A Larger Space for Moral Reflection

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Call this, not a design, but an artist's conception. Ethics committees in 1998 are like pioneers a decade or two after settling in: they have changed the land on which they work, discovered that one year's weather does not predict the next, looked with curiosity as new neighbors arrive, and watched new leaders and rulers with ambivalence. They've been living in log cabins, built with the help of other pioneers. Now they need a new and roomier building, with more furniture, some new appliances, and a better view.

Ethics committees have been places where clinicians could bring uncertainties about individual cases, where in-house ethics education is offered, and where hospital policy is scrutinized. Mature ethics committees are made up of seasoned members who deal with these activities comfortably and competently. Now they need to take up new kinds of work as well. Health care is changing. Hospitals have become health care systems; financing is radically transformed; hospitalized patients are sicker and their stays are shorter. The staff is being asked yet again to do more with less; and so are ethics committees. JCAHO is asking health care institutions to think about "organizational ethics." *HEC Forum*, published for ethics committees, has announced a new section on "administrative and organizational ethics." It points out a persistent blind spot: bioethics lavishes attention on what doctors and nurses should do, and what society as a whole should do, but does not ask what local institutions should do.

This new environment presents new challenges. If the central purpose of an ethics committee is to "keep moral space open," (a phrase of Margaret Urban Walker's) then there's now a lot more space to attend to. As ethics committees design their larger quarters, here's what I'd like to see.

I. Larger Windows

First, most simply but most radically, larger windows: i.e., a larger understanding of what counts

as an ethical issue. Health care institutions affect not only patients but also their own workers; not only the patients within their system, but sunbathers on whose beaches medical waste arives. A health care institution can be the largest employer in town, and wield considerable political clout. (In my own town, a pedestrian bridge has been built connecting the largest hospital with its professional building. The bridge cuts off a view of the state capitol from the main street into town. There were some objections when the bridge was proposed, but its construction was a foregone conclusion. The bridge is a powerful symbol of institutional — *political* — muscle.)

If anyone were to start hospital ethics work *de novo*, working not from the field's actual historical roots but simply from the meaning of "ethics" and of "health care institutions," much of wht I have just said would be obvious. Institutions, like people, are responsible for the results of what they do, and their actions have consequences for many different parties. In business ethics these other parties are called stakeholders, to block the assumption that a company's only obligation is to its stockholders.

In contrast, ethics committees have ordinarily focused solely on the rights and needs of patients. This is more than understandable, given the cases, the scandals, and the JCAHO standards which gave the committees birth. There is something holy about this exclusive focus on patients, but also something simple-minded. "Holy" — I speak metaphorically — because we do indeed hold the lives of the sick in a sacred trust. And holy because of the self-abnegation involved, as ethics committees never consider their members' own welfare. Yet the focus is simple-minded as well. (Harsh language, harsher than I really intend, but I want to make a point.) For one thing, patients are not well served by a staff stretched to the point of abuse. Moral vision as narrow as what ethics committees are accustomed to is likely to miss important dimensions of the landscape. Problems can rarely be solved without attention to context.

I advocate a moral vision that includes everyone affected by the institution; in other words, that introduces into medical ethics something like the "stakeholder" analysis that is fundamental in business ethics. For the most part I will focus on the implications of taking hospital employees seriously. Toward the end of this essay I will touch on some other ways of enlarging a committee's moral vision.

II. More doors, more rooms

Seeing more broadly is only the first step. After recognizing health care institutions present ethical issues of every kind. a committee has to determine which among them to engage. Which are properly its business? Which could it usefully take on? It might be useful to look at some particular examples.

Culture and confidentiality

Part of an institution is its culture. There is a morally deep difference between many health care institutions, on the one hand, and public health departments on the other. In the world of public health expectations about confidentiality create internal walls, barriers to the flow of conversation. Many hospitals and health systems lack such barriers. As Mark Siegler noted years ago, hundreds of people may know the details of an "interesting" patient's case, a fact of which the patient is oblivious. Nor are patients the only ones who suffer from these habits. Hospital employees, too, have a right to privacy, but hospitals are hives of gossip. If an employee were to be tested for HIV, in many places word would be all over the hospital within 24 hours. Many health care professionals choose not to be treated at their own institutions because they know they would have no privacy. Nor is this just a problem when employees become patients. Gossip about one anothers love lives and personal quirks can be just as harmful. Hospital gossip is a problem, a moral problem, and one no one in bioethics talks about.

Once one's focus broadens to include this larger scene, a whole set of ethical issues about information control in health care begins to emerge. There are few barriers to information flow *within* the institutions, but stringent barriers *around* them. If information flows too freely within the institution, perhaps the flow outward is too restricted. Every profession looks out for its own, and health care is no exception. Should more information about what goes wrong, about mistakes and incompetence, be reaching the public?

Confidentiality, then, is a good example of how thinking about the rights of employees reveals a richer and more complex moral landscape.

Workload and moral distress

Pioneering medical ethics grew up around questions that troubled doctors, often questions about discontinuing life-sustaining treatment. As health care financing has changed in recent years, ethical attention has gone to new topics, but these too tend to be doctor-driven. Should doctors be able to order whatever treatment they believe a patient needs? Should doctors serve as gate-keepers? Few people note that the term "moral distress" originated in nursing ethics literature, and that nurses have always suffered from it (although for them, too, the current climate is worse.) Moral distress, in contrast to moral dilemmas, arises when one knows what should be done but cannot make it happen. Ethics committees have helped nurses suffering in this way by offering them recourse, a place where their concerns might be heard and affirmed. But ethics committees rarely address moral distress as a topic in its own right.

Now is the time to do so. Nurses and doctors alike are frustrated by their new inability to give patients what they needs, whether that's drugs and procedures or simply time. The shape this takes for nursing is little understood: Hospitalized patients today are sicker, but there are fewer rather than more nurses to supply it. There is little public hue and cry about this. States now regulate managed care in hundreds of different ways, forbidding "drive-by deliveries," mandating that coverage include bone marrow transplants for breast cancer, and so on. To my knowledge no state has even thought of regulating the nurse-patient ratio. When activists lobby for more days in the hospital, they may not realize that what they want is more days of nursing care: good, attentive, full nursing care. Yet in a highly competitive environment, state regulation may be the only way to *allow* a hospital to keep an adequate nursing staff, since otherwise a competitive environment will punish those who refuse to downscale.

This is not the kind of question for which ethics committees are traditionally well suited. Can anything be done? We won't know until we try. The pitfalls are obvious. Should a committee survey the situation within its own hospital? Should it try to help nurses and administrators to

hear one another? Should ethics committees become lobbyists? Should they try to educate the general public? In a few hospitals here and there, some of these things are being tried. In a climate where a nurse says "Every day I feel as if my heart is being torn from my body," all these things need to be tried..

Here, as in the case of confidentiality, recognizing hospital employees as human beings with rights and obligations of their own helps one see a fuller moral landscape. From that new perspective (and why is it so new?) one sees that "rationing" takes many forms. Doctors are told, "You may not do this for your patients." Nurses are told, "You must do it all. But we won't give you what you need to manage it." In both cases patients suffer; in both cases clinicians suffer. Both cases deserve our attention.

Further possibilities

From this wider perspective, other questions will slowly become evident. Not every committee will take on every issue. JCAHO now asks that ethics committees concern themselves with advertising, particularly with whether or not it is honest. There are many other ways in which advertising can fail morally. It can feed inflated expectations of what medicine can accomplish; it can contribute to the already pervasive moralizing of "lifestyles." (Ask an overweight smoker about people's attitudes toward his illness, even if it has nothing to do with smoking or weight.) Finally, advertising consumes some of those shrinking health care dollars. How proper is it for hospitals to advertise at all? How feasible would it be not to?

There are many other such questions, once one recognizes that there are moral dimensions to almost everything human beings and their institutions do.   After recognizing them one must go on to ask what ethics committees can sensibly take on, since time and ability are always limited.

What I hope, however, is that committees will think seriously about ways to expand their domain. If committees are charged, as I believe they are, with "keeping moral space open," they must be open themselves.

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