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Healthcare Organizations as Moral Communities

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This research project on social processes and barriers involved in the use of ethics consultations in a hierarchical hospital setting provides another example of the ongoing challenges that confront hospital nurses who strive to carry out their ethical obligations to patients. Physicians' power and dominance are powerful factors that influence the behavior of nurses in cultures that still support this power and dominance in many clinical settings. Several nurses in this study experienced moral distress and were often required to weigh risks and practice a form of moral heroism in requesting an ethics consultation to meet their ethical obligations to patients. Additional research is described that illustrates the ongoing nature of such issues in clinical settings that have plagued nurses for decades.

Forty years ago, physician and noted ethicist Edmund Pellegrino expressed serious concerns regarding the working relationships of physicians and nurses in patient care: "While some of our mutual concerns are matters of resources and techniques, a more urgent concern is of human organization and relationships. The focal human problem that we have not yet solved is how best to employ the particular skills of each of the health professions synergistically to the benefit of the patient."[1] Consideration of Pellegrino's concerns in the 1960s lead this author to argue, 40 years later, that issues of human organization and working relationships in hospitals have never become a top priority in today's health scene, in which economic concerns and the use of the latest technologies dominate. Yet, inherent in the working relationships of healthcare professionals and caregivers are significant ethical obligations such as respect and avoiding harm to both patients and to the people who provide their care. Educators of health professionals have recognized for decades the importance of interdisciplinary learning and have made many efforts to realize this in professional curricula. Still, interdisciplinary education efforts founder, as critical goals of technical knowledge and expertise take priority in crowded curricula over the so-called softer areas, such as communication skills, human relationships in complex organizations, and professional ethics. Development of collaborative practice models in patient care settings have often suffered a similar fate, as they require sustained institutional and professional commitment.

Would it make any significant difference in patient care outcomes and the development of more collaborative professional relationships to change our focus, in the current culture of healthcare, from communities of technical expertise and business investment to a focus on moral communities of healthcare in which patients, families, health professionals, and caregivers are all accorded respect and accountability in the patient care decision-making process? In such moral communities, inclusive patient care conferences would be an essential and valued part of the care and decision-making processes. They would be carried out to

practice primary prevention of some of the ethical crises that lead to moral distress, the need for nurses and others in hospital hierarchies to become moral heroes to carry out their professional obligations to patients, and the need for ethics consultations in situations of tension, conflict, or perceptions of "giving up" on patients. In this author's experience, ethics consultations were often the first and only opportunity for health professionals to share their knowledge of complex patient care situations face-to-face and to reflect on decision-making choices and their probable consequences.

One can speculate that significant risks and fears of negative consequences in the use of institutional ethics resources would decrease if nurses (and others) practiced in patient care settings where nurses could trust that administrators and their nursing and medical colleagues were knowledgeable about, and supported, the ethical behaviors and values that are promulgated in the ethical codes of all the health professions. In addition to advocating for patients, examples from the American Nurses Association *Code of Ethics for Nurses with Interpretive Statements* speak to nurses' responsibilities for preservation of personal and professional integrity and the development of healthcare environments that incorporate respectful collegial interactions, support of peers, and identification of issues that jeopardize caregiver integrity, respectful relationships, and patient care outcomes.[2] Gordon and Hamric's study, and others noted in their article, support the need for changes in the culture and organization of working relationships in patient care settings. Hospitals earning the designation of Magnet Hospitals for nursing practice may also provide clues for action, including hospital policy review, development, and implementation.

How many more research projects will be conducted before healthcare leaders in clinical and education settings marshall the will and the courage to change professional curricula and healthcare environments in which both patients and their caregivers suffer the damaging consequences of such hierarchical cultures? Comprehensive education of practicing nurses, nursing students, and others about institutional ethics resources is but a first step on the challenging journey to development of morally responsible healthcare cultures, in which nurses can carry out their ethical obligations to patients without fear of reprisal.

NOTES

1. E.D. Pellegrino, "What's Wrong with the Nurse-Physician Relationship in Today's Hospitals? A Physician's View," *Hospitals* 40 (1966): 70-80.

2. *Code of Ethics for Nurses with Interpretive Statements* (Washington, D.C.: American Nurses Association, 2001).