REVIEW

Managing the Conflict between Individual Needs and Group Interests - Ethical Leadership in Health Care Organizations

Suzanne Shale

Centre of Medical Law and Ethics, King's College London, United Kingdom

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Abstract: This paper derives from a grounded theory study of how Medical Directors working within the UK National Health Service manage the moral quandaries that they encounter as leaders of health care organizations. The reason health care organizations exist is to provide better care for individuals through providing shared resources for groups of people. This creates a paradox at the heart of health care organization, because serving the interests of groups sometimes runs counter to serving the needs of individuals. The paradox presents ethical dilemmas at every level of the organization, from the boardroom to the bedside. Medical Directors experience these organizational ethical dilemmas most acutely by virtue of their position in the organization. As doctors, their professional ethic obliges them to put the interests of individual patients first. As executive directors, their role is to help secure the delivery of services that meet the needs of the whole patient population. What should they do when the interests of groups of patients, and of individual patients, appear to conflict? The first task of an ethical healthcare organization is to secure the trust of patients, and two examples of medical ethical leadership are discussed against this background. These examples suggest that conflict between individual and population needs is integral to health care organization, so dilemmas addressed at one level of the organization inevitably re-emerge in altered form at other levels. Finally, analysis of the ethical activity that Medical Directors have described affords insight into the interpersonal components of ethical skill and knowledge. (Keio J Med 57 (1) : 37–44, March 2008)

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Introduction

In the situation I am about to describe, what would *you* do?

Imagine that you are the Medical Director of a reasonably good general hospital in a large English city. As Medical Director, you are the chief clinician and also an executive member of the hospital Board. You are accountable for the quality of medical care and, along with other members of the Board, responsible for setting and meeting the hospital's annual budget.

Your hospital suffers a constant shortage of intensive care beds. To provide intensive care to your patients when there is no room for them in your own intensive care unit (ICU) you rely on other hospitals nearby. In return, you have agreed to make intensive care available to patients from those other hospitals when they need it, if you have beds available. Because your ICU is always busy, you infrequently receive patients from your partners. So you are 'net exporter' of patients, and depend on good working relationships with other organizations to deliver intensive care to your patient population.

Shortly after you arrive for work today, an eighty-three year-old patient on one of your medical wards suffers a cardiac arrest.[*1] Dorothy is resuscitated, and put on a ventilator in the ward. But now she needs to be admitted to intensive care. In England, hospital specialists have agreed national guidelines for admission to intensive care, and the ICU team have assessed her according to the guidance. They have come to the conclusion that her

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Corresponding Author: Suzanne Shale B.M., M.A., 14 Waterloo Terrace, London N1 1TQ, U.K E-mail address: Suzanne Shale @ clearer-thinking.co.uk

prognosis is very poor, and that she does not satisfy the criteria for admission. Dorothy's family are at her bedside, very upset. Although in English law their views are not binding on doctors, nurses have asked them what they would wish for their mother. They said: 'We know that she has Alzheimer's disease, and that her kidneys are failing. We realise that there is a ninety five percent chance of her not surviving. But to us that means that there is at least a five percent chance that she could live a bit longer. Our mother is not ready to die yet. So we want her to be put on a ventilator in the ICU'.

Members of the resuscitation team are angry because the ICU team still refuses to admit the patient. Individuals in the ICU team are frustrated because they have applied the guidelines, and it is never easy to turn a patient away even if they believe it is the right decision. In the end, a member of the resuscitation team telephones the Medical Director's office to request your help. She wants you to come down to the ward and instruct the intensivists to admit Dorothy to their unit.

What would you actually *do* in this situation? I place emphasis on the verb 'do' because the research from which this example is drawn is an inquiry into the moral *action* that medical leaders take when they are faced with these and similar challenges. Much of medical ethics is concerned with the question 'How should doctors *think* about the moral problems that arise in caring for *individual* patients?' My research question differs from that in two ways. It is, 'What do doctors *do* to manage the ethical dilemmas that arise in *organizing* health care?'

Moral beliefs and ethical actions

Thinking and doing are of course closely related but it is a mistake to conflate the two. Moral beliefs do not automatically translate into ethical action. Many people believe that lying is wrong, but on occasion we go ahead and do it anyway, knowing that it is wrong. There are many reasons we do so. We tell lies with good intent, when we think lying will bring about a more morally attractive outcome than telling the truth. Less commendably, we lie with bad intent. We are tempted by the prospect of personal advantage, and allow temptation to overwhelm our moral beliefs. Or to avoid trouble, we decide to remain silent and allow others to believe what we know to be an untruth. There are many reasons why beliefs, intentions, and actions may not match each other. It is precisely because we often *do not act* in a way that is consistent with what we say are our moral beliefs, that I am interested in how people *do* implement their moral values in the challenging setting of health care.

That beliefs intentions and actions may not be consistent is, to ethicists, a familiar proposition. Less familiar, is the claim that knowing what is ethically desirable is often only a very small part, indeed, perhaps, the least demanding part, of ethical action.

Breaking bad news to patients is an example of just such a task. Doctors and philosophers in the UK and North America generally agree that it is ethically correct to tell a patient of their cancer diagnosis. Whether to break bad news is no longer, to the moral philosopher, a particularly perplexing moral question. But it remains a difficult and sometimes perplexing moral action. A doctor planning to tell the patient his diagnosis would have a morally good intention. But it would not be a morally praiseworthy *action* if he blurted the truth to the patient on the way to another task, spared no time to answer questions, and seemed not to care about the patient's feelings.

Implementing moral action demands much greater care than merely forming a moral intent. The moral action of breaking bad news requires, first, thoughtful planning. The doctor must find an appropriate private space, have information to hand, and rehearse her statements and the patient's response in her own mind. Then it requires knowledge. The doctor must marshal technical knowledge relating to the diagnosis, prognosis, management plan, treatment choices, side effects, and the rest. And the doctor will need to have or get personal knowledge, of the patient's own priorities, interests, concerns, and preferences for how information is presented. Morally breaking bad news requires communicative skill. The doctor has to express herself clearly, hear the questions the patient is trying to ask, and use her mental acuity to tailor information in response to them. Additionally, such moral action demands emotional intelligence. The doctor needs the ability to empathise, to manage anger or distress. And she must also possess the capacity to disengage, because the doctor who over-identifies with patients will soon 'burn out' emotionally. What is a simple ethical question to the philosopher is a demanding ethical task in everyday clinical settings.

The very complexity of the moral task of breaking bad news tells us why doctors sometimes fail to do it as well as they and their patients would wish. It is not because they are simply careless, or unethical. It is because it can be very difficult, and take considerable skill, to shape our ethical actions to achieve our ethical intentions.

Individual and organizational ethics

Like moral belief and ethical action, providing care for individual patients and organizing care for populations of patients are closely related and yet differing tasks. A doctor's duty is to make the needs of his patient his first concern. Similarly, ethical healthcare organizations aim to provide the best possible care for each of their individual patients. But the reason health care organizations exist is to provide better care for individuals through providing shared resources for groups of people. Providing

for an entire patient population confronts health care organizations with ethical challenges different from those that typically confront individual doctors.

It is a paradox of health care organization that sometimes, what the ethical organization must do to secure the interests of groups of patients, may appear to conflict with the interests of individual patients. This paradox is evident in any controversy over allocation of health care resources. Because health care supplies are finite, and health care demand is infinite, all patients are effectively in competition with one another for resources. A budgetary decision to spend more money on medical service A almost inevitably entails there being less money available for medical service B, however needy are the individual cases receiving service B. The decision to allocate a bed to current patient C, may mean none being available for future patient D. As Dorothy's story suggests, ensuring that intensive care beds will be available for the group of patients who can benefit from them most, may mean turning away individual patients who benefit from them least.

Clinical education supplies another example of the paradox, one so familiar it often passes unnoticed. Patients attending hospital attend for the purpose of receiving treatment, and they naturally desire the most skilful treatment from the most highly qualified doctors. But if hospitals are to be able to treat future patients, they must train future doctors. Doctors-in-training, of course, need patients upon whom they can practise their undeveloped skills; and the most highly qualified doctors, who might otherwise use their time skilfully treating patients, must spend time teaching those skills to others. Clearly, an ethical organization has to balance the desires of current patients with the needs of future patients.

Later in this paper, I take two further instances of the 'health care organization paradox' to illustrate how ethical challenges arise out it. These examples are managing admission to intensive care, and managing organizational performance targets. To inform that discussion, I shall first of all look at the first ethical obligation of health care organizations, acting to secure patients' trust. Finally, I shall return again to Dorothy's story at the end of the paper, to consider what moral action should be taken in managing her case.

The foundational obligation: securing trust

Relationships of trust lie at the very heart of medicine. One of the earliest lessons medical students learn is that a doctor's first concern is the well being of his patient. Taking steps to secure their trust must be among his earliest actions towards each patient. The health care organization also owes its first duty to patients, and patient trust is as much the responsibility of the health care organization as the individual doctor.

The trust relationship has two dimensions. There is a cognitive element, where a trusting party makes a rational assessment of risk. And there is an affective element, where emotional bonds emerge through social interaction.[*2]

It is extremely difficult for patients to make a rational assessment of the risks involved in seeking medical treatment from a particular practitioner. In medicine, as in any profession, there is asymmetry of knowledge between professionals and the people who consult them. The primary reason for the consultation is that the practitioner knows more than the patient, so the patient is ill placed to judge the knowledge and competence of the practitioner.[*3] To the extent that patients do assess risk, therefore, they rely heavily upon others to minimise hazard for them.

In the background of the doctor-patient relationship, a multitude of organizations is responsible for assuring standards of professional care and the education of safe practitioners.[*4] A patient submitting herself to medical treatment implicitly assumes that these organizations have faithfully discharged their obligations. When she gives consent to a particular doctor or nurse she trusts that their employer or accrediting organization is assured of their competence. She trusts that the technical resources the hospital or clinic has made available are adequate and fit for their purpose. She trusts that medications and procedures have been properly tested, evaluated and found to be safe. She trusts there is evidence that the treatment she will undergo is capable of providing some benefit. She trusts that the education of doctors in training will be organized in a way that balances their need for educational experience with her need for safe and effective care. Patients place their trust as much in organizations as they do doctors, and justifying this trust is a significant ethical obligation for organizational leaders.

The vulnerability of those who are ill tends to heighten the affective elements of trust. This element of trust is elicited through such actions as demonstrating respect, being responsive to individual patient needs, admitting clinical uncertainty, and acting in a caring manner towards people who are feeling frail and afraid. Doctors' interpersonal skills therefore play a critical role in supporting the leap of faith that is required to procure trust.

But while doctor-patient interaction comes to the fore to elicit the affective dimension of trust, the organization is still at work in the background. The organization that fails to act rapidly, impartially, and wisely when patients complain of poor care, courts feelings of injustice that undermine trust. The organization that discriminates against less favoured groups when it allocates its resources jeopardizes the trust relationship with those groups and probably others. Organizations must respond in an ethical and humane way to the challenges that they

face, if trust is to be maintained.*5

How are trustworthy health care organizations made? It can only be through the activity of those who work in and with them, and especially the people who lead them. It must therefore be one of doctors' many ethical obligations to their patients that they contribute towards building ethical organizations. This is a high expectation of individual doctors. For the medical leader, building an ethical organization is an essential part of their role.

Ethical medical leadership: two examples

I argued earlier that there is a paradox at the centre of health care organization. The needs of individual patients, and the needs of groups of patients, sometimes appear to conflict. The ethical organization will seek a morally satisfactory solution to this problem. In this section I consider two examples that demonstrate how intractable a task this may prove.

The examples of the 'health care organization paradox' are taken from research interviews with Medical Directors working in the UK National Health Service (NHS). At the time of writing, 20 Medical Directors of UK hospitals and Primary Care Trusts*6 have been interviewed about the ethical dimensions of their leadership role.*7 Managing the 'health care organization paradox' is a common characteristic of their ethical experience. Medical Directors experience the conflict between individual interests, and those of populations, more acutely than any other member of the organization. As clinicians, they are obliged to uphold an ethic of practice that prioritises the interests of individual patients. As organizational leaders, they are accountable for the scope and quality of care provided to groups of patients.

Solving the paradox described earlier, between the needs of individuals and the interests of patient populations, is one of the ever-present challenges of medical leadership. The paradox is never wholly dissolved. It is one of the striking features of the ethical life of health care organizations that the paradox 'dissolved' at one level re-emerges in altered form elsewhere. Wherever it re-emerges, medical leaders and their clinician colleagues are charged with re-solving it.

Dorothy's story makes this point well. The only way to relieve resource allocation pressure in a moderately efficient health care system is to require populations to pay for further services, either directly or indirectly through taxation. The UK government has concluded that this solution is neither morally nor politically acceptable. The Medical Director's difficulty over Dorothy arises in part out of the brute fact that he has a limited budget, and increasing the number of ICU beds would mean reducing provision to other services. Let us assume that the Board of his hospital has considered that solution, and concluded that it is morally undesirable. At Board level, the ethical dilemma of how to allocate health care resources has been addressed and a moral defensible decision has been made. But at the bedside level, the ethical difficulties reappear. Hard choices must still be made, about which individual patients should receive the benefit of ICU resources that have been provided for the entire patient population. As the ethical dilemma re-emerges at the bedside, so the ICU admissions protocol is introduced to re-solve it.

In keeping with our theme, the ICU admissions guidelines are intended to benefit both individual patients and groups of patients. First, the guidelines ensure that individual patients who cannot benefit from intensive care, and who may indeed be harmed by it, are not inappropriately admitted. Second, the guidelines aim to distribute intensive care resources fairly. The guidelines allow intensive care specialists to distribute ICU care consistently, and to supply a reasoned, consensus view for their admission decisions. Introducing a consensus based organizational policy distributes the moral burden of difficult decisions, making them as much the responsibility of the organization, and the clinical professional community, as of individual physicians. But, as we have seen through Dorothy's case, the moral pressure points remain.

Attempting to solve the ethical dilemma by using the protocol has simply transformed the arena of ethical conflict once again. Dispute over what principles *should* apply has become a dispute over how guidelines *do* apply, in the instant case. Does this imply that moral conflict has been transformed into mere procedural disagreement? I think not. Managing admission to ICU remains a profoundly moral activity. Certainly, the components of the moral decision are altered, so that clinical judgment comes to the fore and abstract moral principles recede to the background. But it is a judgment with life and death consequences for the patient. It is a judgment given structure and shape by prior ethical commitments. And it is a judgment that invites ethical reflection. The moral identity of individual doctors, the ethos of the medical profession, and the moral culture of organizations, are all a product of how these moral activities are managed.

We must remember, too, the argument that ethical decisions are only a small part of ethical action. Applying the protocol to the instant case to make a decision is only a small part of the ethical work that needs to be done. Attention must be given to how Dorothy's admission or rejection is communicated, to her continuing care in light of the decision, to the needs of her family, and to restoring organizational harmony.

When we conclude our analysis of Dorothy's story in the final section, we will see how ethical action is composed of clinical, interpersonal, and ethical skills as well as ethical knowledge. Before we do so, a second example from my research supplies further evidence of how

the health care organization paradox emerges and re-emerges at different levels to face medical leaders and organizations with ethical challenge.

A little background information is required if readers unfamiliar with the contortions of health care policy in the UK are to grasp the nature of the problem. Since 1948, when the National Health Service was founded, it has been a cornerstone of UK health policy that health care shall be free at the point of delivery to all UK citizens. The UK population pays for NHS services through general taxation, and most hospitals are in public ownership. Ever since the NHS was founded, in most geographical areas, and in most specialties, there has been greater demand for hospital treatment than hospitals could supply. Because there is a continuing commitment to free care at the point of delivery, one of the few means of rationing care has been the 'waiting list'. Patients form a 'virtual' queue for treatment. By the end of the 1990s, UK patients might wait, for example, for two or more years for a hip replacement or knee surgery. Rather differently, patients who attended Accident and Emergency Departments with small accidental injuries (a minor fracture or dislocation, for example) might find themselves waiting twelve or more hours for treatment.

The time a patient waits for treatment is a moral issue. Patients waiting for treatment are often in pain or anxious, their condition frequently deteriorates, and they may face higher health risks when they do eventually receive treatment. It is also a political issue. Determined to reduce the amount of time that patients spend waiting, over the last ten years the Department of Health has set stringent targets for hospitals to achieve. These have been accompanied by financial incentives, and also with penalties for failure. One target is the 'four-hour wait' in Accident & Emergency departments. The aim is that every patient will have been seen, treated and discharged, or admitted to appropriate care, within four hours.

The Department of Health believed that paying organizations to meet their targets, and penalising organizations that failed to do so, would benefit individual patients. For the government, the moral and political problem of waiting times was solved. But many doctors and managers feared that if their organization were penalised for failing to meet particular targets, the penalty would diminish their capacity to provide care to all of their different patient populations. For some, implementing the government's solution to the moral problem of waiting lists posed unanticipated ethical choices.

First, was it best to recognise the moral legitimacy of the targets and to endeavour to meet them, even where there was a high risk of failure? Striving to meet demanding targets could mean taking organizational resources (time and money) from other equally important areas of health need, thus disadvantaging some groups of patients and distorting local health care priorities. But equally, failing to meet the targets could bring organizational penalties that reduced the hospital's capacity to serve their population (as well as damaging individual careers). Perhaps it would be better to protect the interests of the organization, and protect the interests of the wider patient population, by merely creating the impression of meeting the targets?

"A lot of people have applied technical fixes to get around the problem. The technical fix that a lot of people applied to the A & E wait was to just [create] an area behind the A & E department and say 'well, *that's* not an A & E!' At a time when we were struggling to meet that 4-hour target, our A & E [staff] were invited [to see how other hospitals had solved the problem]. So they went to a few places and came back and said 'There's one place, they just painted a line across the corridor — and this side's A & E, and that side's *not* A & E!' You think 'That doesn't really solve the problem at all, what's that good for?' So we spent quite a lot of time arguing through the morality of this, and of the whole situation. My A & E colleagues were absolutely adamant they were not [going to apply a technical fix]. One came to say she'd heard a rumour that something was going to happen, and said 'If this happens I'm going to have to resign, I'm really sorry but I can't work in that way'. Perhaps it went a bit too far on the moral high ground but they certainly were not interested in creating some technical fix to this target."

Second, 'the health care organization paradox' became evident on those occasions when an individual patient's needs threatened to breach the targets. The penalties associated with failure challenged medical leaders to uphold the traditional ethic of making the patient their first concern, when doing so could potentially work against the interests of the organization and therefore of the patient population as a whole.

"At times [targets] begin to jeopardize patient care. That's where the medical manager role, particularly Clinical Director but also the Medical Director, is absolutely essential so that you don't have [hospital] management doing things that end up being fundamentally unethical…A very good example of that would be the four-hour A & E targets. Originally the Department of Health said this target should be fulfilled 100% of the time. If you sit there as a lay person, you say 'Surely you should be able to deal with somebody in four hours in Accident and Emergency, and send them home or admit them to hospital'. You then immediately run into problems, people who are very unstable, very sick, very ill in the resuscitation department of casualty. You've got all the kit there, you've got all the equipment there, you've got all the staff there. If you don't have an intensive care unit bed to move them to, well as far as I'm concerned they stay there until you've got that sorted. Which could be five hours, six hours, eight hours. That doesn't matter.

What's important is you're managing the patient in a safe environment."

To avoid the ethical tensions, we could simply stop setting targets. But although the Medical Directors in my study supplied these examples of the difficulties that targets created, they generally supported their use. The Medical Directors recognised that in the past, good will alone had not produced an efficient and patient-centred health service; and that the much debated and widely disliked 'target culture' had by and large improved the patient experience. Because they accepted the benefits that could come from working towards meeting their targets, they were also willing to accept the burden of moral choice with which these targets sometimes confronted them.

Some components of ethical action

We now return one last time to Dorothy's story, to consider again what you might do if you were the Medical Director. From the dozens of examples of moral action that Medical Directors in my study have narrated, fourteen dimensions of 'doing right' have emerged. Nine of them are relevant to managing Dorothy's case.

1. *Nurture moral networks*. A significant part of what a Medical Director must do, he or she must have done before this problem arises. Medical Directors who have not already earned the moral respect of colleagues are less likely to be made aware of difficult issues, or to be consulted regarding their solution. To be thought a source of moral authority in difficult situations, they will have demonstrated their integrity in past moral action. Probably they will have been observed prioritising patient welfare when other matters are pressing; perhaps they are known for thoughtfully responding to patient complaints; maybe they are seen always to act fairly in disputes between colleagues. The Medical Director sustained by a strong moral network has additional motive to 'do the right thing'. And the Medical Director who commands moral respect is better placed to call on others to 'do right' too.

2. *Realize the problem*. To 'realize the problem' may mean appreciating that it is an ethical dilemma, but this is not always the case. Realizing the problem means understanding that a particular matter needs attention, giving it sufficient priority, and bringing moral awareness to bear upon it. When the resuscitation team telephone to ask the Medical Director to come down to the ward, the Medical Director faces a choice. Is this a matter that needs his attention? Is it more important than other items on his agenda that morning? Is it an issue that calls for ethical leadership, so that it would be right to intervene between the ICU and resuscitation team? Or is it a purely clinical matter, the sole concern of the clinicians involved in the patient's treatment? A Medical Director's first action therefore is noticing (or not noticing) that something needs to be done.

3. *Name the problem*. An early step in the Medical Director's dealing with the problem is recognising — at least in a preliminary way — its components. Dorothy's problem obviously has to do with the needs of the patient, the wishes of her family, and the application of the ICU protocol. For the Medical Director who described it to me, it had other dimensions too. In part, it reflected the junior status of the doctors in the resuscitation team and covering the intensive care unit, who lacked the experience to resolve the conflict themselves; the temporary absence of the senior doctor caring for the patient; and failure to make difficult decisions earlier in the management of Dorothy's case. It also concerned the Medical Director's relationships with other hospitals that might be asked to 'import' his ICU patients. In different circumstances, the problem could have been an expression of underlying conflict between professional groups. Or, it could have arisen out of reluctance to implement a protocol with which some staff disagreed. Each of these causes would call for a different management response from the Medical Director. Such interpersonal issues are rarely the stuff of philosophical analysis, but they lie at the heart of day-to-day ethical action in health care settings.

4. *Explore potential solutions*. Clinical ethics protocols urge clinicians to identify at least three possible solutions in the course of ethical analysis. During their interviews, Medical Directors described how they moved back and forth between the tasks of generating a range of solutions, testing them for 'fit', consulting colleagues, and deepening their understanding of the situation. Some dilemmas, such as the present case, may at first seem to present only one choice. Should the patient be admitted to the ICU, or should the patient be cared for on the ward? But there are other aspects of the problem that require solution. The Medical Director must also address questions around the patient's continuing care, the needs of the patient's family, and the restoration of organizational harmony.

5. *Analyse moral considerations*. Aristotle described as 'practical wisdom' the work of understanding the moral dimensions of specific situations, weighing moral considerations in the balance, and coming to a reasoned moral decision. There are at least five moral considerations in Dorothy's situation that the Medical Director needs to weigh. The first must be the ethical obligation to act in the patient's best interests. Dorothy should neither receive treatment that is too burdensome, nor be deprived of care from which she could benefit. A second factor is the relationship with Dorothy's family. Although Dorothy's own interests come first, and there is no legal obligation to do what Dorothy's family ask, her relatives have significant moral interests that have to be taken into

account. A third factor is the responsibility not to waste resources that cannot benefit Dorothy but could benefit others. Continuing to treat Dorothy, as her family have requested, may do her no harm. But if it does not benefit her either, the resources could be better used for other patients. The fourth factor is the relationship with the hospitals that the Medical Director relies upon to 'import' his ICU patients when necessary. This reciprocal relationship may be jeopardized if he 'exports' patients too frequently, particularly if his ICU admits patients outside of the national guidelines. Finally, the Medical Director will be aware of the organization's need to meet the government's target for waiting times in Accident & Emergency. If there are no beds available in the ICU, the A&E may find itself holding patients who need critical care beyond the four-hour time limit. 'Practical wisdom' requires that the Medical Director weighs all of these factors, decides which should take priority, and considers how, if possible, any negative consequences can be minimised.

6. *Coordinate group action*. One of the tasks of leadership is to decide whom to involve in addressing a problem. Health care organizations are dense networks of formal and informal obligation. In this situation, there are people (such as the senior doctor responsible for the patient) who should be involved because of their formal role; and there will be others affected (such as the resuscitation team) for whom the outcome is morally important. 'Doing right' in these circumstances entails directing the ethical activity of the group. The senior doctor should be present to discharge her responsibility to her patient. Someone must consult the family, and give a compassionate explanation of what is happening. The voices of those morally interested should be heard. This takes us to the next dimension of moral action.

7. *Hear the person*. It is a profound moral act to listen deeply to the expression of emotions such as anger, fear or grief. Giving full attention to strong negative emotion takes courage and self-discipline, but it is an important component of moral relationships. Distress grows when people feel that those who should be listening to them are not doing so. Distress quietens when people feel they are being listened to without being judged. The ethic of listening allows difficult things to be said. It is through careful listening that both speaker and the listener can come to understand the true moral meaning of their situation and thus engage as moral equals.

8. *Give an account*. Difficult ethical dilemmas are those where we are confronted not with a choice between right and wrong things to do, but between right and right things to do. In Dorothy's case, some of those affected or consulted will almost certainly disagree with the outcome. Medical Directors in my study emphasised the ethical importance of giving an account of, and being held to account for, their decisions. In Dorothy's story, the ethical action would not be complete without a thoughtful explanation to the resuscitation team, the ICU team, and the family, about why Dorothy was or was not admitted to the ICU. The giving of a true account is morally important because it fulfils a foundational human need for authentic social interaction. Just as there is an intrinsic moral good to be found in proper listening, so there is an intrinsic moral good to be found in giving a full explanation of one's actions.

9. *Undertake moral reflection*. Learning from difficult situations is a means of redeeming them. Medical Directors emphasised in their interviews the moral gravity of the dilemmas they had faced, and some treated the sense of unease that occasionally remained with them, as an integral part of their ethical identity. Some recounted a process of reflection, during which they reconsidered their ethical performance and reassessed their ethical competence. The final part of ethical action, then, is considering its meaning and effects. The last of your tasks as Medical Director will be to prompt ethical reflection in your teams, and to consider your own conduct.

Conclusion

I started this paper arguing that moral action is as important as moral reasoning, that ethical health care organizations are as important as ethical doctors, and that neither has received sufficient attention in medical ethics. I noted the paradox at the heart of health care organization, where serving the interests of groups seems sometimes to cut across the interests of individuals. I argued that the paradox presents ethical dilemmas at every level of the organization, from the boardroom to the bedside. Furthermore, because the paradox is integral to health care organization, I suggested there can be no lasting solution to any of these ethical dilemmas.

I suggested that the first task of the ethical health care organization is to secure the trust of patients, and that all further ethical action takes place in the context of this primary task. I then demonstrated through two examples, ICU admission and organizational performance targets, how problems addressed at one level of the organization re-emerge in slightly altered form in another. Finally, I considered how nine of the components of moral action that have been identified in interviews with Medical Directors were relevant to resolving a typical ethical problem arising out of managing ICU admissions.

In carrying out my research I have relied upon the generosity of the Medical Directors who agreed to be interviewed. They made time to meet me in the middle of impossibly demanding daily schedules, and gave considerable thought to the questions that I asked them. It is their experiences and insights that have informed this discussion. It seems fitting that this paper should conclude, then, with the reflections of the Medical Director who

supplied the example that I have written up as Dorothy's story.

"The trouble is, that when you're implementing health policy, you're playing the percentage game. You think about how difficult that is, from time to time.

If someone is going to go into intensive care, and there's a ninety to ninety five percent chance they're going to die, the intensivists will feel that's inappropriate. And that's supported by the national frameworks. If I now said to you, 'I've got your nearest and dearest here, and there's a ninety to ninety five percent chance they're going to die' you'll turn round to me and say, 'But that means there's a one in ten, one in twenty chance that if you take them to intensive care they'll *survive*'.

That's the problem isn't it? It's those individual things."

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Endnotes

*1 This story is derived from an example provided by a research participant. The patient's name is fictional.

*2 Calnan M, Rowe R: Trust relations in health care - the new agenda. Eur J Public Health 2006; 16: 4–6.

*3 This is not invariably true. In the case of chronic conditions, for example, the primary purpose for the consultation may be to gain access to medical technologies or medication. The patient often knows more than the practitioner about their condition, how it affects them, and how it is best alleviated.

*4 In the UK these include the medical Royal Colleges, the General Medical Council, the Postgraduate Medical Education and Training Board, the Healthcare Commission, the National Clinical Assessment Authority, the National Patient Safety Agency, the National Institute for Health and Clinical Excellence, Local Research Ethics Committees, and of course health care providers themselves through clinical audit.

*5 The UK Royal College of Physicians argues that just as trust operates at the level of both the individual doctor and the institution, so does professionalism. The individual professionalism of individual doctors depends upon the institutional professionalism of the organization and vice versa. Report of a Working Party - Doctors in Society: Medical Professionalism in a Changing World, Royal College of Physicians, 2005, p 66.p15

*6 Primary Care Trusts (PCTs) in effect direct the budget for health care services for a defined geographical population. They contract for primary care from General Practitioners and commission secondary care from hospitals, and hold a budget for prescribing. General Practitioners run their practice as a private business partnership, and are paid for the services they provide according to their contract with the PCT. Hospitals are paid for the treatment they carry out, reimbursed at a national tariff and according to numbers agreed with the PCT. It is the role of the PCT to ensure that adequate services are available to the population, to enforce standards in GP practices, and to co-ordinate public health activities.

*7 Each has participated in a single conversational-style, semi-structured interview lasting between 90 minutes and 2 hours. Interviews have been recorded and transcribed verbatim, and then analysed using the software package *Atlas ti*. In accordance with the principles of grounded theory, analysis is taking place concurrently with data collection. Emergent themes and concepts are being elaborated and clarified through subsequent research activity. As the data set expands, findings are being comparatively analysed for internal consistency through the processes of coding and thematic categorization. Rubin HJ, Rubin IS: Qualitative Interviewing. Thousand Oaks, California, Sage, 1995. Strauss A, Corbin J: Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. Thousand Oaks, CA, Sage, 1998.