



MEDICAL ETHICS

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The Changing Ethics of Health Care

Health care delivery is changing, and the ethics of health care are changing along with it. Much has been written about how and why health care delivery is changing, driven largely by concerns about escalating health care costs. But far less attention is given to the changing ethics of health care — what the causes are, and what, if anything, can and should be done about it.

What Are Ethics?

Ethics are the moral principles that govern a group or person's behavior, and they are derived from the ethos of that group. *Ethos* is an ancient Greek word meaning “character” that is used to describe the guiding beliefs, values, or ideals that characterize a group, community, or nation.

The phrase “professional ethics” refers to the personal, organizational, and corporate standards of behavior expected of professionals, and is also referred to as “professionalism.” Professional ethics have — at one extreme — the highest aspirational goals of the profession and — at the other end — enforcement and disciplinary action for breaches of only the most basic aspects of professional behavior. There are no unifying structures or rules in health care that guide or control professionals beyond fairly minimal standards of acceptable behavior.

Most of us strive to do the right thing every day and sometimes struggle to know what the right thing is in a given situation, assuming there even is one right thing to do. What we believe is right is defined by our values (our personal ethics). Sometimes, however, our values — at least in a professional arena — are often imposed upon us and are subject to change. Conflict between one's own values and the values of the workplace or profession are the main factor in professional burnout, and this conflict contributes tremendously to workplace turnover.

Changing Health Care

A common theme in how health care delivery has changed over more than a century is the increasing fragmentation of care. In the 19th and early 20th centuries, as medical specialties developed centered around diseases of specific body parts and systems or technologies such as x-rays, anesthesia, and surgery, health care delivery was fragmented across the human body. Each doctor got to pick their favorite part or procedure. That continues today, but now the care of a single episode of illness also is fragmented across multiple sites of care and multiple practitioners. Fragmented care means fragmented relationships and fragmented responsibility.

If professional ethics can be thought of as what we as health care professionals expect of ourselves, then care fragmentation results in practitioners and providers expecting less of ourselves and consequently lowering our ethical standards.

Care fragmentation may have even more severe and negative consequences for patients and providers. This is perhaps best exemplified by changes in the nursing profession. Many of the traditional roles and tasks that nurses have historically carried out have in recent decades been carved up and redistributed to other lower wage workers. For example, at one time, nurses were expected to feed patients, assist with bathing and other personal care, administer medications, vigilantly supervise patients and monitor their condition, and even change the bed linens in a very prescribed manner referred to as making “hospital corners.” Now these tasks have been reallocated to housekeepers, dietary aides, nursing assistants, even “med techs.” Many of these changes arose out of economic necessity as well as widespread nursing shortages, and some of these changes are quite welcome, particularly within the nursing profession itself.

However, the reallocation of labor in this manner was based upon a mistaken belief that now is pervasive within the health industry that health “care” is merely the aggregation of various tasks organized to meet the needs of individual patients. As a purely practical matter, it has resulted in the virtual elimination of ongoing direct supervision and monitoring of individual patients, which was a hallmark of nursing care for millennia. Many negative health consequences have resulted from this shift, including an increase in injurious falls and the failure to recognize changing conditions in time to intervene and save lives. More fundamentally, however, it has redefined the word “care” itself and its moral imperative from being responsible for and caring for another human being to simply performing a task.

How Do Ethics Change?

Ethics change because the beliefs and values of groups change and because ethics are based on relationships and the expectations of individuals within those relationships. As the nature of relationships change, expectations change. As thoughts and beliefs change, behavior changes. The converse is also true. Sometime when behaviors are forced to change by external pressure, then thoughts, attitudes, and beliefs ultimately (albeit reluctantly) change in turn.

Professional ethics change because of changes within the profession, as has been illustrated with the examples of care fragmentation and changes in labor

distribution. Professional ethics also change in response to government regulations and changes in payment; even such things as implementation of an electronic medical record can result in changes in priorities or values among professionals as more work is added to the day or the flow of work is necessarily changed to conform to the demands of the technology. The more time required to document, the less time is spent with patients.

The medical profession once prided itself on upholding the ethical principle of paternalism, in which the “doctor knows best.” Patients were given little information or choice. It was assumed that only doctors possessed the requisite knowledge, skill, and experience to know what was in a patient's best interest. Unfortunately, many patients were denied information that would have been invaluable to them in planning and living their lives. In a national survey of physicians in 1963, for example, the overwhelming majority of doctors reported that for ethical reasons they would not tell a patient they had cancer, for fear of the emotional toll it would take on the patient.

Over the past 40 years, the principle of autonomy, the right to make decisions on your own behalf, has gained primacy over paternalism. The shift from paternalism to autonomy shifts power and control from physicians to patients. Federal laws such as the Patient Self-Determination Act, now more than 20 years old, affirm a constitutionally protected right of patients to make their own decisions, to refuse treatment, and even to do things that others might feel are not in their best interest. It obligates providers to honor patients' advance directives, including their desire not to be resuscitated. Numerous studies have shown, however, that advance directives are routinely disregarded by health care practitioners, particularly if they conflict with the values and beliefs of the individual health care professionals responsible for treatment. It is a typical practice among surgeons and anesthesiologists, for example, to refuse to perform surgery or administer anesthesia to any patient unless that patient revokes their advance directive not to be resuscitated in the operating room.

A Culture of Fear and Money

At some level, most if not all doctors are afraid of their patients and families, as are most nursing homes, hospitals and health systems. Risk management is in large part fear management. We are taught to be afraid. We are taught not to trust the very people whom we expect to trust us. We are taught to practice defensive medicine.

In so doing, we treat ourselves, rather than our patients. We put our own interests ahead of theirs. We do

things to them, rather than for them. Defensive medicine is overtly offensive to many patients and families. Many facilities require patients or families to sign waivers in order to participate in dangerous activities such as eating.

It is a generally accepted belief that money strongly influences the behavior of health care professionals. Changing professional behavior in response to changes in how health care is paid for over the last 30 years or so appears to bear that out. Changes in professional ethics appear to follow suit. Money is considered to be such a powerful motivator for health care providers and practitioners that efforts are underway to replace the entire scheme of fee-for-service practice by other “value-based” schemes that provide different payments based upon different kinds of performance or rather, on patient outcomes. All of these payment schemes have their own moral hazards, however.

Money does influence organizational behavior as well as individual behavior. Money is a way of valuing and prioritizing things. Among health care professions and specialties, some are more lucrative. The implication is that the work performed by professionals in those fields, which are all technical ones, is more important than the work performed by others such as primary care providers, or that the people receiving care (i.e., children, the mentally ill, and the aged) provided by lower-paid practitioners are less worthy than others. But it is a mistake to think that money alone will make human beings consistently do either the right or the wrong thing in a given situation.

As health care delivery has changed, the ethics of health care has changed along with it. Many of these changes have been unwelcome and have resulted in great professional frustration and dissatisfaction. Nevertheless, health care professionals are still among the most trusted people anywhere in the world. We can raise the bar for ourselves and others, and we can help to create a more caring society through our own conspicuous caring example. Hippocrates' admonition was to “first do no harm.” For our modern age it may be necessary to add the corollaries “first do not be afraid of your patient,” and to “care always.” This article was previously printed in the July 2016 issue of *Caring for the Ages*. DOI: 10.1016/j.carage.2016.06.012



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