

Three Ethical Case Studies

What's a Pharmacy to Do?

A Tale of Two Hospitals

No Bloody Way!

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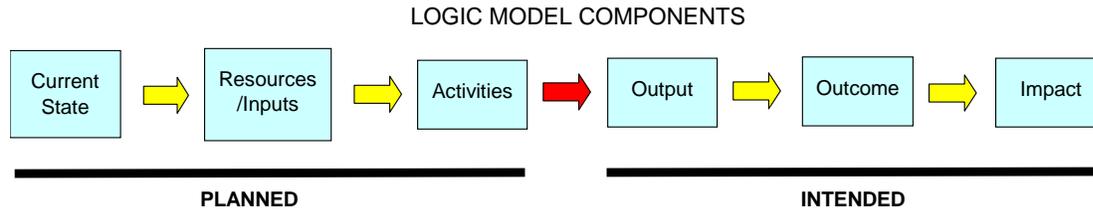
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Relevance to Medical Management

So why should medical managers care about ethics? Must one care simply to check off on business plans that this element has been duly noted? In the post-Enron era, with Wall Street imploding, this defensive, perhaps personal, risk management strategy would certainly seem a prudent thing to do. But is there more a consideration of ethics can do besides such window dressing? I would answer not just weakly in the affirmative but would go so far as to propose that consideration of ethical frameworks is absolutely critical in the medical management environment – an environment where drivers for behavior outside of financial levers are very real and very powerful. This paper will walk the reader through three case studies to demonstrate the value of considering ethical frameworks in medical management, focusing on physician management but also considering other members of the care team.

Let's first consider the role of ethics in basic 'Management 101'. The three primary planning tools for sound medical management are the strategic plan, logic model and annual work plan. The strategic plan typically includes an environmental scan, SWOT analysis (strengths, weaknesses, opportunities and threats), outline of goals and description of strategies to achieve these goals. A logic model builds on the strategic plan by outlining the relationship between resources, strategies and activities on one hand and desired outputs and outcomes on the other hand. The annual work plan builds on these two tools to provide a detailed road map for the organization and/or department to follow the upcoming year to ensure there is progress towards the stated goals.

The logic model can simplistically be broken into components:



Good logic models include consideration of cause and effect relationships and delineation of performance measures. The elegant simplicity of the logic model has been of great value in medical management facilitating logical delineation of the chain of connections between what one does and the expected impact of such actions. Logic models allow an organization to clearly identify the impact of decisions rather than focus on process measurements. Good logic models are based on careful simultaneous assessments of both the current situation and the desired impact, moving away from concentrating solely on measuring activities and outputs. This is where consideration of ethical frameworks becomes so crucial, transforming good logic models into great logic models. With consideration of ethical frameworks, the focus shifts to behaviors that must change in order to achieve outcomes, requisite knowledge and skills required for such change and the impact of culture on the process. Vital inputs include consideration of existing cultures of all care providers. It is the behavior of the people being impacted by strategic activities that will be most crucial if we are seriously considering outcomes and impact rather than just outputs. Changing the ‘human element’ is crucial not only in implementation but, more importantly, sustainability moving forward. This paper concentrates on one member of the care team – the physician – to explore where consideration of ethical frameworks might be expected to have an impact in a medical logic model.

Engagement of physicians is often a major challenge in medical administration but one worth persisting with as success integrating physicians into management teams has been shown

to improve outcomes measured by both quality and financial metrics (Mountford & Webb, 2009; Weiner, Shortell, & Alexander, 1997). Physicians both directly by their fees and indirectly by their actions – writing prescriptions, admitting to hospitals, providing treatments and so on – are significant drivers of costs in the health care system. Given this state, it is therefore even more critical for health care administrators to consider ethical frameworks underlying physician behavior and motivations as an important tool in developing logic models.

At times behavior of physicians appears illogical or paradoxical. Why for example do physicians not more readily adopt evidence informed protocols and standards of care? There is no shortage of these standards that could simultaneously improve quality of care and decrease costs but uptake is often poor in spite of great efforts - often at significant cost - to encourage adoption (Berwick, 2008; Seddon, Marshall, Campbell, & Roland, 2001). Behavior is often manifested by a status quo bias which makes change towards more evidence informed practice even more difficult. In the Canadian system where, unlike the American system, physicians are financial cost centers rather than revenue centers, there is a paucity of financial levers available for medical administrators to manage actions of physicians. Financial levers are typically under a different jurisdiction in large part controlled by the physicians themselves and often not well-aligned with the goals of health care organizations. Efforts to utilize financial incentives can often be met with unanticipated effects in other segments of the physician community given the complex and interrelated networked environment. It is for this reason that consideration of professionalism, education and relationships is so important to more fully understand the physician perspective.

There have been significant changes in the physician ethical paradigm over the last half a century as society placed more emphasis on patient autonomy and less trust in the ‘Marcus

Welby' paternalism of 'physician knows best'. This has left both the public and physician community unsettled. A recent public example in Alberta was the media debate surrounding physician payment during a recent pandemic. The president of the medical associations not uncommonly publically espoused a selflessness of physicians who 'have a calling' (Blackwell, 2009). The public, as represented by the lay press, was becoming less accepting of this characterization as they mused on other motives and questioned the behavior of a physician community they understand to have taken a poorly understood Hippocratic Oath (Diotte, 2009).

This paper will focus on physician behavior. However the same evaluation and framework can be easily expanded to all members of the care team. Health care is at its most basic a service industry where people have both the opportunity and responsibility to care for their fellow human beings. To succeed and remain whole demands consistency with one's own belief system and perspectives in an environment that is constantly changing and questioning existing paradigms. Understanding ethical frameworks helps explain and provide direction in managing all valued members of the team that provides care. This understanding provides a way to influence and model behavior to move all care providers towards integrated teams where all can succeed.

Philosophy and ethics - My Bias and Disclaimer

Ethics is a branch of philosophy. Philosophy is very different than science. In science we look for better answers to questions with an expectation there is one ultimate answer. In philosophy one looks for better questions. Philosophical theories (and in this case ethical theories) facilitate asking better questions without expectation there is one answer to a problem. These theories are best considered lenses one applies to problems to promote understanding and assist developing solutions that reflect and respect the context in which the problem is framed.

When individuals say something is ‘ethically’ or ‘morally’ right this is typically based on their own unique perspective which is most often shared within their local culture. This individuality is often assumed by individuals to be a universal, leading to tendencies within all health care debates for participants to try and capture the moral high ground as a way to advance their case and solicit support for their position. Participants often forget there are multiple, often disparate, perspectives that should be considered – the ‘walk in the other shoes’ so many do not take because of the comfort of their current familiar ‘pair of shoes’ (even if the shoes are old, weathered and torn!).

What we are considering in these cases are normative ethics – the ethics of what one ‘should’ or ‘ought to’ do. What is right and wrong, what is good and bad, are the subjects under consideration for ethicists. In the cases within this paper, the intent of applying ethical theories to management problems is to demonstrate the value of applying an ethical tool set when approaching problems in the health care environment. If I have done my job right, I would not expect there to be agreement with everything brought forward in this document. However, if I have made the reader think about alternatives and contemplate why someone behaves as they do, I will have succeeded. There is always great value in ‘walking a mile’ in someone else’s shoes and ensuring we have an understanding of all perspectives, an understanding that can truly influence culture change and ensure sustainability of action plans.

Project Proposal Outline

Health Services Management Issues

There are significant ethical issues involved in each and every decision made each and every day in what is truly a very complex health care environment. Given health care is best characterized as a complex adaptive system, each decision made will affect the context and

outcome of future decisions. Ethical issues are sometimes up front and obvious while at other times they are unstated in the background. However, they are always present and always relevant. The case studies in this project consider ethical issues involved in three different spheres and how consideration or lack of consideration of these frameworks affected outcomes and impact. The first case examines ethical issues in distribution of scarce health care resources. The second case considers ethical issues when health care providers are asked to put aside their self-interest for the greater good of a community. The final case explores the more personal ethical issues relating on the surface to issues of informed consent but also, on a deeper level, to the interactions between members of care teams and those they care for. The cases have been written so that they can stand on their own – this does mean some duplication of material in the background for each individual case. Following the case presentations the management implications within these cases of applying ethical frameworks will be drawn together and explored especially as to how similar considerations in other contexts might be exploited by health care managers to provide significant impact.

Ethics Case 1: What's a Pharmacy to Do?

Strategic Importance of the Issues Addressed with Case 1. The major strategic importance of issues arising in this case is the primary responsibility of all managers to make resource allocation decisions for stakeholder groups in an environment of scarcity where not all requests can be met. When allocating resources to one stakeholder group there will invariably be another group who receive less than they wanted – the opportunity cost. Given resources are scarce (or there would be no need for allocation), those making the decisions will be held to task by the public for the choices they made.

Governments generate revenue through taxation. They utilize this global revenue to provide services for individual members of the society. There is a limit to how much is available for public goods corresponding to decisions on, and societal tolerance for, taxation levels. Not everyone who pays into the 'system' receives access to the entire scope of care they might desire. Not everyone who benefits from services contributes financially to the revenue base funding services. Different societies have different levels of taxation, different levels of government involvement in providing public goods and different value laden strategies in making decisions about allocation of public funds. Decisions on allocation of the public purse are expected by the public and the press to be made in a manner consistent with the ethical framework of the population providing the resources.

Allocation of resources is usually considered on three levels. Macro allocation issues are those typically considered by governments and involve broad decisions such as whether to invest in health care or road improvements. Micro allocation issues are those at the more granular patient care level such as which of two patients will receive a heart transplant when only one donor organ is available. Meso allocation issues are those in between including decisions involved in allocation between two programs or two sites within a health care region.

Analytical Approach and Setting. Case 1 is set in a pharmacy department of a regional hospital and represents a meso-allocation decision. The question faced by the Medical Advisory Committee (MAC) and hospital pharmacy department is whether to institute a medication auto-substitution policy to take advantage of a financial offer from a pharmaceutical company. The pharmacy has been offered a financial incentive to auto-substitute a medication. There is no apparent harm to patients as there is clinical equipoise in choice of medication. The pharmaceutical company expects to increase market share postulating individuals started on their

product in the hospital setting will more likely continue their brand upon discharge. The hospital intends to reinvest the dividend to resource more medication than possible without these additional revenues. The physicians on the MAC are concerned this auto-substitution is not ethical as it unfairly exploits patients and interferes with physician autonomy in making the best decision for their patients.

The analytical approach considers the variety of ethical frameworks informing this decision. The meso allocation decision in this scenario needs to consider ethical frameworks imbedded in both macro and micro allocation decisions. Macro allocation decisions in Canada tend towards a modified egalitarian approach elevating health care to a basic right as opposed to the libertarian approach in the United States that considers health care more a commodity. From a micro allocation perspective we have a virtue ethic, utilitarian and deontological lens we can apply to the problem. Health care ethics until the mid-1950's were based on a virtue ethic emphasizing the care provider more than the specifics of decisions being made – the actor rather than the act. This theory promoted the virtue of training competent physicians who would then make good decisions; it is the theory underlying paternalistic attitudes of the past that are still seen at times today. In the middle of the twentieth century health care evolved towards a principle based deontological ethic concerned more with beneficence, non-maleficence, autonomy and justice. Imbedded in and influencing both these paradigms were utilitarian ethics promoting strategies to maximize happiness - always a major consideration especially when considering equitable rather than equal distribution of scarce resources.

The analytical approach applies these theories to the specifics of the case before the MAC and will make the argument from all these lenses that the pharmacy and MAC should 'take the deal'. How this applies to like decisions in other contexts will also be considered.

Management Principles. A key management principle is fair and transparent stewardship of those public resources dedicated towards health care to maximally provide evidence informed care to the population being served. Sources of funding need to consider not only direct government funding but also indirect sources as in this case. At the same time, the public will expect an ethical approach when evaluating these opportunities, especially in the Canadian environment where health care is viewed as a basic right.

There will be trade offs that must be made between purchasing the ‘best’ drug in class versus one that is very close but perhaps less expensive. With limited resources, management must always consider the marginal cost of purchasing additional efficacy. In the specifics of this case, a non-negotiable starting point must be an evidence based review of the efficacy of available medication brands to ensure patients are getting acceptable care. In this case, this hurdle was clearly met by the medications being considered.

When marketing products, companies typically segment markets and utilize targeted strategies to exploit opportunities in different segments of the market. Pharmaceutical companies utilize these strategies on a regular basis. There is nothing intrinsically wrong or unethical with this strategy – it is good basic business practice. Rather, it is management who must understand this reality to avoid being exploited. It might in fact be argued implementation of these same strategies by management present invaluable tools for change management strategies encouraging caregivers to adopt clinical practice guidelines and other evidence informed standardized practices.

At times, there are concerns strategies used by pharmaceutical companies to promote their products approach the ‘grey area’ and potentially ‘cross the line’ of ethical acceptability. It is incumbent on those making decisions to clearly identify subtle influences on their decisions to

ensure tradeoffs are being made for all the right reasons. Physicians are not uncommonly placed in situations of potential conflict and, as in this case, need to introspectively explore their own rationalization regarding the ethics of any offer in order to prevent themselves from being exploited. Positioning pharmaceutical companies as the 'evil one' when the companies are themselves pursuing recognized strategies would ignore the responsibility of management and physicians to carefully evaluate all situations as opportunities and apply a lens of fairness and transparency to such decisions.

Ethics Case 2: A Tale of Two Hospitals

Strategic Importance of the Issues Addressed with Case 2. The major strategic importance arising from this case is the challenge involved in developing common ground and/or shared perspectives between two opposing factions within a health care debate to formulate and operationalize strategies for the greater good. The challenge is to optimally engage stakeholders and develop collaborative processes even when one group/side may have to forgo individual advantages to optimize outcome for a wider population. The same trade-off question is not dissimilar to the expectations for physician engagement in administrative decision making where physicians are expected to balance their fiduciary responsibility to individual patients with population need striving to enhance overall quality and improve cost-effectiveness (Mountford & Webb, 2009).

It has long been a topic of discussion amongst philosophers and political scientists as to what drives individuals to join together to form civil arrangements. It is generally assumed all individuals are basically self-interested. Individuals are expected to make decisions that improve their state in life, be it increasing their happiness, their financial situation or their personal satisfaction. However, there is great strategic importance ensuring groups of individuals forego

selected rights and privileges of individualism in order to realize the greater good for society. A choice to form a civil society means individuals must give up some individual rights for the good of the group. Understanding how disparate individuals organize into such groups, how groups decide on membership and how groups either unite or divide moving forward is vital to understanding and trying to influence the behavior of individuals when promoting population strategies.

When considering choices made by individuals it is usual to assume the individual themselves make the decision; this may not be true in health care given the nature of the relationship between physicians and patients. Physicians have since the time of Hippocrates adopted a fiduciary responsibility with patients. This fiduciary relationship implies the physician will forego self-interest in favor of the best interests of their patient. The ethics imbedded in physician training and the ethics of professionalism continue to promote fiduciary relationships between physicians and patients. In the past, this time-honored orientation of physicians meshed well with an underlying virtue ethic in health care and was rewarded with an enviable social status and position of trust. However, societal ethical frameworks have evolved over the last half century towards a more deontological focus where patient autonomy now trumps this paternalistic attitude. Physicians are facing a more legalistic and less tolerant attitude by society. This has not however decreased health care administrator's expectation physicians should provide direction and support as it relates to access to resources.

When physicians are asked to assist management with allocation decisions of resources to populations the basic orientation of physicians towards individuals creates significant ethical dilemmas. As medicine becomes progressively more technology based physicians often feel compelled to respond to allocation decisions for new, most often expensive technologies on the

basis of not just what is *good* but what is *best* for their individual patient (forgetting of course that the enemy of good is better.) In being asked to make determinations of resource utilization, physicians should ideally evaluate the marginal value of interventions in an environment where outcomes are uncertain. For example, when only one CT scan is available should a physician order a seventh scan on a patient where it might be expected to add just a bit of value or the first scan for a different patient where one might assume the scan could add potentially more value? Given the answer to these questions can only be determined *a posteriori* once both scans are completed, these *a priori* decisions become doubly difficult when evaluative criteria (by legal courts and the court of public opinion) invariably consider developments beyond the time frame during which the decision must be made. To add further to this challenge is an environment where there is often significant marketing pressure by pharmaceutical companies and medical equipment manufacturers who are promoting their interventions and the public who are exposed to both advertising and anecdotes in an increasingly networked, internet-worked environment. This environment creates significant ethical and medico-legal tensions for physicians as they are increasingly expected to develop a wider population focus as gate-keepers to access resources, especially when resources are limited.

Analytical Approach and Setting. Case 2 is set in an integrated health region. The region is exploring capital infrastructure options in an area where facilities have outlived their lifespan and in need of a refresh. External consultants have suggested the preferred alternative would be to replace two outdated facilities in communities fifty kilometers apart with a larger regional facility shared between the two communities. This joint facility was envisioned to create the critical mass required to address issues with staffing, bring additional services to this area of the region and address significant operating funding challenges. The joint proposal was

initially accepted by the local funding agency but, when the proposal was floated to the individual communities, there was enough public discontent that this initial support was withdrawn. This case analyzes the response by the community at large but more specifically the attitude of local physicians who were significant opinion leaders lobbying against the proposal.

Analysis of the case involves consideration of the social contract theory originally brought forward by Hobbes and later expanded with the input of Locke and Rousseau. These philosophers examined the underlying drivers for individuals with innate strong self-interest to give up selected rights to form civil organizations. All three philosophers argued strongly and coherently that we are able to advance as societies only because rational individuals with self-interest recognize the best way to move forward must involve pursuing choices that are best for the entire population. These considerations are basic to evaluating and understanding behavior exhibited in this case.

Management Principles. A basic principle of good management in health care is to encourage adoption of clinical practice guidelines to ensure decisions are evidence informed and maximal care is provided. It has been suggested a third of what physicians do for patient care is, at best, of limited value and, at worst, frankly harmful (Berwick, 2008; Seddon, et al., 2001). It has also been suggested there is significant expenditure of health care resources towards ‘defensive’ medicine to ‘make sure everything has been done’ (Searcey & Goldstein, 2009). Getting physicians to adopt standardized population based guidelines is an ongoing management imperative especially since adoption of standards implies loss of individualism and control for physicians.

In considering implementation of evidence informed medicine and adoption of clinical practice guidelines, the art of management is contextualizing strategies for given environments.

It is a truism that culture eats strategy for breakfast. There are historical and cultural realities in training and enculturation of physicians that influence the ability of managers to implement given strategies. Attempting to implement strategies into any environment that is not primed will result in expenditure of a great deal of management time, resources and energy in vain. It will also lead to frustration and an increasing sense of disenfranchisement for all members of the care team. It is imperative therefore that logic models consider underlying ethical orientations when developing strategies in order to ensure outcomes and impact are maximized. Developing pragmatic, politically viable strategies that address the needs of all populations serving and being served is key in our health care environment.

Ethics Case 3: No Bloody Way!

Strategic Importance of the Issues Addressed with Case 3. Health care providers typically manifest an underlying caring ethic. In the most basic sense, they want to help and improve the lot of their fellow man/woman. However, health care decisions on the front line invariably involve ethical challenges reflecting on providers and patients who all bring unique perspectives to the same scenario. It is inevitable there will be clashes of beliefs between different members of the care team that unfortunately often lead to confrontations between individuals, all of whom are attempting to do the best they can both in treating but also respecting the rights of each patient. Development of inter-professional teams is an essential strategy to support caregivers and optimize care.

Analytical Approach and Setting. Case 3 looks at conflict arising in a community hospital over an imposed mandate for post-operative signed consent for blood transfusions. The angst this issue created in the hospital related to a pre-existing, more global consent issue that had not been adequately addressed. This new policy became the ‘straw that broke the camel’s

back'. On an even more basic level the health care environment in which this case arose and the evolving relationships between members of the care team proved to be extremely relevant to this issue. Culture mattered greatly and trumped strategy.

The analytical approach will be to explore the wider contextual issues that reflect on the need for consent utilizing the various ethical theories including the comparatively new lens of feminist ethics. Consideration will be extended to the overlying perspective of informed consent as it relates to subjective, objective and professional standards of both disclosure and, more importantly, understanding.

Management Principles. Healthcare is a team-based journey. There will inevitably be differences of opinion as to how to best manage cases. This includes a shared understanding not only between care-givers and those receiving care but also between the care-givers themselves as to what constitutes acceptable consent processes and documentation. In an era of increasing emphasis on patient rights and autonomy, management needs to carefully consider and ensure validity of the consent process. Of equal if not greater importance, management needs to ensure that members of the care team truly work together as a team for optimal patient care. Forums for caregivers to have input into decisions in addition to open and principled discussions when conflicts arise are critical components to develop respectful environments. Conflicts, when respectfully managed well in such an environment, present valuable opportunities to move forward with improved patient care rather than threaten sustainability.

Case 1: What's a Pharmacy to Do?

Management Issue Being Considered

The logic plan underlying this case relates to effective use of resources. In a situation where there is no clinical difference in the use of a medication it would appear logical to

leverage pharmaceutical companies to minimize costs of medication to provide an expanded total amount of medication to patients being served. Activities involved in minimizing costs in this case were opposed by the physician group because of their interpretation of, and concern with, motive. The wider question of the motives of all stakeholders, including physicians, need to be considered in order to move forward with what would appear to be a logical effort to lower costs while maintaining high quality of care.

Case Presentation

The Pharmacy and Therapeutics Committee (PTC) at a 365 bed regional referral hospital was asked to review a proposal by a pharmaceutical company in regards to a class of drugs called proton pump inhibitors (PPI's). The company was proposing that if their PPI brand were able to attain an 80% share of the hospital PPI usage the pharmaceutical company would directly provide to the hospital a significant cash rebate. Proton pump inhibitors (PPI's) are a group of drugs that decrease the amount of acid made by the stomach and are widely used for treatment of heartburn and ulcers. They are a common medication. There are many different PPI's on the market as several different pharmaceutical companies make this product, all sold under different brand names. There is an interesting history to the pricing of these medications. The cost to local retail pharmacies approximates \$1.50 per pill. However, some number of years prior to the timing of this case one manufacturer decreased their cost to the hospital pharmacy to \$0.01 per pill. The rationale for this action was the hope that when an individual was started on a particular brand of PPI in the hospital environment there was a greater likelihood the patient would be discharged home on this same brand of medication. All pharmaceutical companies followed this lead so that at the time of this case all PPI's were sold to the hospital for \$0.01 per pill. The cost to retail pharmacies continued approximating \$1.50 per pill.

The Pharmacy and Therapeutics Committee (PTC) did a thorough review of all six PPI brands currently on their formulary and concluded from a safety and efficacy point of view there was no overall advantage of one product over another. If anything the brand being proposed in this instance had marginally better performance, as there appeared to be less drug interactions with this product. This however was not felt to be significant so that for all intents and purposes these drug brands had the same overall benefits and side effects. The PTC also confirmed there was no significant difference in the cost of any of the PPI's to a patient in the outpatient retail setting.

In order to achieve the 80% market share required to receive the proposed rebate, the PTC suggested an auto-substitution policy be implemented. The proposal was that when any physician ordered a PPI of any brand, the hospital pharmacists would automatically substitute the brand of the pharmaceutical company proposing the rebate *unless* the ordering physician specifically indicated the patient was to have the brand ordered. This 'preferred' brand of PPI medication from the company proposing the rebate was proposed to become the default for the hospital. All other PPI's would remain on the formulary permitting physicians to order them if they so specified. This proposal was brought to the Medical Advisory Committee (MAC), the senior group of physicians providing recommendations to administration on issues such as this. At the MAC it was suggested by the physicians that this proposal was unethical and not acceptable. The question is and was whether this proposal was indeed unethical and whether or not the auto-substitution policy should be implemented.

Ethical Principles Involved

Resource Allocation. In determining if this rebate and auto-substitution is an ethical proposition one must first determine what kind of a resource allocation issue we are dealing with.

For resource allocation one usually considers three different kinds of allocation – macro, meso and micro. The macro allocation issue would be the larger issues faced by government in deciding how much of their global budget goes to health as compared to education for example. These are global overarching decisions. Micro allocation issues in health care are the day to day patient specific questions such as which drug to give to which patient or which of two equally suited individuals in need of a kidney transplant gets the transplant when only one kidney is available. The meso allocation issues are those ‘in between’ decisions and are often hospital or region based. An example of a meso allocation issue would be whether a hospital with a given global allocation of resources (macro allocation already done) chose to spend its limited resources on a new orthopedic program or an integrated medical-surgical program for obesity. The decision as to which individual got the hip operation within the orthopedic program or obesity operation within the obesity program would be a micro allocation issue.

In the instance we are considering in this case we have primarily a meso allocation issue. The pharmacy has been allocated a fixed budget. Within this budget the pharmacy is mandated to provide maximal benefit to as many individuals as possible without considering the specific individuals who are receiving any given medication. The challenge in a meso allocation decision is that the ethics of considering this resource allocation needs to consider the ethics involved in both a macro allocation decision and a micro allocation decision in addition to those unique to this positioning. I will therefore consider underlying ethical principles of both a micro and macro allocation decision as a background for discussion of the meso allocation issue facing the PTC and MAC.

Micro Allocation Perspective. When considering micro allocation decisions the questions from an ethical perspective become normative questions of right or wrong, good or

bad. The four basic ethical/moral theories addressing such questions are utilitarian, deontological (Kantian), virtue (Aristotelian) and feminist. All four theories are concerned with normative concepts of right/wrong and what we 'should' do when considering options to come to a right and just decision. Of these theories, one (utilitarian) looks at consequences, one (deontological) to motivation, one on the actor (virtue) and one towards context (feminist).

Utilitarianism as originally proposed by Bentham and Mills and expanded by many others over the years is consequence driven (Sen & Williams, 1982). The rightness of an action relates entirely to an algebraic determination of the production of overall happiness. The correct act is that act which maximizes happiness no matter what it takes to get to this point – the end justifies the means. In its pure form, all outcomes are known and can be measured and actions are entirely impartial – not necessarily truths in reality! Major concerns with this 'act utilitarianism' is the realization that optimal outcome will invariably be realized with a strategy of maximally disadvantaging a small group in society for the 'greater good'. Three major concerns with a pure utilitarian approach are disadvantaging a few for the advantage of the majority, acceptance of acts that many would consider inherently wrong such as torturing innocent people, and the promotion of individuals acting only for their own good (free riders). These concerns prompted some utilitarians to develop an alternative known as 'rule utilitarianism'. In rule utilitarianism the rightness of an individual action is not related to its *direct* consequences but rather the *universal outcome* should this individual action become the general rule for behavior. Rule utilitarianism is thus more concerned with the kinds of acts that are done, at the same time still arguing that these kinds of acts be evaluated on their ability to promote maximal overall happiness. Whether or not the ideal world this supposes can exist and

whether for a true utilitarian this rule utilitarianism does not revert to act utilitarianism remains contested.

Deontological ethics, in direct opposition to utilitarian ethics, argues that adherence to duty, rather than consequences, is most important in analyzing the rightness of an action. Immanuel Kant, who first advanced this moral theory, proposed that actions are right when they satisfy the “categorical imperative” (Dudley & Engelhard, 2010). He suggested general rules or ‘maxims’ be considered when evaluating the rightness or wrongness of actions and that these maxims should adhere to one of three formulations of this categorical imperative. The three formulations are 1) maxims should be able to become universal laws, 2) maxims consider treating humanity as an end and never only a means and 3) maxims treat others as autonomous agents. Whereas a utilitarian would justify telling a ‘white lie’ this does not exist for a Kantian since lying could never become a universal law. Deontological ethics are based on four basic principles of beneficence (the Golden Rule - do good), non-maleficence (the Silver rule - don’t do bad), autonomy and justice. One of the challenges for deontological ethics is what to do when adherence to discreet principles collide. In the health care environment, should a patient’s right to autonomy trump what would be the most beneficial treatment plan for the individual? This lack of consideration for context, emphasis on consideration only of rational autonomous beings (discounting non-humans and cognitively impaired for example) and variable formulation of maxims has challenged the Kantian deontological moral theory.

Whereas both Utilitarians and Kantians examine actions, virtue (Aristotelian) ethics consider the actor (Darwall, 2002). Kant specifically indicated that if an individual performs an action within his/her character this is not to be even considered a moral action. Aristotle, the founder of virtue theory, proposed that it is/was consideration of this very character that is in fact

paramount. The actor is more important than the action. Aristotle proposed primary importance is development of virtuous people. Virtuous people will 'naturally' do the right things and we do not need to consider their actions since all actions will be natural outcomes of their character. Being virtuous is a learned behavior that can be taught but requires considerable practice. If a virtue is considered the 'golden mean' between two vices, virtuous individuals consider alternatives, deliberate about them and, as a result of their training, voluntarily choose the correct action based upon the nature of humans to aim for *eudemonia*. Eudemonia represents the state of happiness and well being that, according to Aristotle, is fixed in human nature. It is concern with this concept of what is natural that remains debated in Aristotelian ethics. The lack of direction in evaluating both actions and the progress towards being virtuous are other difficulties with Aristotelian virtue ethics.

Feminist ethics arose because of concerns that classical moral theories not only did not consider gender but, more globally, did not address oppression in all its forms (Walker, 2007). The lens of the feminine gender is proposed more revealing than the more masculine humanist perspective reflecting experiences and intuitions of women that emphasize caring, friendship and relationships. The context of an act is vitally important and acts should not be universalized (as per Kant) or simply outcome summed irrespective of whose happiness and the nature of the happiness (as per utilitarianism). In feminist ethics there is greater emphasis on justice than the absolute nature of autonomy imbedded in previous theories. Similar to virtue ethics there is an absence of rules and/or calculations for making individual decisions.

Macro Allocation Perspective. Classically for a macro allocation decision the major concern relates to concepts around distributive justice – how do we 'justly' distribute both rights and obligations within a society (Kymlicka, 2001)? The two basic models to consider are

libertarianism and egalitarianism. Libertarianism argues that the only thing we owe to each other in society is non-interference; individuals acting in this freedom framework will maximize their personal goods and consequentially increase the 'value' of society. Maximization of civil liberties in this model does not consider health a basic civil liberty but rather a commodity. Alternatively, the egalitarian approach to allocation of health care resources recognizes health as a basic right of the human condition with basic health an intrinsic civil liberty. Egalitarians argue that, in the principle of justice and fairness, the resources of all of society need to be equally distributed as a basic envelope of health services to all individuals in society to maintain the health of all individuals. Egalitarians believe the development of a more healthy population is the only way to ensure individuals can maximize their potential and in so doing increase the 'value' of society.

A total egalitarian approach argues for completely equal distribution of all resources while a modified egalitarian approach argues for equitable distribution, differentiating equity from equality. Much of this thinking is based upon the work of John Rawls (Rawls, 1999) and further elucidated in the health care environment by Norman Daniels (Daniels, 1985). While libertarianism would be most closely represented by the health care system in the United States, a modified egalitarian approach would be closest to the health care system in Canada. Given the Canadian environment where the ethical framework of Rawls has become so prominent it is worth looking at the Rawlsian ethic in greater depth.

Rawls' theories were clearly based in a deontological approach stressing the importance of normative principles of intention. He looked for universal fundamental principles that could be applied to individuals to facilitate harmoniously living together as a society. The principle of greatest concern to Rawls was the principle of justice. He concluded that we ought to decide

what is right and wrong human conduct based upon fairness as the most important aspect of justice. Justice as fairness became the basic tenet of Rawls' approach. He advanced two principles that he believed were integral to justice. The first is that each individual in society has an equal right to the most extensive liberty possible compatible with an equal similar liberty for everyone in society. Second, Rawls suggested for a society to function properly there are reasons permitting inequalities of liberties between individuals. These inequalities might exist because of a necessity to provide greater benefits to fulfill a need to attract individuals to certain jobs or positions. A very basic example would be in distribution of food - should a one hundred pound sedentary retired individual be allocated an identical amount of food as a two hundred and fifty pound laborer? Equality would say yes while equity would say no. Differences also exist as part of human nature, realities Rawls referred to as life's undeserved lottery. Rawls' principle flowing from this line of reasoning was that where inequalities exist, they have to be open to all and ultimately work out to the advantage of everyone. It is the burden of proof of those with the greater liberties to demonstrate their greater advantage is for the good of all of society. Rawls did not dispute there are examples when society itself sets these inequalities, as for example the theological/religious rationalization for a caste system.

In his arguments Rawls was most concerned with functions of a society and made an unstated assumption that all individuals in society are 'context' free with each individual having an equal 'deserve' to everything society offers. He further assumed equal opportunity for all individuals to have equal access to liberties presuming all persons are rational with roughly similar needs and interests. Rawls believed offices in society must be available to everyone. In such an environment each individual should be able to look at his/her situation with a 'veil of ignorance' and accept that given the situation leading to inequalities, the reason for any

difference would be robust enough that he/she would accept either the 'advantaged' or 'disadvantaged' position, understanding any existing difference was for the good of society. Flowing from this 'veil of uncertainty' Rawls argued each individual would be wary of proposing governing principles which gave him/her a peculiar advantage for fear that in the future this same principle, if unfair, might be applied against him/her. This would leave no easy way for anyone to win special, unwarranted advantage for himself/herself. Persons engaged in such a just practice would be able to face one another honestly with mutual acknowledgement and respect.

This 'fair play', Rawls argued, needed to be recognized in society beside the complementary principles of fidelity and gratitude. All three principles imply constraints on self-interest that are essential to society where realization of aspirations of others is at times required for the maximal benefit of all. Rawls was very clear to clarify he was not suggesting his theory was utilitarianism which he characterized as welfare economics. Rawls acknowledged that at times the outcome from a utilitarian perspective and his perspective might look the same. The difference, he argued, related to the intention that led to the outcome. In utilitarianism any differences in liberties are administrative and have the potential to relate to 'accidents' of education or upbringing. The resultant inequalities of liberty are assessed on the basis of diminishing marginal utility and are entirely teleologically (outcome) based. For Rawls, his conception of justice as fairness was entirely duty based. He was clear to differentiate 'unintended' positions in society based on life's lottery from those relating to free choice. An example of the differences in the two approaches would be the treatment of disabled individuals – for a utilitarian, allocating few resources to this group might lead to algebraic maximization in society whereas for Rawls this is an unintended positioning and the question back to society

would be what would a given individual have expected had he/she been born into this situation. Different outcome!

The fundamental moral concept of justice as fairness arises directly from the reciprocal relations of persons. If a claim of uneven distribution of liberties were not in accordance entirely with principles, Rawls, similar to Kant, would argue there would be no moral value in granting this position. The arguments for and against slavery demonstrate how this concept is applied. Whereas utilitarians might assess the advantages of the slaveholder compared to the disadvantages to slaves and society, from the perspective of Rawls, any potential gains of the slaveholder cannot be considered at all as the absence of societal gain already dismisses the argument.

Discussion

This case is a meso allocation decision. Meso allocation decisions typically involve exploring options with both a macro and a micro lens. In this case we need to consider both the perspective of the pharmacy and the physicians on the MAC. We need to also consider in this case the behavior of the pharmaceutical companies.

Macro Allocation. Starting with a macro lens, a libertarian approach would be one of non-interference and suggest physicians should be able to prescribe whatever medication they desire. Or is it? In reality it is the patient who is the most important actor to consider in this instance. One would have to examine why the physician was choosing to prescribe a given brand of PPI given the scientific evidence presented in this case does not support the superiority of one product over another from a population perspective. It could very well be the physician is more comfortable with a given PPI brand because he/she has had good success with this product. It might be the physician is very used to one product and by always using the same product

he/she is less likely to make errors in regards to dosing. On the Devil's advocate side maybe the physician uses the particular PPI brand because he/she has been subject to significant marketing pressure by the pharmaceutical company he/she may not even be consciously aware of.

Pharmaceutical companies have substantial budgets dedicated towards influencing physician behavior especially for this group of drugs that have high margins and little variance between brands. One might argue in this environment of significant and substantial interference a libertarian model is not possible for either physician or patient. It might however have great support from the pharmaceutical company! The libertarian argument would advance the premise that by pharmaceutical companies making greater profits, they are more likely to invest in further research so that, in the long run, there will be benefit the population. This has not been a popular position in our society where the profits of "Big Pharma" are regularly chastised in the media.

A modified egalitarian approach would argue it is the duty of the hospital pharmacy to take advantage of all available resource opportunities to maximize resources and then distribute these resources equitably to those in need. In this situation it would be incumbent on the pharmacy to do everything in their power to provide as much service to as many patients as possible. In deciding which PPI to use the first determination would be one of efficacy. The pharmacy needs first to choose the drug that provides the greatest benefit. As in this instance where this hurdle has been met (in that there is no difference) the pharmacy would then be expected to explore all alternatives to provide the product at the least cost so that additional resources would be available for distribution of other products to others in need. From an egalitarian perspective therefore the pharmacy should 'take the deal'.

Micro Allocation. We turn next to the micro allocation perspectives to consider in this case. The main ethical theories to consider would be a virtue ethic, a deontological ethic and a

utilitarian ethic. From a virtue ethical lens one would be most concerned with the actor and not the act – the theory would propose trusting the good judgment of the caregiver is paramount. If, for whatever reason known only to him/her, the physician requests a product, the good judgment of the physician must be respected. The challenge remains that physicians are often in environments where pharmaceutical companies have bombard them, sometimes directly and sometimes unconsciously, with marketing or propaganda (depending on your perspective). Further, though a major force in medicine early in the century, the virtue ethic of health care has for the most part been replaced by a deontological ethic. The public has adopted a more critical appraisal of individual health needs with a much greater emphasis on patient autonomy.

From a deontological approach we need to consider the principles of beneficence, non-maleficence, autonomy and justice. Beneficence and non-maleficence are really not at issue here as everyone in the micro allocation decision is trying to maximize both. In regards to justice, the ‘veil of ignorance’ John Rawls has proposed would suggest given the limited budget and lack of difference in efficacy, if one were making the choice and not knowing whether one was the patient getting the PCI or one who might be getting additional medication because of freeing up of budget by this alternative, the choice from a justice perspective is quite clearly on the side of the auto-substitution alternative. This is the same argument a utilitarian would make in justifying auto-substitution as an attempt to maximize the happiness of the most people. It would be the sum of increased happiness by those who benefit from the investment in other products, increased happiness by the pharmacy, increased happiness by some physicians who might appreciate the input by pharmacy and other products consequentially being made available, the indifference of the individual getting the PPI (most not affected, some happier because they appreciate doing their part to keep prices down in hospital, some unhappy because of potential

confusion with changing medications), and finally probably some net unhappiness with physicians who have their autonomy interfered with.

Autonomy is perhaps the most contentious principle. The physicians would see autonomy as 'control' over a given knowledge base, including decisions as to which medication to use in given contexts. The ability to make this decision and the power this gives members of the care team in being allowed this privilege would be considered by many a surrogate for professionalism. An auto-substitution policy has the potential to significantly affect physician autonomy and standing within the care team as it has the potential to transfer greater control to other team members. The pharmacy department had proposed a strategy to mitigate this risk with the decision not to pursue a hard auto-substitution policy and allow physician leeway whereby should the physician insist on the product of their choosing such a request would be honored. The physician would also still retain ultimate responsibility which PPI would be prescribed at the time of discharge.

The autonomy of pharmacists is also at issue. Managing a formulary and ensuring evidence based utilization of pharmaceuticals is entirely within their scope of practice. Hospital pharmacists would argue it is their professional responsibility to manage formularies. Physicians have not historically been involved in financial formulary considerations and it has been pharmacists who have been tasked to manage the medication budget. Pharmacists would also insist they have the skills and training to provide important leadership for medication safety in the hospital environment, one of the greatest sources of errors in the hospital environment. Their position as an important member of the care team, autonomy, and professionalism may be considered restricted by not being able to direct which of equal medications will be provided.

Not heard from in this argument would be the autonomous choice of the patient. The reader might have already noticed with interest that the physician professionals and pharmacist professionals framed this case at MAC as their decision to make. The question as placed before the MAC reflects a paternalistic framework in keeping with an historical virtue ethic with the patient apparently not being given any choice in the matter. It also reflects on the fiduciary relationship between physicians and patients. It would have been interesting and potentially worthwhile to have patient participation on the MAC and/or pharmacy committee when considering this decision. (Incidentally, when this was suggested, both physicians and pharmacists rejected patient participation arguing that patients would not have the requisite knowledge to assist in the decision.)

Autonomy and professionalism of pharmacists abutting that of physicians would appear to be the biggest autonomy concern for MAC. Pharmacists had already taken responsibility to ensure efficacy of the brands was equivalent and patients would not have a cost differential on discharge. The literature suggests decreasing and standardizing size of a hospital formulary by offering fewer products improves quality of care by decreasing chances of drug interactions and drug errors (Kile, McGrath, & Schindel, 1987). There was interest locally in the pharmacy community in advancing this field of pharmacoeconomics (Byford & Palmer, 1998). Physicians, however, advanced the argument that irrelevant of population statistics the physician was in the best position to consider the context and individual needs of the patient. Physicians suggested it was their responsibility to consider issues that might arise from potential change of medication brands. They suggested potential confusion might arise for patients taking the medication both within and outside the hospital with resultant potential for errors if physicians were not allowed to direct consistency.

The one ethical framework still to be considered is the feminist ethic stressing the importance of context. This auto-substitution proposal was not without precedent at this institution. The health region already participated in national group buying organizations to minimize cost of supplies, including pharmaceuticals. The rub was that this same auto-substitution suggestion had been instituted for a hypertensive medication in the past, unfortunately with negative repercussions. The impetus at that time was also a financial incentive for the pharmacy with a lower cost per pill for the hospital pharmacy for a given brand. At that time a review of efficacy had also been done and, unlike this case where there was no difference in efficacy between different medications being considered, the anti-hypertensive medication being promoted in this situation was conceded to have *positive* efficacious clinical advantages. Unfortunately, and *not* considered at the time the decision to auto-substitute this anti-hypertensive medication was made, the chosen product was, by a significant amount, the highest priced medication in the retail market. This had a significant financial impact on patients who were prescribed this medication on discharge from the hospital. The concerns of patients at that time were directed back to physicians who in turn raised this issue with the hospital pharmacy. The question as to whether the positive clinical impacts of the anti-hypertensive were significant enough to justify this cost differential was then a challenge for both patients and providers. The question at that time carrying over to this discussion was who should be in the best place to make such decisions. The question was one of control.

Meso Allocation. The biggest concern from a meso allocation perspective raised by the MAC was concern with ‘making a deal with the devil’. An extreme way to phrase an analogy would be whether one should consider taking a donation from a criminal organization known to make its money from extortion. This is obviously extreme and in no way am I suggesting this is

what is happening here but the question is basically should the hospital take this benefit from the pharmaceutical company who, in essence, are making significant profits from the very patients being treated. If the caregivers had a choice they might rather see these savings passed directly on to patients who need the medication. Should caregivers be offended by the decision of the pharmaceutical company to not pursue this option and choose not to participate?

Marketing. In evaluating this option, one needs to consider on what basis this offer by the company was made and what the options are for marketing this drug. First, one might assume if the hospital pharmacy chooses not to take this rebate the pharmaceutical company might instead compete in the retail market and decrease the cost of the medication to the consumers. This is an unlikely supposition as the pharmaceutical company had passed on this marketplace opportunity previously. Consumers/patients have not typically made choices of prescription pharmaceuticals based on cost (a previous case at this hospital having been an apparent exception). Cost is often hidden in drug plans and not visible to consumers. Even if cost is known, the most significant driver of choice of medication remains the choice of the prescriber – their physician. This reality is the driver behind this strategy of the pharmaceutical company to make the offer before the MAC in this case. It would only be the presence of an open market with informed and empowered consumers that would lead to price competition in the retail market as a preferred strategy. The choice to use other marketing strategies including, as in this case, financially leveraging the hospital to gain greater market share is a subset of pharmaceutical company strategies indirectly influencing physician-prescribing behavior as a means to increase profitability.

MAC ultimately therefore has to come down to the question of what is driving the physician to make their choice of PPI in a situation where there is no evidence to support one

medication over another. As mentioned already, pharmaceutical companies are the experts on this state of affairs. We have but to look at the posters, the pamphlets, the pens, the literature displaying their product's name and on and on. Direct to consumer advertising to create brand recognition is increasingly being utilized as a strategy especially in television and internet channels. Company sponsored events for physicians such as learning how to repair hernias (with the company's product) sponsored by the company making a particular brands of mesh, how to insert pacemakers by a company manufacturing one of the pacemaker brands, meetings outlining how certain classes of drugs (invariably their product line) work and the multiple other iterations of techniques to influence physician behavior are readily apparent. One has to but go to the American College of Surgeons meetings and see product demonstrations on a floor space the size of three football fields and multiple inducements being made to understand the scope of this marketing presence. The one glint of light is that these efforts by companies are not devoid of value as there is a wealth of very useful information shared through these channels that undoubtedly does improve patient care.

Most physicians try very hard to resist these types of marketing pressure and would argue they are able to maintain an untainted ability to formulate a decision in the best interest of their patients. It is their fiduciary and professional responsibility – *period*. However, physicians are only human and the resources that are expended on these subtle inducement efforts are always well planned and funded. The volume and success of these efforts are well documented and some might say legendary (Coyle, 2002). One of the cases used at the Richard Ivey School of business at the University of Western Ontario as a demonstration of marketing genius was the suite of strategies used for the introduction of Zantac® (a PPI) to the market (Personal Experience of Author).

At this point one needs to draw back from what might appear to be very high moral ground indeed. Perhaps the auto-substitution is making a deal with the devil but in this instance it could be the devil that gets the short end of the stick. The ability to extract some of the cost savings to reinvest back into products to benefit other consumers is very likely the best one could hope for in this instance. This substitution might be done at the cost of autonomy of the physicians but as long as the studies supporting the equal efficacy of the medication are completely unbiased, perhaps the decision can be framed more positively as support for physician autonomy against incredible market pressure. Rather than decreasing professionalism this proposal could be framed as supporting physician independence.

In summary, it was argued to the MAC by the author that the only answer from all ethical perspectives was to go forward with the auto-substitution policy in a transparent fashion. Should other pharmaceutical companies with products of equal efficacy and retail cost to the consumer make a better deal it should be taken in preference to this one. From a utilitarian, deontological and virtue ethic perspective and from a macro, meso and micro allocation perspective the auto-substitution was advanced as the right thing to do.

Outcome

The rhetoric and opinions at MAC were impressive. It was argued in this particular instance of auto-substitution the vexation was not to the autonomy of either physician or pharmacist, but a united concern with the more global efforts of pharmaceutical companies. It was agreed by the physicians that they needed to both acknowledge and seriously consider these marketing pressures when making these kinds of decisions. The pharmacists who brought forward the studies supporting auto-substitution also acknowledged they were subject to their own set of marketing pressures. It was agreed in this instance the pharmacists' proposal to auto-

substitute was made with careful consideration of the research literature, independent of these same pressures from pharmaceutical companies. In this instance, physicians on MAC and pharmacists united to say this was a line of influence that was crossed and enough was enough.

Ultimately, MAC by a vote of 11-10 defeated the motion for auto-substitution. Their main verbalized justification for this decision was potential mix-up with medications by patients who were on other PPI's at the time of admission. The 'deal with the devil' was of great concern to the MAC. One other interesting suggestion raised at the meeting was concern with the method of payment. Some individuals indicated that had the offer been framed as a reduction in price to \$0.0075 per pill and no rebate rather than \$0.01 per pill plus the rebate this would have been a more palatable position - same dollars but more comfort for physicians! No change in the ethical argument.

Relevance to Other Situations

Allocation Decisions. Very difficult and complex allocation decisions are made each and every day in health care. On a micro level, deciding how to best allocate resources and which patient gets which procedure/intervention at which time is complex. On a meso level, balancing acute health care interventions and preventative strategies is a challenge in an environment where resources are limited. On a macro level, Canadians have difficult choices ahead. Health care spending as a percentage of provincial government spending now consumes almost half the provincial budgets. At the current trajectory of growth within one to two decades it is projected health care spending could make up entire provincial budgets. This trajectory is not sustainable. The relevance of this discussion is the value of transparently exploring these micro, meso and macro issues when considering allocation decisions. Consideration of the variety of ethical frameworks when confronting one of these challenging issues will not directly

provide answers. Rather, proper consideration of ethical perspectives forces decision makers to better frame decisions, consider the multitude of stakeholder views and ask better questions leading to better decisions.

Canadians need to decide as a society what we want our health care system to provide plus what we, as the constituent members of this society, are willing and able to do to make it happen. There are many questions that need to be answered. What is basic health care and what is 'supplemental' health care? Do we as a society wish to continue with a modified egalitarian approach and define a basic basket of services provided to all or do we revert to a libertarian approach and let the market decide? When we consider health, do we consider an all-encompassing definition of health and add to this basic envelope wide ranging services such as access to adequate housing and education? What is the relative value of less expensive preventative health care services compared to the more demanded acute care services? What is the right, sustainable envelope of services? Who decides? Most of health care resources are now devoted to the last short time of life, often proving to be technologically driven and expensive. Is this right? These are all relevant issues and concerns and there has to date been no bureaucratic system that indisputably answers these questions. It certainly does suggest a lot of work ahead for both health care executives and politicians in Canada!

The questions for health care stretch way beyond Canadian borders to even wider questions in our global community. The libertarian argument by pharmaceutical companies wherein it is only by these companies making a 'reasonable' profit whereby society will have introduction of new treatments benefiting the whole of society sometimes runs into a wall of reasonableness. I will concede the current promotion and production of better and more efficacious treatments for male erectile dysfunction (ED) might allow for new and innovative

treatments and as a spin-off save endangered species. (One of the main demands for endangered species is as virility enhancers in some cultures so when Viagra® came on the market the demand for these products markedly diminished.) The question remains whether ED drugs are the class of drug we want to devote this amount of innovative work and resources to. Maybe we should consider other illnesses. Malaria kills many people worldwide. However, given the Western World sees little malaria, economic incentives in the West to innovate novel treatments for this disease are not so great. Innovations in treatment for diseases that are more common in poor economies and cultures are sometimes few and far between.

If health care executives do not consciously and transparently make allocation decisions, big business will. I would argue that it is our collective responsibility to answer allocation questions with the justice perspective advocated by the modified egalitarian model envisioned by Rawls. The fact it is difficult and needs to be done by society at large cannot detract from the correctness of the model. These disadvantages are exponentially outweighed by the basic fairness and justice in providing basic rights for all individuals in society. This includes health. It is difficult for even a hard-line libertarian to argue that the condition in society of a healthy work force to draw on for new ventures, a healthy population not having to turn to crime to survive and a basic overall healthy population does not both increase opportunities to flourish and provide immense advantage. It would be worthless to put resources into a venture and not be able to have healthy workers or a market for products. One might cede to the libertarian philosophy for allowing an additional envelope of services based on an individual's ability to pay *providing* such services do not diminish from provision of a just basic bundle of services for all. It might be suggested such a mixed framework has potential to act as an incentive in the

libertarian mantra - some individuals will strive for greater production and the 'extra' services and in so doing add value to society.

Marketing Pressures. There are other lessons to be learned from this case. This case highlights the effect targeted marketing strategies have on behavior. Pharmaceutical companies and medical equipment companies are highly skilled marketers with substantial resources. Segmenting populations is a marketing fundamental. Populations are segmented along multiple different dimensions and then strategies are individualized for different segments of the market. The strategies classically consider the 4 P's – product, place, position and price. For example, if we segment a market along income in regards to selling cars, the high income market would be offered a different product (Mercedes), price (higher, greater mark-up), position (status) and place (high end dealer in affluent section of town) than we would offer the low income market where we would position a different product (Ford Focus) more in the value dimension at a lower price at a more convenient location. In the case of PPI drugs, pharmaceutical companies have typically segmented the physician workforce by specialty. Those specialties that can influence purchasing decisions for given classes of drugs are courted. One strategy that is popular is to target specialist opinion leaders. In the case of PPI drugs, if the consultant gastroenterologists or general surgeons advocate for a given PPI it is likely more likely local general practitioners referring to them in their communities will adopt this particular brand. Strategies in the past to target these groups (in the experience of the author) have included sponsored attendance at meetings, sponsored national meetings at exotic locations for gastroenterologists and sponsorship of national opinion leaders to make local presentations across the country. The general practitioners were not forgotten, as they would typically receive different inducements that were less expensive but with broader reach – experiences such as

pens, lunches, dinners and perhaps a round of golf of so. Each target group had its own strategic initiative. Recent changes in legislation have limited this extensive marketing to physicians, reflecting how extreme this had become.

Segmentation. The importance of shedding light on marketing to physician groups is to emphasize to those healthcare administrators and policy makers currently chastising segmentation strategies to consider the strength and power these same levers could bring in their environments if they adopt rather than shun such concepts. Segmenting physician populations to strategically encourage adoption of new behaviours by physicians can provide a robust strategy for implementation of change management initiatives. One way to segment physicians would be to divide physicians into four types – the seeker, receptive, traditionalist and pragmatist (Wyszewianski & Green, 2000). Based on Eisenberg's categorization of strategies for changing clinician's practices one could then match these archetypes with either knowledge-oriented or behaviour-oriented interventions (Greco & Eisenberg, 1993). Different strategies would work for different physicians based on these archetypes. Studies such as these also suggest when introducing new initiatives to a health care team one must not only evaluate the team itself but also the participants individually (or at least as defined groups).

Another segmentation strategy that can be used in change management is to segment populations into innovator, early adopter, early majority, late majority and laggard (Kim & Mauborgne, 2003). It is proposed that each of these segments should be offered different interventions when introducing new programs or projects. The innovators, being self-motivated, should not theoretically be devoted a lot of energy. The early adopters are the group that are most receptive to evidence based practice initiatives and not as responsive to marketing efforts. From the manager's perspective, the early adopters, who typically seize on multiple initiatives,

require direction keeping on track usually without demanding a lot of attention. The late majority will eventually 'get there' once the early majority adopts the new strategy. Although laggards are often a lost cause when it comes to change initiatives, major efforts are sometimes needed to keep them from interfering with new projects - it is the frustration of many a manager who ends up unnecessarily devoting huge amounts of time to this laggard group without any progression of the manager's proposed change initiatives. The key to marketing has been managing the early majority. This is the group for whom strong leadership is essential. The greatest management challenge represents the transition of initiatives from the early adopters (who are usually building on the work of often unpublished innovators) to the early majority. It has been suggested that by facilitating crossing this chasm between early adopters and early majority, the implementation of new interventions, processes and protocols will look after themselves. This is the concept of tipping point leadership made popular in the lay press recently (Gladwell, 2000).

Leadership for the physician community in managing this tipping point transition historically has been characterized as 'heroic' reflecting both the tendency to have an expert lead a group and the nature of physician education/training (Arond-Thomas, 2004). The effort in this environment is to enlist physician champions to advance causes. Pharmaceutical companies, as mentioned previously, have consistently exploited this tendency to rely on experts by offering inducements to physician leaders in a community and making extensive use of academic detailing. The challenge with the heroic leadership style of physician leadership is that it is not conducive to development of inter-professional teams, important cornerstones for the current highly networked health care environment. In order to facilitate better standardization of initiatives there must be opportunities to promote 'post heroic' leadership where, by working

with a group, a shared vision is created of what the group wants to become. Leadership in such an environment requires alignment, persuasion, coaching and feedback without micromanaging. It will be the challenge in health care moving forward to develop this new kind of physician leader.

Ethics Case 2: A Tale of Two Hospitals

Management Issue Being Considered

The logic plan underlying this case relates to effective engagement of physicians in managing system problems. How do we ensure that physician participation (outputs) can be translated into physician ownership of issues and challenges moving forward (outcomes)? While it might seem logical that physicians would be expected to make decisions based on what is good for an entire population their underlying ethic is a fiduciary responsibility to individual patients. One must consider this basic orientation in order to engage physicians or, as a second best alternative, lessen physician interference in advancing strategies that best serve needs of entire populations.

Case Presentation

This case benefits from description of context first. Two communities separated by 50 kilometers within the same integrated health region are the setting for this case. The two communities had been fierce economic competitors over many years reflecting their natural resource based economies. Given their geographic isolation, survival in the past had often required intense community engagement. This isolation had been gradually addressed, first with an upgraded road to the southern community and, more recently, an upgraded road between the two communities. Roads further north of the northernmost of the two communities remained less than ideal leaving a challenge to service the more rural, predominately aboriginal

communities in this area especially during times of inclement weather, a not infrequent occurrence.

Both communities had about the same population for most of their history. A decade ago each had a population of around 40,000 inhabitants. There had been recent accelerated growth in the southernmost community related to development of a significant tourism industry. Associated with the tourism industry was a significant increase in the number of people moving to this southernmost community to retire, further fueling development leaving the southern community now with about 10,000 more people than their northern neighbor. The population forecast acknowledged both communities would continue to grow significantly in the future, but the growth of the southernmost community was expected to far surpass that of the northernmost with further divergence in size.

Both communities had hospitals that were approaching their physical end of life and either required substantial renovations or replacement. The hospital in the northernmost community had 60 allocated beds but typically managed a census of 80 reflecting a high cohort of alternate level of care patients. The southernmost community hospital had 110 allocated beds and usually managed within this bed base. The southern hospital had a different governance model than the northern as it was a faith based institution.

The medical staffs in each site had some common services and some unique services. The majority of the medical staff at both sites was family practitioners with roughly the same number of family practitioners (about 50) at both sites. Specialist services at the southern community included general internists (4), general surgeons (3), orthopedic surgeons (3), urologists (3), ophthalmologists (2), otolaryngologists (2), obstetricians (3), pediatricians (2), radiologists (2), pathologists (2) and psychiatrists (mostly outpatient coverage but in conjunction

with several general practitioners with extra skills this group managed 20 regional psychiatric beds in the facility). Three fellowship anesthesiologists provided anesthesia service in the southern community. At the northern hospital there was a specialist staff that included general internists (4), general surgeons (3), orthopedic surgeons (3), plastic surgeons (2), pathologists (2), radiologists (3), one obstetrician and one pediatrician. Three GP anesthesiologists provided anesthesia services at the northern hospital. Both sites had emergency departments staffed mainly by general practitioners with additional certification in emergency medicine.

Some services shared coverage of both sites. The general surgeons and orthopedic surgeons had taken to sharing call between the two sites so that on any given day there was only one site with a general surgeon and one site with an orthopedic surgeon on call (not coordinated between services). The surgeons themselves did not travel between sites meaning patients requiring their care would be transferred to the site with the specialist on call. The southern community provided all call coverage for ophthalmology, otolaryngology, urology and psychiatry. Plastic surgeons provided the bulk of their call coverage from the northern community but did occasionally provide on site coverage for the southern community. The rest of the groups did their own call at their own site. There were gaps in call coverage at both sites reflecting the un-willingness of practitioners to consistently provide greater than one-in-five call coverage.

These call arrangements did create concern. There were times when, because of manpower availability, there were unplanned days without internal medicine coverage at one or the other hospital. There had been instances when, for example, surgery and orthopedic coverage would be provided at a hospital in the absence of general internal medicine coverage in spite of internal medicine coverage at the uncovered site. The anesthesiologists at the southern

community expressed concerns regarding absence of a fellowship anesthesiologist in the northern community in regards to quality control. These are but examples of ongoing concern and rhetoric expressed by both sites of potential future challenges with quality of care. Both communities already cited 'near misses' though there had not been any significant issues of significant quality of care concerns documented at the time of this case.

The major alternative location for services when not available in one of the two communities was a regional center one hundred kilometers south of the southernmost community that provided complete call coverage for all disciplines provided in these communities. This referral community, although larger, did not provide additional services to the menu available between the two sites. Specifically, internal medicine subspecialties including cardiology and respirology were not available. Neurosurgery coverage was not available. All tertiary services were another two hours south of this regional center - three hours by vehicle south of the southernmost community. The practical reality of the physician communities was minimal referral between the two sites and very little utilization of the regional facility. Services not being provided locally at one of the two local hospitals were predominately accessed at the tertiary hospital over three hours away.

Given the realities of deteriorating physical facilities, increasing difficulty recruiting nursing and professional staffs and a non-cohesive medical staff environment fragmented by sporadic coverage, a consulting firm was engaged by the governing body to best determine options and provide direction on the best way to provide care for this population. This consultant group, after extensive consultation, determined the best option moving forward was a single shared hospital to replace both hospitals with enhanced primary care facilities in each of the two communities.

The consulting group did not address capital funding for such a proposal, a major issue given the nature of capital funding for health care projects in this region. Although the governing body (mentioned above) was responsible for bringing forward proposals for capital projects, they did not have funding authority for major capital projects such as this. All capital projects required agreement by the hospital district board given they were responsible, via direct taxation of the population, for 40% of required funding. The reality of the hospital district board was the southernmost community carried the vote on financial issues (proportional voting was in the bylaws for financial motions) but the northernmost community carried the day on all other votes (single member had a single vote). Without support by the hospital district board, there was no funding to move any major project forward. The provincial government was responsible for the remaining 60% of funding from general tax revenues.

This shared hospital proposal was brought to the hospital district board for approval in principle. The board approved the concept as they understood the value of a larger shared site with more services. Both medical staffs and both communities approved this concept. Then the trouble started! The ‘fly in the ointment’ became a difference of opinion as to what both communities had agreed to. Both had made assumptions. It seemed obvious to the southernmost community that any shared hospital needed to be located in their community given their larger size and future projected growth. The northernmost community thought it obvious a shared hospital would be in their community given the southern hospital was closer to a regional center and the northernmost site served the more rural and remote populations. Although there was some support in both communities for a hospital mid-way between both communities, this support was inconsistent given an inherent weakness of the proposal defining what services would remain in each community with a new build.

The proposed solution by the hospital district board to address the lack of consensus was to form a committee composed of two physicians from each community. Other stakeholders and health professionals had not been asked to participate on this committee. The board expected physicians would be able to put aside individual differences and biases to advocate for what would be best for the population. (Really!) Their expectation was the physicians would act as impartial arbitrators. This was not the case as the physicians demonstrated a highly confrontational approach, serving to only further polarize the debate. Although all physicians in both communities agreed there were benefits to a shared hospital they were unable to even start a dialogue to look towards compromises and workable solutions. Both medical staffs became outspoken advocates for a shared hospital located in their individual communities, adding to the developing solitudes. (There were also political realities beyond the scope of this paper which further muddied the waters.)

The debate as to location overwhelmed all other considerations leading to increasing polarization of both communities. The governing body eventually weighed in to the debate proposing a mid-way site; the chosen site, while between the two communities, was nearer the southernmost community. Development of strong advocacy groups in both communities but most especially in the northern (the perceived loser in this proposal) followed. Eventually, after much fractious public debate, the hospital district board withdrew their support for this proposal.

The question at this stage was how, when and where to move forward. Both communities desperately needed better facilities. This need had escalated as, in the process of working towards this shared hospital concept, maintenance at both facilities had decreased to a very basic level awaiting the more comprehensive solution - throwing good money after bad it was said! There were continuing concerns with gaps in the provision of care for both

communities, more public now that this issue had been so vigorously debated. The physicians had previously demonstrated in other venues and this debate an ability to influence direction taken by the politicians but expressed distrust and unwillingness to address the needs of the communities in a collaborative manner. It was clear to all that any efforts to move forward in the future would be significantly impacted by this very sharp polarization of the two communities.

Ethical Principles Involved

The question in this case is how all stakeholders could best work together to optimally provide health care to the individuals in the communities they served. How individuals work together to form a society has long been of interest to philosophers. The dominant view shaping much of western society is the social contract theory. Threads of this theory have existed throughout ethical writings since the dawn of philosophy. Plato's description of Socrates' rationalization to Crito why he had no choice but to stay in prison and accept the death penalty is a reflection of this principle (Jones, 2008). However, it was Thomas Hobbes (Hobbes, 2009) who first espoused and advanced the theory more formally. John Locke (Locke & Sigmund, 2005) and Jean-Jacques Rousseau (Rousseau, 2007) were also prominent philosophers influencing development of this contractarian theory.

Hobbes. In its simplest form the social contract theory argues that in society an individual's moral obligations depend upon a contract or agreement between all individuals who collectively form society. Since all men (these philosophers did not consider women to be part of society) are made by nature to be equals, no one has a natural right to govern others. The only justified authority is the authority that is generated out of agreements or covenants. This social contract theory and its political implications have been extremely influential over the course of time. It has been suggested Locke's argument for the social contract and for the right of citizens

to revolt against their king was enormously influential for the democratic revolutions that followed, especially for Thomas Jefferson, and the founders of the United States.

The social contract theory evolves from two major premises. The first is that humans are, by their basic nature, exclusively self-interested. By this very immutable nature of humans they will be drawn to what they perceive to be in their best interest. Humans, as a basic, universal component of their being, should have an infinite desire to maximally satisfy their wants without concern for the wants and needs of others. The second premise for this theory is that human beings have the ability to reason. Given humans can reason, they would be expected to have the capacity to pursue their desires as efficiently and maximally as possible. While the end goal remains self-interest, rationality is the prime instrument or means to achieve this goal.

Thomas Hobbes imagined what life for self-interested humans would be like in the absence of society, a situation he referred to as the State of Nature. Hobbes suggested that in a State of Nature with limited resources and relative equality amongst individuals, the absence of cooperation between individuals would be unbearable. Every person would be constantly in fear for their own life as other self-interested individuals maximized their wants. This state of distrust would make it rationally impossible for any given individual to fulfill their own wants, needs and desires. There would be a state of perpetual war that would not work towards anyone's advantage. Hobbes argued the rational nature of humans would lead them to willingly submit themselves to political authority. For Hobbes, this was a willingness to submit to the authority of a Sovereign in exchange for a civil society in which members of the society could pursue their own individual self-interest. According to Hobbes, the social contract thus formed has two components. The first is that members of the society will collectively and reciprocally renounce their rights against one another as exist in the State of Nature. Secondly, members

would imbue one person or assembly of persons with the authority and power to enforce this mutual contract. Hobbes' particular argument supported an absolute monarch, accepting that even though the potential for absolute authority can be harsh it would be better than living in an intolerable State of Nature.

Locke. John Locke agreed with the premises of Hobbes in regards to self-interest and rationality but had a much different view of the State of Nature. Locke agreed with Hobbes that the State of Nature is pre-political but argued it is not pre-moral by suggesting there is also a Law of Nature. Locke believed God gave all man the Law of Nature and, as we all belong equally to God, we cannot take away what is rightfully His. Consequently we would be prohibited in the State of Nature to harm one another. This in turn implies that although there would be no civil authority in the State of Nature, it would not be a state without morality. Locke theorized this State of Nature would be a state of perfect and complete liberty to pursue one's self interest as long as there was no harm to other individuals in the same state. However, the absence of civil authority in such a state remained problematic for Locke. If one individual were to steal from another, the Law of Nature would allow this individual to defend himself and this 'harmed' individual may kill another individual. Once this chain of events began it would be iterative and endless. This becomes the reason why rational individuals would abhor the State of Nature. It also explains why property management plays such a pivotal role in the civil authority envisioned by Locke. Locke suggested that in search of property management, individuals hand over power to government agreeing to become subject to the will of the majority in exchange for laws, judges to adjudicate laws and executive power to enforce these laws. Unlike Hobbes who believed there was no turning back from the authority of a Sovereign,

Locke felt that if government did not keep its part of this compact, individuals had the right to return to the State of Nature as a means to construct a better civil government.

Rousseau. Like Locke, Rousseau agreed it is need for property rights that leads to development of civil governments. Private property according to Rousseau was the ‘fall from grace’ from the State of Nature where greed and inequality of ownership lead to development of social classes. Although civil government is established to protect the rights of all, in reality it protects those who already have property thus supporting inequality rather than promoting equality. Rousseau viewed this ‘naturalized’ social contract as responsible for the conflict and competition from which modern society suffers. Rousseau proposed individuals revisit this social contract to ensure we can be free and live together without succumbing to the force and coercion of others. Rousseau maintained we could do this by submitting individual wills to the collective will through agreement with other free and equal persons to form a social pact that would be greater than the sum of its parts. The compact must be committed to the good of all constituents. Individuals are required to conform to the general will; they must be “forced to be free”. For Rousseau, this implied an extremely strong and direct form of democracy as the general will depends on the coming together periodically of the entire democratic body. One implication for Rousseau was the strong form of democracy consistent with the general will is only possible in relatively small states. People must be able to identify with one another, and at least know who each other are. They cannot live in a large area, too spread out to come together regularly, and they cannot live in such different geographic circumstances as to be unable to be united under common laws. Although the conditions for true democracy are stringent, they are also the only means by which we can, according to Rousseau, save ourselves, and regain the freedom to which we are naturally entitled. The implication from this argument is that

populations of 150 to 200 are natural for human beings meaning when populations get larger than this there is a tendency to break off into parts. It is interesting to note in this case each of the two extended physician communities was near the size idealized by Rousseau while the combined staffs exceeded what Rousseau considered reasonable both by numbers and geographic realities.

Discussion

Three issues arising from this case will be highlighted – physician associative behavior, social contracts and health. The first is the behavior of the physicians. The district hospital board had expected a panel of physicians from both communities would provide unbiased direction as to what would collectively be best for the two communities. Both physician communities had supported the concept of a regional hospital. Both expressed concerns about the ability to provide comprehensive care in either community because of difficulties attracting and supporting adequate physician and nursing staffs. There was some surprise by the district hospital board when such a panel was not able to even discuss, let alone advance, alternatives or, as desired, a workable model. The political subterfuge by physicians of plans to move forward with one shared hospital was also puzzling to the governing body proposing the single facility. The second issue warranting consideration is the question of social contracts. What are the principles for both communities either working together as one entity for their populations or maintaining distinct communities with greater independence by possibly less combined care? The third issue is around the concept of health itself. Great emphasis was placed by both communities on the need for acute care facilities with all the new toys and whistles to ensure the ‘health’ of each community was preserved. Deliberating on what is most important for health

was ignored in favor of concentrating on more visible symbols - the bricks and mortar of health care provision.

Physician Ethical Tensions. Changes in health care over the last fifty years have significantly impacted physician behavior (Cruess & Cruess, 2000; "Medical professionalism in the new millennium: a physician charter," 2002; Sullivan, 2000). Better understanding of ethical dilemmas arising from this changing environment is invaluable in both understanding and influencing physician behavior as it relates to adoption of standardized protocols. The ethics of physicians since the time of Hippocrates has been that of a fiduciary relationship – advocating and supporting one patient at a time. This behavior is imbedded in the Hippocratic Oath that in some form is still very often verbalized by graduating physicians today. The responsibility of a physician is to ensure the patient they are honored to care for receives the best care possible. This is not unlike the role of a lawyer in advocating for the rights of their clients. The utilitarian ethic this implies meshed well with the societal ‘virtue’ ethic prevailing since Thomas Aquinas re-introduced the world to Aristotle in the thirteenth century. Good providers provide good care. Together, the physician and patient should work towards maximizing happiness of the patient for maximal utilitarian outcome measured as ‘happiness’ since this is what makes both patients and, consequentially, physicians happy.

Utilitarianism is the teleological (measured at the end) ethic that would suggest ‘right’ is that which creates the greatest happiness. We should call an act right if it creates the most happiness – a ‘white lie’ is therefore completely acceptable. Alternatively a deontological ethic (best outlined in the writing of Kant) suggests ‘right’ is measured by universality. Right acts are those that one would will to become a universal law – one should never accept a ‘white lie’ as a situation where lies are always right would be untenable. It is the clash of these two ethical

perspectives and the clash between the needs of an individual and a population that create the greatest ethical dilemmas for physicians.

Over the past century there has been a paradigm change in the prevailing health care ethic towards a duty based (deontological) ethic that places great emphasis on principles - beneficence, non-maleficence, autonomy and justice - for both individuals and, increasingly, populations. In the medical field, the writings by Beauchamp and Childress have explored this in some detail (Beauchamp & Childress, 2008). Physician-patient relationships over the last half-century have demonstrated a decrease in paternalism creating an increasing 'challenge' from the physician perspective to balance what a physician 'knows' is best for the patient and what the patient 'wants' (if and when there might be a conflict). Physicians are increasingly, and with some distress, being asked not only to ensure that the patient in front of them has optimal care but simultaneously to ensure fair population access to limited resources by acting as gatekeepers to an increasingly expensive technological environment of scarcity. When lawyers are asked to leave their fiduciary advocacy role they become judges – physicians do not have the same luxury of changing hats. A legal environment that continues to demand primacy to the fiduciary responsibility for physicians magnifies this picture of existential conflict.

From a societal perspective, the issue becomes one of resource allocation. As new technologies develop we see an increasing (apparently insatiable) demand often outstripping society's ability to provide. This is reflected by increasing wait times for limited resources. The question becomes how to allocate resources not just for individuals but, more importantly, to prevent implosion of the system for the entire society. Equality for everyone (egalitarianism) versus rule oriented distribution (libertarianism) and rights versus obligations become topics of hot debate. Conflicts arise. What is the right balance between advocating for individual patients

and advocating for the rights of an entire population? Should our one patient get their tenth CT scan accepting there is a very slight chance something was missed on an earlier scan or should someone else (not our patient) get their first? Codes of ethics equally stress both the importance of the well being of an individual patient and the importance of looking after the whole of society. Rather than providing direction when there are ethical conflicts, these codes support both sides of the debate equally. This means these codes are usually not helpful in managing conflicts that inevitably arise in allocation decisions when different principles clash or the needs of the population and the individual are at odds. The codes in fact can lead to greater polarization as tools to capture the moral high ground in conflict situations.

One way to better characterize this struggle is to construct a two-by-two diagram. On one axis we can consider the two major competing ethical perspectives – deontological versus virtue/utilitarian. On the other axis will be whether one is considering applying the ethical framework to an individual or a population. Each of the four resulting approaches can be characterized in the diagram. The following paradigm of conflict exists:

	Utilitarian/Virtue (Outcomes Based)	Deontological (Duty Based)
Individual	Hippocratic	Respect for Persons
Population	Social Utility	Social Justice

In this framework, physicians classically have been positioned in the upper left box reflecting their fiduciary relationship to their patients. It might be suggested the elected officials

(funding agencies) are motivated towards the bottom left box – maximum outcome for a population usually means the best chance of getting elected. The challenge with this box reflects a reality that the way to maximize outcome for a large group is to significantly disadvantage a small minority group. The media would likely be best represented in the top right hand corner. The challenge here is that the way to optimize this sphere is to limit what is provided to only those things that can be provided to all. Further, the challenge is that if one, for example, develops a policy which results in avoidance to ten of a potential bad outcome while at the same time directly creating a negative outcome to one (net happiness of $10 - 1 = 9$), since we cannot identify the ten who did better (nothing bad happened) and can easily identify the one having a negative outcome the policy is doomed to failure. This is a reflection of the power narratives and stories are given in health care communication. It has been said health care communication is the slave of the anecdote. Although a powerful communication tool, this communication style can be a significant impediment to introduction of evidence based protocols and initiatives that are more population than individual based. One can only look to see how many immunization programs that support population health are significantly weakened because of media reports of unusual individual side effects (Schonberger et al., 1979). We have no way to measure and identify individuals who were prevented a bad outcome because of an immunization policy so when bad outcomes are identified we do not have the patient narrative of the patient nothing happened to.

It should be the goal of all health care leaders, especially physicians, to ensure that we all strive together to be where we need to be – the bottom right - social justice. The challenge is the multitude of ethical frameworks involved in the transition to this framework for physicians. When considering asking physicians to provide principle based direction on distribution of

resources to a population, one must consider the multitude of demands placed on the physicians in a very complex health care environment by those advocating for social utility (government) and those advocating for rights of individuals (media). Appealing to ‘professionalism’ as a reason for physicians to participate in these difficult decisions does not recognize the paradigm change involved when fiduciary responsibilities conflict with managing needs for a population. The other challenge is that professionalism, if not the classical fiduciary physician-patient relationship, is not clearly defined leading to a great deal of ambiguity. Appealing to professionalism and ethics to advance physician participation in population initiatives, while a powerful strategy, must therefore be respectful of a wide view when utilized. It often is not.

The physicians in the case before us were challenged to provide a social justice solution for a population without the resources or skills to manage such a task. They had little support and were placed in a media circus without coaching or alternative strategies available to them. Their decision of choosing to continue to advocate for individual patients they saw on a daily basis is not unexpected in a situation such as presented in this case. This should not have been unexpected. While there is no doubt physicians need to be important partners, initiatives such as this cannot be led by physicians. An agency with the political will and resources is required to make these difficult trade-off decisions given there will never be complete consensus. This is what Locke, Hobbes and Rousseau all considered when they identified the need for a governing mechanism to manage such conflicts. While physicians need to be a prominent stakeholder group, the philosophers would argue that any future discussions should *not* look to this group for a final determination or solution. Look to politicians. These are property rights.

Social Contract. So let’s imagine we go forward and identify political leadership. The social contract theory implies members of society must permit some individuality be ceded to a

governing agency for the good of society. The question becomes how does one get the physician group to cede to a leader and who should that leader be? It has been suggested at times physicians behave more like tribes than respectful colleagues. This may reflect the nature of physician development wherein physicians are trained as experts. This leads to a strong individualism that is often difficult to incorporate into multi-disciplinary teams. It is the nature of healthcare that the medical staff as a negative force is a powerful impediment to instituting changes. It is the usually disorganized, impotent, reactive nature of medical staff who have a tendency to come together only in response to perceived threats that make it so difficult to develop a positive medical staff force (Bujak, 2003).

Attracting representative physician leadership is often a challenge. Though physicians often decry a lack of physician leadership they at the same time tend to ostracize those that take on administrative positions. It has been suggested that this dichotomous behavior reflects social science research that people make sense of 'who they are' based on similarities to groups to which they belong and differences to groups they do not belong (O'Connor, Fiol, & Guthrie, 2006). It is the very effort to integrate physicians into the administrative group and the potential threat to the uniqueness of the physician group that is felt to lead to defensive reactions of turfism and tribalism that is often seen in medical leadership and was exhibited in this case.

There have been three prototypical ethical cultures described in health care organizations (Chervenak & McCullough, 2007). Gregorian organizational culture is built on fiduciary responsibility and professionalism. Cooperation by physicians with administration in this model is a matter of obligation and may be easier to marshal. Hoffmannian organizational culture on the other hand is built on the virtue of prudence so that physicians will cooperate with administration when it is in their mutual interest. This culture may be more receptive to uptake

of evidence informed standards. Hobessian organizational culture fits with the social contract model described above and is based on individual self-interest. In this model physician leaders will cooperate reluctantly and only when their short-term and long-term interests are protected and promoted. The Hobessian model is likely most representative of the existing environmental culture in this case. Cooperation by physicians in all these models remains predicated on the interface between individual physician ethics and that of the group they are part of giving rise to a number of dilemmas that have the potential to interfere with physician co-operation with administration.

Locke and Rousseau would most likely characterize the current situation as a return to the Natural State in need of a new social contract. In order for a new social contract to emerge, emphasis must be removed from dissecting the past towards a new paradigm emphasizing quality of care in a new environment (Reinertsen, Gosfield, Rupp, & Whittington, 2007). Any solution must incorporate all stakeholders working towards a solution accepting, as for all social contracts, there must be a governing group who are enabled and empowered to make a decision for the good of the entire population.

Provision of acute health care services for a diverse, widely distributed population is multi-faceted and difficult. While it is not the intent of this paper to consider literature supporting a decision to centralize aspects of care such as surgical services and intensive care services it is worth a couple of points to characterize the issue. There is always a tenuous balance between access and quality of care. Any access is usually better than no access. However, for many complex surgical procedures such as removing the pancreas or vascular surgery, there is evidence that individuals will have better outcomes in larger centers (Urbach, Bell, & Austin, 2003). The question becomes when and where to centralize some services while

at the same time providing the bulk of services closer to home to take advantage of the entirety of what constitutes good health. When one considers centralization of services superficially, centralization does adhere to the principles of social contract - individuals give up their desire to provide care close to home and any incentives associated with such provision in exchange for the greater overall collective good of patients in society. The challenge is that incentives are not always properly aligned for such a noble concept. There are misaligned desires of physicians and patients about who gives up what. From the physician perspective, it will always be more convenient for patients to come to them while the patients would prefer the physicians to come to them. There are also misaligned financial incentives working against a centralized model. Even the changing generational culture of caregivers works against this cooperation as we witness the end of the workaholic Baby Boomer caregiver towards caregivers that are more interested in work life balance (Howe & Strauss, 2007). The physicians of Generation X, Y and Millennium are no longer willing to provide emergent services beyond a certain level of commitment. These are but a few of the multiple factors requiring, at minimum, consideration and, ideally, alignment in this case. However, to bring about lasting change, there is no choice but to systematically consider them all in developing engagement strategies.

What Makes a Healthy Community? Another challenge in this debate was an underlying sentiment of stakeholders that health would suffer in the absence of the newest facilities and technologies as close to home as possible. The sentiment was that quality of health care in a community is reflected by the size and grandeur of bricks and mortar facilities for provision of acute care. Attempts to shift the debate towards discussion of improved outpatient care, improved housing and improved preventative care in both communities was dismissed.

Availability of acute care services was felt by the public to be the major indicator of quality of health care. What was lost in the whole debate was what health really is.

Health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" by the World Health Organization (World Health Organization. [from old catalog], 1948). In 1986, Health and Welfare Canada suggested 'health' ceases to be measurable strictly in terms of illness and death suggesting "It (health) becomes a state which individuals and communities alike strive to achieve, maintain or regain, and not something that comes about merely as a result of treating and curing illnesses and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments" (Health-Canada, 1986). Health is contextual. If an individual has a limp caused by a leg length discrepancy and their goal in life is to be a great scientist they would most likely consider themselves (in the absence of other aberrant variables) healthy. However, if their goal in life is to be a successful marathon runner like their father and brother, they would more than likely consider themselves not to be healthy because this limp that plays no role in a desire to be a scientist now becomes limiting. In this instance, they could become 'healthy' again either by changing current reality (such as surgery for this orthopedic problem) or changing goals (perhaps back to being a scientist).

Health is determined along four axes – physical, mental, social and spiritual. Where one fits on these axes varies not only from year to year but often from minute to minute. Which axes would be considered by an individual as being primary at any given time varies. There is often a complex interplay of perspectives beyond individuals to the wider social networks in which they define themselves. Considering the previous example, it is not only the physical impairment to consider but also the social circumstances (what my father and brother did), mental

circumstances (anxiety placed by not running) and the spiritual circumstances (how being a runner defines my path through life). Where along these axes one defines a state of health relates to the perspective of the observer. There is usually greater consensus about what constitutes poor health than about what constitutes good health since we have a tendency to compare to an ideal rather than to an average. For obvious 'diseases' such as pneumonia or broken bones, there would likely be great consensus about the state of poor health. In the example I gave above, the definition of health would likely be equivalent for an external observer who was aware of the subject's life goals. However, others might argue either the subject was not healthy when he/she thought they were (the limp and the scientist) or that they were healthy when they thought they were not (the limp and the marathon aspirations).

Health can be examined and defined both from an individual and population perspective. Within a population, individual health is often determined by the society's cultural values. What is considered unhealthy in one society may be considered healthy in another. With increasing globalization, imposition of values from outside cultures presents a significant destabilizing force on cultures that previously defined themselves as healthy but are now redefining their health on external metrics. Although intuitively one might consider a healthy population to be composed of individuals who consider themselves healthy this may not always be the case. A good example of this would be the Jim Jones cult who committed mass suicide several years ago in South America (Wikipedia, 2010). One would suspect that if the individuals in the cult had been polled on their individual state of health they would have responded positively from all four perspectives. From a population basis however there would be real concerns about the status especially of the mental and spiritual health of this community. Where and how and whether

these external metrics need to be considered will continue to add great uncertainty as society moves towards a global community.

In this case both communities placed great emphasis on acute care hospitals in their definition of health status. Both communities felt not being able to offer a full complement of secondary services would have serious repercussions on the health of their community. This is a paradigm all agreed would need to be addressed in considering the path forward.

Outcome

Once the Regional Hospital District withdrew their support for the single regional facility, the furor in the local media took an expected burst of blaming all involved. With time this slowly settled. There were several significant changes in the environment over the next few months. There was a local election that included a change in members of the hospital district board. Sadly, there was also an economic downturn in the northernmost of the two communities when a large employer in the community chose to leave the community with significant economic consequences. This all occurred in the midst of a global economic slowdown.

The governing body examined the considerable feedback arising from this process. One of the major deficiencies identified was poor to non-existent definition of what services were to remain in both communities if a shared hospital went forward. It also became apparent that although a shared hospital mid-way between the two communities would be of great value to the specialist physicians it would not be valuable for general practitioners who had less need to centralize in developing critical masses need for recruitment. With the hospitals continuing to deteriorate the need for change was becoming increasingly acute. Relating to the change in the economy, the need for the economic stimulus any new building would bring for both communities also became an important driver for compromise. The choice was made by the

governing body to re-engage the new recently elected district hospital board and promote future development as their responsibility.

A new strategy was developed proposing new facilities in each of the two communities. The new facilities were designed to serve the primary care needs of the vast majority of the communities. Greater emphasis was placed on the wider spectrum of health. In the southernmost community the plan was to offer a wider breadth of expanded regional services while at the same time maintaining existing secondary services in the northern community. The plan was for both bricks and mortar facilities to be flexible, facilitating future accommodation for changing demand over time. It was expected that time and the changing nature of health care would determine the ultimate distribution of health care services. There was also a commitment to establish a combined quality assurance process shared between both sites to ensure quality of service would not only be safeguarded but also enhanced. It was agreed future decisions relating to allocation of resources would depend on a quality rather than a political lens. An outcome of this proposal was agreement by the medical staffs of both communities to form one combined professional and medical staff (could it be each expected the combined quality review would demonstrate their superiority?).

This plan was presented to the medical staffs at both sites. Not unexpectedly both rejected the plan in public forums although quiet conversations with key stakeholders indicated a willingness to develop a workable compromise. The proposal was taken back to the hospital district board and, after further negotiation, a plan with new facilities in each community was agreed to. There was little involvement of either physician or nursing staffs in the process as the goal at this point was not engagement but rather the wish for non-interference. It was clearly communicated to these professional groups that, while their feedback was very important and

valuable in informing a decision, this was not a decision they could or should make. There was not the outcry and mobilization of opposition following the announcement on this occasion. The plan at the time of the writing of this case was before the government looking for their share of funding for the project.

Relevance to Other Situations

Medical care professionals, including both physicians and nurses, have been trained to be fiercely independent with fiduciary responsibility to the patients they serve. The expectations for health care professionals to selflessly devote themselves to a calling are changing for both society and newly minted physicians and nurses themselves. The health care ethic will evolve over time and during this time of evolution there will be challenges as all stakeholders, including physicians, nurses, paraprofessionals and society, collectively redefine relationships. A different skill set is required with a different kind of leadership. Integral to this new leadership will be strong inter-professional teams that work towards the good of an entire population.

In these complex environments physicians no longer enjoy the same leadership role they once held. Although they may no longer always be captain of the huge vessel health care has become they still have a vital role as a team member, a leader for quality and advocates for patient care. Physicians still need to be part of the health care leadership team. To build on the old metaphor, perhaps though they still are captains of the ship they cannot navigate the current uncharted waters in the absence and support of other team members and they are not necessarily admirals of the fleet!

Individuals working within health care need to give up self-maximizing behavior for the greater good of society as without controlling current exponential growth, the health care system, as we know it, will collapse. The uncontrolled demand for provision for maximal health care

services for each and every individual cannot be supported by a public system. In order to facilitate such a change, greater emphasis must be placed on the broader dimension of health including the importance of preventative health care and the social determinants of health. These discussions will require input from the whole of society to determine what basket of services we can collectively provide to the population. The resulting social contract with potential limits to self-interest will be essential to move forward the health care debate in the future.

Finally, in regards to leadership, it will be important to have strong central political leadership to advance whatever changes are required. It is unlikely the ‘Natural State’ described by the philosophers of old is where we want to be whether it be amoral or not. We cannot rely on individual stakeholders to make the major decisions ahead that have to be made. Rather, it must be the role of the governing bodies to make the tough decisions that must be made for the good of society.

Ethics Case 3: No Bloody Way!

Management Issue Being Considered

Health care operates in and depends upon an environment where individuals give up rights and control of their own person for periods of time to a member(s) of a care team entrusted to provide them care. Establishing true consent in such a care environment is therefore an important issue and a critical enabler for development of healing relationships. The nature, timing and scope of this (usually temporary) abrogation of rights become imbedded in the consent process. The primary question facing both health care providers establishing consent and those involved in retrospective analysis of adequacy of consent (when things do not go as planned) revolves around what constitutes real and valid consent. Questions as to who is responsible for both obtaining and documenting consent are major issues in not only the ethical

sphere but also in legal circles. The issues involved in this case are those around processes that reflect true valid consent. The secondary consideration for this case reflects on the more global issue of relationships amongst caregiver teams revolving around power and control that often form the subtext for discussions such as seen in the specifics of this case.

Case Presentation

The Chief of Surgery at a community hospital had been tasked with managing a significant conflict between members of his Department and the nursing staffs relating to concerns with the consent process at his hospital. A couple of years prior to the specifics of this case, management at the hospital had instituted a Pre-admission Clinic (PAC) to facilitate flow of patients and provide better peri-operative care for patients. The rationale for the PAC was that assessing patients in a standardized manner prior to their surgical procedure would facilitate improved coordination of pre-operative investigations and better education of patients in regards to their surgical journey. The need for a PAC had become especially important given most patients were being admitted the morning of surgery in an environment of wait times for surgery with potential significant time lags between the decision to undergo a surgical procedure and the provision of said procedure. Surgeons and the management team had agreed the PAC had been an excellent initiative and there was consensus that institution of the PAC had, within a very short time of its implementation, led to better prepared patients and fewer cancellations on the morning of surgery, realities that had been very trying for patients and surgeons alike.

The challenge the PAC magnified to the forefront was the existing method for obtaining surgical consent. To be clear, the challenge with surgical consent was a long standing issue at the hospital that had never been formally addressed to the satisfaction of all. The PAC adoption appeared to have brought this smoldering issue to a boil. The surgeons' point of view was that

they were conducting 'appropriate' conversations with patients in their office about risks and benefits of surgical procedures being proposed. For them, this discussion served as consent for the entire surgical experience. They felt they owned this process and were solely responsible for the process itself. In spite of this voiced ownership, they did not feel they were responsible for documentation of this consent process as they felt the need to provide such a witnessed, formal document was the responsibility of the hospital. The only documentation of the surgeon's consent discussion would be sometimes found in the admission history that was submitted with the surgical booking card to the hospital. The surgeons' expectation was for the nursing staff in the hospital to get the patient to sign the documentation which the hospital mandated prior to the surgical intervention. They did not expect any further conversations as they felt they were assuming all legal liability that might arise with concerns over consent.

The nursing staff in PAC, on the other hand, were very concerned that not all patients, from their perspective, had an understanding of what surgical procedure was being proposed and, of most concern, what the risks involved with the procedure were. The nursing staff and hospital felt they had significant liability if patients were signing consents without the requisite understanding of risks and benefits. The nurses did enter into conversations with the patients about the nature of surgical procedures being proposed and risks as they understood them to be based not only on the history and booking card but also on their professional training. As might be imagined with such tenuous and strained communication channels, patients were at times alarmed when the description of the procedure and risks being provided by the nursing staff at the time of the PAC consent discussion did not align with what they heard (or thought they heard) from their surgeon.

This state of affairs created significant confusion and anxiety for patients let alone stress for both surgeons and nursing staffs. The surgeons felt that the nursing staff should 'follow orders' and get the required signature without conversation. They should trust the surgeons better. The nursing staff felt the surgeons needed to take greater responsibility in documenting (let alone obtaining) consent. There was concern by the nursing staff that many times patients did not appear to understand what had been discussed at the time of the initial consent discussion with the surgeons. Patients, at times, had unanswered questions about their surgical procedure that the nurses could not answer. It was the professional opinion of the PAC nursing staff that not all patients demonstrated an acceptable level of understanding of risks to a level they would be comfortable getting the patient to sign the consent document. Initially, in the implementation of the PAC process, this state of affairs led to conversations (some of them heated) between surgeons and the nursing staff. With time it basically led to bad behavior. Surgeons would sometimes not return calls. Sometimes, when they did, the conversations were not at a level of professionalism one would expect. It was not unusual for patients to wait long periods of time for these conversations to materialize. When the conversations did not occur the patients would arrive the morning of surgery without a signed consent document. This current state of affairs heightened rather than allayed anxiety in patients the PAC had been designed to manage.

The hospital had proposed to the surgeons that a signed consent document for the surgical procedure be obtained in the surgeon's office at the time of the consent discussion and that this document accompany the surgical booking card. The surgeons pushed back. They felt such a practice would take too much time and the need for a witness to the patient signature on the formal consent document would create challenges for office staff. They acknowledged that for some individuals the consent discussion did involve the patient leaving their office to reflect on

the discussion of the surgical procedure and perhaps consider other options. The challenge for surgeons was how consent documents might be easily garnered for those patients who called back deciding to go forward with the operation without significant inconvenience to the patient and surgeon.

There were other arguments advanced by surgeons against the proposal to provide a signed consent document from their office. Some rationalized that there were risks related to underlying medical conditions that would be better covered by intervening consultations with other care givers such as anesthesiologists and internists. Should not an internist be better able to discuss the cardio-respiratory risks for an individual patient that related more to underlying illness than to the surgical procedure being provided? How, they argued, could they let a patient know what the risks were of an anesthetic without knowing what type of anesthetic (spinal, epidural, general, local, etc.) the patient was going to receive? And should not this be the responsibility of the anesthesiologist? One surgeon indicated he had gone to a meeting at the Mayo Clinic where he had been told that there was no signed consent ever obtained at their sites, respecting the fiduciary bond between surgeon and patient. At the end of the day, few surgeons were co-operating with this proposal to submit a signed consent document with the booking card.

An uneasy truce existed at this point of time. Surgeons did acknowledge the consent document was required. The nursing staff would obtain signed consent documents from patients they had a level of comfort understood the risks and benefits of the procedure being proposed. There were occasional patients that did present with consents from the surgeons office appended to the booking cards and, when these consents were within six months of the procedures (as per the existing policy) the process usually worked okay. However, when patients were beyond six months from booking or the nurse in PAC had concerns that the patient did not understand the

risks of the proposed procedure even with a signed consent document from the surgeon, contacting the surgeon to request clarification or a new consent often resulted in confrontational conversations. Without a signed consent document the operating room nursing staff would not take the patient into the operating theater. It was not unusual for surgeons to get the patient to sign the consent document in the pre-op area, just outside the OR, minutes before the surgery leading many to wonder, in such a stressful environment, how valid such a consent was. Patient care also suffered. If there was a pre-med ordered prior to the surgery that might be expected to impair the ability of the patient to sign the consent (such as a narcotic or anxiolytic that might be given to lessen anxiety) unless the surgeon attended the patient and got the consent in the admission area with sufficient lead time to the procedure, this medication was being held.

Within this context, the hospital introduced a new universal policy for blood transfusion consent. Previously, when in the judgment of a physician a patient required a blood transfusion, no written consent document was procured, the feeling being that consent for a blood transfusion was imbedded in a global consent for care patients signed at the time of admission. The feeling had been that when patients ‘needed’ a blood transfusion, just as they might ‘need’ lab work or ‘need’ intravenous fluid, consent existed. Should a physician be contacted by any hospital ward and told of a low hemoglobin result, a telephone order to transfuse would be processed – no signatures or discussion required. However, the environment for blood transfusion had changed dramatically. There were concerns emanating from a national review of blood transfusions (Health-Canada, 1997) plus increasing concern with risk of infection transmission from transfusion such as hepatitis and HIV. For this reason, the hospital felt they needed to obtain a unique and specific consent for transfusions to ensure the risks and benefits of transfusions had been discussed with the patient prior to any transfusion. This new policy was intended to apply

to all patients admitted to the hospital. Outside of the surgical environment there was agreement by physicians this was a reasonable policy.

The surgeons and nurses, however, had differing points of view as to whether the consent for the surgical procedure was adequate to cover a post-operative transfusion without additional conversation and documentation. The surgeon's point of view was that consent for this post-operative event was already imbedded in the consent conversation and document obtained for the surgical procedure itself. They reasoned that should a patient require an intra-operative blood transfusion the patient was not woken up in the middle of the procedure to get consent prior to the transfusion; why therefore should the blood transfusion just a few hours later for the same purpose be any different? The nursing staff on the other hand felt that there was something new and different about the post-operative environment that required a new consent discussion and signed document. (This angst on the part of the nursing staff likely also reflected back on their bigger issue whether or not the surgical consent met required standards in the first place.) The nursing staff argued there was a precedent for this need for a new consent based upon the existing, agreed to policy for resuscitation codes. The hospital had established three resuscitation codes and would routinely have a discussion with the patient on admission as to which of the three 'codes' was to be followed. The codes were "full" in which case all measures including cardiopulmonary resuscitation (CPR) would be employed, "Do Not Resuscitate (DNR)" which included aggressive medical management with the exception of CPR should a cardio-respiratory arrest develop during treatment and finally "comfort" which was typically used for palliative patients to include comfort measures only. The policy for the hospital was that all patients coming to the operating room were managed as "full code" (irrespective of their chosen code status) from the time they arrived in the OR holding area to the time of discharge

from the recovery room. The code status would revert back to their pre-op status once they were discharged from the post-operative area back to the ward. The nurses reasoned that operative consent covered this corresponding period from admission to the OR through transfer back to the ward meaning that should a transfusion be required on the ward, a separate signed consent document was required. Given the public debate and rhetoric concerning risks of blood transfusions at the time of this case the nurses were concerned about potential legal liability to provide a transfusion without an informed discussion and signed consent in all but the most urgent situations.

The surgeons revolted. They argued that they were already being imposed upon to participate in obtaining a signed consent from patients for the surgical procedure itself and that this consent reasonably included consent for post-operative transfusions. This was a higher level of consent than the general admission consent which they acknowledged was insufficient on its own. They refused to obtain signed consent for post-operative transfusions. They suggested this new dictum was the 'last straw' and they were 'tired of being pushed around'. They argued that should they indicate on the order sheet a patient needed a transfusion and should the nursing staff refuse to proceed with this directive it was 'blood on their hands' should the patient have a poor outcome. At the same time, the nursing staff did not feel they should be obtaining these signed consent documents because they did not necessarily understand the need for transfusion. They were tired of being 'pushed around' and unfairly being made liable for the decisions of others who obviously did not respect them as professionals in the first place. Conversations were becoming increasingly confrontational and collegial relationships were rapidly deteriorating. The Chief of Surgery was asked to deal urgently with this impasse.

Ethical Principles Involved

The establishment and maintenance of nurturing, healing relationships between caregivers and patients is a cornerstone of healthcare (CMA, CHAC, CNA, & CHA, 1999). Patients are often in vulnerable positions, relating to their own medical condition, emotional stress arising from a situation they have unexpectedly being placed in or, as is usually the case, having less content knowledge than the caregivers. In order for a care relationship to bring value to the patient it is essential the patient enter into a mutual binding relationship with caregivers. For physicians this is the classic patient-physician relationship although this same relationship exists between the patient and other members of the care team and internally between members of the care team itself. In considering ethical principles in this case study I will concentrate on the physician-patient relationship though these same arguments can be extended to relationships between patients and other members of the care team, individual members of the care team and between caregivers and other members of the patient's family who might also be involved in the consent process. I will also attempt to highlight challenges within the ethical paradigms themselves.

There has been a dramatic shift in how consent for a surgical procedure is obtained from the overly paternalistic attitude of 'doctor knows best' early in the twentieth century with almost no documentation to the exact opposite of 'client knows best' sometimes manifested by legal reviews of a variety of documents outlining patient's wishes and input by other stakeholders. We now have living wills and personal directives in an attempt to capture what might be an individual's wishes for care in the future. The impossibility of being able to outline all eventualities and the question of who gets to interpret and contextualize these directional documents has created new, just as complicated, issues. Further, the input of stakeholders can

often be a challenge reflecting underlying dynamics in the patient's life journey. What inputs are helpful advice and what inputs are bullying? If the patient is not able to provide consent, which family member should be consulted to determine what the patient's wishes might be when the family members themselves are at odds? Should input by the patient's spiritual community be considered? At what age and under what circumstances can an individual provide their own consent?

Virtue Ethics. The ethics of health care early in the twentieth century, still very prevalent in many micro-systems today, are based in a virtue ethic (Darwall, 2002). A virtue ethic is the ethic that drives and supports the concept of professionalism physicians were and are still held accountable to (Pellegrino & Thomasma, 1993). The emphasis in virtue ethics is on the actor, be it the physician or another care provider, and not the action. It is expected physicians will do the 'right' thing because this is what physicians are trained to do. It is not unusual for both patients and physicians to still consider medicine a calling and not an occupation. Patients expect physicians are trained to know what is best for individual patients and will act accordingly. Reciprocally, patients are expected to trust their physician will establish the 'golden mean' in determining acceptability and applicability of treatment options. The 'golden mean' is that treatment option lying between doing nothing and doing something beyond heroic.

The prominent societal positioning of medical professionals and the expectation physicians will do the right thing has not been a development with a short history. Physicians have been considered professionals for centuries. As such, physicians had ownership of a body of knowledge they controlled very tightly. The training, evaluation and credentialing of new physicians was legitimized by society over the centuries and left in control of physician guilds, argumentatively for the good of society. The underlying fiduciary attitude as first described by

Aristotle centuries ago is at the heart of virtue ethics (Darwall, 2002). This attitude became ingrained into western medicine following Thomas Aquinas rediscovering Aristotle and codifying virtue ethics into the mainstream Christian ethic in the fifteenth century (Singer, 1993).

In the past, when this virtue ethic dominated, there were not nearly the diagnostic and treatment options available today as much of medicine was supportive care. It was truly the art rather than the science of medicine. Medicine is in the midst of exponential change as it progressively becomes more science and less art. Practitioners are struggling to keep up with the virtual explosion of scientific knowledge in the health care field (Committee on Psychopathology of the Group for the Advancement of Psychiatry, 2002). This knowledge is becoming more accessible to individuals in society beyond physician ranks although there remain challenges contextualizing the knowledge base for some patients.

Unfortunately, often played out in the media, physicians have not uniformly behaved for the good of their patients by honoring the trust placed in them. There are increasing reports in the media about physicians who make decisions for patients that do not reflect what is best for the patient in the patient's own context. Some examples include imposition of the practitioner's own personal beliefs (Erdley, 2007), basing care options on remuneration (UPI.com, 2010), refusing to see patients because of the sexual orientation of patients (Rau, 2009), or refusing to see patients because of the history of the patient such as having had cancer (Fayerman, 2008). It might be argued progressive accumulation of anecdotes/evidence to support this disintegration of the consistent fiduciary relationship and wider distribution of such reports in the media is pushing this societal positioning of the patient-doctor relationship to a tipping point. Stakeholders in society have increasingly started to question what their physicians are doing and demand a greater decision role in their own health care.

Deontological Ethics. The prevailing paradigm has shifted away from a virtue ethic where the physician was expected to always do the right thing towards a principle based deontological ethic where patient autonomy and patient rights are paramount (Beauchamp & Childress, 2008). The health care ethic has evolved from concentrating on the actor to concentrating on the action. Patients and their advocates increasingly talk about principles in health care including patient autonomy, beneficence, non-maleficence and justice that form the mainstay of a deontological ethic paradigm. Existing codes of ethics of health care professionals have reflected this change and current codes have been crafted to reflect greater respect for patient autonomy and a principle based health care system (CMA, 2004).

In adopting the principle based deontological ethic there remain conflicts as to which of the four principles should assume primacy in given contexts when adherence to individual principles would suggest different actions. There are times when different principles will clash – do we maximize beneficence (do good) or do we respect patient autonomy when adherence to either of these two principles might suggest different actions. As an example, should assisted suicide be supported out of respect for patient autonomy or condemned because it does what society considers maximal harm to an individual (hasten death). Immanuel Kant, the philosopher who first promoted deontological ethics, suggested this trade-off should be determined by rational adjudication by rational people (Dudley & Engelhard, 2010). In practice, in the value-laden health care environment, this is something easier said than done.

Perhaps the greatest trade-off challenge for health care is establishing the correct balance between an individual focus (as is very compatible in a virtue ethic framework) and a focus on an entire population – the balance between autonomy and justice. We see pressures on the health care system when emphasis is disproportionately weighted towards patient autonomy, especially

by those concentrating on patient rights without considering patient responsibilities. With users having seemingly insatiable desires in an environment of newer, more expensive technologies and pharmaceuticals, there are times when individuals might exercise a self-held 'right' to resources that may not fairly reflect their need, both absolute and relative. Resources are not infinite; any population would be challenged to provide all individuals in society with all the goods and services they might autonomously request. The question turns towards who is responsible from a population perspective to rationalize demand and allocate both benefits and responsibilities. Issues of justice are being given increasingly greater emphasis in the face of increasing resource scarcities (Rawls, 1999). We are in the midst of this debate. The challenge is that while we continue this debate, wait lists continue to expand reflecting this mismatch of supply and demand, the mismatch of individual and population, the mismatch of rights and responsibilities.

Feminist Ethics. There is another ethical framework highlighted in this case that deserves consideration. This would be the lens of feminist ethics, a relatively new framework in the ethical arena (Walker, 2007). Feminist ethics arose from concern that the traditional ethical theories placed far too great an emphasis on masculine traits like autonomy, independence, domination and intellect with less concern for feminine traits like interdependence, community, sharing and emotion. The traditional utilitarian, deontological and virtue ethical theories were felt to inadequately and unfairly consider women's issues or perspectives, subjugating such considerations as less mature or worthy of consideration. The feminist ethical lens is much more considerate of relationships, responsibilities and individual context and less concerned with rules, rights, and universality. The general nature of feminist ethics is to emphasize care-giving issues and issues arising from oppression of any group of people, but most particularly women.

This is especially relevant in the medical care environment which, at its core, is a care-giving environment. Historically, the profession of medicine has been dominated by men and the profession of nursing by women with a fairly rigid hierarchical structure. This comparatively rigid gender differentiation has been evolving over time with less tolerance for domineering attitudes of the past. The line between paternalism and oppression is not as clear as might be imagined. The change in attitude this shift entails significantly influences the dynamics of care being provided. Consent discussions also reflect this changing environment with increasing consideration of context and caring that a feminist lens brings to these conversations.

Principles of Consent. For informed consent both voluntariness of consent and scope of information sharing in a consent discussion are critical. In regards to voluntariness, one needs to first consider competence of the patient. Competence is a continuum varying from a comatose patient through one who is confused intermittently to one who is fully engaged. Beyond basic competence, one has to also consider whether or not an individual truly has an understanding of what is being discussed. Understanding is classically interpreted to be the presence of adequate reasoning. For example, a physician may discuss blood transfusion with a patient and disclose the risks and benefits of the transfusion. If the patient for religious reasons does not consent to a blood transfusion, even though the surgeon may disagree with the religious assumptions in making the argument to refuse, this does not constitute a lack of understanding since reasoning itself would be intact. Often the best way to determine understanding is to have the patient outline the reasoning they have used to make a determination as to their informed course of action and ensure that the logic and the postulates in said arguments are reasonable within the patient's context.

The question of what information is required to be shared by the physician with a patient to establish true informed consent is a parallel consideration. Is it reasonable to outline the entire spectrum of risks or a smaller subset of ‘relevant’ risks? Most would say it is impossible and unreasonable to try and outline each and every possible risk. If one decides to share ‘relevant’ risks the question becomes who decides what is relevant. Is it appropriate to measure relevance to a professional standard (what other physicians would disclose), a subjective standard (what the patient would want to know) or an objective standard (what a reasonable person in similar circumstances would want to know)? A professional standard ignores patient individuality and unique context while a subjective standard can only be determined in retrospect once information has already been disclosed. In the legal environment the consent that is required is the reasonable person standard, a subset of the objective standard category. It has been argued that the ideal disclosure for consent discussions should be an objective standard for disclosure and a subjective standard for understanding (Etchells, Sharpe, Burgess, & Singer, 1996).

Consent Context. Informed consent will vary depending on the context in which it is delivered. A comatose patient bleeding to death requires the most cursory consent, as this is a time for assent not consent. On the other hand, procedures with serious potential for side effects that are performed electively require much more thorough and complete discussion. Further, in the health care field there are two kinds of interventions requiring consent – therapeutic interventions and research. Informed consent for research opens a whole new set of questions that will not be considered completely here other than to recognize the hazy boundary between therapeutic and research consent. When new procedures are being introduced, the experience of the surgeon (or lack thereof) and the establishment of said procedure as a standard of care (or lack thereof again) becomes relevant to the consent discussion. Consent for a surgical procedure

implies the patient understands the procedure being proposed is intended for their benefit and not solely for experimentation. There is an expectation of competence of the provider, an expectation sometimes difficult to quantify with new procedures. One might argue for the first patient(s) a surgeon is providing an operation there is a blur into the sphere of research that perhaps should involve a higher level of consent.

There are multiple sources of information patients consider outside that shared in the conversations between patient and physician. Whereas consent discussions in the past were a private discussion between physician and patient there is now increasing input from a variety of external sources including relatives, the internet, facilities in which procedures are being completed, the lay press, and the legal profession. The internet is a burgeoning source of material for patients. However, the internet is just as much a source of misinformation as valuable information. Discussion about risks of a procedure have additional complexity as they become more centered on refuting/confirming/contextualizing information obtained out of context from external sources than establishing shared understanding.

Informed consent is more a process than an event as, by its nature, consent evolves over time mirroring maturation of the patient-physician relationship. The reality is that we need to consider informed consent documents as living documents unfortunately crafted by fallible parties (Evans, 2006). It is much more an understanding than a signed piece of paper. Written consents in reality are of marginal value in either the formal court or the court of public opinion. Given the power differential existing between a physician and a patient the suggestion of coercion for written consents tends to devalue the piece of paper, should that be called the consent. The best consent remains a solid relationship between physician and patient. Development of this sense of common purpose and shared responsibility early in the course of a

physician-patient relationship remains the best way to ensure valid informed consent. In such a real relationship there *can* exist an environment where risks and benefits of a proposed intervention are shared in a meaningful way.

Principles of Disclosure. Returning to the question of the scope of risks to disclose, the challenge in surgery is no matter how good the surgeon or the surgery, there is always a statistical chance of adverse outcomes. Beneficence needs to be balanced with non-maleficence. Adverse outcomes, although unpredictable as to timing, are inevitable. Adverse events and complications fall into ‘general’ that might occur in any operation (such as pneumonia) to ‘operation specific’ (such as bleeding from taking out a spleen) to ‘unexpected’ (such as risk of death from an anaphylactic reaction in a very simple operation). These are the unanticipated outcomes which are quite different than errors. As mentioned previously the usual standard is to inform individuals of those potential complications that are either relatively common or, if uncommon, very serious should they occur. The challenge in explaining relatively rare complications to individuals is the potential limited ability of patients to understand described processes to a level of complete understanding. These consent discussions invariably occur in what is almost always a stressful time for individual patients – they are being told they need to have a surgical procedure. At such stressful times in their lives, individuals able to understand complex discussions during ‘good times’ will often struggle. It is not unusual, even with the best of intentions, for a patient, when unable to make a valid decision because of inability to comprehend the magnitude of the discussion, to default to a virtue ethic of trust in the physician. This default behavior may be conscious but often is unconscious with the patient truly believing they have made a fully informed decision (Crues & Crues, 2000; "Medical professionalism in the new millennium: a physician charter," 2002; Sullivan, 2000).

Not every patient relishes the autonomy of a principle-based ethic, still wishing to live in a virtue ethic environment were it not for family and ‘friends’. There is often pressure on an individual patient to be more ‘involved’ in their consent than they are often willing or able. The emphasis on the deontological principle based autonomy ethic can sometimes be uncomfortable for certain individuals as the discussion of risks goes further than their comfort allows relating to their own individual context. I have experienced situations where discussing risks of a procedure was specifically forbidden for fear by both the patient and their family that the discussion itself would increase the chance of the untoward event coming to be. This ‘magical thinking’ would not be my belief but in discussing consent it is the belief of the patient that counts, not mine.

The challenge in considering informed consent is matching the level of consent to the underlying ethic of not only the individual and his/her family and friends but more widely that of society as a whole. There are instances when the private and personal compact between a physician and his/her patient may be considered acceptable and appropriate by both the patient and those in his/her immediate environment but vilified by society. Witness to this is the series of arguments that form the basis of debates in countries considering active euthanasia for individuals with late stages of terminal diseases such as Lou Gehrig’s disease (Amyotrophic Lateral Sclerosis) (Knox, 2005). It is no longer unusual for courts to weigh in on these discussions in several jurisdictions (Euthanasia-Ethics, 2010). One might expect this journey to establish a new norm for consent will continue to be a challenge for societies reflecting the lack of uniformity for the basic underlying ethic on which a physician-patient relationship and the informed consent that derives from this relationship exist.

Discussion

Returning to the case study, the question that brought this issue to the boiling point was whether or not a signed consent document was required for post-operative blood transfusions. There are several issues that need to be addressed. One is the underlying and precedent issue of the basic surgical consent. The second would be the need for a specific consent for a transfusion. Finally, there would be the issue of communication and teamwork between the now-opposing factions of the care team who were divided based on professional affiliation. For all these issues it is paramount consideration remains focused on what would be best for patient care. I will address each of these issues in turn and start with the issue of the standard for disclosure relating to the basic consent for the surgical procedure.

Surgical Consent. In the environment as it existed there were two unique groups providing disclosure of risks and benefits for scheduled surgical procedures. The surgeons were expected to have had a conversation with the patient at the time of booking a patient for surgery. The surgeons typically measured the adequacy of their consent disclosure by what they said – not necessarily what the patient heard. For some this was a professional standard and for others it was a subjective standard and for others it would have been an objective standard. There was no consistency amongst the surgeons in regards to the information discussed in the pre-operative discussion of risks and benefits. Some of the surgeons used printed materials outlining all risks for any given procedure, believing this to constitute reasonable, documented evidence of the consent process. One surgeon believed that as long as it was disclosed to the patient that he/she might die from the procedure, disclosure of such a significant risk automatically meant that all ‘lesser’ risks were ‘covered’.

The nursing staffs, on the other hand, were much more consistent in their consent discussions. Whereas the surgical group concentrated most heavily on disclosure, the nurses concentrated much more on patient understanding. In the PAC it would not be expected the staff would have the same understanding of proposed surgical procedures as the surgeons. However, as it relates to knowledge of the patient's context and perspective this might not be the case. At times the nursing staff would know less about the patient's circumstances by not having had the benefit of information that may have been available to the surgeon. At other times, however, the nursing staff potentially had more information, having access to investigations and conversations that might have occurred subsequent to the meeting with the surgeon.

It might be expected that there might exist very different 'power' dimensions in the two consent conversations. If we use Berne's transactional analysis (Berne, 1964), one might suggest the surgeon-patient conversation most likely would be parent-adult at best and parent-child at worst. One would have hoped that in the PAC environment there would be a greater likelihood of the conversation being adult-adult. Different perceptions of the patient's ability to understand information led to unmatched levels of disclosure in these two consent discussions. It is fair to say that different consent frameworks were applied by equally qualified and compassionate individuals with different perspectives; different outcomes often reflected the difference between standards of disclosure and standards of understanding.

We need to especially consider disclosure from the patient point of view. People in general and especially when under stress often do not hear what a given speaker believes they have said. It is the power of concentration and expectation wherein people often hear what they want to hear. When a patient tells the nurse in the PAC that the surgeon did not discuss risks of the procedure with them, it is possible this conversation did not occur. However, it is equally

(and hopefully even more) possible that the surgeon may have divulged an appropriate, contextually aligned amount of information for a patient at the time of the initial consent discussion even though the patient at a later time expresses ignorance of such information. It is conceivable unanswered questions in the PAC might well have been covered by the surgeon at the time of the initial consent discussion but not perhaps fully understood. It is also possible that a significant number of questions might have arisen in the time interval between the surgeon's conversation and the PAC discussion from external sources such as print media, electronic media and further conversations with family, friends and local 'barbershop/salon experts'. Consent is not static but evolving – we, as a health care team, need to ensure patients have a level of understanding that meets their needs and expectations, not ours.

Consent for Transfusion. Let's now assume there has been an excellent consent process with objective standards of disclosure and subjective standards of understanding for the initial surgical consent. Let's also assume that this process had involved a discussion about the potential for a blood transfusion and the risks involved in such a transfusion. In such an environment, should there be a requirement for another consent process (discussion and documentation) for a post-operative transfusion?

Since we are assuming in this case that the consent process was optimal at the time of the initial surgical consent, one must contemplate what such a consent discussion might look like at the time of discussion with the surgeon to properly consider this situation. There would be three reasons why a patient would receive a blood transfusion around the time of a surgical procedure. The first would be a pre-existing low blood count. For example, a patient with a colon cancer that had been bleeding pre-operatively leading to an anemia (low blood count) might have a low blood count prior to surgery. Knowing there would be additional loss of fluid and blood during a

surgical procedure being planned to manage this problem and that there would be limited ways to build up the existing deficiency prior to urgent surgery it would not be unreasonable to discuss with the patient a plan to transfuse the patient intra-operatively. The second reason for a blood transfusion would be ongoing losses, either expected or unexpected. During the surgical procedure, in the face of significant blood loss, the surgical standard would be to transfuse blood while the source of blood loss is brought under control. The final reason for transfusion would be that following control of blood loss, the post-operative blood count is low. Whereas in the past there were 'cookbook' rules for transfusion to occur below a certain value, current practice would be to determine whether or not a transfusion is required depending upon the medical condition of the patient. Older patients and patients with underlying cardio-pulmonary diseases might require a transfusion earlier than younger, otherwise healthy individuals. As well, if there was a concern that there is potential for additional blood loss in the post-operative period then a transfusion given 'earlier rather than later' might very well be appropriate.

If one considers the need for transfusion in the post-operative period, pre-existing anemia would not be an issue. The question would be whether the need for blood transfusion relates to ongoing losses or whether the need for transfusion is more contextually related to both current status and projected future need. Unless the surgeon truly had a crystal ball it would *not* be reasonable to expect the surgeon to have had the ability to be specific enough about the exact reason for a post-operative transfusion prior to the surgery. Rather, it is more likely one of a list of possibilities would have to be considered. Given that transfusions do have risks and that there are alternatives available it would seem entirely reasonable from all standards that a discussion with the patient should occur prior to a post-operative transfusion providing of course the patient is competent within the demands of urgency to participate in the discussion. A proper pre-

operative surgical consent should make such a discussion short and straight-forward as the patient would already be aware of the risks and possibilities. However, it does not mean such a discussion is not necessary.

In the older virtue ethical paradigm which promoted a paternalistic attitude, going forward with a post-operative blood transfusion without a conversation with the patient would have been accepted. However, from the more current deontological point of view, the surgeon's desire for beneficence needs to be tempered with the risk of maleficence (should there be long term effects from the transfusion) and the patient's autonomous right to be involved in this discussion. Even within the virtue paradigm, the fiduciary patient-surgeon relationship should acknowledge the patient's best interest is best served with timely discussion of post-operative transfusion, if only to allay patient anxiety. This is not a responsibility that can be abrogated to another member of the care team who would be unlikely to have been involved in the initial discussion of the risk of transfusion, the surgical procedure that led to the need for the post-operative transfusion or any risk-benefit discussion/decision why a transfusion is now being recommended.

Communication and Teamwork. The perspective feminist ethics brings to examination of consent is very helpful in better understanding consent issues. Consents are context sensitive and reflect relationships be it the patient's relationship with the surgeon, the family, the nursing staff or a weighted combination of all. It would appear in this case that the surgeons concentrated on issues of rules, rights and universality whereas what should be paramount is the relationship with the patient and the patient's individual journey through their surgical intervention. Patients have a right to be involved in decisions that will affect them in the future. Consents are fluid and may change with time. Patients can withdraw consent.

This brings us back to the paternalistic attitude of the surgeons. The surgeons proposed that they, and only they, knew best how to deal with patient's consent for surgical interventions and therefore felt they should be 'trusted' in obtaining consent; this reflects the time when virtue ethics were the mainstream ethical paradigm. These actions would appear on the surface to serve only the physician's sense of power as they seem incompatible with the needs of the patients and the rest of the members of the care team. The nursing staff felt oppressed by these attitudes. The actions of the surgeons might have reflected medical hierarchical relationships that developed over the centuries with imbedded subjugation on the basis of gender but this is an attitude that is no longer accepted in the current milieu. Any and all biases against treating nurses as equal partners in the provision of health care must continue to dissipate for the betterment of not only the care teams but for the patients the team mutually care for.

Outcome

The Department Chief of Surgery in concert with administrative colleagues developed a multi-faceted approach with both short term and long term strategies. Although the long term solution was recognized to be an improved consent process, the short term needed to focus on rebuilding fractured relationships. One of the major challenges was identified to have been the process of development and communication of this new blood transfusion consent policy. Maximal stakeholder involvement exploring all options could have allowed some mitigation of risks if considered at that time. There had been little attempt to engage physician stakeholders in this process. Both the identified need for the new consent and the development of the policy and documentation for the new transfusion consent had been centrally driven. The policy had been implemented without any discussion of the rationale underlying its development and need for such a policy. Those developing the policy did not appreciate the existing strained environment

relating to consent – they missed considering culture. They did not recognize the ‘culture eats strategy for breakfast’ dictum! As emphasized in feminist ethics, context matters and in this situation mattered greatly.

Information gathering was the first step. An environmental survey was undertaken. This involved documentation of both agreed quantifiable risks of transfusion and an understanding of what other stakeholders were doing in regards to transfusion consent. Identification of best evidence informed clinical practice guidelines for blood transfusions were collated and brought forward for discussion with the various stakeholder groups. A lawyer from a respected medico-legal think tank was invited both to give a presentation at surgical grand rounds to the surgeons and to the broader care community.

The conversations were expanded beyond the confines of the specifics of the blood transfusion consent form to the global process of consent in general; beyond considering how a blood transfusion was ordered to the appropriateness of blood transfusions in clinical circumstances and how this might have changed in the current environment. The conversations included all stakeholder groups, including patient representatives. A respected local pathologist who had a responsibility for the blood bank in the hospital was identified as a local champion to lead the discussions around blood transfusion clinical guidelines. A multi-disciplinary group was convened to address the consent issue from a global perspective. This committee was co-chaired by the Chief of the Department of Surgery and a member of the senior executive of the hospital to ensure there was buy-in demonstrated at the most senior level of the organization.

The surgeon group felt these wider conversations looking at underlying issues were more respectful of their point of view. Likewise, the nursing staff in both the PAC and on the wards felt their concerns were being heard and addressed. In the short term there was grudging

acceptance by the surgeons to complete the consent documentation in recognition of agreement to develop a more comprehensive consult process. Over the course of the next year, with wide consultation, a more integrated consent process was developed. The focus was patient need. This process included joint meetings with the PAC staff and the surgeons looking at optimizing the consent process. A new consent form was developed addressing the needs of the various stakeholder groups and more clearly defining stakeholder responsibilities. By the end of this process, these interactions led to an improved consent process with better patient engagement. As a side benefit an audit of blood transfusions suggested that the utilization of blood transfusions better reflected what would be considered best practice.

Relevance to Other Situations

Although on the surface this might be considered a case about consent, at its very heart this is a case about teamwork and support for providers. In the absence of support for caregivers the medical profession will have little support to offer patients. We need to support the caregivers, something we do not always do well as health care managers. Support must involve facilitating better communication between providers to develop strong inter-professional teams. It also means that health care managers need to keep caring and patients at the heart of what every member of the health care team does each and every day.

The challenge imbedded in this case reflects historical training for physicians, especially specialists. Typically, physician training has been provided in a strict hierarchical environment that places great emphasis on both standing and role as an expert (O'Hare & Kudrle, 2007). This is completely consistent with the paternalistic behavior demonstrated in this case and compatible with the virtue ethic that supported development of professions. Pharmaceutical industries exploit this tendency with their strategy of hosting specialist opinion leaders at workshops

promoting their products as a way to influence other constituents of the physician community. The challenge is that deferring to an expert can pose impediments in advancing evidence informed initiatives. Even in our current more deontological-based environment it would appear reliance on experts over evidence is increasing rather than decreasing (Kraemer & Gostin, 2009; Tricoci, Allen, Kramer, Califf, & Smith, 2009). The challenge in health care is that such a strategy of deferring to experts is often a technique to get more resources – get a group of ‘experts’ together, set a standard and then take this to the funding agencies indicating standards have not been met – rather than a strategy for better care.

James Surowicki promoted the insight that when it comes to decision making ‘average’ rather than ‘expert’ is best (Surowicki, 2004). If we have an environment where a group of individuals respectfully come together to make a decision and there are no impediments related to ‘standing’ or ‘status’, this is a powerful method to come to a just decision. This premise was originally introduced as the Condorcet Jury Theorem in 1785. (It is the theory behind why we have jury trials and reflects the adage that if one is guilty choosing a trial by judge is better whereas if one is truly innocent a trial by jury is the best choice.) The idea continues to permeate management literature in multiple forms (Amabile & Khairi, 2008). There are three requirements for the ‘wisdom of crowds’ to prevail. The first is every member of the group has to have sufficient knowledge; they must have at least a 50% chance of making the right decision. The second is members in the group have respect for each other’s diversity and one individual does not have ‘rank’ over others. The physician is not any more right on a decision because he/she is the physician than the janitor is right because he/she is the janitor. There must be a respectful environment. Finally, in order to make the best decisions, the group must come together for decisions and go their own ways following. Groups developing strong social bonds

outside the decision-making forum run the risk the power of their diversity becomes diluted. With time there will be a corresponding weakening of their decision making power.

Development of inter-professional teams has often been thwarted by lack of physician participation. As for any team member, if physicians do not show up at planned meetings they can destroy the respectful environment any group is striving for. It has been said physicians practice medicine alone, together. Physician metaphors still reflect a 'captain of the ship' and 'ordering' mentality, especially for specialists. This position as the independent leader of the care team by the physician needs to merge into a much richer inter-professional team environment where the input of all members is valued, facilitating a richer dialogue and better outcomes.

Conclusion: Management Implications

Society must find a way to control the current rate of growth of health care spending. We need to determine how to best allocate resources for a population (Case Study 1), develop cohesive engagement strategies (Case Study 2) and work together as teams focused on what is best for patients (Case Study 3). There is at present no consensus how to best manage these daunting tasks. This struggle to manage relates in part to lack of a consistent ethical milieu in society to help guide us in this quest. Each of these three case studies provided a lens as to how a consideration of ethics helps to better understand a given situation and options available to move forward.

This change of ethical paradigm from a virtue to a deontological focus has destabilized the framework for both providers and patients. There is conflict for providers between those still rooted in virtue ethics and those promoting the newer, albeit less defined, deontological ethics. With ongoing discussion the hope and expectation is that we will better understand how to move

forward as a society. This will however, involve changes in how individuals work together as teams to provide health care. Should we be abandoning the newer deontological framework in favor of the more manageable utilitarian ethic that summates and maximizes individual outcomes as the best strategy to maximize health care outcomes for a population? The challenge with such a strategy, as for all utilitarian approaches, is the realization that the best strategy to maximize outcome for a population is to maximally disadvantage a small group, a strategy diametrically opposed to the deontological ethic of the mainstream. Perhaps, as some are arguing, the best way forward would be a return to the virtue ethic of the past (Pellegrino & Thomasma, 1993). What is certain is that the journey forward needs to promote respect for each other, a respect that recognizes the rich diverse ethical paradigms in our environments. It will be a challenging but worthwhile dialogue and journey.

Epilogue

As identified at the beginning, these cases have been most focused on a physician perspective. However, the insights that can be gained can be generalized to apply to other members of the care team. As a conclusion, somewhat based on these cases but more importantly as a stimulus for further discussion, I would like to propose, in no order of priority, some general insights that I believe should be considered from the ethical perspective by medical managers. I will call these my Top 20:

1. Managers need to consider *all* drivers of human behavior, especially in health care. The tendency to concentrate on financial incentives will have as many untoward consequences as positive impacts. There are four basic drivers for human behavior – acquire, bond, comprehend and defensive. We tend to use the acquire driver most, especially the acquisition of economic rewards. Not to be forgotten are other acquire

drivers such as prestige and a sense of worth. The drive to be part of a high functioning team (bond) and the drive to learn and understand (comprehend) are very powerful drivers in health care that are often ignored. The defensive driver of command and control might provide short term success but long term in health care will not provide lasting effects.

2. Relativism is very significant, especially for physicians – it is not just what an individual receives but just as important what other ‘like’ individuals receive.
3. Consider segmentation of care givers. Different people require different incentives. Marketers do this consciously every day – we need to learn these skills not to exploit those we manage but rather to provide the most appropriate support for those providing care. We succeed when they succeed.
4. Promote justice as fairness to encourage long term buy in. Walk a mile in somebody else’s shoes.
5. Be conscious of who owns a given decision – this will vary if the decision is made at a micro, meso or macro level.
6. Principles will invariably collide as the urge to ‘do good’ (beneficence – the Golden Rule), not ‘do bad’ (non-maleficence – the Silver Rule), be just and respect autonomy cannot all be maximized for every situation. They should, however, all be considered and balanced. Different situations will require different maximization and doing so transparently with one’s head up will always be the best strategy.
7. When thinking about organizational structures and forming groups remember that groups above about 150 - 200 individuals have a tendency to split into smaller groups. It is

better to plan for group sizes to accommodate these realities of social networks and social contracts.

8. Individuals will always be involved in multiple groups at the same time.
9. Identify and respect the informal leader of a group. The formal leader of a group will not always be your best ally.
10. The best way to care for our patients is to care for our providers. We need to respect and support those who provide front line care with more than just a pay check.
11. Everyone – our patients and our providers – have and live in a life narrative. Respect and try to understand everybody’s narrative.
12. While change is difficult one can’t purposely change what one does not understand; the only change possible without understanding will be destabilization. Investment in understanding will pay great dividends.
13. Health is not the absence of disease.
14. A virtue is the golden mean between two vices (one of excess and one of deficiency).

Some people are just working to get to virtue with a bit more experimentation than you might be comfortable with today; there will be a tomorrow. Nobody wakes up in the morning intending to ‘do bad’ - sometimes it takes a bit of work to figure out what the good is that is being intended.
15. Stories are more powerful than statistics in health care.
16. True consent is understood not written.
17. Physicians are typically trained as experts, not team players but they do have the capacity and the basic motivation to evolve.

18. The wisdom of a crowd in a respectful non-hierarchical environment will always exceed that of the best experts in the group. We need to develop high functioning teams in health care to optimize care.
19. Develop emotionally and physically safe, respectful environments for optimal patient outcomes and provider performance.
20. Not everybody will like you – that is a reality outside your control. However, whether people respect you or not is within your control as it will reflect on how you treat those around you more than what you say.

Science is organized knowledge. Wisdom is organized life.

Immanuel Kant

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