A Moral Compass for Management Decision Making: A Healthcare CEO’s Reflections

JOHN J. DONNELLAN JR., FACHE

SUMMARY • Ethical behavior is good for business in any organization. In healthcare, it results in better patient care, a more committed and satisfied staff, more efficient care delivery, and increased market share. But it requires leaders who have a broad view of the role that ethics programs—and an effective, sustained ethical culture—play. Ethical organizations have integrated and shared ethical values and practices, an effective ethics infrastructure, ongoing ethics education for staff at every level, ethical and morally courageous leaders, and a culture that is consistent with the organization’s values. The mission, vision, and values statements of these organizations have been successfully translated into a set of shared values—a moral compass that guides behavior and decision making.

John J. Donnellan Jr., FACHE, is adjunct professor of health policy and management at New York University’s Robert F. Wagner Graduate School of Public Service. He is the former director of the New York Veterans Affairs (VA) Medical Center and the VA New York Harbor Healthcare System.
Healthcare organizations are, by their very nature and mission, values based. I cannot think of a healthcare organization—public, private, or nonprofit—that does not have a mission statement rooted in a carefully articulated set of organizational values. Indeed, the principal organization that accredits healthcare systems, The Joint Commission (2011), requires one to be in place. But have these statements been translated into shared values that are apparent in the behaviors of the organization’s associates at every level, that is, trustees, staff, contractual partners, and so forth? Are they reflected in day-to-day clinical and managerial operations and strategic decision making? Do they serve as a moral compass to guide the organization and its staff?

Translating an organization’s mission, vision, and values statements into a set of shared values—a common morality, a “moral compass”—is critically important to steer behavior and decision making, especially in times of ethical uncertainty. Doing so requires that leaders of healthcare organizations take a broad view of the role of ethics in managing a healthcare system, that responsibilities traditionally viewed as managerial be examined on their ethical merits, and that ethical behavior be defined as more than merely obeying the rules. In what follows, I explore the differences between ethics programs and compliance programs and offer some practical suggestions for establishing a solid ethical infrastructure that guides organizational behavior and decision making, resolves current and prevents future ethical conflicts, and reduces moral distress.

Ethics as the Foundation
The business of healthcare is distinct from the business of business: “Health services organizations . . . are social enterprises with an economic dimension, rather than economic organizations with a social dimension” (Darr 2011, 289). Those who provide care to patients—clinical practitioners such as physicians, nurses, social workers, and pharmacists—have long adhered to codes of professional ethics, which reflect a set of shared practitioner values. In all of these codes, the practitioner’s responsibility for the care of each patient is paramount.

Freeman and Stewart (2006, 3) state that an ethical culture starts with ethical leaders who “embody the purpose, vision, and values of the organization and of the constituents, within an understanding of ethical ideals.” They offer the following ten-point framework for developing and evaluating ethical leadership and creating an ethical organizational culture.

**Ethical leaders must**
- articulate and embody the purpose and values of the organization;
- focus on organizational success rather than personal ego;
- find the best people;
- create a living conversation about ethics, values, and the creation of value for stakeholders;
- create mechanisms of dissent;
- take a charitable understanding of others’ values;
- make tough calls while being imaginative;
- know the limits of their values and ethical principles;
- frame actions in ethical terms; and
- connect basic values to stakeholder support and societal legitimacy.
Similar codes have evolved for non-clinicians who manage the business of healthcare—board members and trustees; executives; financial managers; and a range of administrative professionals who are accountable for setting and fulfilling the mission of healthcare systems, monitoring organizational performance, managing finances, and overseeing regulatory compliance. One such code, the American College of Healthcare Executives Code of Ethics, defines the professional healthcare leader’s responsibility to patients broadly: “to maintain or enhance the overall quality of life, dignity and well-being of every individual needing healthcare service and to create a more equitable, accessible, effective and efficient healthcare system” (ACHE 2011).

William Nelson (2011) argues that a healthcare organization’s ethical values are its foundation and framework, which ultimately determine if the organization will be successful. Just as a building’s steel and concrete foundation serves as the base on which the entire structure rests, so too does the organization’s common morality (e.g., respect for patients, fair and equitable treatment, avoiding harm) form the foundation that supports the organization’s entire structure. And in the same way the wood and steel framework that rests on a building’s foundation dictates building functionality (e.g., open space versus individual rooms or offices), the organization’s ethical framework (e.g., mission statements, codes of ethics, ethics committees, ethics policies and procedures) determines the organization’s culture and the manner in which it “lives out” its day-to-day commitment to patients, staff, and community.

**The Common View of Ethics in Healthcare**

Providers and those managing the delivery of healthcare face three types of conflicts or problems: (1) those involving uncertainty in clinical decision making; (2) those involving the ethics of research activities; and (3) those involving compliance with institutional rules, regulations, laws, and standards of professional conduct.

*Clinical ethics* pertain to matters of ethical uncertainty in clinical decision making, which usually fall under the purview of ethics committees and ethics consultation teams. In place at most healthcare organizations, clinical ethics processes are most often conducted on a case-by-case basis when staff members perceive the values of others, such as patients, administrators, or other staff, to be in conflict with their own personal, religious, or professional values or with their interpretation of the organization’s values. Consider the example of a nurse caring for a grievously ill and nonresponsive patient who believes the patient’s physician is encouraging a course of treatment that is both futile and painful and that the nurse deems unethical. An expanded discussion involving an ethics committee or a consult team can clarify legitimate differences of opinion and help caregivers and family members reach consensus by applying an ethical foundation and framework to the decision-making process.

*Research ethics* are the set of statutes, rules, regulations, and policies that guide an organization when it sponsors or participates in research activities. Most important among these is *The Belmont Report*
(National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979). The report spells out the three fundamental ethical principles that must guide all research involving human subjects (Darr 2011, 108):

- Respect for persons
- Beneficence
- Justice

Most individuals who oversee or manage healthcare—especially those who manage academic healthcare systems—are well aware of the myriad laws, regulations, and policies governing the proper conduct of research activities and the consequences associated with nonadherence.

Compliance relates to those statutes, rules, regulations, and policies that govern administrative conduct. The concept of managerial ethics is often considered in terms of compliance. Training in managerial ethics is typically given by legal counsel, compliance officers, or human resources staff. This training focuses for the most part on making sure staff members are familiar with codes of conduct, regulations, statutes, and case law governing business practices (e.g., billing, coding, contracting, conflict of interest, acceptance of gifts or donations) and that they understand the consequences associated with violating these rules—with the focus largely on preventing fraud, misconduct, abuse of office, discrimination, and so on.

**Compliance, Ethics, and the Need for a Broader View**

Compliance is demonstrated by carrying out one’s responsibilities to the organization in conformance with law and established practices. An effective compliance program is an essential component of risk management. It reduces costly litigation, negative media attention, and the loss of community support. It also reflects the organization’s commitment to an important shared societal value—that one should obey the law.

But compliance has its shortcomings. Compliance programs rarely provide guidance in uncertain situations. Does simply being compliant with laws or directives mean one acts ethically? How should one act if she believes a law or an organizational mandate directs her to behave in a manner that she considers unethical? For example, how should a physician proceed in a situation in which she believes that complying with organizational policy (e.g., discharge of a frail geriatric patient from acute to subacute care) is contrary to the patient’s best interest? How should a hospital CEO proceed with the closure of a community health center that provides vital care to low-income and non- or underinsured individuals but consistently incurs significant financial losses in spite of repeated efforts to improve efficiency? An established venue in which clinical and administrative staff can articulate and clarify the ethical conflicts they face, identify competing values and viewpoints, and discuss alternatives for action can set the stage for improved decision making and reduced staff distress.

An American Medical Association (1994) opinion clarifies the distinction between law and ethics, noting that ethical obligations exceed legal obligations. The opinion states that “when physicians believe a law is unjust, they should work to change the law” and further notes that a physician being “acquitted or exonerated in civil or criminal proceedings does not necessarily mean that the physician acted ethically.”

The three types of ethics in healthcare—clinical ethics, research ethics, and
compliance—are all important components of an effective ethics program but do not constitute an integrated ethics program. An integrated ethics program incorporates all three in a broader view than they provide separately to guide the development of policies and procedures that are consistent with the organization’s mission, vision, and values; to guide clinical and managerial decision making; to respond to situations involving ethical uncertainty; to provide staff with ongoing ethics education; and to prevent the recurrence of ethical conflicts and reduce moral distress.

Nelson (2011) notes that a well-developed ethics program “takes an organization to the next level—a level at which decisions are made not only to comply with the law, but furthermore, to always do the right thing.”

**When everything is made important, nothing is.**

**The Five Things Healthcare Managers Do and the Place of Ethics in Each**

Managers of healthcare delivery systems operate under extensive regulations; performance metrics; and operational, strategic, financial, and human resource targets. The expectations for managing and achieving each are overwhelming, and leaders may easily lose focus—when everything is made important, nothing is.

My career in healthcare ultimately brought me to the view that leaders of healthcare institutions can maintain focus on what is important by observing five basic principles, which are simple to state but complex to deliver on:

- Assess and continuously improve the quality of care.
- Ensure that healthcare is available and accessible to the community served.
- Nurture an institutional culture grounded in and supportive of the organization’s mission and objectives.
- Ensure resource effectiveness and financial accountability.
- Ensure compliance with applicable standards, regulations, and statutes.

These “five things” (a term I coined against the advice of my executive suite staff—I wanted these principles to be universally understood and applicable to all) came to serve as my personal guide. They emerged over time, being rooted in my early work in a clinical practice setting, evolving and sharpening as a result of graduate education and various mid-level management experiences, and becoming more clearly defined during my tenure as a senior healthcare manager and CEO. My thinking about these five things continues to evolve in my current role as a teacher of graduate healthcare management students.

The absence of the words ethics and values in these principles is not by accident or omission. Indeed, the earliest versions of my principles specifically referred to institutional ethics, as opposed to institutional compliance, because I still equated ethics with compliance. Over time I came to realize that an organization’s ethics and values were not discrete things—they were the thing that pervaded all five. Success in these principles is not measured by simply achieving clinical, financial, patient satisfaction, or compliance targets; it is evaluated by considering all five things as gauged by a moral compass. Let me expand on each.

**Assess and Continuously Improve the Quality of Care**

Many activities in healthcare are measured because they are required to be
measured, be it to monitor achievement of internal performance targets or to meet the requirements of external monitoring groups and accrediting organizations. The measures are well intentioned and important clinical targets but are too often selected because they are easily quantified (e.g., number of vaccinations given, length of stay, number of hospital-acquired infections, laboratory tests performed). Frequently lacking is sufficient thought as to how the measures relate to broader, mission-related objectives (e.g., community health). In my view, a decision about what should be measured is as much an ethical question as it is a performance management question.

Do performance standards and metrics flow from mission, or have they become the mission? Leaders can prevent a misalignment of mission and measures by considering the organization’s ethical responsibilities when selecting measures and reporting results. For example, an organization may identify specific HEDIS (Healthcare Effectiveness Data and Information Set) measures and set specific goals for improving performance above and beyond benchmark requirements on the basis of a strategic determination of need in the community it serves (e.g., improved screening for breast cancer, improved medical management for persons with asthma). And when deciding on which performance targets to emphasize, leaders need to consider the tools (e.g., training, data systems) and resources (e.g., staff) needed to achieve performance targets and recognize that failure to achieve these targets may point to a failed process design rather than a failure of individual execution.

Marketing campaigns for healthcare organizations frequently promote those institutions as the best place for the treatment of a specific condition without reference or in contradiction to evidence. An ethically grounded marketing campaign supports such claims. Should an organization strive to be recognized as best in practice, or should it strive to achieve excellence in practice? Focusing on being better than the competition, as opposed to achieving excellence, may result in unacceptable opportunity costs—for instance, the inability to provide an underserved community with excellent primary healthcare.

What do healthcare organizations do with the results of performance measures? A commitment to achieving excellence requires that leaders consider not only performance targets but also performance floors—unacceptable performance levels at which clinical service lines might be exited or temporarily suspended pending full examination of root causes. Take the case of a medical center renowned for cardiac care that has reported higher-than-expected risk-adjusted mortality for interventional cardiology procedures for three successive periods. Should care continue while potential causes are examined, or should interventional cardiology be suspended pending complete analysis?

A commitment to truthfulness and transparency demands full and public sharing of performance measurement results as well as comparison with other institutions in the market, for better or for worse. In an article in The New Yorker, Atul Gawande (2004) provides a powerful and moving account of a healthcare system’s journey to achieve excellence for the care of persons with cystic fibrosis through full and public disclosure and a commitment to continuous improvement.
Ensure That Healthcare Is Available and Accessible to the Community Served

If the organization’s mission statement is consistent with the ACHE Code of Ethics in aiming “to create a more equitable, accessible, effective and efficient healthcare system,” then revenue strategies and program initiatives should reflect the healthcare needs of the community. Are new initiatives designed to meet community need, or are they designed to produce new demand and new revenue? How does the organization address the problem of charity care, and how are charges set for those not otherwise covered by government health programs or commercial insurers? Approximately 58 percent of healthcare community hospitals in the United States enjoy nonprofit tax status (AHA 2012, 8). Spencer Foreman, former president of Montefiore Medical Center in Bronx, New York, has spoken eloquently on the ethical obligation of nonprofit teaching hospitals to accept responsibility for the healthcare needs of their communities, however difficult and seemingly intransigent those problems may be. He describes this obligation as “an implicit social contract . . . in exchange for large amounts of public financial support” (Foreman 2004, 1154).

Nurture an Institutional Culture Grounded in and Supportive of the Organization’s Mission and Objectives

In a Health Affairs article, Chassin and Loeb (2011) urge healthcare delivery systems to become high-reliability organizations—organizations committed to achieving consistently high quality in patient care and safety. They note that achieving this goal requires committed leadership, the application of proven quality improvement methods, and a culture of trust. Achieving a culture of trust—that is, a culture that promotes honest dialogue about our strengths and opportunities to do better—requires leaders who accept the mantle of cultural and moral leadership and who display moral courage. Organizational codes of conduct and codes of ethics insist on honesty and transparency; organizational actions must promote the same.

One way to do so is to publish a column—perhaps titled “Cases from Patient Safety” or something similar—in an internal employee newsletter. The column can openly share redacted versions of sentinel events and near misses that occur at the leader’s hospital. These cases can serve as a vehicle to celebrate the culture of transparency that led to reporting the incident, the open and nonpunitive process through which the error or event was investigated, the lessons learned and the actions taken to prevent recurrence. At the suggestion and strong encouragement of patient safety and quality improvement staff, I initiated such a process when serving as the director of a Veterans Health Administration medical center. Although initially viewed with skepticism by some, the process was received positively by staff and was subsequently cited as an organizational strength by the Department of Veterans Affairs Office of Inspector General.

Process improvement methods succeed when staff are empowered to call attention to systems that are not working well or processes that can be improved. Leaders should ask if their actions encourage this behavior. Does the organization provide mechanisms for bringing forward constructive suggestions for improvement...
without fear of reprisal? Are staff who do so viewed as shining examples of individuals committed to making the organization an excellent one, or are their suggestions sometimes seen as personal attacks? Are these staff members viewed as heroes or as malcontents or whistle-blowers? When leaders actively promote inquiry, when they publicly acknowledge and reward questioning the status quo as an example of commitment to mission and values, others in the organization follow. Leaders should have the courage to not only accept criticism but welcome it. They should consider establishing regular events that publicly recognize, through monetary and nonmonetary awards, those staff who display the courage to bring inefficiency, unsafe conditions, or ethical conflict to the attention of leadership.

**Ensure Resource Effectiveness and Financial Accountability**

Obviously, leaders need to ensure the financial well-being of the organization for which they are responsible. Ineffec-

tively delivered care is suboptimal care and results in lost opportunities to pursue needed clinical strategies and enhancements. Leaders have an obligation, within the boundaries of the law and good, safe clinical practice, to maximize the sources and amounts of revenue and the efficiency with which resources are deployed.

But is more required? The responsibility of healthcare leaders to be stewards of the resources of both their organization and the larger community has been described in recent healthcare management literature as not only a matter of good financial management practice (Berwick and Hackbarth 2012; Wennberg, Berkson, and Rider 2008) but also an ethical imperative (Brody 2012). Where fiscal responsibility is viewed as both a fiduciary and an ethical obligation, organizations ask whether care is delivered efficiently, effectively, and in a manner consistent with organizational values; whether current medical evidence supports the efficacy of care provided; and whether the care provided is not only profitable but also medically necessary. To meet this responsibility, organizations’ leaders and trustees

- promote strategies to improve the financial health of their institution and the overall health of their community, even when improving community health reduces revenue;
- consider if strategies to acquire and grow revenue are not only compliant but also ethical;
- ensure that fund-raising efforts, and the uses to which the proceeds of these efforts are applied, are aligned with the organization’s ethical values;
- ensure that financial reports are not only carefully reviewed by executives and trustees but also made available for staff and public review; and
- ensure that pay, benefits, bonuses, and perquisites are awarded fairly throughout the organization and based on contribution, not title.

**Ensure Compliance with Applicable Standards, Regulations, and Statutes**

Responsible healthcare leaders want to be known, and want their organizations to be known, for unwavering integrity in business practices. They are keenly aware that deviation from acceptable practices can result in severe legal consequences, financial penalties, and devastating losses of public confidence. Such leaders devote considerable attention to ensuring that staff responsible for medical coding, collections,
The leaders of values-driven organizations understand that successful employees not only abide by but also share the values of the organization.

and contracts understand and adhere to applicable regulations and statutes. Their organizations have in place educational modules, internal controls, appropriate checks and balances, and anonymous reporting systems to detect and prevent instances of conflict of interest, theft, embezzlement, and fraud.

More is demanded when a compliance program is proactive rather than preventive and reactive. The proactive view considers the vetting of new employees and the ongoing competency education of existing clinical, administrative, and executive staff to be an ethical responsibility of leadership. And the rules of compliance extend to governance: Trustees understand their responsibility as both ethical and fiduciary agents of the organization and are selected on the basis of their competency and their availability to perform these responsibilities. They are afforded all necessary training, are free of conflicts of interest, have the independence to act only in the best interest of the organization, and are transparent about and publicly accountable for the work they do on behalf of the organization.

Leaders with an expanded view of compliance programs are committed to guaranteeing that rules are applied and adhered to equally at every level of the organization. They also understand the limits of regulation and apply both a legal and a moral compass in times and situations of ethical uncertainty. Regulations inform a leader as to whether or not a patient seen in the emergency room was billed appropriately for the visit and should be required to pay; regulations do not inform the leader if the hospital’s charity care policy needs to be reexamined for ethical appropriateness. This leader sees compliance as more than obedience—it is a responsibility to ensure excellent care is provided and to always do the right thing.

When Ethical Values Do Not Guide Decision Making

Ongoing ethical conflict and uncertainty in a healthcare organization are not benign. The degree to which they create philosophical and psychological tension (moral distress) and lead to an undesirable work environment may be debated, but the fact that they have an impact on the work environment seems intuitive. The concept and impact of moral distress among healthcare providers has been discussed frequently in the nursing literature. Kain (2007), for example, discusses the impact of moral distress on nurses providing care to dying infants in neonatal intensive care units. She notes that nurses frequently face ethical dilemmas that cause moral distress when called on to provide invasive and potentially painful procedures unlikely to benefit the infant.

Less obvious is the impact that ethical conflict and uncertainty have on an organization’s bottom line. Nelson, Weeks, and Campfield (2008) examined the potential costs of ethical conflicts in healthcare organizations, arguing that both a moral obligation and a business case support the establishment of an ethically grounded institution. They cite an example of a nursing home administrator who admitted an individual to a nursing home bed who was a major contributor to the nursing home’s parent hospital, bypassing others on a waiting list for admission. The costs associated with addressing the damage that can result from such an ethical failure include negative publicity to both the nursing home
and the parent hospital, the potential cost of public relations consultants to address the ensuing media crisis, the diversion of senior leaders’ and trustees’ time, and the overall negative impact on staff morale.

The researchers note that the ethics consult and ethics committee strategies typically employed by healthcare organizations are reactive, resulting in the resolution of particular cases but not a reduction in the probability of recurrence. As shown in Exhibit 1, they frame the impact of ethical conflict and uncertainty in three broad categories—operations, legal, and public relations—and for each category discuss the impact on direct, indirect, and long-term costs (Nelson, Weeks, and Campfield 2008, 48). While recognizing the value of maintaining robust structures that examine and resolve individual instances of ethical conflict, they also recommend that healthcare organizations take a more expansive, proactive approach toward understanding the root cause of the conflict and deploying strategies to prevent recurrence, reduce negative impact, and reduce costs. This approach includes determining whether the problem arose from the unethical behavior of a single individual or was caused by a system failure (e.g., inconsistently applied policy, lack of guidance for staff facing an uncertain situation).

**The Role of the CEO**

An organization is defined by its culture—for better or for worse, for stakeholders and constituents alike. And that culture shapes the behavior of staff. An organization’s ethical culture includes the values and beliefs that underlie day-to-day decision making as well as the observable daily behaviors and interactions of staff, especially toward patients and each other. The behavior of the organization’s most senior leader is a critical factor in defining and shaping the ethical culture.

Ethical leaders honestly examine the behaviors they reward and the behaviors they tolerate. Are the rules applied fairly on the basis of intent? Is bad behavior ignored, or is it challenged immediately? Is the organization, and are its leaders, open to suggestions, criticism, and dissent? As mentioned earlier, leaders should establish mechanisms by which to recognize staff who come forward with ethical conflicts and concerns. Staff who report ethical concerns still often do so at great risk to their career and their relationship with superiors and coworkers; public recognition and praise from leadership goes a long way toward changing the culture of the organization from one of silence and concealment to one of openness and sharing.

What makes an ethical CEO? Staff and patients alike expect healthcare leaders to set a good example and to embrace the organization’s values in their professional and personal lives. An executive who diligently abides by professional rules but is disreputable in his personal financial or social dealings brings discredit to the organization and sets a poor example for others to follow. The leaders of values-driven organizations understand that successful employees not only abide by but also share the values of the organization.

Some cite the need for moral courage—the willingness to act in accordance with one’s ethical values despite the risks (Lachman et al. 2012; Murray 2010). Are staff fully open with patients and families in cases such as accidental and inconsequential damage to a nearby organ during a surgical procedure or a medication error that occurs without adverse effects to the patient? Do managers display the values
of justice, fairness, and compassion when considering discipline for a staff member who may have done the wrong thing, but for the right reason, such as not coding every component of a patient visit so as to limit the out-of-pocket expense for a patient with known financial hardship?

<table>
<thead>
<tr>
<th>Exhibit 1</th>
<th>Potential Costs of Ethical Conflicts</th>
</tr>
</thead>
</table>
| **Operation cost categories** | **Direct costs** | • Staff time  
| | | • Ethics consultants time  
| | **Indirect costs** | • Staff and consultants time diverted from patient care and/or other activities  
| | | • Staff and consultants stress  
| | | • Decreased staff morale  
| | **Long-term costs** | • Staff burnout  
| | | • Staff turnover  
| | | • Additional staff needed  
| **Legal cost categories** | **Direct costs** | • Risk management staff time  
| | | • Legal fees  
| | | • Court fees  
| | | • Settlement costs  
| | **Indirect costs** | • Staff work diverted from other activities  
| | | • Staff stress  
| | **Long-term costs** | • Higher malpractice costs  
| | | • Budget adjustments for settlements and awards  
| | | • Additional staff needed  
| **Public relations cost categories** | **Direct costs** | • Public relations time  
| | | • Public relations consultant costs  
| | | • Advertising costs  
| | **Indirect costs** | • Public image needs to be rebuilt  
| | | • Staff work diverted  
| | | • Staff morale and stress  
| | **Long-term costs** | • Negative public image  
| | | • Loss of self-referrals and market share  
| | | • Decreased philanthropic support  


**Some Practical Suggestions**

How can an organization be transformed into one in which a shared ethical culture is apparent in all that transpires within it—one that provides staff and associates with a moral compass? A suggested first step is to subject the organization to an
annual ethics audit, conducted in much the same way that a financial or operational audit is conducted. The ethics audit team might be drawn from different backgrounds and organizational or geographic areas, if applicable, and include board members, community leaders, patients, ethicists, and staff with diverse managerial and clinical responsibilities.

The audit begins with some tough questions, such as those that follow, the answers to which should be accompanied by evidence to support them.

- Are the organization's stated ethical values shared by staff at every level, and do they apply equally at every level?
- Do these values guide strategic planning and investment strategies?
- Are values woven into the fabric of organizational policies, procedures, and day-to-day decision making?
- Are the organizational code of ethics and statement of values living documents, guiding the organization and its constituency through uncertain events and times, or are they no more than a set of rules to be followed blindly?
- Does the organization live out the expectations of its mission, vision, and values statements?

A 2009 *Healthcare Executive* article offers the following ethical checklist to assist healthcare leaders in assessing the ethical culture of their organization (Nelson and Donnellan 2009, 46):

- Do clinicians' and administrative executives' actions reflect adherence to the organization's values?
- Does leadership talk openly about the importance of ethics?
- Are executive decision-making processes and decisions transparent?
- Do healthcare executives consult with the organization's ethics committee?
- Do healthcare executives serve as role models regarding ethical behavior and traits?

**Conclusion**

Ultimately, being known as an ethical organization is good for business. It will result in enhanced patient care, a committed and satisfied staff, efficient care delivery, and increased market share. But ethical organizations do not just happen. They require an effective and sustained ethical culture, one that their leaders constantly tend to and nurture. High-performing ethical organizations have integrated and shared ethical values and practices, an effective ethics infrastructure, ongoing ethics education for staff at every level, ethically and morally courageous leaders, and a culture that is consistent with the organization's values. The ethical leader, through words, example, and recognition, motivates and empowers staff to act ethically and provides them with the resources they need to do so. A strong ethical culture, supported by a well-established ethics program that is relevant to and integrated across clinical and administrative processes, equips staff at every level of the organization with a moral compass by which to address the occurrences of ethical uncertainty they will surely face.

**Acknowledgment**

I want to express my sincerest gratitude to Ms. Kim Arslanian, Dr. Anthony Kovner, and Dr. William Nelson, all of whom generously shared their ideas on the topic with me and provided valuable feedback on the manuscript.
REFERENCES
Joint Commission. 2011. Joint Commission Accreditation Manual for Hospitals. Leadership Standards LD.02.01.01, LD.03.03.01. Oakbrook Terrace, IL: Joint Commission Resources.