
Patient Rights and Organization Ethics: The Joint Commission Perspective

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A health care organization has an obligation to act in an ethical manner in clinical and business relationships with the public it serves. When examined closely, the boundary between these clinical relationships and business relationships is blurred, as is the boundary between clinical ethics and business ethics. Examples of ethical challenges that arise in a health care organization's business relationships are identified and a method for resolving these challenges suggested. Joint Commission standards that address an organization's business ethics, with special reference to managed care, are reviewed. It is suggested that the function of current ethics mechanisms in health care organizations (e.g., ethics committees and consultation services) be expanded to encompass business ethics.

In 1995, the Joint Commission on Accreditation of Healthcare Organizations changed the name of its standards chapters on "Patient Rights" to "Patient Rights and Organization Ethics," to reflect the addition of standards on ethical business behavior. What lies behind this change? This paper will address the relationship of a health care organization's ethics to patient rights, key themes in an organization's business ethics that are addressed in Joint Commission standards, and special ethical challenges raised by the growth of managed care. Consideration of these issues leads to suggestions concerning the future role of ethics services in health care organizations.

An Expanding Paradigm

The paradigm for health care ethics has been gradually expanding. The earliest paradigm focused on the *practitioner's* obligation to the patient. The third century BC Oath of Hippocrates states

Whatever house I may visit, I will come
for the benefit of the sick, remaining free
of all intentional injustice.

In 1859, Florence Nightingale echoed this theme of "do the sick no harm" in her *Notes on*

Hospitals.

But in the latter half of the twentieth century, the paradigm's focus expanded from the professional's obligation to include a source of that obligation — the rights of *patients*. This expansion arose from three sources:

1. The idea that a person does not forfeit his or her universal human rights by virtue of having become a patient; every patient has the right to be treated with respect as an individual. Both the atrocious experiments on patients in World War II and sociological studies on the inevitable loss of dignity that accompanies routine medical care emphasized the need for respect of persons in health care;
2. The realization that a patient who participates in his or her own health care — from decision making to therapeutic activity — is more

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likely to have a desirable outcome than is the person who does not participate; and

3. The advent of consumerism in health care, in which key elements of a supplier-customer relationship have been recognized as part of the clinician-patient relationship (i.e., the choosing and using of a service, irrespective of paying for it).

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The patient's perception of and response to his environment [of care] are important factors in his progress and recovery. Environmental considerations are reflected in the standards in certain general principles which may be said to represent a set of rights accruing to the patient. . .

The 1972 "Patient's Bill of Rights" published by the American Hospital Association echoed this idea with the clear statement that the "institution itself has a responsibility to the patient."

Themes of the Joint Commission's 1970 statement included that the patient has the right to

- Ethical and humane treatment
- Respect for his or her individuality and dignity
- No discrimination based on race, color, creed, national origin, or source of payment
- Physical privacy
- Confidentiality of communication
- Information about his or her problem, planned treatment and procedures, prognosis, and how to care for himself or herself.

An important expansion of this list of rights occurred in the 1978 *Accreditation Manual for Hospitals*, with the addition of the patient's right to informed participation in decisions involving his or her care. To enable the patient to give voluntary informed consent, the patient has the right to clear, concise, understandable information about his or her condition and proposed procedures, which includes the probability of success, the possibilities of any risk or problems that might arise, and significant alternatives to the proposed treatment. Should there be any lingering question, the right to refuse treatment (to the extent permitted by law) was explicit. The 1978 statement had another significant addition. It introduced the idea that the patient has rights as a customer or consumer, i.e., the patient is entitled to an itemized, detailed explanation of his or her bill.

This brief, historical summary suggests that a health care organization's obligation to patients derives from two relationships:

1. The patient-provider relationship that is built on the patient's acceptance and trust in the provider's commitment to do no harm, to treat the patient with respect and dignity, and to make the patient a full participant in decisions about his or her care.
2. The customer-supplier relationship that is built on the trust derived from the organization's business practices.

The former relationship is governed by "clinical" ethics, and the latter relationship is governed

by "business" ethics. But these two relationships and their ethical dimensions are not independent. For example, bad customer-supplier relationships can lead to avoidance by patients of needed care, provision of unneeded care (with its attendant risks) to patients, and failure of patients to participate effectively in their treatment, i.e., to "comply" with treatment recommendations. Any of these are likely to lead to less than optimum health outcomes. That is, there may be clinical "harm" to the patients that arises through acts of commission or omission in business behavior.

Challenges in Business Ethics

Challenges in health care business ethics have been attributed to the financing mechanisms and organizational structures in the health care system. Consequently, some observers have proposed that the solution is one or another mechanism or structure. But each mechanism and structure brings its own ethical challenges, such as the following:

- Fee-for-service incentives that favor overutilization of services, with the subsequent unnecessary risks and costs that accompany some diagnostic tests and treatment;
- Risk sharing (e.g., DRGs and capitation) incentives that reward underutilization of services and not informing the patient about alternative, perhaps more effective, treatments;
- Independent services provided by multiple organizations with incentives involving fee-splitting for referrals, or, less overtly, mutually beneficial reciprocal referrals that do not reflect the patient's best interests; and
- Integration of services within one organization, which promotes self-referral for unneeded but separately reimbursed services (e.g., outpatient consultants acting as "recruiters" for nursing homes that are part of their system).

Clearly, ethical challenges are unavoidable. In some cases, the challenge derives from a conflict between the interest of the patient and the success, at least for the short term, of the organiza-

tion. In other cases, the conflict is between two ethical principles, such as the good of the individual vs. the good of the community. What should be the organization's response? It could try to resolve the challenge by telling the patient *caveat emptor*, but most providers and patients would find this not only unsatisfactory, but unethical in itself. The organization could rely on the personal ethics of each practitioner and administrator in the health care system to withstand all temptation and to do the right thing. This, however, doesn't account for the fact that some individuals do not live by high ethical principles, that most of us have occasional ethical lapses, and that knowing the "right thing" can be difficult when ethical principles conflict. Or, organizations can face the ethical challenges and meet them.

How are these ethical challenges managed? There are five steps:

- *Recognizing* and *acknowledging* the challenge;
- *Discussing* the challenge openly with stakeholders and decision makers, gathering pertinent information, listening to the various viewpoints, identifying pertinent ethical values, and identifying relevant ethical principles;
- *Resolving* the challenge, through consensus whenever possible;
- *Building in protections* against behaviors and outcomes that the resolution desires to avoid;
- Being *accountable* to the public — patients and other health care consumers — for the resolution and its implementation.

The Joint Commission Response

Within this context, the Joint Commission introduced new standards on organizational ethics in all its 1995 and 1996 accreditation standards manuals (i.e., for ambulatory care, behavioral health care, health care networks, home care, hospitals, long-term care, and pathology and laboratory services). These new standards arose out of well-publicized concerns about abuses in which patients were admitted to hospitals

unnecessarily and were discharged or transferred only after their insurance expired. Patient advocates and health care professionals proposed that the Joint Commission address these abuses because unnecessary admissions and inappropriate discharges can affect patient care quality. Some health care professionals also believed that a response by a professionally sponsored standard-setting body would convey to the public that most professionals were opposed to such unethical behavior.

The standards (in the language of the 1996 *Accreditation Manual for Hospitals*) are as follows:

- The hospital [or other health care organization] operates according to a code of ethical behavior;
- The code addresses marketing, admission, transfer and discharge, and billing practices;
- The code addresses the relationship of the [organization] and its staff to other health care providers, educational institutions, and payers.

The intent of these standards is as follows:

An [organization] has an ethical responsibility to the patients and community it serves. Guiding documents such as the [organization's] mission statement and strategic plan provide a consistent, ethical framework for its patient care and business practices. But a framework alone is not sufficient. To support ethical operations and fair treatment of patients, an [organization] has and operates according to a code of ethical behavior. The code addresses ethical practices regarding: marketing; admission; transfer; discharge; and billing and resolution of conflicts associated with patient billing. The code ensures that the [organization] conducts its business and patient care practices in an honest, decent, and proper manner. (*Accreditation Manual for Hospitals* 1996)

To meet the intent of these standards, the orga-

nization must recognize and acknowledge the ethical challenges it faces in these areas and must discuss and resolve them in order to generate its own code of ethical business behavior. What mechanisms can be used for discussion and resolution?

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Since 1992, standards in the "Patient Rights" chapter of the accreditation manuals have required every organization accredited by JCAHO to have a mechanism for consideration of ethical issues that arise in the care of patients, and to provide education to staff and patients about ethical issues in health care. The standards do not specify the mechanism to be used, but give examples that include ethics committees, ethics consultation services, and formal ethics forums. This deliberate reticence acknowledges that different mechanisms may best meet the needs of different organizations and that innovation in developing more effective mechanisms is to be encouraged. The common mechanisms currently in use — ethics committees and consultation services — have generally focused on issues in clinical ethics, often involving the care of an individual patient. While not required by Joint Commission standards, it is suggested that existing mechanisms, such as ethics committees and consultation services, be expanded to provide services to those facing challenges in the area of business ethics.

This suggestion is based on the following two considerations:

1. The boundary between "clinical" ethics and "business" ethics is not clear and in many cases is nonexistent. While marketing and admission practices are seen as issues related to "business" ethics, they can lead to unneeded admissions or demand for unneeded services, both of which can unnecessarily expose the patient to the risk of side effects or complications. Likewise, underutilization of needed services is likely to lead to less than optimal health outcomes.
2. The knowledge and expertise of the individuals in existing mechanisms, such as ethics committees and consultation services, have much to contribute to the resolution of challenges in business ethics. For example, effective members of ethics committees and consultation services have: knowledge of ethical principles; knowledge of how to reason about ethical questions; skills in communicating and educating about these ethical principles and methods of reasoning; and skills in facilitating ethical dialogue and decision making.

Each of these bodies of knowledge and skills is necessary to resolve ethical challenges in business decisions and practice, and their expansion to that realm will help prevent artificial separations between "clinical" and "business" ethical issues. But this suggested expansion in the scope of the ethics mechanism may require an expansion in the expertise of participants (usually through augmenting membership of existing committees and consultation services to include administrators and other nonclinicians) and will require that the mechanisms be accessible to the organization's nonclinical administration and staff.

If an organization recognizes and acknowledges the challenges and discusses and resolves the issues, it must also protect and be accountable to the public for its actions. Ultimately, accountability means telling health care consumers

what risks they face from the ethical challenges, how they are being protected from those risks, and how successful the organization is at protecting them. Effective ways to protect the patient and other health care consumers are to make public the organization's code of business ethics and its criteria for admission, transfer, and discharge, and to encourage patients to review their bills. Public disclosure not only is an incentive to the organization and its staff to make good ethical decisions and to live by them, but also enlists the patient as a participant in his or her own care, including protecting himself or herself from harm.

Just as there has been advice to patients to ask the doctors and nurses about the medication they receive, likewise, they should be encouraged to ask questions about their admission, discharge, and treatments and to inquire about alternatives. This encouragement should go beyond the requirements set forth in current Joint Commission standards, which stipulate that the organization have a publicized mechanism to review and expeditiously resolve complaints from patients and their families and to inform the complainant of the outcome.

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Issues in Managed Care

As noted above, a health care organization such as a managed care organization that is at financial risk in providing care to a defined population, faces a potential ethical challenge that culminates in risk of underutilization of necessary

services. Because of financial risk borne by the organization, there can be a temptation to provide fewer services and the least expensive services to an enrollee. This temptation could influence the ordering of diagnostic tests, referrals to specialty care, admission to a more intensive setting (e.g., the hospital), the use of specialty services (e.g., rehabilitation), the list of medications included in the approved formulary, the organization's policy on off-formulary prescribing, and recommendations for therapeutic and rehabilitative procedures.

The need for the organization to contain costs within a fixed income can place pressures on clinicians and administrators to act in ways that are not in a patient's best interest. Certain methods of risk sharing with clinicians and/or administrators can transfer this pressure from the organization as a whole to the individual. For example, if a portion of a physician's income is based on how much money is *not* spent on patient care, the physician may be tempted to avoid services needed by the patient. Associated with these pressures is another risk: some managed care organizations have, by written or unwritten policy or through incentives, restricted the physician's freedom in informing the patient about alternative treatments that are either costly or not offered within the organization's benefit package.

These pressures tend to exacerbate certain ethical challenges including those that involve:

- The interest of the patient vs. the interest of the organization, including employees and their families;
- The interest of the one — the individual patient — vs. the interest of the many — the population served by the organization; and
- The interest in constraining choice so that it involves using the most cost-effective intervention vs. the patient's right to be informed about alternative treatments (some of which may have merits other than cost-effectiveness, or which may not yet have received adequate study regarding cost-effectiveness) and to

participate in decision making.

To address these challenges and risks, in 1994 the Joint Commission expanded the scope of the organizational ethics standards for managed care organizations accredited under its Health Care Network Accreditation Program. The following new standard was added (in the language of the 1996 *Accreditation Manual for Health Care Networks*):

The network's code of ethical business and professional behavior protects the integrity of clinical decision making, regardless of how the network compensates or shares financial risk with its leaders, managers, clinical staff, and licensed independent practitioners.

The intent of this standard is

To avoid compromising the quality of care, clinical decisions, including tests, treatments, and other interventions that are based solely on member health care needs. The network's code of ethical business and professional behavior specifies that the network implements policies and procedures that address this issue. Policies and procedures and information about the relationship between the use of services and financial incentives are available on request to all members, clinical staff, licensed independent practitioners, and network personnel.

This intent statement makes clear that the standard requires that the organization recognize and acknowledge the ethical challenges that arise in connection with financial incentives or sharing of financial risk, and requires that the organization discuss and resolve the ethical challenges in order to create its own code of ethical business and professional behavior. The organization must then protect the public — patients and enrollees — from these risks by establishing policies and procedures that reflect and implement the resolutions embodied in the code, and it must be accountable to the patients and enrollees by

publicly disclosing the source of the risk ("the relationship between the use of services and financial incentives") and its method of protection from this risk ("policies and procedures").

It is the organizations themselves that must struggle with the ethical challenges they face and resolve them in the contexts of their own ethical values.

The pressure to reduce costs could also tempt a managed care organization to base the composition of its practitioner panel predominantly on financial consideration. While managed care organizations or fee-for-service settings, including hospitals, may use economic, including utilization, criteria in appointment and reappointment, these decisions can affect the quality of care. Not only could they be disruptive of a patient's long standing doctor-patient relationship, but they could also be unintentionally biased toward practitioners who succumb to the incentives for under-utilization of needed services. To address this risk, the Joint Commission introduced the following standard in its 1996 *Accreditation Manual for Hospitals* and *Accreditation Manual for Health Care Networks* (in the language of the Network manual):

Decisions on appointments or reappointments [and clinical privileges in hospitals] consider criteria directly related to the quality of care.

Thus, when a contemplated decision is based on financial aspects or considerations other than quality of care, the potential impact of the decision on the quality of care must be considered before it is implemented. That is, the organization must *recognize* and *acknowledge* the potential risk, and must *discuss* and *resolve* it, making its own record of its decision and rationale.

Conclusion

In today's turbulent environment, health care organizations face ethical challenges on a daily basis. Some challenges seem directly related to decisions about an individual's care, and have been traditionally thought of as issues in *clinical* ethics. Other challenges seem more related to business decisions, and have been thought of as issues in *business* ethics. In both realms, the health care organization, as an organization, plays a role, whether in establishing procedures for obtaining informed consent — a focus of clinical ethics — or in establishing guidelines for truth in marketing — a focus of business ethics. Hence, in a health care organization, clinical ethics and business ethics together comprise its *organization* ethics.

However, the boundaries between clinical ethics and business ethics may turn out to be ephemeral or illusory. For example, business decisions and practices in marketing, admissions, discharges, transfers, and reimbursement mechanisms can all affect patient care and, ultimately, patient health outcomes and patient satisfaction. Patient health outcomes are as close to *clinical* as one can get. Separating business ethics from clinical ethics in practice, therefore, is unlikely to serve the best interests of either the patient or health care organization or of those who are trying to resolve the ethical challenges in health care. Regardless of the issues from which the challenge arises, a sound approach to resolving the challenge has the same elements: *recognition* and *acknowledgment* of the challenge, *discussion* and *resolution* of the challenge, *protection* against failure to act in accordance with the resolution, and *accountability* to those at risk — the public, including individual patients and plan members — for the organization's decisions and actions.

The basic knowledge and skills needed to successfully use this approach in resolving ethical challenges often can be found in existing organizational structures and mechanisms used to resolve ethical issues that arise in the care of patients, such as clinical ethics committees and

ethics consultation services. An expansion in the scope and business ethics expertise of these mechanisms, and in their accessibility, would build on the mechanisms' strengths, and would help avoid an often artificial and unproductive compartmentalization of ethical issues.

While the Joint Commission, through its standards, has called upon health care organizations to act ethically in their business practices, it is the organizations themselves that must struggle with the ethical challenges they face and resolve them in the contexts of their own ethical values. Ultimately, the public will hold them accountable for those values and decisions.