Medical practice in the 21st century has changed substantially from the eras of Hippocrates and Nightingale, but physicians and nurses are still taught, and take an oath, to uphold the primacy of patient welfare. The tenets of ethical principlism that serve patient welfare include respect of autonomy, beneficence, non-maleficence, and justice. Nurses and physicians have sworn an oath to advocate for patients. However, if they are employed by a health care organization, they are also contracted to abide by that organization’s rules and regulations, including obedience to its chain of command. When the realities of complex organizations collide with the primacy of the patient, what is the clinician-employee to do? The following case-example explores the tension inherent in these 2 obligations:

In 2009, amidst the Great Recession, a small community hospital in a large city with multiple hospitals prepared for a financial worst-case scenario. Costs were reduced substantially by reducing technical support and increasing nursing ratios. Hospital administrators received approbation from the board of directors for a positive balance sheet, during a period in which most other hospitals suffered substantial operating deficits.

A year passed, and the hospital experienced sizeable surpluses. The nursing director of the intensive care unit (ICU) complained that her nurses were demoralized, frightened that they couldn’t keep up, and that patient safety was suffering. Other nursing directors privately agreed, but were hesitant to confirm her observations. Formal surveys suggested good morale and the hospital’s quality department had noted no uptick in adverse events.

The ICU nursing director politely objected to her supervisors. She also gathered research from several other city hospitals that showed their nursing ratios were lower and tech support greater. She was discouraged from reiterating concerns up the nursing chain of command, so she turned to physician leaders. Some agreed in principle but did not intervene because the hospital’s finances were favorable and there was no other indication of reduced morale or patient safety.

Finally, the executive officer summoned the ICU nursing director to a meeting and explained that although she admired the nursing director’s dedication to patients, the organization could not tolerate continued
open dissent. Discouraged and exhausted, the ICU nursing director resigned.

This scenario is likely to have played out at many hospitals over the past several years as developments in health care collided with economic duress. The 2008 recession coincided with a period of (relative) nursing oversupply; so nurses were both “replaceable” and economically vulnerable. As health care becomes an increasingly complex business, hospitals are led by officers and boards of directors who are not clinicians or are clinicians who have become full-time business people. In such a climate, what are the ethical obligations of the clinician when corporate interests undermine patient safety?

The Ethical Conundrum

Being fully human includes considering, prioritizing, and acting on one’s values and interests. The term conflict of interest generally describes a situation in which an individual has more than one competing interest in the performance or outcome of an endeavor. Most often, the term implies that some selfish interest could potentially affect how a decision is made by competing with a more objectively selfless interest or duty. Conflicts of interest are not inherently bad or good; they are simply implicit in many human endeavors. To the extent that selfish interests can subvert supervening duties or obligations, conflicts of interest must be managed through acknowledgment and care taken to ensure that neither conscious nor unconscious selfish interests inappropriately influence choices. Let’s consider how interests and conflicts of interest can differ amongst the “players” in hospitals.

Conflicts of Interest for Clinicians

Nurses and doctors take oaths that promise beneficence, which often requires subjugation of selfish interests for the good of patients. But we also may take oaths to country, God, or other value systems, and every person weighs each interest differently. Selfish interests include salary, job security, bonuses, investments, and gifts that compete with the arguably ascendant duty to beneficence. It is important to emphasize the distinction between one’s reasonable well-being (eg, a fair wage for medical care provided) and use of the clinician-patient relationship to accrue extra-ordinary benefit. These are normative distinctions and the lines are not always definitive. For example, there is increasing consensus that if a company offers expensive gifts to physicians to coax their use of products, this creates an unacceptable conflict of interest for those physicians who accept the gifts.

Much has been written about conflicts of interest in health care. However, the arguably prevalent tension between health care providers’ primary obligations to patients and their obedience to employers, as illustrated by the case-example, is underappreciated in the literature. Literature that examines the obligations of physicians who work for managed care organizations (MCOs), where cost-saving is inherent in employment, is relevant to our topic. These examinations center on clinicians’ “fiduciary responsibility” to patients. The asymmetry of power inherent in the doctor-patient relationship requires that the physician act as a fiduciary, that is, subjugate his self-interest to that of the patient. Martin Tobin referred to this relationship as a “covenant.” The patient enters this covenant with the belief that the physician will apply his superior knowledge of our highly technical field for the benefit of the patient, not the physician. The asymmetry of the doctor-patient relationship implies a greater duty on behalf of the physician than is typical of a simple contract in which all parties are considered equals.

Doctors working for managed care have been challenged ethically and legally for failure to disclose financial incentives that could influence their prescriptions or referrals. The ethical-legal issues for physicians in MCOs are similar but not identical in the quandary explored here. When physicians do not disclose conflicts and act in financial self-interest at the expense of patients’ welfare, they may violate their fiduciary responsibility. The nurse-patient

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Clinicians who are concerned with practices that might negatively affect patients’ welfare are obliged to respond professionally, proactively, and constructively.

Conflicts of Interest for Administrators

Some, but not all, hospital clinician-administrators swear an oath to the ethical practice of medicine. Medical ethics compete with a variety of other interests, including the hospital’s financial well-being. Whereas clinicians consider one patient at a time, administrators must balance the good of the one and the good of the many. And, they must consider the future. In any capitalistic venture, more capital can be used to provide more services, training, or better quality services. Administrators apply available capital to satisfy exogenously determined minimal standards, then expend discretionary resources to develop the best local blend of cost for increment of good—whether that is good is more nurses, more staff training, a better physical plant, or other “goods.” Quality and safety of care, which are the predominant ethical interest of clinicians, are only 2 of many competing values of administrators’ interests.10,11

In the past decade, emphasis on the use of quality and safety as performance measures for hospital executives has been increasing,12 but hospitals have differed remarkably in focus and accountability in these areas.10,11 Herein lies a fundamental difference and the potential tension of ascendant interests: clinicians think one-patient-at-a-time and administrators invest limited resources in hope of providing the best “yield” that includes aggregate patient outcomes, staff satisfaction, and community health over time. The well-being of the company is also an end in itself because if the company fails, nobody gets care (and/or the administrators lose their jobs). Clinicians would never sacrifice the individual under any circumstance, whereas administrators may sacrifice some individuals if the aggregate good is served. Additionally, administrators often have personal interest in the form of financial remuneration or bonuses for company performance. If boards judge company performance by using financial metrics more than evaluating quality of care, then there is at least theoretical potential for administrators to be rewarded for running a company that diserves patients.10

Conflicts of Interest for Boards of Directors

Boards of directors have a legally binding fiduciary responsibility.4 Ideally boards’ ascendant interests include beneficence and justice for individual patients, as an end to the same for the aggregate community. Boards also share a duty to defend the company for the same reasons as administrators. However, some have argued that the company is not an end in itself if patients are disserved.10,12 Although there is increasing attention, many boards do not yet fully comprehend nor do they possess the expertise to satisfy robustly their duty to patient care and safety.10,12 Boards are not bound exclusively to beneficence and primacy of the patient, whereas this is the ascendant interest and ethic for clinicians.

Because the interests of clinicians, administrators, and boards overlap but are not identical, the potential for tension is substantial as well. What are reasonable ethical obligations for health care professionals who are employees? This article suggests taking a professional approach to exhaust intra-institutional mechanisms for patient advocacy, but also reviews recourse if imminent risk to patients is not addressed.

Solutions: Constructive Engagement

Clinicians who are concerned with practices that might negatively affect patients’ welfare are obliged to respond professionally, proactively, and constructively to solve the problem.2 All avenues should be exhausted within the organizational hierarchy to solve the problem before resorting to extraorganizational remedies. This includes constructing well-reasoned, evidence-based arguments that center on the primacy of patients’ welfare and presenting them in a nonadversarial manner. The Table lists a series of graded responses for addressing patient safety or quality concerns.

Validity of the Concerns

It is of paramount importance to establish the objective validity of patient care concerns. The ideal
will decrease. In other words, there will be an optimal decrease, the marginal return—aggregate patient safety "macro" level. In theory, as patient to nurse ratios right and wrong, but must also remember that administrators have responsibilities to the collective and may see a bigger picture or possess critical information that is not readily discernible to individual clinicians. In vacuo, physicians and nurses have an ethical responsibility to object politely to staffing cuts that are likely to negatively affect patients' safety. The data supporting optimal patient to nurse ratios, however, are not definitive. Yet common sense and (admittedly, level II) published evidence suggests that cutting nurses and support staff beyond a certain point necessarily affects patients (ie, less time and attention available for each patient) unless substantial workflow reengineering accompanies the cuts. But where is that critical point? Is there a single optimal patient to nurse ratio? Herein lies a substantial difficulty, as numerous nurse-related variables are likely to affect outcomes, including: (1) acuity of illness and turnover of patients, (2) physical and intellectual abilities of the staff, (3) efficiency of work flow and (4) flexibility (eg, float or call systems) to accommodate acute increments of acuity and patient numbers.

Administrators consider this problem at the "macro" level. In theory, as patient to nurse ratios decrease, the marginal return—aggregate patient safety outcomes, quality of care, employee satisfaction, and patient satisfaction—will first increase, but then will decrease. In other words, there will be an optimal patient to nurse ratio (that is most likely unit specific), after which adding more nurses costs more than is warranted for the diminishing improvements of outcome. Taken to its extreme, 1 to 1 nursing might maximize aggregate outcomes, but the cost to benefit ratio is so high that money is better spent elsewhere. Individual clinicians are not ordinarily privy to sufficient information to consider this calculus.

Every hospital has unique financial constraints that influence its acceptable cost to benefit ratios. For example, hospitals with excess available capital will be much more likely to incur the higher cost for each additional nurse even if marginal improvements in outcome decline. Irrespective of these theoretical discussions, there are minimal standards of care that are exogenously determined by local and national practices. When there is a preponderant local and national practice, staffing below these thresholds violates standards of care in ways that can be externally verified. Clinicians should first seek to understand the bigger picture from administrators and explore with them the trade-offs inherent in cost-benefit of violating local and/or national standards.

Beyond clinicians' ethical obligation to patients, a reasonable argument can be made that the employee has a secondary contractual obligation to object to perceived wrong-doing. Clinical mishaps could expose the hospital to medical-legal claims, extra cost, or negative publicity. Other economic risks of understaffing include declines in employee satisfaction, employee health (due to both physical and mental injuries), and patient satisfaction, and nursing attrition with the associated

### Table

**Recommendations for graded engagement when patient needs collide with financial constraints**

1. Gather objective evidence that the patients and/or staff are at risk.
2. Share data and concerns with direct supervisors and clinical allies (eg, physicians of patients at risk) to: a. ensure that the objective data supports the concerns, and b. to develop relationships with stakeholders who might help make arguments up the chain of command.
3. Reassure hospital administrators that "we all share" this problem, and "let's try to engineer a solution, together, for our patients."
4. Enlist help of clinical allies to do the same.
5. Suggest a concrete methodology (eg, a task force or committee) and schedule for addressing the problem.
6. If the methodology and/or schedule fail to stimulate sufficient progress (at a rate that is problem-appropriate), ensure that upper levels of management are apprised — allow supervisors the opportunity to present the problem, rather than going over their heads.
7. Go over their heads through the chain of command, not in an accusatory but rather in a constructive manner, and only if supervisors impede or refuse to address the problem substantively and at problem-appropriate pace. Proper channels are discipline-specific, but include the nursing management hierarchy for nurses and medical executive committee for physicians. Both groups should have access to members of the board of directors if proper channels and sufficient time fail to yield progress.
8. "Nuclear options" (used only when patient life-death issues are at stake and senior management is aware but explicitly refuses to act). Unless carefully approached, unintended harm to the hospital, patients, and self is very likely. Examples include "whistle-blowing" and/or reporting to regulatory agencies or the press.
costs of recruiting replacements. Accordingly, the clinician-employee has a contractual obligation to argue against changes that are likely to negatively affect hospital outcomes beyond patients’ medical well-being. Administrators might counter that substantial uncertainty in health care requires conservative financing to gird for reductions in reimbursement that would threaten future financial solvency of the hospital, thereby threatening the core mission and employees. Indeed both administrator and clinician are obliged to make such arguments; but how they work together (or not) to resolve this tension determines high-stakes outcomes.

How Concerns areExpressed

The ideal approach to such high-stakes workplace interactions is to approach the discussion with the goal of aligning interests. An accusatory, presumptive approach (eg, “as an administrator, you wouldn’t get the patient primary thing”) is unfair, counterproductive, and self-defeating. The goal is to convince supervisors that interests overlap. Even if patient welfare isn’t in itself enough to move them, focusing on benefits to the hospital’s financial status, such as employee satisfaction and retention, and patient satisfaction, can help bring administrators along.

Common sense is supported by empirical evidence that demonstrates financial disincentives to understaffing; an argument that might increase traction with administrators. For example, lower patient to nurse ratios (and, in general, happier nurses) are associated with better patient outcomes. There is less nursing burnout, enhanced retention, and reduced cost of recruitment and training. Shouldn’t patient outcome be enough to drive policy? Ideally, yes. But if data are available to increase the intersection of the clinician’s patient-centered interests and the administrator’s patient and financial/organizational interests, these data should be leveraged to ally with, rather than confront, the administrator. Administrators usually want to do the right thing too, and you can provide the evidence to align interests.

Recourse If Internal Mechanisms Fail

If the hospital perseveres with changes that the clinician believes to be unsafe, she has a number of options. First, she can do her personal best to “make the most of it,” to help reengineer the workplace to make the changes less likely to cause harm. Presenting data that demonstrate a policy or process worsens outcomes is the ideal method for pursuing reversal, but this is generally beyond most clinicians’ abilities and is vulnerable to statistical error. High-quality evidence from peer-reviewed literature should be the basis for grounding concerns about patient safety and quality of care. Local, anecdotal outcomes may be useful, but they do not trump well-conducted studies and “standards of care” (ie, predominant practice in a region).

Where Are the Physicians in This Case?

Physicians share the at-risk patients. Increasingly, inpatient care is provided by hospitalists or intensivists employed by the hospital, not by primary care doctors who by virtue of their longitudinal relationships are natural patient advocates. So hospitalists/intensivists may have the same conflicts of interests as the nurses. Unless hospitalists/intensivists can dictate care to chief executive officers (not likely), they are neither likely to “stand with” nurses nor to advocate for patients if the choice risks unemployment. In this model of commodified health care, a preponderance of power rests with hospital executives whose interests include both finances, which are easily quantified for the boards to which they answer, and patient primary, which is ethereal. Nonetheless, critical care nurses are core members of a potentially strong interdisciplinary team, in which the combined voices of professionals such as physicians, nurses, respiratory therapists, and nutritionists may be more likely to affect managerial decision making.

What about executives who are clinicians? There is a chief medical officer and a chief nursing officer, after all. They are, perhaps, the most conflicted of all if they’ve sworn an oath to patient primary and then depend upon the financial solvency of the hospital for their own well-being. When hospital executives are paid six- and seven-figure incomes, stakes, and conflicts of interest are particularly high.

Staff medical executive committees that comprise physicians are another potential voice for patients. But members may include physicians who are also conflicted, and their aptitude as strong advocates for safety and quality in hospital governance varies substantially. So, despite a system made up mostly of individuals whose focus and oath is to the primacy of patient welfare, conflicts of interest abound that could emasculate organized patient advocacy in unjust cultures.

If physicians are unwilling to ally with nurses’ concerns, then there are additional intrastitutional avenues. Boards of directors are morally and legally responsible to defend patient safety and quality of care. Board members should be available to hear and respond responsibly to complaints brought in good faith. Most boards have patient safety or quality assurance committees made up of physician members who can be approached to share concerns. Most organizations have guaranteed protections—
Just and Unjust Cultures

The ethical tensions described here are attenuated or obviated by a *just culture*, which "learns and improves by openly identifying and examining its own weaknesses." It includes notions of transparency, accountability, and employee empowerment that have been widely practiced in some highly reliable industries such as civil aviation and nuclear energy. Health care has been slow to adopt just cultures. In varying degrees, hospitals often have subverted patients’ interests, due to parochial conflicts of interest such as finances or fear of litigation. In a just culture, clinicians’ dissent, even if that dissent is occasionally invalid, is embraced as an end in itself and a vehicle for safety.

In *unjust cultures*, dissent is seen as a threatening indictment of mismanagement that might undermine authority for its own sake. Obviously, dissent that is rudely expressed, ill-founded, or malevolent is unacceptable in any organization. However, if objections are brought through the chain of command, politely and without evident self-gain, dissent is a powerful tool to improve organizations. Due process helps define just culture, and psychological safety—a process wherein employee participation is encouraged—promotes patient safety.

Ultimately, even in just cultures, administrators may make the final decision. Sometimes the clinician simply isn’t right or doesn’t see the bigger picture. Sometimes the values and interests of the clinician and administrator differ so substantially that they both look at the same problem with complete information, but come to different conclusions. Although the clinician may not agree, she must determine whether she’s made a good enough argument, and, if not, redouble efforts via the chain of command. Going “over the heads” of supervisors, or extramurally when all internal mechanisms are exhausted, should be a last resort, when patients are certain to accrue severe harm.

Unjust cultures will connotate stepping outside the chain of command, which can be seen as insubordination, so this is a high-risk approach. Many workplaces can terminate employees “without cause.” In theory, employees who, in good faith, voice concerns about legality, ethics, or safety are protected by corporate compliance and wrongful termination laws. When an employee observes laws being violated, she also has recourse to state and federal whistle-blower systems.

Whistle-blowing raises the potential for numerous unintended consequences including harm (eg, bad publicity or legal/financial sanctions) to the institution and patients that the clinician purports to defend. All approaches, inside or outside the chain of command, intranstitutional or extraninstitutional, entail substantial vocational perils. The employee risks demonization, marginalization, termination, and reduced likelihood of reemployment.

Courts have not uniformly supported plaintiffs who act on behalf of patient safety. So unless the employee is absolutely certain that verifiable harm is coming to patients, it is advisable to exhaust all internal mechanisms and deploy exogenous remedies (such as anonymous complaints to Department of Public Health, Joint Commission, Center for Medicare Services, and job actions, publicity, or lawsuits) only when stakes to patients are very high and an organization refuses to move. It could be argued that the wisest conclusion to such a situation is to avoid the years of anxiety and conflict, and move to another workplace where organizational values match your values.

Conclusion

Employee-clinicians who choose to champion patients’ interests—even politely—when their employer has chosen another path are subversive and risk their own well-being to defend patients. The risk is lower in just cultures and when clinicians employ a professional, collaborative approach that emphasizes ethical duties to patient primacy. Nonetheless, this conflict of interest deserves greater ethical-legal focus, to better articulate organizational pathways for dissent to be heard by executives and directors. The crux of this article is to examine whether clinician-employees are obliged to risk their livelihoods when patients are at risk. Most would argue that personal self-sacrifice to the point of termination of employment is beyond the call of duty, but this does not negate the conflict of interest at the core of the dilemma.

As hospitals employ more physicians as hospitalists and in accountable care organizations, mechanisms are essential to safeguard the integrity of the medical profession and the primacy of patient welfare. Clinicians who champion patients’ safety and quality of care should be embraced by just organizations and protected by the law. If Hippocrates is to harness hospitals, and not vice versa, attention is required to protect, nurture, and support those who risk their well-being because of their moral duty to patients.

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Hippocrates as Hospital Employee: Balancing Beneficence and Contractual Duty
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