduate Medical Education.

MR. DAVID HITT: A speaker on a program like this, unless he is first, usually finds that the previous speakers have said many of the things he had planned to say, or that they have said things which, on the surface, seem different but may not actually be different. We have already heard very stimulating ideas articulated well and I will be repeating some of them but hope to cover them from a perspective that is somewhat different.

I was asked to speak on the ethical or value content of the hospital administrator's decisions dealing with resource allocations, program and service development, capital investments and other policy and financial considerations. There seemed to be two options as to examples to be used: one was to go with global examples, such as the right to health care. Instead, I elected to discuss operational types of decisions, the types that apply daily in the hospital setting—or as Firestone Tire Company might describe it—"where the rubber meets the road."

The importance of ethical content in these daily operating decisions is undeniable. Health services are personal in nature. The major impact of the health care system on people—on the recipients, on health providers, on others—occurs locally, where the services are rendered. A lot of policy concepts that are easily agreed upon at the conceptual level become controversial as they get nearer the implementation level and it is as important, or maybe more important, to realize the role of value judgments in decisions made at the operating managerial level as the decisions made more remotely.

Operating decisions in hospitals obviously do reflect ethical or moral values because they are made subjectively and they affect people. They can impact in a major way on the present or future welfare of employees, patients, physicians, taxpayers, the community—individually or collectively.

They continually raise questions of fairness because they usually favor one person or one group over others; people are affected both directly and indirectly, in ways that are both predictable and unpredictable. The most routine managerial decisions can involve value judgments that are open to challenge. For example, let us just consider some mundane questions that occur daily, or at least are answered daily.

Can hospitals that pay premium prices for supplies and equipment, explain a policy of paying below community wage levels to personnel? Can we rationalize using money from patients or the public to continue employment of those employees whose work is clearly substandard? How is a decision made that one person's time is worth $3.00 per hour to an organization and another's is worth $4.00? Can we justify paying two employees in the same position the same rate when there are perceptible differences in their attitude or initiative? How do we decide to authorize one laboratory unit

to have more space, more employees, while denying the growth of another laboratory? When expenses are too high, which departmental budgets get reduced and why? How do we decide which ideas, whose suggestions, to discourage at the outset and which ones to explore further, develop, use? Whose requests are to be honored and whose will be ignored or rejected? Which groups receive our personal attention? Which surgical specialties are more likely to receive priority in the allocation of new operating rooms and why?

These questions arise routinely and are dealt with instinctively as the individual requests come to us. But do we dare look at them cumulatively and acknowledge their impact on the morale and motivation of the people, individuals or groups that are involved? Do we dare examine the equity of such decisions? How often do we use precedent as an excuse not to rethink the options? Do we review the "opportunity cost" of past decisions—what would have been the cost/benefit if different options had been chosen? To what degree would we find that our method of considering ideas, proposals, alternatives, is actually a form of "impulse buying"? To what extent would we find that the plans, the studies, the statistics, the rationale, furnished to us by subordinates are little more than tools for selling us on preconceived results—either the result they desired or the result they thought we desired?

Would we find that our traditions are sacrosanct, that the resource allocations to existing programs go unquestioned while new programs that are proposed must compete with each other vigorously for the few resources that are considered "extra"?

Such questions as these illustrate well the complexity of both the technical and the moral aspects of the executive's personal decisionmaking. The executive, of course, is also concerned with the larger questions dealing with the institution's system of priorities and these questions involve even more complex philosophical considerations because the health care institution is a confluence of groups with status, power, and specialized priorities. However, we elected to discuss the ethics of the personal decisionmaking process, not the group process, and even this is a challenge because the depth to which even the simplest, or seemingly simplest, decision the executive makes can reach in its implications for the persons to whom the institution has a duty. Even minor decisions can explode unexpectedly; they can fester, build up, create major identifiable problems; they can manifest themselves in generalized symptoms, such as uncooperativeness; or they can have all of the appearances of being acceptable. Either good or bad decisions can be popular, or they can be unpopular; the reactions of groups to a decision can reverse quickly, without notice.

Hospital administrators, in common with other executives, certainly would prefer to believe that we are looking ahead, that our decisions are fair and sensible, that our choices are good, factually based, and fair. But we live with constant awareness that our weightiest decisions are made with only part of the facts needed. The exigency of taking action or the volume of other work forces major decisions to be made by snap judgments. We know how regularly we wish an action could be delayed until more information is obtained or an idea, approach or solution is found that fits our instincts better or might seem more palatable to others. Certainly we agonize when every alternative has so many disadvantages that the goal is to select the least bad choice.

Even after decisions are made, we find ourselves only marginally satisfied with the quality of our choice; this feeling comes sometimes on an unpopular decision; sometimes on one that has the enthusiastic support of others. While the support of other people is always imortant, we as executives often are the only ones really in position to see and worry about the potential pitfalls. After all, it is management's role and obligation to look for the risks, and to weigh them on a comprehensive scale. We learn to be cautious and to respect our fears even when others are optimistic. We must also have an appreciation for the value of boldness and be willing to be decisive when others still have doubts. It is not always arrogance that leads us to rely most heavily on our own evaluations and honor our personal instincts, even when we are not sure why. Hopefully, our instincts will be good, our self-sufficiency will work positively, so that when we perceive potential benefits that are not apparent to others, we can forge ahead on our own if necessary.

I suppose the acid test of ethical and moral strength is whether the individual can make a decision that he is convinced is right even when it is unpopular or when the personal risk is great. However, in judging oneself at such times, it is difficult to be objective and to distinguish between courage and foolhardiness. Therefore one needs to be especially wary of situations where he is isolated in his convictions. Usually he is placing himself at

risk but he is also placing the institution at risk in a decision that could backfire.

In considering whether decisions are ethically acceptable, we have to begin with the intent of the decisionmaker, that is, whether he wishes his actions to be moral. Certainly a person who is unconcerned about morality lacks the ethical qualifications to have control over the welfare of people or of an institution. One who does not place a very high value on fairness to others and who does not perceive a health care institution in terms of its overriding obligations to serve people cannot be trusted to make major decisions of the sort we are discussing here.

Good intentions, however important, are only the beginning. They must be accompanied by conscientiousness and competence. When people or institutions are harmed, it is serious, whether it occurred because the decisionmakers were careless or impetuous or too busy to do a good job or were grossly biased, or because they were exercising powers beyond their capabilities. We should feel personal regret when our actions cause harm, regardless of the circumstances or the excuse.

The hospital administrator with an appropriate sense of personal and professional responsibility will be as much concerned about the inadequacy of his knowledge or experience to handle a problem, as concerned about his subconscious biases, as he is about the more patent reasons for errors.

He should instinctively feel concern when he realizes that he did not exercise skill and diligence in a situation. The word "realizes" is very important because it is not always evident when harm has occurred or when harm occurred unnecessarily. Some problems become evident only through acute sensitivity to people's reactions, immediately or over a period of time.

When appraising one's actions and decisions and their impact, it is vital to use standards that are high, but managers must avoid the tendency to expect perfection of themselves and to judge every apparently poor result as a failure on their part. Guilt is a destructive force which leads to indecisiveness and worse. The essential factor is not perfection but the willingness to examine the effects factually and to make the adjustments that it calls for.

To this point, we have discussed management as though every decision is to be approached as a new venture. This is certainly not practical in real life and I do not think it is even desirable. Actions are usually judged largely in terms of the expectations of the people involved; fairness is closely related to what people have been led to believe they are entitled to receive. Consistency is an important element in decisionmaking. Precedents must be evolved carefully. Patterns of administrative behavior must be reasonably predictable. These are givens without which an institution cannot gain momentum. Delegation cannot occur when the institution lacks a sense of policy (and by the word "policy" here, I refer not to the written policy but to the general understanding that people have about how an institution functions).

Givens can be overdone, however. One example is that all of us have a tendency to classify ourselves and fall into a pattern of thinking. We express our philosophy or goals in simple terms, describe our management styles in terms of slogans that appeal to our ego and that we consider best suited to the circumstances. However valid these slogans might be in their own right as elements in a balanced concept, if we idealize or adhere to them excessively (to the exclusion of other essential emphases), we become, in effect, caricatures of managers and our decisions become distorted. Concepts that do not fit the mold receive less attention than they deserve.

To mention a few of these managerial caricatures, one is the manager who takes great pride in being financially oriented, measuring success predominantly by economic results. Some of these managers are attracted to the quick payoff and to the pennies saved today, while others preoccupy themselves with long-term, capital investment. Programs, services and people tend to be treated secondarily by these managers.

Another caricature is the manager who promotes educational programs and goals relentlessly, who rationalizes or even is proud of enormous costs of educational programs. He might condone (or even contribute to) extreme subordination of patient service to the convenience of educational programs, in a way that obscures the point that education is only a means and service is the end.

Some administrators picture themselves as modernists. They feel successful only when their hospital has the latest system or gadget. They make decisions in a way that channels funds to the newest project, even at the expense of routine requirements.

Other administrators think of themselves as patient oriented, using some narrow definition of what is best for patients. They might have an appreciation for scientific services only. Or they might place priority on general patient services and amenities for patients and reject disruptive change, sci-

entific complexities and "prima donna specialists."

Some managers think of themselves as shakers and movers. They have activist characteristics that dominate their decisions and the people around them. There are also managers who regard themselves as quiet or democratic but are actually passive and often yield to pressure from other people. Such people are unreliable in difficult situations. Passiveness can be a major liability in meeting one's obligations to people under changing conditions.

Dozens of such examples of affectations or extremes in management emphasis could be cited. Such differences in managerial philosophy and managerial behavior are pertinent to a discussion of ethics in health care management because they are an integral part of value systems of those individual managers and their decisions and actions reflect those values. For example, the manager who gains his satisfaction from financial success instinctively places a low priority on other considerations that are essential to the formally established goals of the institution. His decisions are very likely to incur the resentment of people in the organization, especially those who are patient-oriented or science-oriented or teaching-oriented, and who desire expenditures directed toward their goals—and, in fact, deserve attention to their goals. Unfortunately, those groups with specialized interests are likely to regard any value system the manager employs as "lopsided" if it favors other interests or even if it reflects a balance of interests.

An institution and the people in it can find themselves personally and professionally disadvantaged with the manager who makes biased decisions —diverts funds to scientific programs that are needed for routine services or vice versa—spends all of the money for equipment, leaving too little for staffing or allows all of the money to be used for current expenses, leaving too little for capital —or makes massive investments in the future growth and development of the institution, possibly overexpanding it to the point of insolvency or ineffectiveness.

Are these matters that are ethical in nature? They might not be, because such results can come from entirely prudent judgments that later prove to be faulty, or they might be due to causes or pressures beyond the control of the manager. On the other hand, they have serious ethical implications if the manager who makes the decision knew, or should have known, about the risks or the significant tradeoffs but did not take them into account.

The ethical question is present where the manager assumes that his own value systems and priorities are superior to the others', even those who might be in better position to make the decision. Where he takes such a position and the decisions prove to have been wrong and damaging, he must bear a heavy personal burden of moral responsibility.

In summary, hospital management is a series of choices between alternatives which typically are unacceptable to some of the people concerned—that involve risk, that entail costs, that commit the institution in known and unknown ways, and that subject it to serious future consequences. Each action can become a precedent for a future demand by the hospital's public, its medical staff, or its employees. Some actions can become legal precedent for future performance, legally binding on future policies.

Each manager in the hospital, even the chief executive officer, finds that his practical alternatives are circumscribed by external pressures and requirements of all types. With the time constraints and the restricted choices available, we are greatly tempted to fall back on prescriptive or formulae answers, or upon how other hospitals are handling the matter, or what would bring the least criticism at the time, or what can be done most easily and quickly. Taking "the easy way out" is probably the greatest basis for concern about the morality of our decisionmaking.

Said in another way, how can a person deem himself to be just, either in a professional or general sense, if he knowingly makes decisions that seriously affect people, or the present status of his institution, or the potential of his institution, without searching for the alternatives and weighing them carefully?

On the other hand, is it possible for a manager in a small institution—much less one that is large and complex—to take into account all of the interests of all of the key people involved in the decision—the patients, the physicians, the employees, the public, the people who pay for the care, such as taxpayers, employers, et cetera? Can one really encompass the many tangible and intangible advantages and disadvantages a decision might have in the short run, much less the advantages and disadvantages it might have in the long run under the conditions that can only be predicted? Can one give full cognizance to the *technical* aspects of the

decision, as well as the *personal* aspects, that is, the "things" considerations along with the "people" considerations?

With each major decision having so many ramifications, and with the accumulation that occurs as decisions interrelate, the manager's obligations to make decisions are solemn, indeed. Indecisiveness and inaction can bring even more serious damage than making a wrong decision.

Everything so far leads me to three special points I would like to make on what we, as hospital executives, need to be doing to meet our ethical obligations in decisionmaking. These three points are not exhaustive; they are just ideas.

The first point is for the manager to know himself, as has been mentioned earlier. One way to begin this process (as it applies to making the kind of decisions we are discussing today) is to evaluate his stated or declared value system or managerial style, to look at what he says or thinks he believes, and to try to realize the implications. One's stated value system is important not only because he probably does adhere to it to some extent but also because his subordinates probably declare themselves in favor of similar values. Probably most of us have a clear conception of what we think *should* be the priorities in our institutions, although we might not be totally candid about them publicly.

After examining our stated value system, we need next to look at our *actions* and how we really spend our time—our actual value system. If our actions and our attentions are at odds with our declared goals and management philosophy, this creates credibility problems for us and for the organization. This, of course, is a major ethical liability.

We cannot escape being considered inconsistent; even when we are acting generally consistently, it might not appear so to outsiders. The manager must have a solid awareness of the extent of, and reasons for, his inconsistencies and how they appear to others.

The manager must also recognize how his judgment is colored by his personal beliefs and goals. Wherever possible, he must understand the *basis* for his sense of urgency as to which problems to solve, his priorities on which new activities to foster and which group to please, and the balance he strikes between serving today's needs versus preparing for tomorrow. In summary of the first point, the manager who can affect the welfare of others must have an acute self-awareness.

The second point is that the manager must keep his knowledge and understandings up to date, broaden his perspective, strengthen his objectivity. This process is popularly entitled "continuing education." Many of our future challenges with ethical overtones will come as changes in health care institutions require new relationships to be developed, profound revisions to be made in programs and goals, new controls to be complied with, etc. These will place many pressures on relationships among people in our organization. We as managers will have vastly more need for new knowledge about trends and developments than in the past. We will need a steady flow of new understanding about the ways to accommodate or implement changes, so the necessary managerial decisions can be made with the least disruption to the people involved. Appropriate decisionmaking in the health care industry unquestionably will depend tremendously upon our being openminded, receptive to new ideas and sensitive to the rights of people.

Formal and informal learning activities can do much to sharpen our awareness of alternatives and keep our attention focused on the future. It is all-important that we do our best and I don't know of any better tool to recommend than a systematic program of continuing education for the executive.

The third point has to do with the need to strengthen the management staffs of hospitals to provide the time and expertise necessary to practice participative management, to make good decisions, to follow through on them properly.

We've mentioned several times the necessity for decisionmaking to receive adequate time and attention—time to identify and appraise alternatives more than superficially, to make choices that are technically and morally sound, to implement decisions satisfactorily, to reevaluate them and to amend them. This cannot occur when the manager is too busy to think and reflect, too busy to develop relationships.

Relationships often are more important than technical considerations in whether a decision is successful. For example, the communication of decisions has much to do with their impact on the people affected by them. Adequate amounts of time must be available for this communication activity, both when the issue is still fluid and later when the decision is being implemented. We know that the involvement of the people who are to be affected by a decision in the deliberations, during the planning stage, can do much to assure understanding and acceptance of the decision and its intent. Thus, in hospital management we face the dilemma of a radically expanding number of decisions to be made, a more complex environment in which to

make them, with the average decision deserving much more time than in the past, all of this during the period when the other demands upon our schedule are multiplying.

Hospital management traditionally has consisted of one administrator, perhaps with an assistant or two, personally managing everything and serving as liaison with the external and internal forces affecting the institution. This picture is reminiscent of the one-man band. Under this traditional concept, the administrator will have less and less time for sound and defensible internal decision making, for relationships, or for external participation. Even for the larger hospitals, the size and expertise of the management staff has grown in a very limited way.

I, for one, am convinced that all aspects of management in hospitals will suffer more and more and that our decisions affecting people will be less satisfying to ourselves and to them, unless hospital management staffs are enlarged and organized in much more sophisticated ways than the traditional pattern. Achieving this will not be easy, because boards of trustees are unaccustomed to equating hospital management staffing needs with management staffing needs of a bank, insurance company, commercial or industrial corporations of similar size. Unfortunately, the expansion and development of the management staff typically has not been approached by governing boards with the same openness they have accorded other resource allocation decisions. Although I believe the expansion can be more than justified by financial and other criteria as well, its value in providing the time for appropriate handling of management's moral responsibilities to patients, employees, physicians and the public is certainly a major consideration. Selling the board on this need is a task that deserves the administrator's best efforts because without better organization many of his other ethical obligations to the institution will be impractical to meet.

Managerial Ethics in Practice
II. A Physician's View

ALVIN R. TARLOV, M.D.

CHAIRMAN MAY: The next speaker is Dr. Alvin Tarlov who is Chairman of the Department of Medicine and a Professor of Medicine here at the University of Chicago. He has written extensively in areas as diverse as metabolic disease and medical education. I have known Al for some time and I have enjoyed every contact I have had with him. He is an extremely thoughtful, informed, and articulate person and, I am sure, will provide us with a number of thought-provoking ideas.

ALVIN TARLOV, M.D.: In preparing this presentation, I thought back to my own training and asked myself, "What sort of training have I had in ethics or in moral behavior which might influence the decisions I make every day in the management of a department of medicine and as a member of the executive staff of the hospital that I serve?" I even reminisced about the moral training I had received from my parents. I could remember only one formalized ethical lesson which had any impact on me, at least on my conscience, and that one is not related to this particular talk. It had to do with a situation in the town where I lived—I was 14 at the time—in which the undertaker's daughter had become pregnant out of wedlock. But the stern lecture my father delivered at dinner that evening did not prepare me for this experience today.

I appealed to the Bible next, as a standard of ethical behavior. It was reassuring, because in the Bible the ethical demands made upon the individual are those demands placed by God upon Man. These require us to refrain from harming our fellow man and to avoid doing evil to the weak. They enjoin us to do justice; avoid bribery, robbery, oppression; defend the widow and orphans; be compassionate toward the slave; avoid gossip; sustain the poor, feed the hungry, and clothe the naked; avoid unfounded hatred, as it destroys the life of the society; and what is hateful to you, do not do unto others.

From all of these things, it follows that doing what is right, doing what is just, is the essence of biblical ethics. In fact, although there was no formalized training in my home either in religion or otherwise, this, in fact, is what my father and my mother demonstrated to me.

But then after an evening with the Bible, coming back to this particular assignment, I felt that the Bible, although interesting, didn't help me. So I appealed to a hero of mine, Thomas Jefferson, who is a man known for his integrity and sense of ethics.

I found a letter of his which in 1771 stated: "A lively and lasting sense of duty is more effectually impressed on one's mind by reading King Lear than by all the dry volumes of ethics and divinity that have ever been written." That kind of left me without a crutch because I began to appreciate at that time that I was going to have to construct this talk in the raw without any basis in scholarship or leadership, and I was going to have to do it out of personal experience.

My qualifications for this talk are very simple. As part of a large urban hospital complex, I am involved almost daily in the decision-making process with which, if it only involved ethical or moral issues which could be resolved simply into questions of "right" or "wrong," I would have no trouble whatsoever. But the problems that we are facing today deal less with issues of yes or no, right or wrong, harm someone or not, than with questions of priorities in a situation in which the resources are extremely limited. We are forced to make decisions to favor or develop one program to the exclusion of others which necessarily implies the lack of support of a competing program which might be very important to another constituency. I think that the background from which I speak, as a physician and departmental chairman involving myself in these kinds of decisions daily, is my qualification.

In my readings, I also came across a statement by George Edward Moore in his preface to *Principia Ethica* which appeared in 1903. He said, "It appears to me that in ethics as in all philosophical studies, the difficulties and disagreements of which

history is full, are mainly due to a very simple cause, namely, to attempt to answer questions without first discovering precisely what question it is which you desire to answer." In the context of this discussion today, the question is: How does someone in an administrative position of responsibility arrive at a decision regarding resource allocation when those resources are scarce, when there are competing demands and requirements most of which are rational and most of which would be beneficial to those receiving the services.

I am talking about such issues as: How does one decide whether to modernize the emergency room, an emergency room which receives on the average of 200 adult patients a day, is a principal medical resource of the community, and probably delivers care to 65% of the residents in that community, when the hundreds of thousands of dollars which would be necessary are the same resources that one might use to purchase a radiological instrument which would provide extraordinarily useful diagnostic information regarding diseases within the head? The radiological instrument will not pay for itself in the hospital, yet it will add to the prestige of the hospital and it will project an image of sophisticated care which the purposes of the hospital demand.

Or, how does one decide between assigning more social service workers to the general medical clinic where the residents of the neighborhood receive their care and the development in our institution, for example, of a section of clinical pharmacology which is extraordinarily important to the practice and teaching of rational therapeutics in the institution.

How does one decide whether to pour a hundred thousand dollars into a program which we judge would contribute to the amenities of our institution and would help attract patients from afar who require highly sophisticated technology, when at the same time we have subspecialists in cardiology, ophthalmology, ear, nose and throat, and so on, which have capital equipment needs that run into the hundreds of thousands of dollars.

So, in my context at least, we have the academic imperatives, we have the imperatives of our own image, and we have imperatives which are impinging upon us from the outside, from society, from the government that represents society, and from other constituents that are looking to the medical center for care.

In thinking about these issues, I have arrived at some conclusions which seem to be fundamental truths—at least they are in my context.

The present and the future of the hospitals are really in the hands of the people who make decisions. These are administrators, members of the executive committees, the board of trustees, and others who sit on the decision-making bodies. As a result, it would seem to me, we ought to pay a great deal more attention to the physical and the intellectual health of the people who are making the decisions. Otherwise a computer might make the decisions more expeditiously and with less trouble than those of us who sit on the executive board. I will come back to this in a minute.

In addition to the health of the decision makers, certain realities, certain inevitabilities which are determinant of existing social order, should be accepted as facts, or truths, and responded to in a constructive way.

For example, the American people in the last 20 years have worked through a system of needs in terms of health and they have developed a hierarchy of priorities which is now accepted by everyone. It is that access to health care is a right of all citizens. I think we ought to accept that. Our health facilities and the services that we deliver are rapidly becoming, and have already become in many instances, public utilities. The public utility has a certain responsibility to its constituents which, in my view, is dominant.

There are large problems ahead regarding the overpopulation of the world, underproduction of food stuffs for their needs, contamination of the air, the sea and the waters on our lands, and the common denominator, the end point of all of these world problems, is health. We ought to accept that the responsibility of health care delivery goes beyond our immediate surroundings, goes beyond what might have been the policy or the philosophy of the boards of trustees of our hospitals, we ought to regard ourselves as a keeper of a resource that is, in a sense, at the very root of the continuation of our civilization as we know it.

The Federal government's financial investment in our health care system is of such a proportion that the government undoubtedly will use it as a lever for change in the delivery system to improve services. We in the medical centers ought to accept a larger responsibility for the development of a rational health care plan for the region in which our medical center is located. We ought to seek relationships and partnerships with other providers toward the end of improving the services for the

people in our area. We ought not wait for the federal government to provide us with mandates, which in the end could not possibly be as rational as those we could develop voluntarily within the area if the initiative was forthcoming.

Within the medical centers we ought to "proportionalize" our plans for the hospitals. Too often hospital administrators, physicians, and other interested groups present plans for their hospital in an all-or-none way. That is, we are either a referral center or we are something else; or we are a community hospital or we are something else. I don't believe that such planning provides the hospital with the flexibility that it needs for the challenges ahead. This tendency to unify philosophy for the future, or to polarize around an absolute, I think, is destructive to the overall tenor and responsiveness of the institution.

And lastly, I feel that a fundamental truth is that it is no longer possible, profitable, feasible or wise for the medical profession to dominate the health care industry and service institutions as it has in the past. The dampening of the dominance by the health profession should occur simultaneously with the development of a constructive partnership between the profession, the hospital administrators, and the citizens' groups.

The above I accept as "givens." You may not, but at least they help me in making my decisions.

Now, regarding recommendations, I have three. They are not particularly learned. They are not profound. They are simple. They have to do with a way of life. That way of life is based, in my view, on simplicity and common sense. These three recommendations relate to the physical health of the decisionmaker, the intellectual health of the decisionmaker, and a consideration of the ethical imperatives.

Regarding the first, that is, the physical health of the decisionmaker, I feel particularly strongly about this because I have had pointed personal experiences which have indelibly imprinted on my mind a fundamental connection between physical health and the quality of decisions that I make and that others make. And I think within our institutions we have paid too little attention to that.

In construction of benefits to employees too little attention has been paid to maintenance of good health practices. I am concerned about employment habits and customs which might affect physical conditioning of the people within the hospital who make the decisions: maintenance of proper weight, a decided decrease in the consumption of caffeine amongst the administrators and the physicians, and partaking of personal indulgences in moderation.

It is surprising how little ingenuity we have seen coming from industry and other large employee groups regarding the maintenance of good physical health amongst its employees and remarkably little is written regarding the quality of intellectual health of those who enjoy good physical health practices versus those who do not.

Another one of my heroes is William Osler. Osler, who is recognized as having been *the* most influential internist in world medicine, was Chairman of the Department of Medicine at Hopkins and subsequently left to assume the Chair at Oxford. In 1913 he was invited to Yale for a lecture. The evening before the lecture he delivered a sermon to the students at Yale. I'd just like to read parts of his sermon.

"Some of us are congenitally unhappy during the early hours but the young man who feels on awakening that life is a burden or a bore has been neglecting his machine, driving it too hard, stoking the engines too much, or not cleaning out the ashes and the clinkers, or has been too much with Lady Nicotine. A fair mind and a fair body—one cannot be sweet and clean without the other. Rabbi Ben Ezra said: The great truth is that flesh and soul are mutually helpful. Voltaire said: "No dyspeptic can have a sane outlook on life, and a man whose bodily functions are impaired has a lowered moral resistance. The clean tongue, the clear head and a bright eye are birthrights of each day. In the young, sensations of morning slackness come most often from lack of control of the two primal instincts. While largely habits, both of them, the one is concerned with the preservation of the individual, the other with the continuance of the species. Be models of dietetic propriety. To drink, nowadays, but few students become addicted, but in every large body of men a few are to be found whose incapacity for the day results from a morning clogging of nocturnally flushed tissues. As moderation is very hard to reach and as it has been abundantly shown that the best of mental and physical work may be done without alcohol in any form, the safest rule for the young man is that which I am sure most of you follow, abstinence."

Then he goes on to talk about tobacco and caffeine and he ends by saying, "The other primal instinct is the heavy burden of the flesh which nature puts on all of us to insure a continuation of the species. But to drive Plato's team taxes the energies of the best of us—one of the horses is a raging, untamed devil (that's the hospital administrator)—who can only be brought into sub-

jection by hard fighting and severe training. This much you all know as men. Once the bit is between his teeth, the black steed passion will take the white horse reason with you and the chariot rattling over the rocks to eternal damnation."

Well, that's eloquent and it's humorous but I am suggesting to hospital administrators that they pay more attention to the physical health of the staff in the hospital and particularly to those in decision-making positions who will affect the life of the institution and its future.

Secondly, regarding the intellectual health of the decisionmaking staff it seems to me that a system ought to be evolved in the hospital that would allow a person's mind to work properly. It doesn't in our hospital. In our hospital there is frenetic activity amongst the administrative staff and the medical staff from 7:00 in the morning until we leave the hospital exhausted in the evening. Nobody's calendar provides a free hour or hour and a half for profound thought or simple thought or even refreshment of the mind. No one's 15 minutes between appointments is protected. Everyone who is serving the hospital apparently either feels or accepts the dogma that every moment of the day belongs to someone else. And this is extraordinarily shortsighted because this leads, in my own view, to poor judgment, a poor spirit within the institution. It leads to slovenly thought and behavior in the early morning hours when it becomes no longer a pleasure to arise and enter the hospital for constructive activities.

I would recommend that hospital administrators, boards, physicians, think very seriously about allowing one's mind an hour and a half or so of solitary thought per day. Not for routine work. Expect the staff to provide a continuous supply of fresh ideas for improvements in their areas of responsibility and give them the solitude in the environment that they need for at least 60 to 90 minutes a day in order for them to better serve the institution and to better serve themselves.

The third point has to do with ethical imperatives. It seems to me—and I am deeply impressed as I listen to students, house officers, community representatives and others talk about their particular needs—that the ethical standards upon which decisions are made are in a continuous state of evolution and flux and it is no longer useful to look to the decisions which were made at the time of the founding of the institution or anywhere along in its course for guidance regarding the decisions which have to be made today when resources are scarce and when a different set of social priorities existed.

Therefore, in view of the dynamic state of ethical standards, it would seem to me that the fundamental ingredients in making the best possible solutions for the institution and for the constituents of that institution rest in the resources of the decisionmakers themselves, their personalities, their characteristics, and the closeness with which their thoughts interact with diverse groups. I would suggest that in the hospital a new body be created which would be called the Hospital Council. This Hospital Council's function would be to broaden the source of input to the decisionmaking process in order to reflect the evolution of ethical imperatives as seen by the constituents and those responsible for the hospital on a continuing basis. With the frenetic activity we have already described, it is too easy for the decisionmaker in the hospital to become isolated from events and from the patterns of thought which are taking place in the community surrounding—the community in the broadest sense.

I would suggest that the Hospital Council, then, include patients or recent patients in the hospital, government workers, health underwriters, community and regional representatives, hospital employees, hospital administrators, students, interns, residents and professional staff. I would suggest that this Hospital Council include individuals of all age groups, spanning the many generations the hospital serves, and that this broadly based group ought to be selected on the basis of their serious interest in the hospital, their general intelligence, and their wisdom. I would further suggest that the members of the Hospital Council be remunerated for their efforts, that their term of appointment to the Hospital Council be limited to one term of three years so that their decisions can be made without any interest at all toward their reappointment or continuation of their remuneration. This formalized Hospital Council should have a status within the hospital next to the Executive Board and, on occasion, the Executive Board and the Hospital Council through representatives on a federated board should meet for exchange of information and for deliberations regarding decisions.

The point of all this is to bring into the hospital in as close a way as possible, in a way which would impact most potently on the judgment of the ad-

ministration and the medical staff of the hospital what society regards today as the imperatives. The hospital, then, through its executive committee will make its decisions. I am not suggesting that the Hospital Council have decision-making powers, but I do suggest that it get into the decision-making process in a real way and that the information that is exchanged between the Hospital Council and the Executive Council and the medical staff be free, current, and as forceful as possible.

Managerial Ethics in Practice: III. A Trustee's View

MEYER L. GOLDMAN

CHAIRMAN MAY: Our third speaker is Meyer Goldman who is President of the Beacon Printing and Publishing Company of Kansas City. He will present the view of the hospital trustee. He is Vice President of the Board at Kansas City General Hospital and Medical Center and, he told me just now, on the Board of a new organization that is seeking to form an HMO in the Kansas City area.

He is, or has been, Chairman of the State Health Planning 314-A Agency in Missouri. He is Past President of the Community Blood Bank in Kansas City and a spokesman, I think, for a lot of the health activities that are going on in his local area. As such, he is eminently qualified to speak to our topic.

MR. MEYER L. GOLDMAN: This is something of a new role for me for a couple of reasons. First of all, I am not used to facing a battalion of administrators. Four or five at a time is usually my quota.

Secondly, my role, when I do meet with them, is usually one of listening and not having an opportunity to talk. So I am glad to be here, and I will be interested to see how I fare.

As a matter of fact, I have already had a fringe benefit from participation. Preparing for this gave me an excuse to walk down paths of thought that too many of us as board members and probably as administrators seldom have time to walk.

The chance is rare to look at ourselves, explore our motives, consider our responsibilities as a whole. Usually we must approach them problem by problem on the ad hoc basis that becomes so frustrating at each meeting of a hospital board or its committees.

It is both good and bad that I appear as the last speaker on the panel. It is good for me because —as the nonprofessional member—I have had the benefit of listening to the prior presentations, to adjust my thinking accordingly. Less good perhaps for you—because I come with no research or documented presentation. Many of my observations will simply be variations on the better orchestrated themes that have already been played.

I will say that I have been extremely gratified at the number of times I have been able to nod in agreement with the points that have been made. While I am speaking from the standpoint of the Board, it is heartening to see there is so much recognition, acceptance and agreement on the problems as they exist because it makes for that team work in the organized approach to consideration of ethical problems which is probably the closest I can come to recommending as a solution.

I have always considered myself an expert on the problems of the health care field. On solutions I am an amateur. I am glad to see that I have fellow experts here on the problems because we seem to agree on them. But I won't relinquish my position as the primary amateur.

Trustees today come from all backgrounds, all types of experience and all political philosophies. They are selected for many reasons and have a variety of motives for accepting their appointments. They bring their individual viewpoints based on their own experiences and apply their own standards and guidelines for decision making.

These standards and guidelines are seldom organized and systematized within or between the individuals.

I have a friend, a remarkable man, who for many years had as his job the development of recommendations for the expenditure of funds by a number of substantial eleemosynary trusts and foundations. It was a fine authoritarian position, an opportunity to make judgments and have considerable power.

In describing his work he called himself a philanthropoid. He explained that if a philanthropist is one who gives away his money, a philanthropoid is one who gives away somebody else's money. So in this sense I am a medipoid. I don't deliver health service. I make no attempt to. It is my job on the board to help those who are professionals and competent and knowledgeable to render the services

that we believe are needed and worthwhile and just.

It is hard, I think, to realize sometimes that making ethical judgments is not a long established traditional function of most boards of trustees. Generally speaking, the basic reason for joining a board of trustees of a health organization is to render humanitarian service. Other considerations may influence individuals, but service is the common thread of motivation that must sew together the fabric of the board.

The definition of "humanitarian service" in each case rests with the board and its members. The decision-making activities of the board must depend on the consensus as to this definition. Implicit to me in the purpose of this symposium is the development of a consistent ethical definition of humanitarian service as it applies to our hospitals today.

As physicians, administrators and board members, we must deal with specific problems and make concrete decisions. A philosophy or code of ethics is effective only if it can be applied in sufficient cases to produce consistent, justifiable and useful decisions.

Value judgments as influences on these decisions, of course, are made in all institutions and activities whether the objective of the institution is profit or service. Recognized or unrecognized value judgments affect the decisions about that institution's operations.

In a welfare service institution, value judgments are particularly basic to the decision-making process. They must involve both the judgments of the persons who provide the service and the values of those persons being served.

In a business establishment, failure to attend to the wishes of one's customers can be economically catastrophic. In our health care delivery system, the unique prestige and specialized knowledge of professionals until recently permitted policies to be made and executed with a minimum of attention to the input of patients, employees and the public. Health care service customers were willing or resigned to accept the value judgments of the professionals.

In the light of present economic and social trends, then, it is necessary to consider the function of the trustees of the hospitals in terms of their commitment to broader ethical considerations. It seems to me that most of the issues—those that require direct application of moral judgments—that draw our greatest attention today, would not have been recognized as responsibilities of hospital boards or perhaps even administrators or physicians 25 years ago. Our institutions have changed in the services they render and in their direction as much as any other institutions in our society in the past quarter century.

Certain primary responsibilities of the hospital board, of course, seem not to have been changed much. The development of sound fiscal and financial policies remains at the heart of the trustees' responsibility. If I refer less to this element, it is simply because its importance is so obvious.

One can render little health service in a bankrupt or defunct institution. Even here, however—even in this role—the function of a board member has changed. The searching development of a budget by the board now involves the most painful application of priorities in emphasis and expenditure for services and facilities. These priorities must derive from sound, clear value judgments developed by the board. In practice this has not been a traditional approach of all hospital trustees.

There was a time when most hospital board members were chosen to perform three functions. Application of judgment was confined to deciding the best way of accomplishing them. First, the board member was expected to exercise influence in the collecting of funds for capital improvement, construction, equipment and expansion. Second, he was expected to provide, either through personal contribution or solicitation, funds to meet the annual operating deficit of the institution. His third responsibility was that of loyalty to the purpose and philosophy of the sponsoring organization if it existed, as in the majority of cases it did.

Hospital policies were developed either by the medical staff or the administration or both. The value judgments implicit in these policies were determined and applied by the professions. They were presented to the board with explanation and justification and were accepted by the trustees as parameters of their fund-raising effort.

It is as hard to generalize about hospitals as it is to generalize about board members, but the tradition of service that was fostered in the religious, fraternal and socially conscious groups, who in the past 300 years developed so many of our outstanding hospitals, has not been lost. I am grateful for this. I understand it, and I am comfortable with it, but the new times have changed the delineation of hospital managerial responsibility.

The catalog of services which the hospital renders has proliferated far beyond the realm of those who rendered health care in the past, and the general environment of society within which the hospital renders its service has produced an equally great influence for change.

The vast explosion of medical knowledge is perhaps directly at the root of the changing role, but the widespread social developments have had substantial impact.

These points need little elaboration, but I must repeat some of them simply because the ethical posture of the institution and the challenges to the board members rest in the acceptance and interpretation of their new role.

The rise of third party payment which spreads among the total community the cost of health care for the individual; the entrance of government into health care—research, financing and delivery; the shortage and maldistribution of health care professionals in many medical and paramedical fields; the development of many new health care professions; and the rising expectations of consumers who demand as a right "the best" in health care—all call for establishment of a continuing and consistent ethical position on the part of the trustee.

The recognition of these responsibilities is being hastened partly by the institution's own awareness of its community, partly by pressure from third party payers, including the government, partly by community groups that look more searchingly into the manner in which the hospital serves the public, and partly by legal actions and decisions which directly and precisely fix on the board responsibility for many of the hospital's operations which the board previously had not recognized as elements of its concern.

That the hospitals themselves are accepting their broadened responsibilities is reflected in the changing nature of their boards of trustees. No longer is wealth or financial influence the sole requirement for board membership. In some cases it is not the primary requirement. The ability to bring to the governing body a reflection of the interests and values of many elements of the community and to help develop courses of action that are responsive to the needs and wishes of patients, prospective patients, the institution itself and other providers of health services is a major contribution of these new members.

In the past, medical staff membership on a board of trustees of a private, non-profit hospital was not only rare, but discouraged. The presence of physicians on boards today is increasingly common. In addition, joint board-staff committees are becoming more active and more influential both in the making of policy and in oversight of policy execution.

In addition to broader representation, in general, members from other parts of the hospital community are being added to some boards. Representatives of professional groups other than physicians, paraprofessional groups, even patients. The result is a sharing of points of view at a board policy-making level that did not exist in the past.

The blending of these diverse points of view into a smoothly operating body is not proving simple. The complicated interrelations between departments of a health care institution take time to learn, but given serious interest on the part of board members and a cooperative attitude among administration and staff, this new style of board seems to me not only workable but necessary in the light of the demand being placed on the institution.

From this team can arise the approach to ethical decisions on issues that press the health care field today in all its aspects. The board becomes not merely the governing body of an institution but also a tool of society itself in the effective operation and an improvement of the entire health care system including the hospital.

May I suggest some of the questions that underlie these decisions and inherently include judgments of good and bad, right and wrong and the very important and difficult decisions on ethical priorities.

What is our hospital's role in the community? Has it changed? Are we doing too much or too little? And what can we afford?

The outstanding change in the role of the hospital in the past three decades seems to me the change from a position of an isolated community in itself to one of a vital element in a health care service continuum. Ethical judgments now must be applied to determine exactly where in this continuum the individual institution should fit.

I feel today the primary ethical guidance for hospital trusteeship must be toward the welfare of the total community and the strengthening of the hospital as part of the health care community in particular and of society in general.

The hospital cannot and should not any longer try to be all things to all people. Its relation with other hospitals must be developed on what is good or bad, right or wrong for the community including those who are at present in good health but inevitably at some time will require hospital service.

The next question with ethical considerations as well as practical implications is that of the hospital's responsibility to its patients both before and after they are confined. I don't believe the hospital can

isolate itself from consideration of ambulatory care or of convalescent care or of long-term care. I don't mean that the hospital must or should render these services itself, although in some cases it may be practical to do so. But the hospital's board must, at least, understand and relate the institution's policy to the existing and any new systems of ambulatory care that arise in the community.

Similarly, the hospital's responsibility cannot always end merely upon the discharge of a patient as no longer requiring acute bed care. The welfare of the patient is the concern of the health care system. The hospital is a part of the system. The board must at least have a policy that facilitates coordination with agencies that supplement the hospital's service.

Other questions move the hospital board into areas of ethical issues that need study or restudy.

For example, what is the hospital's present and proper position toward medical care for the poor and underprivileged? In Kansas City today a vigorous effort is being made by local government to remove the tax-exempt status of several major nonprofit private hospitals on the ground that they are no longer charitable institutions; that they decline to accept patients who cannot pay or accept an insignificant number, and therefore, are not entitled to tax exemption. The effort so far has failed, but the attitude that fosters the effort is significant and must be considered.

Cost control has become a major concern and a political issue because of the rising cost of health services and because the government is involved in payment for some of these services. Beyond the unquestioned requirement to develop policies that promote efficiency and reduce waste, what can the hospital do? What should it do to control costs? How is cost control equated against the availability or variety of services? We are back to the problem of the budget, to the priorities, this time more directly from the moral approach.

What are the hospital's responsibilities in medical education in terms of ethics? How are the interests of the patient properly balanced against the needs of the students? Conversely, what is the proper role of the hospital as a teaching institution in training of young physicians and paramedical workers in understanding their responsibilities for the welfare of patients and the dignity of people?

What is the hospital's responsibility toward its own employees? Does it instill a feeling of dignity in work and a sympathy for the patients? Does the hospital as a service institution have a special responsibility in this regard?

These are some of the areas of ethical concern that I see directly and unavoidably in the purview of today's hospital board. And as these are considered, others previously unrecognized will continually arise. I do not believe they can be dealt with effectively one at a time. Each relates to another as the hospital maintains its personality and its conscience.

It is not my purpose to suggest the proper decisions that any single institution should make in any of these areas. I merely point out that positions must be taken in each and that the positions should be logical, recognized and integrated.

I maintain my status as an amateur on solutions, but there are several ways the board can approach these issues.

As I noted, the changing nature of the board's membership will sooner or later force each issue onto the agenda for consideration, but the many ramifications of each would make hopeless the chance of resolution at board meetings and would greatly impede the day-by-day decision-making that must continue simultaneously.

Although from experience I am most reluctant to add to the lush overgrowth of hospital committees, I do believe that a joint committee charged with recommendation of ethical positions can in many cases be a productive project, and I was delighted to hear Dr. Tarlov's presentation of a similar approach to the resolution of ethical problems. I would envision representation of the board, all departments of the staff administration and involvement of persons of broad judgment and experience from the health community and general community. Recommendations of this committee when presented to and approved by the board could provide valuable guidance and integration of ethical policies.

The issue of ethical guidance is sufficiently important to warrant special sessions of the board from time to time. Workshops or retreats in which issues may be explored might be arranged. From such sessions could develop a consensus that would unify the board in its approach to more specific problems and relationships.

The physicians and the administrators, yourselves, obviously have a key role in the development of the board's ethical posture. It is you to whom the board must turn for explanation and guidance through the forest of professional and technical considerations that it must travel.

As a board member I expect at the least the frank factual input of administration and staff on these issues and proposals as they come up before

the board or its committees, and I further expect the complete cooperation and sympathetic help of the administration and the staff in their approach to ethical issues which the board determines are vital.

As an experienced board member, I depend more today on the advice, opinions and recommendations of staff and administration than I did when I first joined the hospital board, and I believe that one of their most important tasks is to alert the trustees and call for decisions on issues before crises arise and while there is time for deliberate study.

It is easy for the board members' decision to be affected by unrelated experience, emotion or ethical postures brought in from other fields. Sometimes this is good. Sometimes it is harmful. The staff and the administration are the ones who are most directly in contact with the services the hospital provides and at the same time with the persons to whom the services are rendered. Their experience is for real!

Thus, I see a major role for the staff and administration not only in assisting the board in forming its judgments, but also of being ahead of the board in recognizing the issues and in seeing their relation to each other, and then in formulating possible courses of action to be presented either directly to the board or through the committees or workshops I have mentioned.

My board, I think, would be sympathetic to Mr. Hitt's appeal for stronger administrative personnel and support if he would show the way in which these issues would be approached and the institution helped by such expansion.

I have refrained from discussing the most specific moral issues, the firing line decisions, that harrass hospital boards and administration today. I have not approached the direct and controversial questions of attitudes toward the individual problems that we wrestle with.

I am well aware of their importance and the dilemmas they present. A decade ago I was involved as a board president in an action by the Federal Trade Commission against our community

blood bank. The issue that ended in federal court involved whether or not human blood is a commodity for trade and therefore subject to laws affecting commerce. The implications were vast; this was before the popularization of transplant surgery; and argument of the moral question of the status of blood as a commodity in commerce was both novel and heated. It cost the medical and general community of Kansas City a quarter of a million dollars to defend one moral position.

I am involved in developing other courses of action in equally controversial areas today. I don't believe I beg the question by failing to discuss them as specific issues. My feeling is that ethics are basic and principles must come before specifics.

I think the ethical decisions on specific issues ultimately must be made by the total community. When we decide our individual positions, the effectiveness of our decisions will be determined as much by others as it will be by ourselves. By searching study, consultation and logical deliberation, however, the hospitals can still demonstrate profound leadership in the eventual decisions. Until society's position is established either by consensus or by law, our own approaches must continue to be decided by each board in the context of its own social, political and legal situation. Such decisions will be easier to make, more defendable and more comfortable if the attitudes I have suggested and the steps I have proposed today can precede them.

I am glad this Symposium has been held. I hope its thrust will be repeated regionally and locally. In these difficult days when problems seem to multiply geometrically, and solutions disappear arithmetically, it is stimulating to devote some time to basics, and as long as "ethics," "good and bad," "right and wrong," are basics of our health care delivery policies, then board members, administration and staff together will be moved toward a better health care system and our patients and the community will be the gainers.

DISCUSSION

with David H. Hitt, Alvin R. Tarlov, and Meyer L. Goldman

CHAIRMAN MAY: We have been addressing an area which clearly has numerous dimensions. We have been given a number of very explicit examples of issues which involve ethical behavior. We have identified the fact that the ethics of a given situation are not fixed, immutable kinds of things that you can read in the Ten Commandments. They are rather some sort of composite—not an averaging, not a priority ranking, not an addition—but some combination of goals which are being thrust on us

by publics in our environment: goals which we are bringing to our jobs as a result of our training and our experience; goals which are being generated as the result of interpersonal relationships and conflicts and contacts within the work setting.

We have lots of issues. We have lots of problems. We have had some approaches at solutions. We have had some suggestions today about how to set priorities and how to choose the action with the highest priority as being the thing to address first. We have heard the greatest good for the greatest number both espoused and rejected several times as a criterion.

We have been told a little bit about the standards we might use for judgment. We have had some suggestions about how we might improve the judgmental process that we are using. We have had two suggestions for the formation of the committees to help us in these judgments.

I really don't think that gets us all the way or even very far, and I am not faulting the speakers. I think the speakers did an outstanding job in an area with very little to go on except their own experience, their own expertise, and their own intellectual power.

I think what we have done so far is address the question: What are some of the things we might consider doing in our institutions as the result of the ethical issues which surround us? I think we have also addressed the question: How should you go about doing it? What management style is the most appropriate or the most ethical? And I think we have talked a little bit about how to improve the decision process. We have been urged to introspect and think about our own attitudes toward the situation.

The one question which I think is really crucial and which no one has addressed yet is: How do we as hospital administrators decide what *not* to do? There are lots and lots of things we can do. Every one of you, if you took two minutes, could write down more things that your hospital ought to be doing than you are going to have money to do in the next ten years. All of the items on the list are good, all of them are useful, all of them are desirable.

There is no problem in thinking of the things that we could be doing in fulfilling our ethical obligations to society as managers of health care institutions.

But it is a big problem to decide what not to do. It is a big problem to sit in a situation with finite resources as such as Dr. Tarlov postulated, knowing we can do only one of a whole host of potentially useful things with the resources. In our discussion to this point in the symposium we have dealt with some of the ways to decide which one to do. So as health care executives we make a choice and carry it out. Then we sit back and say: We have fulfilled an obligation to society, and we are proud of ourselves for having done so.

But what about the things we *didn't* do with the resources? Do the implications of not doing them have any ethical content?

MEMBER: I would like to pose a hypothetical situation to the panel and ask that you respond in sort of the context of today's discussion.

Assume that you are in a community hospital and that you have an unrestricted gift for approximately $250,000. You have a staff physician who has put a great deal of pressure on you to buy a particular piece of equipment. You also have pressure from the community to support a badly needed drug program. There have been several deaths in the community from overdoses.

How do you as an administrator make a decision on that? What ethical principles or values do you draw on?

MR. HITT: I don't think there is any good solid answer to a problem as difficult as that. The question of drug programs and programs that are generally not related to the patient population which is the primary source of revenue for your hospital is a difficult one to deal with.

I think the ethical question is whether it is right to divert funds from a specific patient population to a more general patient or public population problem.

The thing I would be most interested in or most receptive to is doing everything possible to look for the financing outside to pay for a drug program from resources that are appropriate for a drug program. That might not produce a drug program as quickly as an arbitrary decision to dispense with this equipment and shuffle the money over to that, but I suspect in the long run it would be a more satisfactory decision. You can divert the money for any equipment purchase, even a very large one, to a drug program and still go through it very fast and have nothing left. We have a large center, but even if we spent all of our equipment budget for a drug abuse program, it would be a fairly small program.

DR. TARLOV: I would respond in this way. I don't think that you could make the decision as an iso-

lated proposition. One would have to consider many other things.

For example, I would want to know about the physician groups who are going to use the equipment you refer to. I would want to know what prior commitments had been made to them, whether their activities had been properly supported in the past, whether they shared the standards of service and excellence which I would expect from the institution, and whether or not the equipment that they were requesting genuinely provided an area of excellence which they were capable of delivering. I would try to weigh their genuine capability against more human desires and motivation which we all have to advance our own particular field of activity for reasons which are sometimes extraneous to the delivery of services. I think a whole profile of the group—the history, the commitments, the qualifications, the capabilities, their performance—have to be considered.

MR. GOLDMAN: I, too, would have to have more specifics before a decision could be made. I think I would probably first be most concerned with the capability and the appropriateness of the institution for the program or for the equipment.

Most of the equipment that we would like to have, we have on a priority list right now. I suppose you are hypothesizing a totally new piece of equipment or a new service along with a new drug program. Not only the capability of the hospital to perform the service, the appropriateness, but the availability of either the equipment or the service in the rest of the community should be part of the decision, and in our determination of priorities, we try to allow these factors some consideration.

MEMBER: We are getting close to the real world now. I would like to have a reaction, if I may, to the question of the ethical issues involved with initiating a service with new monies or rendering an existing service that doesn't "serve" anything except the educational environment for prospective doctors. For example, a hospital may have an OB service specifically because it considers itself a teaching institution, but its population just doesn't use it. What are the ethical issues regarding that?

DR. TARLOV: I have no problem with that question, personally. I think plenty of my colleagues do, but from my own point of view, I am not wedded to the idea that all of the teaching at a university should be in the university hospital. Rather, I am of the point of view that the health care system in our region will benefit greatly by development of genuine teaching hospitals at the site where services are being delivered. I think that not only will it be a service to the people, but that this is the best way to attract doctors into areas in which there is a doctor shortage. I feel I know what motivates young physicians when they go to set up their practice. One of the things that they are terrified of is medical obsolescence. And one of the great attractions to them is the educational program in their community hospital or their region. So I am personally attracted to the idea of developing teaching services in community hospitals.

Now I am not a dean, but in internal medicine, for example, I think that the outpatient experience which is so terribly important for a young internist is best carried out elsewhere. The university hospitals have never developed good outpatient services in internal medicine, and I believe that these educational resources ought to be developed elsewhere. I would say the same thing about obstetrics and gynecology. If your own service is obsolete, then why not develop your teaching service somewhere else?

MR. HITT: I think the question of maintaining excess capacity in obstetrics or any other service as a means of keeping doctors is a serious question. You balance that between what you know is right in the long run and what you can afford to do in the short run. Closing obstetrics is a lot more complicated than people who just look at empty beds in obstetrical units think it is. For example, if you are in a heavy cancer program and losing your obstetrics means losing your gynecologists: you can't operate a good cancer program without gynecologists. You get into tradeoffs here that are excruciating. You look at those empty beds, and you want to do something about that, but until you are able to schedule obstetrics on a smooth plane, you learn to live with them.

CHAIRMAN MAY: Let me raise an additional issue in this area.

In the context of activities like area-wide planning and certificate-of-need legislation, external approval is required before the decision can be implemented. Let's say one or the other of a pair of competing proposals is likely to be approved by the certificate-of-need group. The hospitals know that. Should an individual hospital direct its atten-

tion, program planning, and developmental activities toward those things which are most likely to be approved, trying to be there first with a proposal before the people down the street can get it. Indeed, is this an ethical matter at all? Would you jump for it if you thought it was likely to be given to one hospital but not two?

MR. GOLDMAN: If the function—and I am speaking personally—if the function is not one that is appropriate or fits the service of the hospital but is a totally new thing, I would pass it by unless I could find a sufficient reason within the role of the hospital to start something new. I am not really a proponent of the type of grantsmanship which tends to build an institution rather than integrated services. Of course, the reason I am a little slow speaking is that I have had to sit on both sides of this fence and have become very adept at withdrawing from any consideration in my own community or any case where I might have a direct knowledge or involvement at all. So when you ask a question, I am speaking both from the community agency and from the hospital side.

I think that in my experience the agencies have caught on to this rather rapidly. When there is multiple application, or the possibility of it in our area, they have been rather sensitive. Appropriateness has become a factor in their decisions.

MR. HITT: I would like to go at your question a bit from the other end. I think any institution has an obligation, and its officials have an obligation to the institution, to have planned far enough ahead to know what their role is and how various things are going to fit in it. If you can see that the institution really needs or should have a particular thing, and if one is going to be approved, then it is just good management to know that far enough in advance so that you can proceed in a timely fashion.

As far as I am concerned, there is no ethical question involved unless you divert the service from the institution that really ought to have it. Of course, that in itself involves a value judgment.

CHAIRMAN MAY: What I was really wondering was whether the ethical responsibility passes from the institution to the planning agency or to the certificate-of-need group in that situation.

MR. HITT: I don't think an institution can divert its planning responsibilities to any planning agency any more than I think a rate review board ought to do more than review the proposals of the institution. The planning has to start in the institution, and it's a cop-out to say that you are going to make your decisions according to what the planning agency will approve and not try for the others.

MEMBER: I think there is a dimension that hasn't been mentioned yet, and that is the ethics that are associated not so much with the substance of the question, but the process by which the decision gets made. I tell people I was appointed to my position. I was not ordained to it. And I was not ordained to impose virtue on the environment of which I am a part. It does seem that a case can be made on any of these things and that hospital managers do have some responsibility to see that all of the relevant—that is a value judgment—arguments get made, that all of the pertinent—that is a value judgment—parties have a fair shot at the question, and that the timing is likely to generate a result that everyone in the end is going to live with comfortably.

If the people in their wisdom, through their planning organization or what not, have decided that there is a shortage of some service and a surplus of others, it is perfectly legitimate for an institution to bend its program in that direction. After all, where does truth and wisdom come from except somehow out of a hopefully open and fair process by which everybody who is concerned or involved has a decent shot at the outcome? I mean, if everybody has, and there is reasonable domestic tranquility when it is over with, why isn't that a reasonable definition of virtue under the circumstances?

MR. DUCE: I think you have a very good point there. In my experience, however, this sometimes does not occur, and for several reasons. Occasionally, an administrator is so concerned about his own institution that he is afraid even to get into a discussion with other administrators for fear his institution will lose something in the process. Other times it seems to me it doesn't occur because somebody simply is left out in the process. He is not even taken into account when the discussions occur.

It is very important that we learn this lesson: that both in the goals and in the processes of reaching the goals we must begin to cooperate.

We have talked a lot about negotiation and the ethical aspects of negotiation. After all, isn't that ultimately the motif of our democratic society? Nobody gets exactly what he wants in a democratic society, and he shouldn't. On the other hand, everybody should have some say in determining

what is ultimately obtained. So I would have to agree with you fully that it is about time that we started talking to one another.

MR. HITT: I agree with you. Often we have so many institutions that do not share the same community objectives. You can announce your plans, and they will use your plans, and do well on them.

MEMBER: That is happening all the time.

MR. HITT: It is a very difficult competitive situation.

CHAIRMAN MAY: Now you have raised some questions in my mind. One of them is, whose job is it to determine what is pertinent and what is relevant? The original question dealt with the pertinent and relevant views. The conclusion was that as long as everybody has been involved—not the "everybody" who would be interested in being involved, but the "everybody" that someone chooses to have involved—the decision process was ethical. The other question is: Is the democratic process really a surrogate for ethical decision making?

MR. DUCE: That is a difficult question since one doesn't determine either truth or goodness by the counting of noses. On the other hand, it seems to me that important in the democratic process is the discussion that goes on before you count noses. Obviously, most of the decisions are made in our institutions in terms of majority opinion. I don't necessarily mean just numerical majority, but in terms of a persuasive majority, which is sometimes a numerical minority. But this is, after all, a characteristic of the democratic process.

What I was really trying to say before was that the discussion is just as important as the voting.

I don't think that the democratic process in its formal aspects is a surrogate for ethical judgments. I think ethical judgments come from within the individual, first of all, and secondly, from the society which has accepted these and made them part of its culture. On the other hand, there is a constant interplay between individuals and society in a democratic society. Consequently, the judgments of both change and are mutually influenced.

I would want to say that any ethical standards that are accepted without careful thought by the great majority of the people are not truly ethical standards. They are some kind of habitual rules that nobody knows why you obey. To me that is not ethical. Titus in one of his books suggests that there are three kinds of morality: habitual morality, legal morality, and finally ethical morality. Ethical morality is ultimately decided by people who have thought very seriously and who have conferred about these things and don't just accept either the legal expression of habitual authority or habitual authority itself.

MEMBER: We have had some discussion which indicates that in the approach to any of these situations, we ought to involve everybody. We have extrapolated that to hospitals, relating to hospitals in a given area. Indeed, we ought to have joint discussions and look at the developments and so forth together. If, in fact, we had done this, we might not have as much heavy hand of government as we have.

I would like to have examined for a minute the ethics and morality of government because if we don't get together and talk, the government's heavy hand is going to push or legislate us in that direction. On the other hand, there are areas where the government prefers that we not cooperate and may fault us because we have set the salaries we will pay nurses, interns, physicians, maids and housekeepers or set up some other kinds of conditions which are totally inappropriate in terms of government views.

Now it seems to me that in some sense we have to find a middle place. We are kind of like a Ping-pong ball between the two patterns waiting for a resolution of our relationship with government. Ethics and morality, I think, have a sizable part to play in it.

CHAIRMAN MAY: I agree. Perhaps without realizing it, we have slipped into a kind of a situational ethics approach. We have applied a test which said that if the right people are involved and the outcome is satisfactory, it is ethical.

In that context, the government is an exogenous factor. It simply stands outside and ratifies or rejects the outcome. So perhaps we ought to start from your point and ask some of the panelists to look at the question: Does government, indeed, determine ethics, or does government respond to them? How does it fit in?

MR. GOLDMAN: Most of the effort I have put into the health field and the health planning field has been put there because I believe a community can

and should make the decisions of good and bad, and right and wrong, and practical and impractical, on its own level better than anybody from outside could, and I see the encroachment of government into the health field for two reasons. One, the default at the community level of doing the planning and looking ahead that has been necessary, and certainly very inadequately approaching any effort to produce a system in the interest of the patients. Second, simply because some of the problems became so widespread and so great that no one local community could solve it.

I don't think that any community, for example, is going to be able to solve its health manpower problem as a local community. This is one where you don't have the capability. I still believe that most of the problems we are talking about here can be met on a local level by the community, by the hospitals in their respective areas.

I think we need a great deal more communication throughout the community and among the institutions to arrive at a basis for individual decisions and to lay out the parameters of concern at each level. Health planning might not have worked well in some areas. I think it made things considerably better than they would have been in its absence. I have hopes there will be enough acceptance of the new provisions of the National Health Planning and Resource Development Act to produce cooperation and permit the decisions to continue to be made on as local a level as possible.

MEMBER: Do you think government is going to let the new system last long enough to get the system working before they change it again.

DR. GOLDMAN: I think it will need to produce some results. All of us here and all the people concerned in the operation of any medical institution are going to be part of the basis for making the decision. Comprehensive health planning worked very well in a minority of states. It didn't work at all in a substantial number, and it was inadequate in others. I think it was given a fair chance nationally. If enough of the local communities had done their jobs, it might have saved some of our decisions for us.

MR. DUCE: I would like to comment with regard to a statement you made, Joel, that we were moving toward a situational ethnic, and to some extent I would agree with that. Interestingly enough, a most famous author in situation ethics, Fletcher, makes the statement that the decisions are not made purely in terms of the situation. You may remember he had the law of love as a general principle which should guide, to some degree, persons in a situation.

Now I don't like to repeat myself, but there is one thing that I feel very strongly about. It is this. As I said this morning, you can't say there are no absolutes. That statement in itself is self-contradictory. I believe there are absolutes. Some things are absolutely right and some things are absolutely wrong, but the one thing that I have learned (and I think all of us need to learn it) is that I am not absolute, and my judgment of what is right and what is wrong is going, to some degree, to be relative—relative to my experience, relative to the cultural ethics or interpretations of the absolute that through my training and my experience I have come to. So what I am really saying here is that deep within us we have a consciousness that some things are right and some things are wrong. This is always the case, but when it comes to specifying what they are in particular situations, then my own relativity comes into play.

MEMBER: I have two comments that really lead to a question. One comment is out of every approximately 185 people here, only 6 come from institutions which are governmental in their source of sponsoring which seems kind of peculiar since those are the kind of problems I deal with being at a state institution. The question has been raised about the role of government in terms of affecting private institutions, whereas government doesn't do it at the secondary level. It is a direct level upon directly sponsored institutions.

It is very hard to define what the ethics of a particular legislative constituency is whether at the state level, county level, or municipal level. Often, you come to a situation where the administrator is forced to make an ethical decision in regards to not making a decision. In other words, the person "cops out" on making the decision to say, "Let it be defined by the governmental sponsoring group." I am wondering if you might have some observations on that. Also, how would this relate to situations where you have individuals who haven't decided what it is they are willing to die for, not in the sense of physical death, but mental, functional, or spiritual death, because of not being able to stand up and say, "This is what I believe."

CHAIRMAN MAY: You would include professional death in that, I presume?

MEMBER: Right.

MR. DUCE: I would like to deal with the first part of his question. As some of you know, I have been connected with an educational institute for Federal Health Care Executives. In June I will participate in it as a faculty member for my 38th time, and on July 1 will become the director of that Interagency Institute for Federal Health Care Executives.

I have discovered in meeting with those men that in spite of the fact that many of the decisions which govern their activity as managers are made in Washington or in a regional office, they are still concerned with the same problems that we have been talking about all day. In fact, the same kinds of questions come up at every one of these institutes, because after all, these are human beings who have to make decisions within certain confines. I think I would have to say that the rest of the administrators in private situations are also within confines, some of which are made by the same government that makes the decisions for the Federal Hospitals in the Army, the Navy, the Air Force, the VA and the Public Health Service.

What I am really trying to say is that government does not determine our ethics. Governmental agencies are just as thoroughly involved in ethical situations, which, in a sense, come from beyond them or come from their human nature rather than their governmental nature.

MEMBER: I wish to direct a dismal observation to Leonard Duce. For many years now we have been told that if the community and the voluntary sector do not solve whatever problems we need to solve in the health field, government will enter in. I will assert that there are no politically acceptable performance standards for the voluntary sector to hook itself onto because it is never good enough. Since it is never good enough, then we are bound to fail. The last resort is the government, and then there is no place to go. We live with that constantly.

MR. DUCE: The only thing I can say really is that I am in full agreement; but from that doesn't there arise a sort of ethical judgment upon the voluntary system? Why have we never set up standards? Why haven't we been able to get some? Simply because of the nature of the system, that standards are very difficult to agree on. It is the very nature of the ethical situations of the human being that ethical standards are very difficult to agree on.

Let me give you an example. I suppose nearly all of us would subscribe to the Ten Commandments. How many interpretations of the Commandment "Thou Shalt not Kill," have there been? Even Hitler subscribed to this, but what he said was, "Thou Shalt Not Kill An Aryan." You could kill a non-Aryan anytime you wanted.

The Parcaes went very much further than that, and they accepted "Thou Shalt Not Kill," but they said, "Thou Shalt Not Kill Anything." You mustn't step on a bug. What I am really saying is that I am not sure that we have been concerned about formulating these standards as we should have been. We may have for our own individual institutions. This is why I use the term "nonsystem" in the health care field.

Incidentally, it is only recently that we have attempted to do it in education, and we haven't succeeded to do it too well there, but we have gone further, I think, in education than we have in the health field.

MR. HITT: I would like to reply to the "dismal observation." I think the speaker is more than right.

For example, take the Joint Commission on Accreditation. It is purely a voluntary effort, spontaneous from the medical community, existing long before government considered it to be anything like their role. But at the present time, the Joint Commission is being harassed by government because it doesn't meet some standards that some people think are high enough, and as a consequence, they are using an inspection technique that no one can afford to use in proving that the Joint Commission is negligent. I think that that is part of the process that we are up against in the review or evaluation of the voluntary system.

I don't think the word "nonsystem" is all derogatory. A lot of good things occur that don't come out of systems. As a matter of fact, the system has a great many things that it perpetuates, things that are bad as well as those that are good. Government will not necessarily add an ethical element or an effectiveness element in everything it does, by any means, although it undoubtedly will do some good. If it does enough, after all, it will inevitably not do it all wrong.

CHAIRMAN MAY: If the decision to take the health care system from the voluntary sector and place it in the public sector is based on judgments that the voluntary sector is inefficient in conducting the system or inadequate in conducting the system,

then I don't think it has anything to do with ethics. But if the decision is based on a judgment that the voluntary system has acted in interests other than those of the general public, and therefore, government is defining it as being unethical, then I think it is a terribly relevant point. Which do you think the main reason is?

MEMBER: Well, I suppose the main reason is because it's inequitable. But every system is inequitable in various degrees and by definition, the voluntary system is more inequitable than the governmental system. Also, we are going into a cost crunch. So we want to sit on the system by going governmental.

I can't conceive of any particular performance standards which could be set up and which the body politic would accept. Therefore, we go government. Given certain crises, we go government further and further until there is no place to go. Then we live with it in that particular framework.

MEMBER: I'd like to raise a question, perhaps more in the management context than in an ethics context. Does the end justify the means? In terms of the ethical decision making, may we hurt someone slightly, in a word, to accomplish an end which represents a greater good? From the ethics standpoint, may you hurt somebody and do it legitimately if in the end a greater good is accomplished?

DR. TARLOV: I think it is a quantitative question. If your responses are limited by your resources, then I would answer yes. By my standards of ethics that would be justified. But if you have the capability to do both, then I think that the ethical question is a little bit stickier.

MEMBER: I am assuming from a practical standpoint that we don't have all the resources available. Keeping a scarce physician on our staff, for example, may be an extremely desirable goal for our community. But in the process we may intentionally hurt another physician or another department by taking money away from them which they could very legitimately use and give it to this physician in order to retain him on the staff.

DR. DUCE: I have always thought that the system of ethics which said that the end justifies the means is an oversimplification. I think the reverse would be equally true, that the means justify the end. John Dewey (with whom I haven't agreed too much) did say that means and ends were, shall we say, an indivisible continuum. Where do the means stop and the ends begin, and vice versa?

I don't know. I don't know enough about the law of causality really to be able to say. Therefore, I think that you have to examine both the means and the end in terms of what other standards you have.

To me, ethics has to include both levels of investigation to be ethics at all. What I am really saying is that you have to ask what the *unintended* consequences of these means might be (in addition to the end you have in mind). What will these particular ends do to the means that you may have in mind to use to accomplish other ends?

It is a much more complicated process than the simple formula of the end justifies the means, or vice versa.

Anything you and I do has side effects, no matter how good the intention might be. Some of those side effects are likely to be negative. That is our finite human situation. I hate to admit it, but I think it is true.

MEMBER: How does a board of trustees, a doctor hiring a resident, an administrator hiring a staff, get at what appears to be a very critical issue of hiring somebody with a proper set of priorities, values, integrity, principles, ethics, morals, whatever we have called them today? I think we are talking about people, and I am not sure if anybody knows how to go about it.

MR. GOLDMAN: I am not sure I do either. I suspect that first the person doing the hiring has to have some of those qualities himself. I think he has to know what he is looking for. He has to have formulated the qualifications of the person whom he intends to hire. He has to exercise his own judgment in setting up those qualifications. If he has not considered the matter, if he does not have some of these qualities himself, then there is no reason to expect him to apply them elsewhere.

There is a certain amount of self-interest in this. If he has set up the criteria correctly, his choice will result in his own benefit, so that there is some motivation for any individual to select the "right" person for the job.

MR. HITT: You have to go from there to the reality that you might make a mistake in judgment, and you have to avoid, I think, putting the person in a critical position. That is, where you can't pull him back if he gets into difficulty at the very beginning. Test him as you test people for other

characteristics, and if over a period of time he passes the test, then you count yourself fortunate. If he doesn't, then you have to take whatever action is appropriate. If you find you have a person whose standards won't support the level that you feel is essential, then you have to treat that as any other lack of qualification for the job.

MEMBER: Would you send the candidate to an industrial psychologist and take his evaluation?

MR. HITT: I never have done it. I don't know. That might be a reliable method, but I never have been totally convinced that that is it.

DR. TARLOV: I would like to respond to that. In the recruitment process, through letters of recommendation and talking to friends, reviewing the record, etc., one comes to a pretty fair knowledge of the individual and his capabilities, his background and the way he thinks. However, you take an individual and you put him in hospital administration today, or into internship or residency, or on your faculty. You are putting him in one of the most stressful positions in American occupational life today. It will only be a very short period before characterological disorders become manifest, and I think that that is a fundamental problem.

That is to say, I don't think the problem is in selecting the people. I think the problem is in what happens to them when they get into the position, and I think, for example, that most hospitals that I am familiar with are underadministered. There just are not enough people to do the job. I agree entirely with David Hitt that the hospital administration has got to have more staff. People cannot be spread as thin as they are in order to give us the best service, and I think that we have got to pay much more attention to that aspect of the life and the work itself.

MEMBER: Several of the questions, it seems to me, have revolved around a very important point. A lot of the discussion today has been about the administrators and managers looking within themselves and trying to establish the effects that an ethical framework has on their own decision making. Some of the more recent questions have stepped out of that framework and said, "At what point should we as managers or as people individually stand up, and I guess preach our own ethical system as the one that is applicable for a given situation or one that is applicable for problems that are found in our community."

I think an important fact about government is that they impose their own ethical system, and we cringe because they make ethical decisions. One of the reasons that the voluntary system may not be as efficient in people's eyes as the government is because we really can't decide on an ethical framework in which to make decisions.

I would like to get the reaction of the panel to the question of when we as administrators have the responsibility to say, "This is the way it should be done"?

DR. TARLOV: One standard, already established, has to do with the discontent of the American people with the health plan, with the health system or nonsystem. I think that principal discontent revolves around lack of access to care. When care is available, I think they are discontented about the impersonal nature of it. I think that those are two standards that are easily measured, and as an individual hospital administrator or as a member of the board of trustees of the hospital, it would seem to me that a regional look at access is one standard that you can set in your own area that I think the health planners at the federal level would listen to.

MR. GOLDMAN: I would suggest that the responsibility of your administrator to emphasize his own ethical beliefs and opinions based on his knowledge are on two levels. In the area of his direct job responsibility, he should exercise it and show his personal strength and make his decisions. With his knowledge he has an educated, informed opinion, and therefore, possibly a more justified ethical position in areas beyond his own field.

I suggest that he ought to keep those separate. He can have a considerable influence outside of his own institution and in the general community in effecting ethical judgments as an individual; but I think there is a limit for us administrators, physicians or trustees in how much of the burden of decision we should carry and how far in our official capacities we should attempt to impose ethical judgments.

I don't know whether this makes it easier for you or not, but there are many times when I have to decide these questions at the hospital board meeting.

I might be quite vigorous as an individual in pressing my point, but the first judgment has to deal with the limits of my area of responsibility.

Beyond those limits we have prestige as individuals, but neither power nor authority.

DR. TARLOV: In exercising your judgment, do you consider the needs of the region or of your hospital and the patrons of the hospital? If you are considering the needs of the region, are you talking to the other boards of the hospitals in that region?

MR. GOLDMAN: In the areas that affect the operation of the hospital or in which the hospital can operate, I try to make clear that you should talk as widely as possible with the other hospitals and probably with other health care institutions or services including the general medical community, the other health community and the region. I strongly believe that the hospital cannot operate as an island, that its decisions must be based on judgments made on knowledge from the entire community. Otherwise, it will duplicate and may therefore operate inefficiently. It will compete in areas where competition is impractical, and the worst thing is that it won't even know what it is doing. In other areas of human and institutional behavior, this is called enlightened self-interest. In terms of the motivation for helping keep the institution alive, this is a broader judgment.

PANEL DISCUSSION

J. JOEL MAY, *Moderator*

Reactor Panel:

ELLIOTT ROBERTS, *Chief Executive Officer and Commissioner, Detroit General Hospital, Commission on Health and Hospitals.*

ODIN W. ANDERSON, PH.D., *Director, Center for Health Administration Studies, University of Chicago.*

SISTER GRACE MARIE, *Administrator, Good Samaritan Hospital, Cincinnati, Ohio.*

PAUL R. TORRENS, M.D., *Director, Program in Hospital Administration, University of California–Los Angeles.*

JAN HOWARD, PH.D., *Health Services Research Unit, University of California, San Francisco, California.*

CHAIRMAN MAY: Next on our agenda is a reactor panel—a group of people who, by virtue of their specific interests or competencies, were invited to come and listen to the discussion, provide their response to that discussion and then field questions from each other and from the audience.

Immediately on my left is Elliott Roberts. Elliott is Chief Executive Officer of Detroit General Hospital and a Commissioner of Health and Hospitals in Detroit.

To his left, Odin Anderson, Director of the Center for Health Administration Studies. I said during my introductory remarks yesterday there would be sociologists on this Panel. I am not sure that Odin really is still a sociologist. His recent book, *Health Care: Can There Be Equity*, was reviewed very favorably in a number of places. One of the reviewers said that he was a political scientist and one of the reviewers said that he was a sociologist.

Sister Grace Marie is on Odin's left. Sister Grace is the Administrator of the Good Samaritan Hospital in Cincinnati and Chairman of the Board of the Catholic Hospital Association.

To her left, Paul Torrens, Director of the Program in Hospital Administration at the University of California–Los Angeles.

And on the far left, Dr. Jan Howard who is with the Health Services Research Unit, the University of California–San Francisco, a sociologist who has looked into some of these questions.

MR. ELLIOTT ROBERTS: I guess it would be fair to say that in accepting the invitation to be on the panel, I did this without a full awareness as to what I had committed myself to. Right up to the end, I thought perhaps I might have a paper to glance over and something to help me to be certain that I had captured all that was of essence in order to be able to respond intelligently today. That didn't happen. Therefore, I thumbed back through my sketchy notes and wracked my brain to see just what, in fact, would be meaningful by way of a response that would spark some interest and hopefully allow for the kind of discussion that we are looking for this morning.

Let me say first of all, that as I looked over the program, I did not get the impression that we were going to be speaking about the pure concept of ethics. Other than the presentation by Dr. Duce, the program has dealt strictly with the aspects of ethical implications for the management process. From my own perspective I had to think of this in terms of the things that I do on a day-to-day basis.

I have to admit that I have not considered myself a philosopher. I have been trained in the art of administration. I feel I carry out that process according to my own design and have not in the past, at least prior to this meeting, given consideration to reflecting on the ethical implications of the things which I do.

I think that that which I heard will cause me to think about what I have been doing, and the manner in which I tend to arrive at decisions. I

would also like to think the boards of trustees, in their own wisdom in an attempt to make the institution whole, in an attempt to continue to provide a wide range of health care services, have in their own ingenious ways taken advantage of some patients in order to subsidize other services. The underlying question is: How much can you reduce that subsidization without losing something in the process?

Prior to this session, I don't believe that I consciously thought about decisions that I had been making on a day-to-day basis in terms of the implication of ethics. Having been exposed to this program, I am not certain that I want to really face the question of whether there have been ethical implications in some of those decisions. On the other hand, I recognize that once I have been exposed, then I can't hide. I see the need to look at personal ethics as it relates to institutional ethics.

Once we become adults, we do have a basic set of beliefs against which we test principles or decisions. This was my point when I said that to the degree that you recognize yourself, you really don't have a problem in the decisions you make, no matter how wrong they might seem to others. The fact is that on a day-to-day basis, the decisions are so intertwined with so many other factors, and they come at such a rapid pace, that you make the decisions based on your own individual being. Thus, to the degree that you are strong within yourself, I don't think you have the real problem of worrying about a wrong decision or whether it was ethically or morally wrong. Rather you go ahead and compensate, if you will, at the next turn of the road because there is another decision coming right behind it. Still, there are major institutional decisions that are the real problems. They aren't in the majority, and I think to the degree they aren't it helps to keep you rolling, if you will.

One thing that I look at, as it relates to the issue that is being raised, is the isolation of an area or an activity and how any change in that will impact the total organization. I think that is where the crux of the matter lies. In other words, the institution has to remain whole.

I don't know whether we look at the specifics or at the principles per se. I wouldn't have a problem with charging for a specific item so long as that ratio of profit, if you will, does not reflect itself in the total departmental operation, wherein you then find that a department operating at 600% above cost is really supporting two, three or four other departments. Yet I have no idea what the percentage of, say, the pharmacy operation is; but let's bring it back down to a more appropriate and/or realistic margin. To what degree does that throw that hospital into deficit? And if that, in fact, happens, who is going to pick up the tab? This is the thing that I think impinges on the operation of our institutions today as various external factors see fit to become a part of some of the management decisions. The administrator must be sufficiently strong in his own being to not be ruffled, if you will, by the thought that he has made a decision that may have hurt someone on one side or given someone else an overt advantage on the other side.

I think that, in the hectic course of a day in the life of an average administrator, you do perforce tend to rely heavily on the input from your staff in terms of helping you to make a decision, and I am certain there are times when snap decisions are made. I am certain that as you reflect you will find that something could have been and probably should have been done another way. But one of the things that I recall in my early days in training was that the administrator is judged on the basis of the number of right decisions he makes. I think that we recognize that we are, as has been said, finite individuals, in other words, not perfect. I also think we take ourselves to task, more than others, for our "failure," as decision-makers. Also, I think you can measure whether you have made the correct decision or not by how long you stay where you are.

This provides, I think, a measure of the degree that ethics have been involved in the making of that decision. You as an individual make certain that hopefully the greatest good has been done for the greatest number. When it was not, you hope the good which was done was the greatest good even though it didn't serve the greatest number. If this is true, I think that you can be satisfied. This then in the long run is really where it is at anyway.

You have to take yourself to task. If you go back and think in terms of the acts of Socrates, he was not concerned with what the greatest number thought of him. He first had to live with himself, and I think that is what ethics is all about. If you can live with yourself, then you can live with the criticisms of others. I think if you keep in mind the ethical implications in the management process as it relates to what you do on a day-to-day basis, you will go a long way.

DR. ODIN W. ANDERSON: It will be recalled that the title of this Symposium is "The Ethical Issues in Health Care Management." Since the symposia

are designed mainly for health service managers, it helps me considerably—and I hope the audience—to be quite specific to the ethical problems of the manager. It helps me to be more concrete than if I paid equal attention to all the interest groups with which the manager must interact, as outlined by Callahan and Duce, and whose rights and obligations the manager must take into account to be an effective manager. The *manner* or *style*, as Duce put it, with which the manager *negotiates* (as Callahan put it) with the various relevant interest groups has a great bearing on the ethical issues that flow from this style.

It would seem that in the "good old days" the manager and the hospital and those associated with them were autonomous enough and the influences impinging on them sufficiently manageable so that the manager could function on ethical principles that were literally taught at the mother's knee. There were a great number of internalized norms giving a great deal of autonomy to the manager and the hospital. The primary loyalty was to the integrity of the hospital and to the integrity of the manager. By integrity in this context I mean a situation in which there was a great deal of discretionary room to maneuver in a local situation and maintain one's identity. The highest duty of the manager was to maintain and continue to push for the best hospital (in terms of both quality and quantity) with whatever resources he could muster and, hopefully, enhance his managerial status in the process. The context was an ethics of expansion, i.e., more for everybody.

The essence of the moral problem as presented by Callahan is how the manager balances all the interests—trustees, professional groups, custodial staff, and patients. Obligations to laws and regulations were a minor problem because they were relatively simple. These regulations assumed that men were likely to act morally in a climate of enlightened self-interest in an expanding economy.

Now, I believe the essence of the current ethical problem facing the manager is that he and his hospital are losing their autonomy, and in turn, can easily be defined as losing their integrity as functioning entities. Ethical and moral issues are actually being settled at higher and higher levels of authority and lost in larger and larger impersonal bureaucratic structures. As a result personal responsibility is becoming increasingly difficult to pinpoint. Once personal responsibility is lost in the maw of complicated structures and regulations, the manager can say that his actions are determined or, at least, constrained by higher decision-making levels. The ethics of adjusting to compliance and contraction replace the ethics which were expressions of a period of expansion. He has lost his autonomy and if you lose your autonomy—or if the nature of your autonomy is not redefined—the whole system becomes unresponsive to profound ethical issues because the manager finds no hook on which to hang his integrity.

I come then to the conclusion that the highest current duty of the manager is to continue to struggle for the integrity of his position and his institution until he meets an irresistible force and then he relies on situational ethics to plan his next course of action. This would be the "realistic" style of managing as described by Duce. And it seems to me the "realistic" style is a natural adaptation to American ethical and religious diversity. It combines structure and process. There is a wider range of ethical options. It is much easier to be ethical in Sweden, because the concensus on ethical and moral behavior is narrower. It helps that they are all Swedes and all nominal Lutherans. There are very few "strangers" in Sweden, and therefore, less competitive and more cooperative plans flow quite effortlessly from the value structure of the society. A case in point is the Swedish official discomfiture with the three thousand or so gypsies who clutter-up the tidy social and political system, by not conforming to welfare state regulations. There are many "strangers" in this country including sometimes the impersonal federal government impinging on local autonomy.

It is an unworkable recommendation to managers and hospitals that they decide between themselves in what areas they should compete and in what areas they should cooperate. Rather, in both processes of competition and cooperation will be merged into a constantly negotiating and bargaining stance to maintain the best hospital in the area in the face of increasing constraints in order to share scarce resources. If this can continue, it will be an ethically and morally challenging environment—the manager is working for the integrity of his institution and himself in an atmosphere of candid self-interest. If the system becomes tighter and more and more decisions are relegated "upstairs" the manager and hospital can then shunt off responsibility to those "upstairs." Discretionary and personally responsible behavior, the essence of a meaningful ethical system, will be considerably reduced.

SR. GRACE MARIE: While I agree with everything that was said, I think I also have a couple of points that are important, maybe, that we stress.

Maybe Dr. Anderson would put me in a class with the "homogeneous" Swedes. I am a Catholic. I already have a code. So it may be it makes it a little tidier, but maybe it makes it a little harder. I do think that whatever code we have, whatever our ethical beliefs or whatever our own conscience as the chief executive officer happens to be, our kind of philosophy had better be pretty widely spread through our organization. That is, I tend to think that everybody working for you had better know what that thinking is.

I think it is terribly important that the Board of Trustees set up some kind of a code, as Mr. Goldman suggested, or some kind of a philosophy, which can then be spread throughout the organization, and I think decisions can be made much more easily from that.

Now I don't mean to oversimplify. I think there are a lot of crisis situations that require different kinds of decisions. Most of the questions—the important operating questions—which can and should be asked can't be answered easily because they deal with specifics and the answers depend on whatever the philosophy of the institution is or the ethics of that chief executive officer or board. Questions like: Do you cooperate, or do you take the lead? Do you buy every piece of equipment coming down the pike? Do you start a new program, or don't you? The answers depend upon what happens to be the code of that particular place.

I think a chief executive officer can probably promulgate that code in one of two ways: either having it part of an education program, so that all of the assistants and everybody aboard knows what it is; or you can simply do it by your own behavior, by your own decision-making process, by your example.

I take a little exception, I think, to the people who said we need larger management staff, so as to relieve the pressure on us and give us more time to think.

I think your conscience and your ethical behavior are formed through your life, and I don't know that busyness necessarily keeps you from thinking about your philosophy of life or your style of administration.

I believe that you could have all the assistance in the world and not really come up with a very ethical situation.

Another danger is that all of you will begin thinking alike and that the addition of levels of management will simply begin to shield the executive from "unpleasant" but important facts. I think if everybody aboard shields the chief executive officer from the things he ought to know or he ought to be hearing in regard to any given situation, the wrong decision might be made.

I have a favorite saying to my own assistants, "If all of us think the same thing, somebody can go." That doesn't mean we ought not all have the same principles, but I don't want to be shielded from what they are thinking about the decisions I am making.

I don't want to be kept from the kind of input that they ought to be making on a particular decision.

We have recently, in Cincinnati, come up with a joint venture on a limited care hemodialysis program because of the planning group. Somebody outside the hospital made the decision that there would be only one, and we have a statement in our organization philosophy that says we will only take on new things provided they are needed in the community and if somebody else in the community can't do it better. Armed with that, the people who work for me went to work to see who could do it better. We concluded that another hospital in town could do it at least as well and had more direct access to the resources needed for start-up. So we have a joint effort, but it was based on a statement of philosophy that was pretty clear in our organization and I am sure was equally as clear in the other.

In a different vein, I think we have brushed a little lightly some of the conflicts of conscience that we are going to have in the future. I believe Dr. Anderson touched on that when he said that fewer and fewer people are making decisions. I couldn't help but wonder what do we do with our conscience in this situation. I am not one that believes you can kill it. I think you can send it underground, but I think it will give you a lot of trouble, if you do. With a lot of outside influences, it seems to me that we are going to have a lot more conflicts, and we had better know ourselves pretty well and know what we can do with them.

I am at the age where I don't think it is going to come before I can retire, but I think other people had better give some thought to the kind of consciences they are forming and to some of the things that are going to be facing us.

I think another thing that is coming down the road very fast is a still further increase in the terribly expensive kinds of procedures we are doing. Do we offer these things because the public wants

them or the public is demanding them? Is that meeting their needs, or do we tell them what they need? Who can have them and who can't? I think these questions and others will definitely pose serious ethical questions.

I noticed, and you probably did, too, in the *Wall Street Journal* some time ago—a story of the United Brands chief executive committing suicide. I don't usually read the suicide column but I read that one because the heading was: Did Eli Black Commit Suicide Because He Was Living in Two Worlds? Some of the issues raised were: Was he in conflict with his conscience? Can you run a business and still maintain a social conscience? I read on further, and one of his closest friends said that he always seemed to be measuring his conduct with standards that were not the same as other people's.

I think we have to be realistic about what our standards are going to be. I think we can. I am optimistic about it, but I think we do have to start giving it some thought, and it's institutes just such as this that will do that.

DR. PAUL R. TORRENS: Whenever I go to a meeting, I try to take notes of the stories as well as everything else, and I notice that we haven't had very many stories because we have been thinking so seriously.

I would like to begin my remarks with a story which, I believe, has direct application.

It's about a young girl from a small town going to Europe for the first time on a ship. She keeps a diary.

The entry for the first day reads: "Dear Diary: I came on the boat, and everybody is wonderful and friendly. It looks as if it's going to be a wonderful trip. Everybody is so attentive to me. Even the Captain has asked me to have dinner in his cabin with him tomorrow night."

The next day's entry reads: "Dear Diary: It has been a wonderful day. The trip is going fine. I had dinner with the Captain in his cabin, and he made some improper advances to me which have shocked me, but he says if I don't submit by tomorrow, he will sink the boat."

The third day's entry reads: "Dear Diary: Today I saved 1,500 lives."

Questions of ethics sometimes come down to something like that. It matters sometimes, whether it's the boat that is dependent upon you or just you yourself.

I came today because I have a specific problem that I have been wrestling with, and I would like to share that one with you for just a few minutes.

We carried out a study in California of what hospitals were charging for drugs to patients. We tried to find out how much are patients being charged, and how hospitals come up with charges for drugs.

We found some interesting results. The most important was that there is a 600 percent variation in what different hospitals charge for exactly the same drug, for exactly the same dosage. There is no relationship between charges and actual cost for providing that service, no relationship between charges and the numbers of money-losing services elsewhere in the hospital.

Hospital charges were 30 to 70 percent higher than the charges for the same drug in community pharmacies, so that literally if patients could get up out of bed and walk across the street, they could get it for less—much, much less.

Hospital pharmacists don't unilaterally set prices for their services. The administrators do, or the business offices do, so that the professionals who provide the service don't control the cost for their service. Most upsetting of all, individual administrators and official hospital associations have not been interested in looking at this problem and talking about it openly, and in fact, have been most anxious to see the results of our particular effort go away.

I can't blame them in some ways, but even in private, they are unwilling to say that there may be something in their own institutions that we, as an association, should look at.

The ethical issue that is involved is: How does one set prices for services? How much can one shift financial burden from one group of patients to another without that second group of patients knowing that they are having the financial burden shifting to them without their compliance? Which comes first, the interests of the individual or the interests of the institution?

The usual answer to the dilemma that I posed is that the most important thing is the bottom line of the earnings report. The hospital has to stay in existence. That is quite true, but at some point, the questions of how much you take advantage of the patients who are your captives for the continued existence of your institution, and of how much control should the manager have over the professional producing the product arise. How much responsibility do we have to inform patients of the charges for items, and how we arrive at charges.

We found, incidentally, in our study that patients

don't know what they are paying for specific services. They are not presented with an itemized, detailed bill very often. So their ability to make judgments in their own behalf is very limited.

In reviewing my dilemma and what has been said so far, I began to see some generalizations appearing.

First, of all, it seems that there are several different kinds of ethics applicable at different levels of decision-making. One might be called a social set of ethics, those that involve social problems of a broad nature which are basically social judgments. Then possibly a second set of ethics which involve the institution, a localized situation, within which a manager makes decisions that affect that institution primarily, and do not necessarily deal with the broader social context.

A third is a set of personal decisions that are personal ethics, individual ethical decisions.

One of the things that struck me is that we often have had difficulty in determining which level we are talking about. In fact, there are different kinds of ethical judgments needed at different times, calling for different rules, calling for different sets of behavior.

Possibly we might say that social ethics might very well be determined by what the society itself and the decision-making system for that society is. The institutional ethics are, perhaps, the prerogative of the board, of the administrator. Maybe personal ethics is the concern solely of the individual who is involved.

Secondly, one of the confusing things is our inability or unwillingness to develop a definition of ethics. We have all been talking about ethics, but I am not sure that we are all talking about the same thing. We are certainly talking about different ranges of problems, and possibly the definition that we use is quite different.

Finally, the third thing that has struck me is that if the institution doesn't have a set objective as to where it is going, if the institution and the board of trustees have not stated clearly, "This is what we are here to do," it is then impossible and impractical and unfair to ask the manager to make ethical decisions in a confused situation, particularly when he is making decisions on things that really affect the institution.

In many ways, before a manager can make ethical decisions of a certain kind, probably the institutional kind mentioned above, it must be clear what the institution itself and particularly the Board accepts as its objectives and as its code of ethics.

Some things are clear cut. The individual manager must always behave in a certain way in a personal ethical situation. In an institutional situation, he may not have any freedom of choice in that the decisions may be made for him, but what can be done is to make those decisions easier and clearer by the institution or organization by saying: This is exactly what we are in business for, and this is how we will behave.

Now most of you will say, "But we do that all the time," but in fact, most institutions do not. Most institutions have guidelines which are practically meaningless in terms of action guides except perhaps when it comes to the expenditure of money. If the Board doesn't take a hand in improving that situation and if they don't express the ethical position of the organization clearly, how can the manager express it clearly? It will be very difficult for him to make the Board act ethically if they haven't chosen to set up a code of ethics of their own.

In conclusion, it seems to me that while we are talking about a search for a set of ethics, as if it were a definite and unambiguous thing, it is obvious that it is not.

There are certain circumstances when we have no choice. We must do something. We cannot embezzle, for example. But in most situations the relevant set of ethics is very unclear and will be determined by the situation.

The challenge, then, is to be sure that the situation is one in which the best ethics are called forth and used by the manager—a weighty responsibility and a ringing challenge to him.

DR. JAN HOWARD: Let me comment from a sociological perspective on several issues concerning the ethics of health-care management.

In the presentations and discussions so far, the concept of ethics has been vague, connoting subjective states that are difficult or impossible to measure. I would like to counter argue that much of what we have been talking about *is* measurable. It simply has not been measured. By systematically observing peoples' behavior, an objective social scientist should be able to determine what ethical premises are actually guiding human action. One could observe the behavior of administrators of health care, the behavior of patients, or that of providers. Such studies could be very helpful in identifying value priorities and ethical mandates.

We tend to be oblivious to our ethical persuasions until we face a conflict of premises or some barrier to the fulfillment of goals and values. Then our priorities come to consciousness. If there are

no conflicts, we can go about our daily business without recognizing or being aware of the moral principles guiding our actions.

One way to avoid value conflict is to select work environments and work constituencies which make compatible rather than contradictory demands on behavior. Thus, an experienced administrator will seek a setting in which the goals of trustees, practitioners, and patients are harmonious and also compatible with the administrator's own values.

If you want to escape the moral dilemmas associated with serving Medicaid patients or Medicare patients, or the mentally ill or hippies—where monetary and time constraints can subvert your ability to provide high-quality care—you will try to serve a constituency that pays its own way and that presents authentic and legitimate "organic" symptoms In California, practitioners are very cognizant of this screening process. The majority of physicians deliberately restrict the number of Medi-Cal patients they accept.* They then feel comfortable with their patient constituencies and can honestly say: "We don't have any problems with Medi-Cal patients."

The avoidance of an ethical issue is itself an action with moral implications. I think Joel was alluding to this yesterday when he asked you to consider what kinds of issues you would *not* address yourselves to as hospital administrators.

Relevant to action and inaction is knowledge about behavioral and moral options. Thus, the research of social scientists may impinge on ethical issues in hospital management. Data which suggest the possibility of alternative courses of action may be brought to the attention of hospital administrators thereby increasing the probability of ethical dilemmas. Research findings can disrupt the status quo by shedding light on the moral consequences of routine patterns of behavior and bringing these habits to consciousness. At this point, failure to adopt an alternative strategy becomes deliberate rather than inadvertant, and "inaction" can be judged by the same ethical criteria as actions which it avoids.

The data on drug costs in different institutions which Dr. Torrens presented bears on this question of knowledge and moral options. His research raises an explicit ethical issue: the fairness of drug prices in various institutions. Now that this issue has been brought to consciousness, your failure to study drug prices in your own hospital would be as much an ethical or unethical act as any effort you might make to change those prices.

Let me offer a further illustration from my research on breast cancer. I have been studying rates of localized and metastatic disease at diagnosis for breast cancer patients at various hospitals in the San Francisco Bay Area. I find great discrepancies in these proportions from hospital to hospital. They are all community facilities, not tertiary institutions where referral patterns profoundly influence severity rates.

Two of the private hospitals are ten blocks apart. In one, the proportion of localized disease at diagnosis (lesions localized to the breast) is 68 percent for white women. In the other the comparable figure is 44 percent. Since breast cancer survival rates are highly correlated with the extent of disease at diagnosis, this is clearly a life and death issue. If we look at the charts of these women we begin to understand some of the reasons for the differential proportions.

Most breast cancer lesions are detected by the women themselves, but a significant percentage of tumors are initially discovered by physicians. In the hospital with the high rate of localized disease, the majority of lesions detected by physicians were found during routine physicals or in the follow-up of fibrocystic disease. At biopsy these were generally localized malignancies. In the second hospital most of the physician-detected tumors were discovered in connection with the care of another medical condition (such as flu) or in connection with the diagnosis and treatment of remote metastatic disease resulting from an undetected primary in the breast. This is obviously not preventive medicine, and the malignancies were generally metastatic. The women who detected their own lesions had localized or metastatic rates similar to those of the physicians in their respective hospitals, which suggests similarities in examination practices.

If we can determine what patient characteristics are associated with early and late detection, we might approach the staffs of these hospitals and make recommendations along the following lines (I am anticipating our research here):

"If you have adult female patients who are black, or of low socioeconomic status, or who are in their thirties, or divorced—take any opportunity you have to examine their breasts. If they come in with a cold, the flu, or a stomachache, take an extra few minutes and practice a little preventive medicine. Otherwise, when they or you finally get

* Charles Petit. "Anger Over Probe of MediCal," *San Francisco Chronicle* (April 2, 1975), p. 10.

around to taking a look, it is likely to be too late."

Assuming we make such a presentation to the physicians and administrators in these hospitals, we will be apprising them of the consequences of different medical practices and suggesting courses of action which might reduce death from breast cancer. If they then choose to ignore the research data or to continue existing practices because alternatives would be too costly in time, money, and effort, they would consciously be opting to follow one moral course rather than another. In this case, as in the drug-price situation, knowledge of available options and their consequences can lead to ethical dilemmas and expose implicit moral premises.

Remaining aloof from critical scrutiny and ignorant of consequences and alternatives can be a purposeful cop-out to avoid moral dilemmas. A less obvious escape is to engage in what I call "ritualized ethics"—going through ethical motions without paying attention to their substance. Informed consent procedures are illustrative. The usual goal of the process of informed consent is to obtain the patient's signature on the consent form. Of secondary importance to most health professionals, it seems, is the patient's ability to really comprehend what he or she is consenting to—the human experiment to be conducted, the surgery to be performed, or the privileged communication to be shared with others.

The ethical *substance* of informed consent is not a signature on a piece of paper. It consists of patient comprehension (internalized information) and voluntary, not coerced, consent. Bradford Gray's recent book on human experimentation in hospital settings* suggests that a high proportion of patients who formally agree to participate in these experiments have little understanding of what is involved or feel that they have no way of saying "no."

If we genuinely want to practice the ethics of informed consent, we must do more than have human subjects committees forms. We need to learn whether patients understand these forms and whether they feel free to turn us down. The ritualized ethic of obtaining the patient's signature for its own sake may disguise and legitimize actions which subvert true informed consent.

I acknowledge the counter argument that researchers and surgeons are honestly acting in the best interests of patients and that the real ritual is having to obtain the patient's consent at all. Informed consent does present an ethical dilemma if the informative process deters patients from authorizing helpful procedures. But the fact is that very few patients say "no" because the medical environment and the people in it subtly and unsubtly pressure them to say "yes" without really understanding why they ought to do so.

It has been asserted that the Soviet Union pays attention to health needs rather than health demands. Such an approach has far-reaching ethical implications. To the extent that the assertion is correct, that society is essentially saying that patient needs and patient wants are not universally commensurate: that consumers of care do not necessarily know or seek what is in their own best interests. Furthermore, it suggests that health administrators have the legitimate right to decide what patients ought to want and how these needs should be met. Perhaps it also addresses another ethical dilemma—how to satisfy the needs of patients and the demands of providers when these are contradictory. According to this view patient needs supercede the wishes of health professionals, at least with regard to locations of practice; but eventually most providers learn to like the areas to which they are assigned.

Americans generally argue that patients and professionals should have freedom of choice. If the constituency of a hospital want 24-hour availability of care rather than some other service, their wishes should prevail as long as health workers are willing to staff the facility. The incentive might be higher fees for the off-hour services. Suppose, however, that 24-hour care is not as critical for the health of that community as a service which the community rejected. Do we become elitist and decide for patients what services they must receive? On what grounds should we make decisions for other people? Through effective salesmanship we can convert "needs" into demands by convincing people to want what *we* think they need. Is that more ethical than superimposing our own values on others?

This introduces the subject of power. Ethics are not really enforceable without power. We can talk about constituencies or groups to whom administrators are responsible, but I seriously doubt that they will *be* responsible unless these constituencies exert manifest or latent power. For consumers, power in a competitive market is the power of purchase and the ability to go elsewhere. For providers it is scarce talent and the freedom to practice or not to practice. For both consumers and providers power can take the form of legal action to enforce an ethic. Thus, according to Mr. Goldman consumers in Kansas City are threatening the tax-

* Bradford H. Gray. *Human Subjects in Medical Experimentation.* New York: John Wiley and Sons, 1975.

exempt status of certain hospitals, on the grounds that they are not providing charitable care.

A few years ago a number of the staff at the medical center where I work sported giant buttons with the inscription: "Think Patient." If you have to be told to think patient in an institution that is four blocks long and 16 stories high and that is presumably dedicated to nothing else but patients, or teaching people how to care for patients—something must be wrong with the system.

Unless incipient power lurks behind those buttons, they will not change the status quo. More convincing than buttons is the option of patients to go elsewhere if they dislike the service they receive. When MediCal came into being, welfare patients were given that option. The supply of cases for students to learn on in certain county hospitals with teaching programs visibly began to dwindle. And just as visibly administrators began to worry about the constituency they were losing. They were forced to "think patient" by the power of those patients.

Under some circumstances ideologies can be strong motivating forces in their own right and thus a form of power. I have tremendous respect for certain religious institutions and the people in them who have dedicated themselves to serving the health needs of patients abandoned by the larger society (for example, the aged and the mentally retarded). But not all health workers have internalized the ethic of thinking patient; and the good intentions of those who are committed may be subverted by counter obligations and pressures. So if health care is to be a right rather than a privilege, it must be an enforceable right.

Lastly, let me briefly discuss the significance of personalized care (humanized care) for the ethics of hospital management.* This issue has been mentioned by several speakers but not considered in any depth. Humanized care has many connotations. From my perspective it means care that enhances the dignity and autonomy of patients and health professionals alike. Such a definition contains a potential paradox. What enhances the dignity and freedom of health professionals may undermine and curtail the dignity and freedom of patients, and vice versa. The trick is to humanize patients without dehumanizing providers and to humanize providers without dehumanizing patients.

Achieving both goals simultaneously is difficult because sick patients have a vast number of physiological, psychological, and social needs which may also be translated into demands. And providers of care have corresponding needs which cannot be satisfied if they are overworked, harried, and inundated by the demands of patients.

Humanized care may be an end in itself or a means to other ends. Its relative value to patients and providers probably varies with their personal and social characteristics and the condition or illness being treated. We tend to assume that the practice of modern medicine necessitates the sacrifice of personalized care—that this is the price of universal access, technological progress, and superior treatment through specialization. We also tend to assume that the process of making care more humanized would require tremendous commitments of money and manpower and should therefore be restrained. This point of view is based largely on conjecture rather than empirical fact and calls to mind three counter arguments:

1). Even if the costs are high, humanized care might be warranted on strictly moral grounds. If resources are scarce as they seem to be, decision makers would have to weigh this moral value against competing ones; but it can certainly be argued that humanized care is justified in its own right.

2). Sizable investments in personalizing care may be offset by short- and long-term economic benefits. Egbert found, for example, that giving surgery patients proper pre-operative psychological preparation reduced their stay in the hospital by 2.7 days.† There is also evidence to suggest that personalized care reduces the incidence of malpractice suits. When patients are treated with dignity and warmth, they are less likely to sue their practitioner or hospital for an alleged medical error. Impersonal providers and facilities are more vulnerable. Furthermore, humanized care could offer economic benefits from increased provider morale and work continuity, from increased therapeutic compliance by patients, and from a reduced number of "no-shows."

3). Many of the changes and adaptations necessary to make care more personalized may be inexpensive, essentially free, or cheaper than existing practices. What may be required is a change in "atmosphere." Unfortunately, some "atmospheres" are predetermined by the physical struc-

* For a much fuller discussion of personalized and depersonalized care, see Jan Howard and Anselm Strauss (eds.) *Humanizing Health Care*. New York: John Wiley and Sons, 1975.

† L. D. Egbert, *et al.* "Reduction of Post Operative Pain by Encouragement and Instruction of Patients," *New England Journal of Medicine*, vol. 270 (April 16, 1964), pp. 825–827.

ture and face of the institution. Medical centers that tower in the air or sprawl over block after block of city streets may be inherently dehumanizing for patients and staff* because they are breeding grounds for anonymity. To convert these facilities into humanizing environments might be impossible at any price. This raises an important question: Do we need these towers of anomie to deliver high-quality care? Do we need them for primary care? For secondary care? For tertiary care? For teaching purposes?

What about the towerless health facilities? How much would it cost to change their atmospheres? Adding highly skilled health professionals could be very costly, but employing effective triage personnel should be less expensive. And filling existing slots with health workers who could relate humanistically to patients might not increase the economic burden at all. If a new spirit were communicated to patients, the atmosphere would change—possibly free of charge.

Let me provide an illustration from my own experience—not in a medical setting but in a traffic court. Recently I had the occasion to appear in traffic court to contest a speeding ticket. For the better part of an hour I sat through arraignment after arraignment listening to people plead "not guilty" and "guilty" and argue for leniency from the judge. Gradually it dawned on me that something about this traffic court was different from others I had observed as a citizen and sociologist. The accused were being treated as human beings!

This occurred just a few weeks ago in San Jose, California. A large proportion of the defendants were Spanish speaking or of Mexican background. A few blacks were present as well. I seemed to be the only professional person in the room besides the judge and one or two lawyers. For the most part, the defendants and their friends were young and dressed in jeans or other clothing that my guidebook forbids me to wear to court. Yet, the judge treated everyone with dignity and with an empathy that comes from genuine understanding of the realities of life. He did not address anyone as "boy" or "girl" or by first name. Each of us was addressed by our full name or by surname and appropriate prefix.

The judge was obviously aware of the unemployment situation in the county and of the difficulties fines would impose on those without work. So he asked the guilty parties, in a respectful nonpatronizing way, if they would need extra time before paying their fines. He generally assumed that a month would be necessary to raise as little as $10. After observing and listening for an hour, I realized that this court had a humanizing atmosphere. I suspect that at the end of the day the judge was more relaxed and more at peace with himself than most judges I have heard dressing down defendants and giving little speeches and acting as though the whole world should be able to hold their speed at 55 on any freeway, at any hour of the day, under any circumstance, and that every muffler should be silent all the time.

What was the cost of humanism in this court? Probably less than the cost of a dehumanizing atmosphere. The judge was actually a "traffic referee" rather than a judge in the traditional sense, which suggests that he selected traffic duty, that he was not relegated to it. The key here is to determine the ingredients of a humanized atmosphere, to calculate and weigh their costs and benefits, and to use this knowledge realistically to change dehumanizing environments.

I am not optimistic that this will come about by the grace of moralists per se, unless to paraphrase H. Jack Geiger, the angels form a union and collectively exert pressure for change.† I do believe, however, that in a democracy felt needs can be converted into effective demands. And demands can force us to bring to consciousness habitual patterns of behavior which have dehumanizing consequences. This is the first step in the quest for rational alternatives.

DISCUSSION

CHAIRMAN MAY: Thank you, all. They were both interesting and provocative comments.

I would like to spend a few minutes exploring a thread that I think was un-spun some yesterday and further unraveled today.

What is it we are talking about when we mention ethics? We talked some about the fact that ethical positions are essentially negotiated stances that one comes to through a variety of processes. Odin this morning explicitly stated that it is through a negotiation process that ethical conclusions are reached. On the other hand, Paul Torrens and Sister Grace pointed out that it is not a negotiated thing at all. It is something that fundamentally exists underlying decisions and actions regardless of its source.

* Roslyn Lindheim. "An Architect's Perspective," in Jan Howard and Anselm Strauss (eds.), *op. cit.*, pp. 293–303.

† Jan Howard and Carole C. Tyler. "Comments on Dehumanization: Caveats, Dilemmas, and Remedies," in Jan Howard and Anselm Strauss (eds.), *op. cit.*, p. 255.

Yesterday we had one question on the subject of what you would give your professional life for. How far can you be shoved by various groups, various interest groups in the negotiation process before you sit back, until you plant your heels and say: "No further?"

Odin believes, as I know, in academic freedom. Odin, in the context of choosing an ethical position as a result of negotiation, how far would you be willing to sacrifice academic freedom in order to insure that the Center for Health Administration Studies would survive and grow?

DR. ANDERSON: The last stand in an academic setting in this kind of society is freedom to publish. There might be constraints, or there can be constraints, on what you might study. I mean, when you have to have access to people's bodies or minds or what not, there should be limits as to how much privacy they retain. But once the process of studying starts, no outside forces can or should forbid you to publish. Otherwise the whole system falls apart. If the Center for Health Administration did get to a point where there was nothing but contract research and the buyer decided whether or not we could publish, I would resign.

CHAIRMAN MAY: The analogy to health care management, I think, is clear. Each of us has some perception of what our role as a health care manager is, of what the role of our institution is, and what the expectations of society are concerning it. But every day in every way we are pushed one way and another within the context of these positions.

We are being pushed back to a basic fundamental stance with respect to the role of manager, and/or we are being pushed around with respect to our stance concerning the institution's purpose. We are being pushed around with respect to social purpose, and I think rightly so and understandably so and even perhaps constructively so. That is what the negotiation process is all about.

But it strikes me that each of us ought to have a position with respect to our social responsibility, with respect to the institutional role, with respect to our personal integrity where we refuse to be pushed any more; where we are willing to bear a fairly high personal or professional cost to maintain the stance that we are holding.

I don't know what that stance ought to be. I doubt that it would be the same for any two people. But I think we ought to know it exists. I think we ought to know what it is. And I think when we know that it exists and what it is, we have a code of ethics for ourselves. Are there questions?

MEMBER: I want to mention that, as hospital managers, one of the things that I think requires us to talk to ourselves frequently is the fact that we work simultaneously on the two levels that were identified this morning. The one is at the level of institutional ethics and the other is at a level of personal ethics.

In my moments of cynicism I say that administration is really a form of prostitution in the sense that we sell our capabilities to the highest bidder. I mean by that that once we accept a responsible position in the hospital administration, then I think we obligate ourselves to some extent to be advocates of the ethics of the institution with which we are associated, even at points at which they depart from our personal ethics. Consequently, we really have less responsibility and are not fully personally accountable for the selection among the alternatives.

There is an institutional process to which we pledge ourselves when we agree to take the monthly pay check. The process of trying to come to some personal peace with our role as advocates of an institutionally-determined ethical posture, which may vary from our personal ethical posture, seems to me one of the things that makes our roles complicated. I have observed for some time that young people entering the field have considerable difficulty in distinguishing between those two roles and reconciling them in a way that, as someone said this morning, they can live with themselves.

CHAIRMAN MAY: Would you define as a sign of professional growth the submerging of one's personal ethics to the institutional ethics, or alternatively, the recognition of one's personal ethics and the decision of when to choose them over and against the institutional ethics?

MEMBER: I would define the professional growth as the ability to reconcile the two in a mature fashion which doesn't totally sell out either one to the other. And to reconcile the two in a way that allows you to maintain some kind of personal integrity.

DR. HOWARD: I might mention a possible third level of ethics, and that is professional ethics which in some instances are interfaced between personal

and institutional ethics. I think this is a process of selection where you do the best you can not to have these things in conflict.

You go into a profession, and if you stay there, presumably it is in harmony with your personal ethics. Then you try to find an institution which is also in harmony. Yet sometimes the three things get out of phase, and you rely on your professional colleagues to validate your own ideas which may be that you did right professionally, and to hell with the institution. (At that point you may have to leave and find a new position.) I think Sister Grace has tried to amalgamate her personal ethics, her professional ethics, her institutional ethics, and as she said, she has a practicing code. She probably tried to find a place where she could live comfortably herself. I think we all do that in less obvious ways.

CHAIRMAN MAY: Who are the salient people in the organization that you are going to listen to? I think the manager of an institution chooses, based on his own managerial expertise or naïveté, a set of salient others to whom he listens. These are the people whom he thinks represent the carefully thought through ideology of the institution.

I think he can make wrong judgments about whom to listen to.

It is also not a simple process of adding up opinions and dividing by the number of people you listen to. Still, I believe that is exactly what the administrator does. How he goes about doing it is a measure of how good an administrator he is.

MEMBER: I would like to pursue just a little bit further the question of who I am willing to look to to define the institutional ethics for me, given that most institutions are not defined very well. I am inclined to accept what seems to be the definition in my institution today, knowing that next month they might be entirely different. What are the consequences of that pattern versus trying to stand up more firmly for my own code and looking in terms of the outside publics that the hospital has to serve to define my code of ethics?

I think the process of developing an institutional ethic itself is an intensely ethical thing that we haven't had occasion to go into. I am not sure that I am very anxious to see an institution develop a very concise and stable ethical posture. Institutions have too much power for that. I see the development of institutions' ethics as a constant process or as constantly evolving out of a negotiating process. I suppose that adds further complexity to it, but it does relate to something that was said this morning.

If a decision somehow arises today and you can't live with it, or you have trouble with it, one way to deal with it is to say, "Well, I will get another shot at this one of these days."

I think you can bring yourself as a manager to feel that the process by which the position is arrived at was fair and that it represents in some fashion an acceptable consensus of judgment among people that you can generally believe are honorable. For whatever it's worth, that helps me a great deal, even though I don't necessarily subscribe to it. If I believe that it was arrived at by honorable people in a fair way, I can live with it.

DR. TORRENS: I would like to explore the assertion that an ethical position or outcome can result from a negotiated stance or a compromise.

I am reminded of a conversation I had several weeks ago with a labor leader in Los Angeles about a strike in a hospital. I was trying to find out for my own purpose his side of the picture and how he approached the negotiations. He said, "Well, the first thing I have to do is to know what the issues are. I have to know the absolute minimum I must get. Then, the next layer, how much extra I would like to get, and then how much beyond that I may be lucky to somehow or other receive." He said, "If I don't know that clearly, I don't know what I am negotiating for, and then I don't know how to negotiate because when an issue comes to me, I don't have any framework for handling that."

If he and the union leadership didn't have clearly in mind the minimum that they will keep and the optimum and the extras, they wouldn't know how to behave in that negotiation. If we don't know in our own minds what our own basic personal ethics are, I think we are really in trouble. I get that sense as a very clear point. If the ethics that we bring as people to any situation are not strong and clear, whether it is the Judeo-Christian tradition or whatever, we are lost. Additionally, if we don't have clear in our institution what the ethics of the institution are, we are also lost.

Beyond those two it really is a matter of negotiation. But without those two strong bases you are just a will-o'-the-wisp which can be blown in any direction.

I guess one of the lessons that comes out of this is that for educators, as people, we have not stressed ethics. Most programs in hospital administration don't have a course in ethics. They don't even talk about ethics. We presume students are going to have

ethics and that our faculty has ethics. Like Elliott, I guess I really haven't thought much about before this Conference. But I begin to see much more clearly that this is a responsibility that all of us with staffs have to them as well as in our own personal development, because any institutional ethics begin with an individual person's ethics.

MEMBER: It seems to me, that ethics are (1) individualized and personal and (2) they are very difficult to define. It also seems, particularly as some of the problems that Dr. Howard brought out and Dr. Torrens brought out illustrate, that there are very realistic problems in the industry today. There are very explicit promulgated ethics by professional groups which in some ways provide obstacles to overcoming problems rather than efficient mechanisms and avenues to solve them. So my question is: If ethics are something that are personal and very difficult to define (1) should professional organizations promulgate ethics? How much help do you really need in an institution or in trying to run an institution? And I would gladly welcome anyone's input regarding the question of: Should they be promulgated by professional groups?

DR. TORRENS: I guess my reaction would be, "Yes, maybe." If we are talking about a negotiated situation, or at least, a situation with many inputs, we then should have as many good inputs as possible, as many opinions as possible. Whether we act on them, that is something else.

Let's say, for example, that the neurosurgeons may decide, as a professional association, that every hospital ought to have a neurosurgeon, or all neurosurgery that is not plastic surgery should be done by a neurosurgeon, or something, that might be quite defensible from their own limited point of view. They might put that forward as a code of ethics of some kind. But then on the other side would be your own personal appraisal of that situation which might lead you to conclude that it is just not practical nor possible. But that adds something to the input.

It comes down to the crunch when you have an individual whose professional association has established one set of professional ethics which are neither practical or possible in his particular working situation. He is told, in effect: "You are working in an unethical situation," and he replies, "Yes, but that is the only situation that is possible here."

I think that it gets to be complicated. Until a lot of these questions are resolved, the more inputs there are, the better off we are. Indeed, professional associations *should* have ethical standards because I think it can't do anything but good even though in specific situations it may make it more complicated at that moment.

CHAIRMAN MAY: In preparation for the program I did read over many of the codes of ethics of professional associations. The elements of the codes as written fall into three distinct categories.

There is one category which essentially advocates professionally protective behavior: things which nurture the profession, or improve its image, are considered ethical. These are not necessarily the most important or the most numerous, but they are there.

Another category into which the elements of these codes fall are matters of what I referred to in my introductory remarks as etiquette rather than ethics—behavioral statements of the "thou shalt not" sort which are really a matter of how one should behave under certain circumstances.

And then finally, they contain a fair number of elements which address matters of human decency, honesty, truthfulness, which for the purpose of our deliberations and the direction we are taking here, are pertinent, but not terribly informative.

I called one of the national associations and asked them if they did have a representative to serve on this panel. I described the subject matter of the conference in some detail, and the response was: "The person you need is St. Thomas Aquinas." They did not suggest a representative of their organization to attend.

MEMBER: The Patient's Bill of Rights was adopted by the House of Delegates of the American Hospital Association and since then has been enacted by a number of states as law. It represents a situation where a professional society has promulgated an ethical system as you have indicated, and I am wondering what the experience has been of the people involved in the panel. Dr. Howard did mention some of the things relative to that such as consent and information.

I am wondering what is the role of the health professional, administrator, or manager in promulgating that code. I wonder if in some instances it hasn't been decisive leadership that has enabled this code to come into being. I think about certain states like Massachusetts where patients' representatives feel that there ought to be something on the order of a legal entity to enforce this. On

the other hand, in Minnesota, particularly at our hospital which was one of the pioneers in the field, you have an advocate system involving an ombudsman. I am wondering whether the decision to either take the legal route or take the ombudsman route isn't in a sense an ethical decision. We now have a system of ethics through which we can choose to manage one way or the other. The way in which we do it, either by action or nonaction, can make a difference in how we resolve these ethical issues.

SR. GRACE MARIE: I would agree that if a professional organization is going to develop a code of any kind, that it simply be used as input; but I think in reference to the patients' bill of rights, there were people in the profession who found at least small parts of it to be in conflict with their own personal ethics. In that way I think we are very fearful of having a document like that legalized and imposed from someplace else.

There was really no negotiation, as it were, between the personal ethics, the professional ethics and the institutional ethics. It was simply a code that was meant to be a guideline. Subsequently, it has been given force in law. It is not a direct answer to your question, but I think there is a danger in turning things into a legal document when they could create conflicts.

DR. HOWARD: Just because I mentioned legal forces as part of the power behind an ethic doesn't mean that I think everything should be legalized in the system. It couldn't be.

On the whole, I am not opposed to having these things set down in black and white as guidelines, and I think that if certain aspects of them can be made law, at least administrative law, that it would be helpful. It gives us a form of backup in the face of difficulty. The real problem is that in order to even enforce the law, you must have some power.

As far as whether these things ought to be turned into ethics, I think ideals are always useful and hopefully they raise people above the standard they could or would attain in the absence of such ideals. Yet, informal ideals are as important as formal ones, maybe more important, and what is really more important is the extent to which the values that are laid out in ideals are actually realistic.

The worst thing that can happen is the shock of finding out that the things you have been taught are not applicable or that nobody follows them. This may be so disillusioning that it leads to cynicism. Many of the ethics, including perhaps those in the Hippocratic Oath are much more concerned with relations between providers and lack of competition within the profession than they are with what you do for patients.

I am not suggesting that it is wrong for providers to protect their own interests and ethics. But it is interesting to read what is on the wall of the doctor's office. You find that it is concerned with doctors not cutting their buddy's throat (although it is put in more prosaic language than that), and with encouraging their sons to be doctors. So I think it matters what is in these codes, and how realistic they are, and that is my concern here.

MR. ROBERTS: I was on the Board of the American Hospital Association when the patients' bill of rights was adopted, and I saw it come back to the Board, not once, but about four times. Then painfully after much rewording it finally passed the Board, then the House of Delegates. Even then, in each instance when I was called upon to vote, I was mindful of the fact that the impact of this was going to fall on me in my own institution.

On any of these codes, one of the positions I have taken, as one who has to shoulder some of the responsibility when they are promulgated, is that they are intended to be guidelines. They are intended to be used by the institution to help that institution to find its way if it is involved in the situation. They are not ever intended to be law.

It was recognized that some would run headlong ahead with them and others would go slowly. A code like the patients' bill of rights has a whole host of implications beginning with the responsibilities of the Board, the medical staff, the administration in terms of how one deals with patients. I think in the climate in which we live today as it relates to where malpractice is taking us, it is an explosive device if used incorrectly. It can be a double detriment if the hospital is not structured and organized as to be able to deal with it.

I think one has to recognize that the responsibility as it relates to the patients' bill of rights falls squarely on the shoulders of the physician. In public teaching hospitals where there may not be a close physician-patient relationship, the code becomes particularly crucial as it relates to what a physician says to a patient, how he says it, the degree of acceptance and the result of that both on the patient as well as on his family.

To give you a specific example, when I was in New York, at the Harlem Hospital, we had what was known as a patient advocate who was not on

salary but was a community person who spent a good deal of time in and out of the hospital. This was during the time that the patient bill of rights was in committee, and this individual happened to have been a patient in the hospital. As far as I was concerned, she was an important patient. I finally got up to see her after she had been there for some time, and when I did, she said she had been waiting for me because she had a few things to tell me. One of the things that she mentioned was that she had been to surgery and had come back. Two days later a nurse came by and said to an aide, "Prep her for surgery."

The patient looked around because she was the only one sitting there. She said to the nurse, "Prep who for surgery? I just came back from surgery." Whereupon the nurse said, "You are going back to surgery. Didn't the doctor tell you?" He hadn't.

Now when you consider the fact that things like this do happen in institutions, it makes you as the administrator wonder.

DR. TORRENS: I think it is important to follow up on that because we keep talking about how the things that are promulgated should only be guidelines, but in fact, in practice they become law. The way things are now, professional standards, codes, and guidelines get picked up, added into court actions of one kind or another, and then become the basis for law.

Local, state and national associations have codes as to what hospitals are supposed to charge for services. The philosophy is that you should keep it as close to cost as possible or something similar and of a very general nature. Transplanted into a court action, suddenly it is no longer a general statement of what we ought to be doing. Rather it is a specific statement of what the law is going to be, and I guess that is why I am very schizophrenic on this issue.

On the one hand we have to have those codes because they help move us ahead in our judgments and our own ethics. On the other hand, almost as soon as you say them, they become law. As Sister said, we may not be ready for them to become law. I don't know how to get out of that dilemma.

In this day and age almost anything that goes down on paper that has a seal or an association of any kind immediately assumes an importance and a use far beyond what it was originally intended for, and that is a problem.

MEMBER: I am somewhat confused. We have been talking a lot about the institutions' ethics, and it seems to me that these can only be a function of all kinds of inputs but primarily the administrator's and the manager's. We conclude that managers are able to work best with similar others. Then we come into an educational process, part of which has the purpose of socializing the new members of the profession to the ethics that make us similar to others, and therefore able to work together. The thing that strikes me about all of this is that it seems there may be inadequate input from the patient's standpoint. When do we get back to considering the patient's right to health, or whatever that amounts to? How do we consider patients as consumers and consider their needs even though doctors are actually the consumers.

DR. HOWARD: One of the difficulties is that people accommodate in every society to some pretty horrible things.

If you really want to see how people accommodate, you should read what happened in the concentration camps. If you walk into a number of city hospitals, you really wonder why people put up with the way they are treated. I think the relevance of this is that trying to find out what people really want when they have a stake in pleasing you is difficult. I think you should recognize that if you want to find out if people are happy in your institution, there are many people that are going to be afraid to say anything else, including employees. This expresses itself in the problem of informed consent. If you read Bradford Gay's book, you find that many women volunteered to test a labor-inducing drug because they were afraid to say anything else: they wanted to have their baby.

Therefore, I think if you want to find out, you have got to get people that are less vulnerable, in a sense. Perhaps the sick are not the best people to speak for the sick on all occasions, and yet, somehow their viewpoint has to be understood.

The patient advocate whom Elliott referred to is an ideal case, but after all, she was either self-selected or other selected to speak for patients. So she is going to be somebody who articulates this pretty well.

There are ways to find out what patients want and where patients really hurt in terms of the system, but it is easier sometimes not to look. I think if somebody really wants to look, there would be no difficulty in bringing in some people who could help.

I don't think this helps too much, but I am

afraid that people don't really want to know, and that is the first barrier. Administrators, providers, and sometimes patients don't really want to think of alternatives, either because of inertia or a fear that not all change is going to be good. There are all kinds of unanticipated consequences of change which I didn't speak to, as you well know, but I don't want to emphasize them too much.

There is a new law that has come down in California now, at the Supreme Court level, which will probably be retested. It states that psychiatrists have to divulge dangerous situations that may occur with respect to their patients. Somebody was killed as a result of this lack of warning in Berkeley. This protects the community, but what does it do to the patient? You know these laws are going to be evaded. People are simply going to stop taking notes so that there is no record. With regard to the rights of people to look at their health records, there are going to be things that don't get into the record. This will lead to the creation of an informal, *sub rosa* information network.

There are ways to get around these laws, but if somebody such as an administrator really cares, farsighted and wants to find out what to do, I am sure there are ways to effectively accomplish that.

MEMBER: This is just a comment, really. I was very pleased and appreciative of Dr. Howard's perspective on the power than can come to play to enforce ethical decisions upon us if we don't do it ourselves. However, I was reminded of situations when, as a child, your mother told you to do something worthwhile which you were just about ready to do anyway. As soon as she told you to do it, you began to resist, and you didn't really like doing it quite as well.

I think the perspective that society does have the power to enforce certain ethical behavior, for example, the IRS for charity care and the legal issues surrounding informed consent, are areas of practical application for this symposium. Previously, I hadn't recognized the power that society does have available to it and is using. I would personally like to see our institutions anticipate these societal actions. I think we can get a much greater satisfaction from our own initiative than when it is forced upon us from some external power base.

DR. HOWARD: One comment on power. A problem is that patients really aren't the kind of group that is easily organized. Patient groupings are quite ephemeral because the membership is so transient. I can't see people running through the community and organizing you because you may be going to use that hospital in the future, or because you used it in the past. So in a sense the hospital administrator has a much greater power base than he or she might think because patients don't make strong power blocs.

Now if there is an organized group like a trade union, this is a potential focus of power. I would suggest that these may be more organized and visible in the future than they are at the present time.

If health maintenance organizations have certain definite memberships and somebody gets going and says, "We have got to do something about our facility," that could really be a meaningful and important source of power countering that of the administrator.

CHAIRMAN MAY: It seems to me that there might be, as a result of this accommodation between individual and institutional ethics we have been discussing, the development of a kind of incestuous process whereby the institution would employ only individuals who shared the appropriate ethical structure; conversely, individuals would seek employment only at institutions at which the ethical situations were similar to their own.

Mr. Goldman, as a trustee of an institution, do you have a feeling about how the institution can be led through the proper choice of managerial personnel?

MR. GOLDMAN: I think it is an interactive process. As I said yesterday, the ethical position that the board takes is going to be molded in substantial part by communication with the administration, and I don't see a position ever as a fixed code. I see it as an ongoing process. I don't think that a board is ever going to look for or accept a new administrator whose position is radically opposed to the ethical standard of the Board as of that moment.

I think it would be very shortsighted to explore too deeply the individual's personal ethics. I can't conceive of a board having either the time or the inclination to do it—that. I think there would be substantial latitude, but in itself I think this could serve as a protection because it provides for evolutionary change rather than revolutionary change in the ethical position. So I don't see that as a problem or a danger to the administrator who really has considered the problem.

At the present time, neither boards nor administrators have thought through an established ethical

position from which to approach issues to the extent they should—and must.

While I have the floor, I'd like to say that I think the symposium has served an excellent purpose in arousing thought in an area that needs organized thought, introspection, consultation and communication very badly. We have spent a lot of time delving into more specific areas of the application of ethical judgments that we haven't really made. We have talked about the process and some of the applications which might lead to problems. I would hope that the main outcome of all of the discussion is that we will go back and think about the problems; think about how to approach ethical issues.

I have less fear of the dangers or concerns that will be produced in coming to personal ethical decisions. I have considerable confidence in the majority of the people in our field, whether it is the administrators or the Board or the professions. I am old-fashioned that way.

I think that the application of ethical judgments and policies is going to prove easier in the long run than some of the discussion here has indicated simply because the decisions are being made today. We are living with the consequences, and we are making those decisions on such an ad hoc basis and with so little concern about their broad implications that we create new problems without expecting to. The least that we will get if we give some consideration to an organized approach to the application of ethical judgments is that we will know whom we are hurting when we make a decision to help one group, and what effect the decision will have in other areas.

The only concern I would have would be that none of us go back and say either that these problems are too tough to approach or that they belong to somebody else because I think in either case we would be wrong. You have a tool in ethical consideration that should make the decision process easier and more comfortable to live with and perhaps even reduce the side problems that we face after every decision.

Concluding Remarks

J. JOEL MAY

Early in this symposium the analogy of a bridge was used a couple of times, and I think in a way some of Mr. Goldman's final comments have enabled me to expand that analogy and bring our meeting to a conclusion.

I believe that we have done here just about what the engineers who built the first bridge across the Niagara gorge did. They studied the structural properties of the bridge they were planning to build. They estimated the traffic patterns. They thought how crowded it was going to be at various times of the day. They looked at the features of the terrain. Then they wheeled their equipment out there and they settled down on both sides of the river. The engineers and the scientists and the construction people said, "All right, our plan is to get the bridge across the river." So they put a fellow in the river in a boat, and he started to paddle across the river towing the cable to make the first crossing, but the boat was swept down the river, and he didn't make it. They tried again and again, but the current was too strong. They were frustrated. They knew what the problem was. They knew what they wanted to do about it, but they couldn't get started.

So finally they saw a little boy flying a kite. They brought the boy over, and he flew the kite across the river; then brought it down. They then tied a very light rope to the kite string and pulled it across. They tied a wire to it and pulled it across. And that is the way they got the bridge started.

I believe in our deliberations here we have gotten about as far in the direction of solving the problems of ethics in health care management as choosing the boy with the kite. But I think that that is a big step. I hope that we will now be able to work at getting the kite across, getting the cable across, and ultimately getting the bridge built.

I thank the panel. I thank the audience. I have learned a great deal and have enjoyed it thoroughly. I hope the same is true for you.

See you next year.

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