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CODE OF ETHICS

As amended by the Board of Governors on November 13, 2017.

Preamble

The purpose of the *Code of Ethics* of the American College of Healthcare Executives is to serve as a standard of conduct for members. It contains standards of ethical behavior for healthcare executives in their professional relationships. These relationships include colleagues, patients or others served; members of the healthcare executive's organization and other organizations; the community; and society as a whole.

The *Code of Ethics* also incorporates standards of ethical behavior governing individual behavior, particularly when that conduct directly relates to the role and identity of the healthcare executive.

The fundamental objectives of the healthcare management profession are to maintain or enhance the overall quality of life, dignity and well-being of every individual needing healthcare service and to create an equitable, accessible, effective, safe, and efficient healthcare system.

Healthcare executives have an obligation to act in ways that will merit the trust, confidence and respect of healthcare professionals and the general public. Therefore, healthcare executives should lead lives that embody an exemplary system of values and ethics.

In fulfilling their commitments and obligations to patients or others served, healthcare executives function as moral advocates and models. Since every management decision affects the health and well-being of both individuals and communities, healthcare executives must carefully evaluate the possible outcomes of their decisions. In organizations that deliver healthcare services, they must work to safeguard and foster the rights, interests and prerogatives of patients or others served.

The role of moral advocate requires that healthcare executives take actions necessary to promote such rights, interests and prerogatives.

Being a model means that decisions and actions will reflect personal integrity and ethical leadership that others will seek to emulate.

I. The Healthcare Executive's Responsibilities to the Profession of Healthcare Management

The healthcare executive shall:

A. Uphold the *Code of Ethics* and mission of the American College of Healthcare Executives;

B. Conduct professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon the profession;

C. Comply with all laws and regulations pertaining to healthcare management in the jurisdictions in which the healthcare executive is located or conducts professional activities;

D. Maintain competence and proficiency in healthcare management by implementing a personal program of assessment and continuing professional education;

E. Avoid the improper exploitation of professional relationships for personal gain;

F. Disclose—and when appropriate, avoid—financial and other conflicts of interest;

G. Use this Code to further the interests of the profession and not for selfish reasons;

H. Respect professional confidences;

I. Enhance the dignity and image of the healthcare management profession through positive public information programs; and

Code of Ethics (cont.)

J. Refrain from participating in any activity that demeans the credibility and dignity of the healthcare management profession.

II. The Healthcare Executive's Responsibilities to Patients or Others Served

The healthcare executive shall, within the scope of his or her authority:

A. Work to ensure the existence of a process to evaluate the quality of care or service rendered;

B. Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices;

C. Work to ensure the existence of a process that will advise patients or others served of the rights, opportunities, responsibilities and risks regarding available healthcare services;

D. Work to ensure that there is a process in place to facilitate the resolution of conflicts that may arise when the values of patients and their families differ from those of employees and physicians;

E. Demonstrate zero tolerance for any abuse of power that compromises patients or others served;

F. Work to provide a process that ensures the autonomy and self-determination of patients or others served;

G. Work to ensure the existence of procedures that will safeguard the confidentiality and privacy of patients or others served; and

H. Work to ensure the existence of an ongoing process and procedures to review, develop and consistently implement evidence-based clinical practices throughout the organization.

III. The Healthcare Executive's Responsibilities to the Organization

The healthcare executive shall, within the scope of his or her authority:

A. Lead the organization in prioritizing patient care above other considerations;

B. Provide healthcare services consistent with available resources, and when there are limited resources, work to ensure the existence of a resource allocation process that considers ethical ramifications;

C. Conduct both competitive and cooperative activities in ways that improve community healthcare services;

D. Lead the organization in the use and improvement of standards of management and sound business practices;

E. Respect the customs, beliefs and practices of patients or others served, consistent with the organization's philosophy;

F. Be truthful in all forms of professional and organizational communication, and avoid disseminating information that is false, misleading or deceptive;

G. Report negative financial and other information promptly and accurately, and initiate appropriate action;

H. Prevent fraud and abuse and aggressive accounting practices that may result in disputable financial reports;

I. Create an organizational environment in which both clinical and management mistakes are minimized and, when they do occur, are disclosed and addressed effectively;

J. Implement an organizational code of ethics and monitor compliance; and

K. Provide ethics resources and mechanisms for staff to address organizational and clinical ethics issues.

Code of Ethics (cont.)

IV. The Healthcare Executive's Responsibilities to Employees

Healthcare executives have ethical and professional obligations to the employees they manage that encompass but are not limited to:

A. Creating a work environment that promotes ethical conduct;

B. Providing a work environment that encourages a free expression of ethical concerns and provides mechanisms for discussing and addressing such concerns;

C. Promoting a healthy work environment, which includes freedom from harassment, sexual and other, and coercion of any kind, especially to perform illegal or unethical acts;

D. Promoting a culture of inclusivity that seeks to prevent discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, age or disability;

E. Providing a work environment that promotes the proper use of employees' knowledge and skills; and

F. Providing a safe and healthy work environment.

V. The Healthcare Executive's Responsibilities to Community And Society

The healthcare executive shall:

A. Work to identify and meet the healthcare needs of the community;

B. Work to identify and seek opportunities to foster health promotion in the community;

C. Work to support access to healthcare services for all people;

D. Encourage and participate in public dialogue on healthcare policy issues, and advocate solutions that will improve health status and promote quality healthcare;

E. Apply short- and long-term assessments to management decisions affecting both community and society; and

F. Provide prospective patients and others with adequate and accurate information, enabling them to make enlightened decisions regarding services.

VI. The Healthcare Executive's Responsibility To Report Violations of the Code

A member of ACHE who has reasonable grounds to believe that another member has violated this Code has a duty to communicate such facts to the Ethics Committee.

ADDITIONAL RESOURCES
Available on **ache.org** or by calling ACHE at (312) 424-2800.

1. ACHE *Ethical Policy Statements*

   "Considerations for Healthcare Executive-Supplier Interactions"

   "Creating an Ethical Culture Within the Healthcare Organization"

   "Decisions Near the End of Life"

   "Ethical Decision Making for Healthcare Executives"

   "Ethical Issues Related to a Reduction in Force"

   "Ethical Issues Related to Staff Shortages"

   "Health Information Confidentiality"

   "Impaired Healthcare Executives"

   "Promise Making, Keeping and Rescinding"

2. ACHE Grievance Procedure
3. ACHE Ethics Committee Action
4. ACHE Ethics Committee Scope and Function

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ETHICAL POLICY STATEMENT

Ethical Decision Making for Healthcare Executives

August 1993
February 1997 (revised)
November 2002 (revised)
November 2007 (revised)
November 2011 (revised)
November 2016 (revised)

Statement of the Issue

Ethical decision making is required when the healthcare executive must address a conflict or uncertainty regarding competing values, such as personal, organizational, professional and societal values. Those involved in this decision-making process must consider ethical principles including justice, autonomy, beneficence and nonmaleficence as well as professional and organizational ethical standards and codes. Many factors have contributed to the growing concern in healthcare organizations over ethical issues, including issues of access and affordability, quality, value-based care, patient safety, mergers and acquisitions, financial and other resource constraints, and advances in medical technology that complicate decision making near the end of life. Healthcare executives have a responsibility to address the growing number of complex ethical dilemmas they are facing, but they cannot and should not make such decisions alone or without a sound decision-making process. The application of a systematic decision-making process can serve as a useful tool for executives and others in addressing ethically challenging situations.

Healthcare organizations should have resources that may include ethics committees, ethics consultation services, and written policies, procedures and guidelines to assist them with the ethics decision-making process. With these organizational resources and guidelines in place, conflicting interests involving patients, families, caregivers, the organization, payers and the community can be thoughtfully and appropriately reviewed in a timely manner.

Policy Position

It is incumbent upon healthcare executives to lead in a manner that sets an ethical tone and models ethical behavior for their organizations. The American College of Healthcare Executives believes education in ethics is an important step in a healthcare executive's lifelong commitment to high ethical conduct, both personally and professionally. Further, ACHE supports the development of organizational resources that enable healthcare executives to appropriately and expeditiously address ethical conflicts. Whereas physicians, nurses and other caregivers may primarily address ethical issues on a case-by-case basis, healthcare executives also have a responsibility to address those issues at broader organizational, community and societal levels through a systematic process. ACHE encourages its members, as leaders in their organizations, to take an active role in the development and demonstration of ethical decision making.

To this end, healthcare executives should:

- Create a culture that fosters ethical clinical and administrative practices and ethical decision making.
- Communicate the organization's commitment to ethical decision making through its mission or value statements and its organizational code of ethics.
- Demonstrate through their professional behavior the importance of ethics to the organization.
- Offer educational programs to boards, staff, physicians and others on their organization's ethical standards of practice and on the more global issues of ethical decision making in today's healthcare

Ethical Decision Making for Healthcare Executives (cont.)

environment. Further, healthcare executives should promote learning opportunities, such as those provided through professional societies or academic organizations, that will facilitate open discussion of ethical issues.

- Ensure that the organizational resources addressing ethics issues are readily available and include individuals who are competent to address ethical concerns and reflect diverse perspectives. An organization's ethics committee, for example, might include representatives from groups such as physicians, nurses, managers, board members, social workers, attorneys, patients and/or the community and clergy. All these groups are likely to bring unique and valuable perspectives to bear on discussions of ethical issues.
- Ensure that ethics resources are competent to address a broad range of ethical concerns (e.g., clinical, organizational, business and management).
- Seek assistance from ethics resources when there is ethical uncertainty. Furthermore, encourage others to use organizational resources to address challenging ethical issues.
- Evaluate and continually refine organizational processes for addressing ethical issues.
- Promote decision making that results in the appropriate use of power while balancing individual, organizational and societal issues.

Approved by the Board of Governors of the American College of Healthcare Executives on Nov. 14, 2016.

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ETHICAL POLICY STATEMENT

Ethical Issues Related to a Reduction in Force

August 1995
November 2000 (revised)
November 2005 (revised)
November 2012 (revised)
November 2017 (revised)

Statement of the Issue

As the result of shorter lengths of stay, the increase of ambulatory care, higher productivity, new technology and other factors, the capacity of some healthcare organizations could significantly exceed demand. As a result, these organizations may be required to reduce their workforce and related costs. Additionally, mergers and consolidations can result in further reductions and reassignments of staff. Financial pressures will continue to fuel this trend. However, patient care needs should not be compromised when determining staffing requirements.

Careful planning, diligent cost controls, effective resource management, transparency and proper consultation can lessen the hardship and stress of a reduction in force. Formal policies and procedures should be developed well in advance of the need to implement them.

The decision to reduce staff necessitates consideration of the short-term and long-term impact on all employees—those leaving and those remaining. Decision makers should consider the potential ethical conflict between formally stated organizational values and staff reduction actions.

Policy Position

The American College of Healthcare Executives recommends that specific steps be considered by healthcare executives when initiating a reduction in force process to support consistency between stated organizational values and those demonstrated before, during and after the process. Among these steps are the following:

- Recognize that cost reduction efforts must be appropriate—if they are too aggressive, the consequences for patients, staff and the organization can be as harmful as doing too little or proceeding too late
- Explore and evaluate best practices from similar organizations which could be helpful in designing and implementing a workforce reduction plan; best practices can be identified by conducting a thorough literature review, attending seminars and speaking with colleagues
- Develop a workforce reduction plan that effectively describes its rationale, objectives, implementation process, timeline and impact assessment techniques
- Obtain input and advice from senior management and human resource leaders on the number and type of positions to be reduced, which open positions should not be filled, and when and how communication regarding the reduction plan should be made. Include other key components, such as discussing the rationale and process with the organization's governing body, medical staff leadership and, if necessary, the media

Ethical Issues Related to a Reduction in Force (cont.)

- Develop a process to review the impact of a reduction in force on the quality and safety of care delivered in the organization
- Consult with labor counsel
- Provide timely, accurate, clear and consistent information—including the reasoning behind the decision—to stakeholders when staff reductions become necessary
- Review the principles and ideals expressed in vision, mission and value statements, personnel policies, annual reports, employee orientation materials and other documents to test congruence and conformance with reduction in force decisions
- Support, if possible, through retraining and redeployment, employees whose positions have been eliminated. Also, consider outplacement assistance, appropriate severance policies and continued support through the organization's employee assistance program, if possible
- Address the needs of remaining staff by demonstrating sensitivity to their potential feelings of loss, anger and survivor guilt. Also address their anxiety about the possibility of further reductions and uncertainty regarding changes in workload, work redesign and similar concerns

Healthcare organizations encounter the same set of challenging issues associated with reductions in force as do other employers. Reduction in force decisions should reflect an institution's ethics and value statements.

Approved by the Board of Governors of the American College of Healthcare Executives on Nov. 13, 2017.

Richard A. Culbertson, PhD

Ethics of Mission and Margin Revisited

Bringing the issue into public debate, rather than withholding the unpleasant realities.

In the September/October 2012 issue of *Healthcare Executive,* an article titled "The Ethics of Mission and Margin" was written based on an ACHE program held in conjunction with the San Antonio Cluster in May of that year and led by me.

There is another duty of the healthcare executive posed in the Code of Ethics*, and that is to "Encourage and participate in public dialogue on healthcare policy issues, and advocate solutions that will improve health status and support quality healthcare.*

At that time, I was quoted as identifying the mission versus margin debate as a "conundrum," and continued, "I think margin has been pretty well looked after in the past decade, and as we move into a new health reform era, I would put in a plug for looking at the role of mission—seeing how we can sustain mission in the face of economic challenges." In a 2013 issue of the American Medical Association *Journal of Ethics* devoted to this topic, editor Alessandra Colaianni suggests that "No margin, no mission is too simplistic."

These articles appeared in the flush of optimism that followed the adoption of the Affordable Care Act and the prospect of significant reduction in the burden of uninsured or underinsured patients. With the passage of five years since these publications and a new administration in power, it seems that a current reflection on the ethics of mission and margin is in order to see what ethical issues persist.

Margin and Mission Defined

The expression "No margin, no mission" in healthcare has a history dating to the 1980s in which Sister Irene Kraus, former CEO of the Daughters of Charity Health System, was said to have popularized the expression. In a 1991 profile in *The New York Times*, her management of the then third largest system in the United States is extolled as exemplary based on operating margin generated by its 36 hospitals and its Aa bond rating from Moody's Investor Services. All of this occurred concurrently with a commitment to spend 25 percent of operating income on charitable efforts. Without adequate financial resources to support the provision of high-quality care and the charitable mission, the work of the Daughters would not be sustainable.

The work of the eminent management theorist Peter Drucker also is reflected in the phrase as well. In his book *Managing the Nonprofit Organization*, he writes "There are always so many more moral causes to be served than we have resources for that the non-profit institution has a duty … to allocate its scarce resources for results. …" Drucker does not directly address the revenue side of mission management, but certainly speaks directly to the point of efficiency and focus in selecting and managing expenditures.

A Controversy Reignited

A highly anticipated result of the Affordable Care Act was the reduction in the number of uninsured patients that would take place primarily as a result of expansion of the Medicaid program. In the Nov. 17, 2017, *USA Today* article "This is How the U.S. has Become a Medicaid Nation," Phil Galewitz of Kaiser Health News describes the wide ranging and sometimes unanticipated impact of the program's success in reducing numbers of uninsured in states where expansion has been accepted. He notes that Medicaid is

the nation's largest health insurance program, covering 74 million Americans. As coverage is episodic, 25 percent of Americans will be on Medicaid during the course of a year as a result of changes in employment and earnings.

Public health advocates argue that the benefits of expansion have been substantial with regard to earlier detection of disease and heightened utilization of preventive and primary care services. As an example, a report by Jim Richardson, PhD, of the LSU Public Administration Institute, credits Medicaid expansion in Louisiana with an additional 35,733 breast cancer screenings, resulting in 338 confirmed diagnoses; and 48,482 adults receiving specialized outpatient mental health services. From an ethical perspective, this is a beneficence for the population as a whole.

Yet it is also argued that Medicaid expansion has reduced access to care as physicians and provider organizations are overwhelmed by increased demand for services, resulting in reduced access to care in certain areas. Julia Paradise of the Kaiser Family Foundation notes that while 70 percent of physicians nationally accept new Medicaid patients, there is a distinct range from 39 percent in New Jersey to 97 percent in Nebraska. She also reports that 85 percent accept new commercially insured patients, and that rates vary by specialty.

From the perspective of the healthcare executive responsible for the financial health of the organization, the substitution of compensated patients for uninsured is clearly beneficial. However, Peter Ubel suggests in *Forbes* magazine that on average Medicaid pays 61 percent of Medicare rates (subject to regional variation), which is in turn lower than commercial insurers' payment.

The strategy of attracting more highly insured patients at the exclusion of others is a widely employed strategy. Even safety-net public hospitals seek to partially solve the "no margin, no mission" conundrum by offering services that will attract highly insured patients to their doors.

Which Approach Is Ethically Preferable?

Health economist Paul Feldstein of the University of California-Irvine devised a model of patient composition of physician practice by payer category. In a rational economic world, a physician would progress from the most to least remunerative payer categories and close her or his practice to the lesser categories once available practice time could be filled. Thus, physicians who could fill their appointment books with cash, commercial insurance and managed care patients would close their practices to Medicare and Medicaid patients.

Numerous medical schools have adopted graduation oaths in which new medical doctors pledge to see all patients regardless of "economic standing or ability to pay," which is a portion of the physician oath at Tulane School of Medicine. This is a laudable aspiration, but one that experienced practice managers such as Frederick Wenzel and Jane M. Wenzel, PhD, would caution needs to be balanced against available revenues.

Ethical Guidance From the ACHE *Code of Ethics*

In the ACHE *Code of Ethics*, there is a clear mandate for the healthcare executive to "Work to support access to healthcare services for all people." There also is an obligation to "Provide healthcare services consistent with available resources," and in the event of limited resources, "work to ensure the existence of a resource allocation process that considers ethical ramifications."

There also is an admonition to ensure that the executive's organization will engage in "sound business practices." Given the scope of healthcare organizations' multipronged missions of patient care, community service, and in many cases, teaching and, research, it is common practice to seek to maximize returns from patient care to subsidize losses in the other mission elements.

There also is an admonition to assure that the executive's organization will engage in "sound business practices." Given the scope of healthcare organizations' multipronged missions of patient care, community service, and in many cases, teaching and research, it is common practice to seek to maximize returns from patient care to subsidize losses in the other mission elements.

The *Code of Ethics* also articulates a duty of veracity on the part of the executive. The executive is to "Be truthful in all forms of organizational communication, and avoid disseminating information that is false, misleading, or deceptive."

The German philosopher Immanuel Kant identified truth telling as an absolute imperative of duty-based ethics. In his system, the obligation to truth telling is immutable and tolerates no exception. This maxim still is invoked in bioethics with regard to patient autonomy and the caregiver's obligation to provide truthful information to the patient as reflected in the AMA *Code of Ethics*.

Yet there is another duty of the healthcare executive posed in the ACHE *Code of Ethics* and that is to "Encourage and participate in public dialogue on healthcare policy issues, and advocate solutions that will improve health status and support quality healthcare." As the future of the ACA and the accompanying expansion of Medicaid in many states are the subject of intense political debate, bringing the issue of margin versus mission to public scrutiny is a responsible step.

Lacking full information, policymakers and the public may assume that all is well with institutional and professional providers, and that any loss of covered patients can be easily absorbed by these providers in the near term. It is likely, therefore, that pressure to optimize payer mix will only grow. The ethically responsible course is to bring the issue into public debate rather than withhold the unpleasant realities. ▲

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Perceived Ethics Dilemmas Among Pioneer Accountable Care Organizations

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EXECUTIVE SUMMARY

This study of Pioneer accountable care organizations (ACOs) suggests that the ACO model is creating moral distress for physicians and business leaders in seven critical ways:

1. *Incompatible reimbursement models:* The combination of fee-for-service and risk-based contracts creates conflicting incentives.
2. *Two standards of clinical care:* Patients who are enrolled in an ACO have access to more effective care management programs than patients who are not enrolled.
3. *Financial incentives versus patient choice:* Providers are incentivized to refer patients within the ACO network, regardless of patient preferences.
4. *"Best" care disagreements:* Incentives to provide only necessary care result in disagreements between physicians about the right care, and the perception of rationing resources.
5. *Required ACO metrics versus evidence-based care:* Some required metrics do not reflect current evidence-based practices.
6. *Shifting resources to focus on prevention:* Creating the capacity to provide team-based comprehensive primary care could result in better patient outcomes at lower cost; however, clinician burnout is a risk.
7. *Limited support systems for resolving ethical conflicts:* Fragmented approaches to resolving ethical conflicts result in mismatches between organizational values and clinical and business practices.

Despite an overall sense of optimism associated with the ACO model, our research identified an underlying sense of moral distress at most sites. A clear opportunity exists for ACOs to use a more comprehensive, coordinated approach to proactively resolving ethical dilemmas while continuing the march toward risk-based contracts.

For more information about the concepts in this article, contact Dr. Westling at Craig.R.Westling@Dartmouth.edu.

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) defines an accountable care organization (ACO) as

> groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program (CMS, 2015).

The ACO concept has been compared with the managed care organization (MCO) experiment in the 1990s, which was extremely unpopular and eroded trust among patients, providers, and payers (AHC Media, 1999). The ACO and MCO models share a basic intent to help control healthcare costs. However, the ACO model is designed to preserve trust and reward providers for improving the quality of patient outcomes while being mindful of costs. The ACO model is intended to result in (1) healthier patients and (2) a reduced growth rate in healthcare spending.

A typical ACO combines fee-for-service (FFS) with risk-based contracts. Consequently, in order to generate revenues to support current business operations, the ACO must increase utilization for FFS contracts while adjusting utilization of all services to appropriate levels for shared-savings contracts. This tension creates opportunities for ethical dilemmas.

Traditional biomedical ethics has focused on single patient–provider episodes of care. The *American College of Physicians Ethics Manual* states, "The interests of the patient should always be promoted regardless of financial arrangements. . . . A sense of duty to the patient should take precedence over concern about compensation" (Snyder, 2012). This patient-only focus may contribute to overutilization of healthcare services in an FFS environment in which personal income is driven by the volume of services provided.

ACOs aim to create incentives for physicians to be stewards of common resources, which leads to a population-focused ethic. This approach is also expressed in the *American College of Physicians Ethics Manual*, which defines a population-focused ethic as stewardship: "Physicians have an obligation to . . . [be] steward[s] of finite healthcare resources so that as many healthcare needs as possible can be met, whether in the physician's office, in the hospital or long-term care facility, or at home" (Snyder, 2012).

This tension between the single patient–provider emphasis and the stewardship of limited resources exists in every health system (Daniels & Sabin, 2002). The purpose of our study was to more fully understand the various domains of ethical dilemmas present in organizations participating in the Pioneer ACO model of care. The Pioneer program is of particular interest because it was designed for leading health systems to be early adopters of the ACO model.

METHODS

One of us (C.R.W.) designed the research study and conducted all of the semistructured interviews with key informants at Pioneer ACOs. Invitations to participate were e-mailed to senior leaders at all 32 of the original Pioneer ACO sites, including the 10 that dropped out of the program before or during our data collection period (i.e., May to September 2014). We sought interviews with administrators who were responsible for finances or operations, as well as with physicians making patient care decisions.

We searched public records via Google to identify leaders at each of the original Pioneer ACOs. We e-mailed invitations to these leaders to participate in the study and sent reminders to nonresponders 2 weeks and, if necessary, 4 weeks later. An interview guide was developed, and interviews were conducted face-to-face or via telephone. All sessions were recorded with the participant's permission.

We stored the names of the organizations and participants separately from the interview data by using numeric identifiers. After the interview, the digital files were transcribed verbatim and saved to a password-protected computer.

One of us (C.R.W.) conducted a content analysis to identify themes and categories. For guidance, we used the following definition to identify an ethical dilemma (Beauchamp & Childress, 2001, p. 10):

> A situation in which there is some evidence that indicates an action would be morally wrong and some evidence that the same action would be morally right, but all the evidence, taken as a whole, is not conclusive. In an ethical dilemma, if one does act, one's actions could be seen as morally acceptable in some respects and morally unacceptable in other respects.

We prioritized findings on the basis of the strength of the evidence, with issues mentioned by multiple people in multiple organizations considered strongest.

Study Limitations

One limitation of this study was the small sample size, which was partially addressed through purposeful inclusion of three different roles at each of the seven sites; however, all sites were high-performing healthcare systems, and, in some cases, the request for an interview came from a superior. Another limitation was the primary researcher's (C.R.W.) role as an employee of The Dartmouth Institute for Health Policy & Clinical Practice, Lebanon, New Hampshire, which is well known for its research on ACOs. This factor may have introduced both selection and response bias. Finally, an important limitation is that no patients, community members, or nonphysician providers (e.g., nurses, therapists, and social workers) were interviewed. Future studies must obtain the perspectives of all these stakeholder groups. Given the frustration expressed by the Pioneer ACOs regarding patient engagement, it is especially important to understand patients' perspectives and the dialogue that occurs between patients and all members of the healthcare team.

RESULTS

We contacted all 32 of the original Pioneer ACO sites via e-mail with a request to participate in the study. Seven sites accepted our invitation, and four sites declined. The remaining 21 sites did not respond. Three people from each participating site were interviewed, including an ACO administrator, a primary care physician (PCP), and a specialist physician. In all, we conducted 21 interviews.

Seven major findings emerged from the key informant interviews, all of which illustrate ethical dilemmas resulting from—or reinforced by—the Pioneer ACO model (Table 1). These seven findings are (1) incompatible reimbursement models, (2) two standards of clinical care, (3) financial incentives versus patient choice, (4) "best" care disagreements, (5) required ACO metrics versus evidence-based care, (6) shifting resources to focus on prevention, and (7) limited support systems for resolving ethical conflicts.

Incompatible Reimbursement Models

The issue of incompatible reimbursement models results in ethical dilemmas because an organization operating under an FFS model thrives by seeing a high volume of patients and maximizing utilization of tests and procedures. Under the ACO model, the organization thrives by meeting agreed-upon benchmarks for quality while reducing utilization of tests and procedures. An ethically grounded healthcare system would ensure access to basic healthcare services, regardless of the payer model. This ethical dilemma was mentioned most frequently, as illustrated by the following remark:

> The single biggest risk we face as an organization is the transition between payment models. If you move your contracts before you're prepared to fully change the way you deliver care, or the other way around, you've lost. And how do you make that transition? There is not a proven way to do it.

Hospital-centric ACOs are particularly affected by the shift in revenue from acute care to prevention. A physician administrator offered an example of how the changing reimbursements affect hospitals:

> It's tough to be in an ACO world and a production-based world simultaneously. Let's say you have someone who comes into the emergency [department who] doesn't really need to be there. At an ACO, your goal is to utilize the minimum amount of resources for the most effective quality of care, whereas in a private model, you make money by those visits and encounters. We're moving from revenue centers to expense centers, and that's a very interesting, conflicting world.

This transition for hospitals and the resulting revenue shift is a major disruptor to a U.S. healthcare system built to deliver acute care. Eventually, excess capacity will be eliminated from the system:

> We're trying to balance decreasing volumes by helping our hospitals figure out what are the essential services. We realize that not every single hospital may need expensive machines or needs to be the very best at providing a

TABLE 1
Summary of Major Findings

Ethical Issue	Description	Ethics Domain
1. Incompatible Reimbursement Models	The combination of fee-for-service and risk-based contracts creates conflicting incentives for an ACO to simultaneously increase and decrease utilization.	Justice
2. Two Standards of Clinical Care	Medicare-enrolled patients who would benefit from an ACO's effective care management program may not be enrolled because they are not attributed to the ACO. As a result, they receive uncoordinated and potentially inferior care.	Beneficence Justice
3. Financial Incentives Versus Patient Choice	Providers are incentivized to keep referrals in the ACO network even if they or a patient would prefer to refer out of network.	Autonomy
4. "Best" Care Disagreements	Incentives to provide only the necessary care can result in (1) disagreements between physicians about the right care and (2) the perception of rationing resources.	Beneficence Nonmaleficence Justice
5. Required ACO Metrics Versus Evidence-Based Care	CMS requires some metrics that do not reflect current evidence-based practices, thus creating financial incentives to provide care that may be inferior.	Beneficence Justice
6. Shifting Resources to Focus on Prevention	The ability to provide team-based, comprehensive primary care services could result in better patient outcomes at lower cost; however, clinician burnout is a risk.	Beneficence Justice
7. Limited Support Systems for Resolving Ethical Conflicts	A fragmented approach to dealing with ethical conflicts results in a mismatch between an ACO's values and its clinical and business practices.	Autonomy Beneficence Nonmaleficence Justice

Note. ACO = accountable care organization; CMS = Centers for Medicare & Medicaid Services.

certain type of service, so we're really trying to take some of that excess cost out of our health system.

Two Standards of Care

Dilemmas pertaining to justice and beneficence arise when patients or providers perceive the existence of two standards of care. This scenario occurs when an ACO has effective care management programs but patients who qualify clinically are not enrolled because they are not attributed to the ACO, which may result in inferior care. The situation

is complicated because, according to our study participants, the Pioneer sites are experiencing a 15% to 30% turnover of patients every year, so a nonattributed patient who presents at an ACO could be attributed to that ACO in the future. Alternatively, a patient attributed in one year may not be attributed the following year. Thus, it is impossible to know with certainty which patients might be "eligible" for enhanced care management, which creates stress for physicians.

A medical specialist described a case involving a patient who received additional attention from a care manager associated with the ACO:

> I had an example a week ago of somebody who's diabetic, very overweight with extensive heart problems, and, on top of that, is blind, lives in a rural setting, and is quite poor. He [phoned the] care managers to help him with his diabetes test strips and some medication issues, rather minimal things, but he described somebody just being in contact with him as changing his life. It is kind of remarkable how a rather simple intervention helped his depression.

However, a participant from a different ACO site expressed the frustration a physician feels when he or she recognizes a patient might benefit from the attention of a care manager, but the patient's insurer is not part of the ACO:

> It's a bit of a struggle because we walk into a room and don't necessarily pay attention to the insurance products. So you might be thinking, oh my goodness, this person really needs to have the [congestive heart failure] nurse follow him because his weight is going up and he has more edema and needs that [attention]. And then you make the phone call and [are told], 'Hey, that sounds great. We'd love to pick them up. What's their insurance? Oh, you know what, they have insurance X, which we don't take risk for.' [The resources person then offers] some other general community resources and contact information, but can't put [the patient] on our management program.

Interviewees expressed particular frustration about having to parse patients from the same payer (CMS) because some may end up not being attributed to the ACO. One physician said, "I know there are better outcomes, better scenarios for people as far as maintaining their health. It does get frustrating to have the resources, to have the programs in place, but not necessarily be able to get people appropriately plugged into them."

Financial Incentives Versus Patient Choice

The issue of financial incentives versus patient choice pertains to the ethics domain of autonomy. This dilemma arises when a provider feels financial pressure to steer patients toward the ACO referral network, which could interfere with the patient's (or provider's) choice. One physician said, "The most frequent ethical dilemma we face is the decision process between keeping care in network, which we all feel has certain benefits but also [involves] some potential financial gain, and the idea of patient choice."

Several interviewees described the challenge of being responsible for the health of patients and cost of care, while having only the ability to influence (rather than direct) patient behavior. As

one physician administrator said, "In no way, shape, or form are patients engaged. They don't even know they're in an ACO. If they're on Medicare, they know they can pretty much go anywhere; they don't need a referral."

Best Care Disagreements

Disagreements among physicians about what constitutes best care create dilemmas regarding justice, beneficence, and nonmaleficence. Specialists voiced a concern about the potential for harm to patients who do not receive the care they need in a timely way, as noted by a cardiologist:

> All too many times I see patients who would not have ended up in the hospital if they had seen a cardiologist sooner. Sending a patient to a cardiologist is not necessarily a bad thing when it comes to keeping patients out of the hospital. It may help with the overall care of the patient, as well as with the economics.

Required ACO Metrics Versus Evidence-Based Care

Pioneer ACOs use a set of quality measures and thresholds that must be met for providers to earn shared savings disbursements; however; a few of the measures do not reflect current medical best practice. This situation creates dilemmas related to the justice and beneficence ethics domains, because providing care in accordance with the latest research evidence may be detrimental to reimbursement or may encourage waste. For example, a PCP explained:

> Some of the scientific evidence has changed in the last year or 2, such as lipid criteria and blood pressure criteria. The Pioneer [ACOs] are still measuring based on standards written in the mid-2000s, and the new guidelines just came out in 2013. They are completely different, and our clinicians are stuck in between. Our population health group made the decision to go with the latest standards, even if we take a beating on that by [CMS].

Shifting Resources to Focus on Prevention

The issue of ACOs' shifting resources to focus on population health results in justice and beneficence dilemmas. The PCPs interviewed generally believe that the Pioneer model gives them access to more and better resources, leading to improved patient outcomes. However, they reported a challenge in managing teams of nonphysician providers in place of—or in addition to—seeing patients themselves. Most of the PCPs had not been trained to be managers or to lead improvement efforts. As one administrator reflected, "These days we think about the role of the PCP as a team leader, not just a patient care provider. And that's new, and some doctors are not so good about it." Meanwhile, specialists expressed dissatisfaction with their work shifting away from procedures and toward care management.

Limited Support System for Ethical Dilemmas

Interviewees from the Pioneer sites inevitably must react to ethically challenging situations while implementing the ACO model. At least two of the sites have taken a deliberate organizational ethics approach to resolving systems and

process dilemmas, with varying degrees of formality and success. The other sites, however, reported a fragmented, informal, and limited approach to dealing with organizational conflicts. This approach results in organizational values being disconnected from business and clinical practices. One participant remarked:

> The new way of delivering and paying for healthcare is going to bring new ethical challenges. We're learning as we go, but we don't have a formal program to deal with the ethical challenges. I don't think such a resource [is] available once you get into a population-based payment and all the challenges that come with it—both on the front line and back line—clinically and financially.

DISCUSSION

Healthcare leaders' concern about financial survival is reflected in the challenge of having organizational revenues coming from two reimbursement models that apply diametrically opposed incentives. The ACO concept was designed to help organizations move toward value-based reimbursement by continuing FFS reimbursement while creating a shared savings incentive. The fundamental question is this: "What is the tipping point when an ACO can shift from productivity-based payment to population based payment?" Although no definitive answers exist, the interviewees in this study projected an overall sense of optimism that the major financial challenges will be resolved over time. Thus, this issue represents a difficult transition between payment models, not a permanent state.

The theme of patient outcomes encompasses the majority of our findings, but many comments drift into the financial survival realm. For instance, a tension exists between providing the right care at the right time while making sure that limited resources are allocated to patients who are (or will be) attributed to the ACO. This situation creates a system with two standards of care, which is troubling for providers and highlights the ethical dilemma created by the need to focus on the individual patient while being stewards of finite resources.

Although two standards of care are common in environments with multiple payers, the ACO model is drawing this scenario into sharp focus because eligibility is expanded to Medicare-enrolled patients, who may or may not be attributed to the ACO. As a result, providers cannot simply direct patients to forms of care on the basis of their payer. This dilemma is particularly challenging because each ACO has an incentive to care for patients who might be attributed to it in the future, but there is no way to predict this with certainty. In addition, a patient whose health is managed primarily by a specialist in the ACO may drop off the ACO's attribution list if that provider is not eligible to be counted in the patient attribution formula. Ultimately, this issue relates to the need to create an ethical and fair process for allocating limited resources.

The tension between financial incentives and patient choice also straddles the topic of patient outcomes and the financial bottom line. Determining what is best for the patient should be providers' primary concern and, in some

situations, patients and physicians may believe that going out of network will result in better outcomes. An ideal system would have transparent outcome metrics to objectively inform patient decisions, thereby creating competition among providers to continually improve services and outcomes, including those in the ACO network.

Disagreements regarding best care are present in any system that distributes limited resources (including capitation, global payments, and bundled payments). The ACO model brings these issues to the forefront because of the in-network referral pressure and the emphasis on shifting resources from acute care toward prevention.

Specialists' comments about "too much" care being shifted away from them and toward primary care (resulting in the risk of poorer outcomes for patients who receive specialty care too late) reflect the pain associated with the health system's seeking to rightsize itself while adjusting to new incentives. Research has demonstrated that the oversupply of healthcare resources drives unnecessary spending and often results in poorer health (The Dartmouth Institute, 2015). Theoretically, rightsizing will be good for patients (assuming resources are realigned to produce better health) and for those who pay into the system (including taxpayers). However, rightsizing is painful for people whose jobs are eliminated or change dramatically from what they like to do. We should note that rightsizing is not an ethical issue in itself. The ethical issue is whether limits to specialized care have been set in a fair and justifiable manner.

The problem of ACO metrics conflicting with evidence-based care (as defined in the scientific literature) is also more complex than it first appears. It is unreasonable for ACOs to be penalized for doing the right thing. However, the ethical issue is really about ACOs' measuring the right things, which requires flexibility on the part of CMS with regard to certain rules.

Physicians have a moral obligation to recommend evidence-based care, and if they fail to provide such recommendations, they must be able to explain their rationale. However, recommending evidence-based care is not feasible in all situations, so ACOs need to know how to deal with limits. Well-thought-out ethically justified limits may be unfortunate in some cases, but they are not bad medicine. A process is needed to discuss and determine these ethically justified limits.

The challenges associated with shifting utilization toward primary care settings create a situation in which PCPs are being asked to lead teams through the changing healthcare delivery landscape without having formal management, quality improvement, or leadership training. This challenge affects all ACO stakeholders who depend on the primary care clinics to quickly adapt to delivery changes to manage the health of their attributed populations. Without the adequate skills to manage and lead in a rapidly changing environment, PCPs will be at risk of experiencing burnout.

Taken together, the study findings point to a dominant refrain of moral distress among physicians, which affects the well-being of the very people upon

whom the ACO program depends. Some of the causes of this moral distress are byproducts of well-intentioned actions, such as asking physicians to lead teams, capturing patient information in specific (and sometimes laborious) ways to help with reporting, and deciding who should be enrolled in care management programs. Nonetheless, such an environment could contribute to physician burnout, particularly for PCPs who are already in short supply.

CONCLUSIONS

Issues that result in moral distress should concern all ACO leaders, because there is growing evidence that such stress affects the "satisfaction, recruitment and retention of health care providers, and [has] implications for the delivery of safe and competent quality patient care" (Pauly, Varcoe, & Storch, 2012, p. 1). All of the Pioneer ACO sites participating in this study have developed ad hoc techniques for mitigating various issues before they become urgent, such as engaging physicians in developing compensation plans, looking to specialty societies for best practice guidance, accepting limited numbers of non-ACO patients in ACO care management programs, and linking quality improvement efforts to resolve systemic issues. However, few of the sites have proactively addressed ethics at the organizational level in a deliberate, coordinated way. Such an approach involves examining how organizational systems and processes create or mitigate distress, and establishing feedback loops to fix root-cause problems (Nelson, Taylor, & Walsh, 2014). We will examine in more detail how Pioneer ACO sites are addressing organizational ethics in a future report.

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PRACTITIONER APPLICATION

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Given our changing healthcare system, Westling et al. chose a timely topic for investigation. The number of accountable care organizations (ACOs) is increasing each year, and at least one organization identified more than 800 ACOs in the United States as of January 2016 (Muhlestein & McClellan, 2016). At WellStar Health System in Atlanta, Georgia, our ACO continues to grow, with nearly 42,000 patients enrolled and more than 1,250 providers participating. We see the growth of our ACO and others, in conjunction with this investigation of ethical issues, as the perfect time to evaluate ethics program structures and functions.

WellStar recognizes the need for a systematic and integrated approach to ethics. In 2015, we revamped our ethics program structure, modeling the approach recommended by the Catholic Health Association of the United States and Ascension Health (2014). This model focuses on identifying the type and range of ethics services that support organizational identity and integrity including, but not limited to, ethics consultation, ethics education, ethics policy development and review, community outreach, ethical leadership, ethics research, and integration.

These services are essential to developing and enhancing ACOs (DeCamp et al., 2014). For example, the study points to the need for both ethics program resources and the education of ACO providers. Our experience with ethics programs is that they often lack an understanding of the payment structures in healthcare and the ethical tensions created (e.g., the "incompatible reimbursement models" reported by the Pioneer ACO interviewees in the study). WellStar has tackled this problem by educating our ethics program participants (i.e., ethics committee members and ethics consultants) about the intricacies of the ACO payment model and how ACOs can create ethical tensions for providers, patients, and the system. In addition, we educate physician leaders about ethical tensions and dilemmas faced by clinical healthcare leaders. Finally, as Westling et al. note, these issues function at both an organizational and individual level, thus calling for education of providers in the ACO about potential ethical issues arising at the system and patient–provider levels. Our experience is that providers are aware of some of the traditional ethical dilemmas occurring in medicine, but as care models change, education about new ethical concerns is warranted.

As Nelson (2013) and others have mentioned, healthcare leaders need to ensure that their organizations have ethics structures and use them to the fullest extent. Given the size of WellStar's healthcare system, we created a system ethics committee responsible for the overall direction of the ethics program and the initial handling of

organizational ethics concerns. These concerns include those arising from our ACO. For example, a member of the ACO team recently raised an ethical issue regarding the need for clear notification of patient enrollment in the ACO. This situation led to the appointment of the ACO's physician leader to our system committee to assist in the early identification of issues and improving collaboration between the ACO and the ethics program. Thus, health system leaders need to examine their ethics resources (primarily ethics committees) and determine whether the appropriate people are participating. Leaders should ask themselves whether the committee has adequate representation from its ACO community, including administrators, providers, and patients. Does the committee include members from departments in the organization that interact with the ACO?

The interaction between an ACO and all components of the ethics program is key to success in a healthcare organization. Westling et al. highlight the need for such interaction, and we look forward to their research on how Pioneer ACO sites address organizational ethics issues.

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Redefining Criticism

Think differently to create cultures of psychological safety.

Healthcare organizations are quick to laud, with good reason, employees who fix problems on the fly and make things work, all too often in the face of seemingly impossible situations and systemic barriers. Organizational leaders are sometimes less exuberant about employees who point out defects or potential sources of failure in our systems. Employees who repeatedly identify opportunities for failure are often viewed as chronic complainers. Managers may dismiss them as disgruntled persons who are not team players; colleagues may regard them as disruptors to a comfortable status quo. Worse, they may be labeled "whistleblowers."

But in reality, do disruptive complainers do more to fix important system flaws and improve safety and performance? Do leaders have an ethical responsibility to be sure their voices are heard?

In her 2018 book *The Fearless Organization: Creating Psychological Safety for Learning, Innovation and Growth*, Amy Edmondson argues that the degree to which healthcare organizations achieve greater safety and efficiency can be explained to a large extent by the culture of psychological safety that exists; specifically, how safe do employees feel about identifying organizational failure or the opportunity for failure? Edmondson speaks to three types of failures: two that are not so good (*preventable* and *complex* failures) and one (*intelligent* failure) that is not bad at all.

Understanding Three Types of Failures

The first are preventable failures, which occur when a person or persons deviate from recommended procedures. These types of failures may be caused by carelessness or malfeasance, but they may also be a consequence of unacceptable or unsafe processes, working conditions or situations. Regardless of cause, we need to learn from these and prevent reoccurrence.

The second are complex failures, which occur when multiple factors align simultaneously and in a way that is not expected nor previously experienced, resulting in adverse outcomes. In a 2012 lecture given at Harvard Medical School, Donald Berwick, MD, president emeritus/senior fellow, Institute for Healthcare Improvement, described his own experience with complex failure.

The lecture, published in Berwick's book *Promising Care: How We Can Rescue Health Care by Improving It*, details how when he was a first-year pediatric resident administering an exchange transfusion, human error and system flaws aligned to cause things to go horribly wrong, nearly resulting in the death of an infant. Berwick describes the shame and self-loathing he felt not only about the error, but how he did not feel safe to speak about it openly, to critically examine what happened and ask how such a failure could be prevented from ever reoccurring. Berwick tells us the experience haunts him to this day but that it affirms for him the ethical responsibility healthcare

ACHE Safety Resources

- ***Leading a Culture of Safety: A Blueprint for Success***, created jointly by ACHE and the IHI Lucian Leape Institute, features a section on creating a just culture. Such cultures encourage staff to speak up to prevent errors and potential system failures that lead to such errors. Download the blueprint and read more at **safety.ache.org/Blueprint**.
- ACHE's ***Code of Ethics*** and **Ethical Policy Statements** at **ache.org/CodeofEthics** offer guidance on safety issues.
- **ache.org/Safety** provides you and your leadership team with practices to develop your team and to keep moving forward on this critical journey. Here, you can commit to leading for safety by signing our "We Lead for Safety" pledge and receive a Leading for Safety certificate. A safety self-assessment is also available.

providers and leaders have to change cultures of shame, fear and silence so employees feel safe and empowered to discuss failure openly.

Preventable and complex failures demand thorough examination via root cause analysis and internal and external reporting. They may necessitate holding specific individuals accountable. We do not celebrate adverse events; they point to significant patient safety failures and have a negative effect on patient and staff satisfaction. But we should celebrate the culture that encourages reporting of failures and the individuals courageous enough to bring them to our attention.

Finally, there are intelligent failures, which occur as the result of well-intentioned, well-considered and well-executed attempts to improve the way we do things. All organizations want staff to continuously look for ways to do things more safely, more effectively and more efficiently. But does the organizational culture actually encourage employees to experiment with, or even think about, ways to improve processes?

Experimentation involves risk, and failures will occur; indeed, failures must be expected. Do we recognize and celebrate intelligent failures as a learning process, or do we place so much emphasis on achieving desired (and maybe unrealistic) expectations that we create a culture in which failure is not tolerated?

As previously mentioned, too often the culture in healthcare celebrates and rewards employees who hunker down and make things work despite systemic obstacles (first-order problem solvers) but overlooks and discourages employees who regularly point out failures or system inefficiencies and offer new ideas (second-order problem solvers). When we ignore or discourage those with the courage to speak up and those with the courage to fail, we send a message about the organization's culture—just not the right message. In reality, the message given is that failure is not an option, and real change may not be what is desired or supported by leadership. The message becomes "be quiet and leave well enough alone." But it is not well enough.

Promoting Cultures of Psychological Safety

Edmondson offers leaders some strategies for destigmatizing failure and promoting a culture of psychological safety:

- ***Reframe failure***. To encourage more open and honest communication and emphasize opportunities for learning, Edmondson discourages the use of words such as "error" and "investigation," preferring words with less negative connotations, such as "failure," "accident" and "study."
- ***Speak in a manner that encourages open discussions about failure***. Don't ask staff if they committed or witnessed an error; rather, ask if things are as safe or efficient as possible and if they can speak to examples of such system failures. Encourage conversation that removes the stigma of failure. It is not the case that effective performers do not fail but, rather, that effective performers learn from failure and share what they've learned with others.

Below are additional suggestions for consideration:

- ***Make it clear that identifying and reporting of failures is acting in accordance with the ethical values of the organization***. Reward employees who model honest reporting of unsafe or ineffective practices or processes. ACHE's *Code of Ethics* calls on healthcare executives to "create an organizational environment in which both clinical and management mistakes are minimized and, when they do occur, are disclosed and addressed effectively."
- ***Connect identifying and reporting of failure*** to The Joint Commission's culture of safety domain, as outlined in the *High Reliability Health Care Maturity* model and the IHI's *Framework for Safe, Reliable and Effective Care*.
- ***Change the language we use***. Eliminate the term "whistleblower," and reframe criticism with a label that portrays reporting as a constructive rather than a disruptive activity.

Healthcare leaders have an ethical responsibility to give voice to and reward those with the courage to speak about failure openly and who are willing to risk failure in search of a better way. ▲

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To Minimize Risk, Ethics Audits Are as Essential as Financial Audits

Paul B. Hofmann, DrPH, FACHE, *president, Hofmann Healthcare Group, Moraga, California*

The media frequently report on highly respected companies with enviable reputations that seem to have lost their ethical compasses. Google and Facebook are among these organizations that perhaps need chief ethics officers (Swisher, 2018).

Unfortunately, healthcare organizations and their leaders also may suffer ethical lapses and, as a result, face increased business risk. Hospitals have reportedly hired doctors with revoked licenses and failed to report potentially dangerous clinicians (U.S. Government Accountability Office, 2017). Other questionable activities include "cherry picking" patients to increase an institution's quality scores (Phillips, 2018) and making illegal payments in exchange for patient referrals (U.S. Department of Justice, 2016). Even the most prestigious healthcare organizations have been subjected to adverse publicity about unethical or illegal activities (Ornstein & Thomas, 2018; Kolata, 2018).

An ethics audit may not have disclosed inappropriate behavior in such organizations, or even if it did, corrective action may not have been taken. The absence of an ethics audit, however, increases the likelihood that improper conduct will not be identified.

In 1995, the American Hospital Association (AHA) appointed an organizational ethics task force. With the assistance of the Ethics Resource Center of Georgetown University, a six-part ethics survey was produced and pilot-tested in a couple dozen hospitals, many of which then participated in AHA-hosted ethics institutes to discuss the results.

Around the same time, I published the first of two columns on ethics audits (Hofmann, 1995, 2006) for the American College of Healthcare Executives (ACHE), and Thomas C. Dolan, PhD, FACHE, then president and CEO of ACHE, invited me to draft an ethics self-assessment tool. With the assistance of Wanda J. Jones, then president of the New Century Healthcare Institute in San Francisco, I produced a document that has been published annually with periodic revisions since 1997 in ACHE's *Healthcare Executive* magazine and is also available online (ACHE, n.d.).

Although the individual ethics self-assessment tool has found a receptive audience, there is little evidence that ethics audits have gained traction among health systems, hospitals, and other healthcare organizations. Nonetheless, the benefits of performing such audits have been recognized elsewhere.

For more information about the ideas in this column, contact Dr. Hofmann at hofmann@hofmannhealth.com.

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For example, an ethics audit can help executives "evaluate how well a company has fulfilled its economic, legal and ethical obligations, discover or prevent ethical risks and plan corporate social responsibility activities strategically to satisfy stakeholder interests. . . . [The audit is a] process for evaluating and diagnosing the external and internal consistency of an organization's values and their congruence with real behavior" (Ojasoo, 2016, p. 9).

Unethical and illegal behaviors are not the principal reason for encouraging ethics audits. More importantly, such a process can help identify and highlight endemic issues that have not received adequate attention. Sexual harassment, use of inappropriate language, and other forms of misconduct—particularly by those with supervisory and clinical authority—often go unreported for fear of retribution and increase an institution's potential liability. Furthermore, staff members may be reluctant to express concerns for their safety. In an American College of Emergency Physicians (ACEP) survey of more than 3,500 emergency doctors, 47% said they had been physically assaulted while working, and 71% said they had witnessed the assault of a colleague (ACEP, 2018). Emergency room and psychiatric nurses, as well as support staff, are also obviously at risk.

A hospital trustee with extensive management and teaching experience identified 63 board leadership barriers as part of a governance quality diagnostic tool (Conway, 2018). Not surprisingly, each barrier has significant ethical and financial risk implications. For example:

- Aims are externally driven and miss internal "losing sleep" issues.
- "Favorites" get their projects resourced; there is no transparency to justify choices and trade-offs.
- Patient and staff harm is not discussed in the boardroom.
- The same types of errors are repeated, without improvement.
- Interconnections among clinical, financial, service, and experience outcomes are ignored, leading to unintended consequences.
- There is little, if any, best-practice sharing or learning.
- No one asks, "Could it happen here?" when a serious event occurs elsewhere.

Frankie Perry, RN, LFACHE, has written eloquently about the kinds of management dilemmas and moral challenges healthcare managers face. In a book (Perry, 2014) that will be published in a new edition in the coming year, she uses actual case studies to highlight why and how these issues demand greater attention.

WHAT SHOULD BE DONE?

Ethics audits are not commonplace in health systems or hospitals at present. However, guidance for establishing them is available, and existing survey instruments can be easily expanded.

The National Council of Nonprofits, for example, published a two-page roadmap for conducting an ethics audit. Among other topics, it describes who should be involved, what should be examined, and how frequently an ethics audit should be performed (National Council of Nonprofits, 2011).

The vast majority of hospitals conduct periodic employee satisfaction and physician engagement surveys, but they usually do not include topics related to ethical issues. As the case statement for the AHA's 1995 organizational ethics initiative noted (Ethics Resource Center, 1995):

> Organizational ethics is intimately linked with personal, professional, clinical and medical ethics. Trust, caring, honesty, compassion, confidentiality and respect are only a few of the essential ingredients that provide the firm foundation on which to base important personal, professional and operational decisions.
>
> To be truly successful, an organizational ethics initiative must be internalized at all levels throughout an institution or system and provide open avenues for communication, dialogue, feedback and training. Such an effort takes time and the commitment of the CEO and other hospital leaders to model critical values and behaviors in their own actions—formally and informally. *Ultimately, the effectiveness of any organizational ethics initiative is inexorably tied to the concrete, observable behaviors and decisions of a healthcare institution's senior management and professional staff* [emphasis added].

To assess the ethical culture of an organization, the initiative recommended 55 statements for an anonymous and confidential staff survey. Respondents are asked if they strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree with statements such as the following:

- All employees are treated fairly.
- Respect for employees is important in my organization's policies and practices.
- Organizational ethics are openly discussed within my organization.
- The system of discipline within my organization is fair for all staff.
- The standards at my organization are clear.
- I feel pressure to compromise the standards while performing my duties.
- I know I can freely approach any manager to ask a question about business ethics.
- My senior management acts in accordance with the organization's standards.

Like a financial audit, an ethics audit is simply the first step. What does an ethics audit reveal, and what actions should be taken to address its findings? Physicians and employees reasonably assume the findings will be shared and steps initiated to ensure an ethical culture is maintained and enhanced.

A recent article presented the results of a study involving 3,605 employees of a large, integrated, religiously affiliated healthcare system in the mid-Atlantic region. The study's purpose was to determine whether a correlation existed between employees' perception of their managers' behavioral integrity and being more engaged in their job, seeing their coworkers demonstrate more organizational citizenship behaviors, and having a more favorable view of the service quality of both the unit and the hospital (or other entity) in

which they worked. Not surprisingly, there was indeed such a correlation (Prottas & Nummelin, 2018).

Health system and hospital mergers, consolidations, and acquisitions are occurring with increasing frequency (Kaufman Hall, 2018). Invariably, the due diligence process focuses on balance sheets, financial statements, governance and management topics, improved cost-effectiveness, and efforts to preempt concerns about antitrust issues, while only minimal attention is devoted to similarities and differences in organizational culture. Comparing ethics audits as well as financial audits provides additional transparency when assessing organizational compatibility.

No responsible healthcare executive condones institutional or professional hypocrisy, and yet eloquent vision, mission, and values statements are not always reflected in institutional performance and individual behavior. When there is a disconnect between rhetoric and reality, patients, families, and staff are undeniably compromised (Hofmann, 2008). An ethics audit reduces the probability of such a disconnect and helps the organization identify and address deficiencies, just as financial audits are essential in rectifying fiscal management issues.

Given the seismic changes in the healthcare field, it is essential now more than ever before to perform ethics audits to improve performance and reduce liability exposure.

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