THE ROLE OF GOOD PRACTICES IN THE MANAGEMENT OF ETHICAL PROGRAMS IN HOSPITAL ESTABLISHMENTS. A FURTHER STEP FROM ETHICS COMMITTEES

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Abstract
This article is a review of both the functions and roles played by ethics committees in hospital establishments, and respectively of the challenges they are confronted with, in the general context of activities concerned with organizational ethics. Furthermore, we analyse international good practices, such as they intervene in the organization of ethical programs, and also the place the committees take up within these programs. Our qualitative research is based on the analysis of the websites of 144 hospitals from Romania, classified within the first three competence levels, and aims at highlighting the fact that ethics committees do not have sufficient visibility, which is certainly not beneficial to patients. In this context, our research demonstrates that there is plenty space for improvement in quality of care based on ethics program and its tools and the experience of other countries could serve as a viable guide.

Key-words: ethics committees, Romanian hospitals, organization ethics, ethical program,

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1.Introduction

The notable increase of ethical initiatives in hospitals is due to the requirements demanded by the accreditation standards applied by the Joint Commission on Accreditation of Health Organizations (JCAHO). At the end of 1980s, the commission imposed standards regarding patients' rights and ethics. In 1992, these were supplemented with other standards that required the set-up of ethics committees, with a consultative role in matters related to the patients' health care. In 1995, all accreditation text books, elaborated by the Joint Commission, comprised standards for patients' and residents' rights, and also ethical provisions, with a wide field of application (treatment for life sustenance; preliminary directives, informed consensus, supply of transplant organs, confidentiality and intimacy, the use of chemical substances and physical restraints, but also standards that evaluate the ethics of the organization and of its business (Joint Commission, 1998, p. ix) [13].

The experience of the European countries in introducing the ethics committees in the hospitals activity is heterogeneous and different, depending on the tradition and context-related with legal concerns for the patient rights and quality of care. In Romania, the concern for the establishment by law of ethics committees [1] is relatively recent (2006). One of the issues often raised is related to the functions and effectiveness of these ethics committees.

The purpose of our article is to bring attention to the importance given to these ethics committees in hospitals in the U.S. and Europe (including Romania), which are the particularities in the organization and functioning of these committees and their impact on quality of medical services. For this purpose, we make a comprehensive review of studies and research found in the literature. The situation of ethics committees in Romanian hospitals is analyzed through a personal research, of qualitative nature, aiming to highlight the extent to which Romanian hospitals classified in the first three grades of competence, provide information on their ethical commitment and the tools used for this. One of the specific objectives is to analyze whether Romanian hospitals offer through their websites visibility of these committees. There are also some examples of international best practices on the implementation of ethics management programs in hospitals, examples that could be replicated successfully in our country.

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[1] The term that is used in the Romanian legislation is "ethical council" (according "Ordinance 1209/2006 for the approval of competences and prerogatives of the ethical counsel which functions in public hospitals" (published in the Official Gazette 854/2006), the 4th article)

2. The roles of ethics committees

In time, numerous unexpected cases and dilemmas in medical practice history indicated the need for the set-up of ethics committees in hospitals. A frequent example in scholarly literature is the famous case of Quinlan from 1976, whereby the Supreme Court of Justice form New Jersey defended the idea of involving multidisciplinary committees in solving the dilemma regarding "end-life of care" (McCruden & Kuczewski, 2006) [20]. The Court established criteria based on a medical prognosis and allowed those involved (patient's family and doctors) to apply it with the help of a medical ethics committee (according www.libraryindex.com), the latter being recommended as an organizational resource for the support of doctors in difficult situations. Another case is Saikewicz (1977), when the Massachusetts Court admitted as proof the taking into account of the committee's verdict in order to demonstrate the doctor's good faith and the adequate application of medical standards in the healthcare process (Congress, 1987, p. 128) [6]. In 1980s, powerful establishments as American Hospital Association (1986) and American Medical Association – Ethical and Judicial Council (1985), proposed them for approval (Hackler & Hester, 2008) [11]. They became, nevertheless, a constant presence in USA since 1992, when the requirements of the accreditation commission, Joint Commission, regarding the necessity of an ethical function were generally approved. The committees were created as a formal mechanism, with a role to play in solving the ethical issues from hospital's activities and "the solving of disputes", especially those related to the patients' health care and their right to decision and autonomy. They must not be confused with the ethics committees in medical research (scientific committees which ensure that medical research on human beings respects ethical principles and norms), with the ethics committees that hold a consultative role, at national level (they take decisions and make recommendations regarding important ethical issues present in the biomedical practice and science, they formulate and structure national policies on the subject of bioethics). Ethics committees have a role to play in the evaluation of hospital's ethics, either upon their own initiative, or following the complaints of the patients or of their relatives (Rendtorff, 2002, pp. 9-10) [29].

The functions of these committees are based on multiple principles: "the good-deed presumption; the necessity of confidentiality; the principle of the decision-taking focused on the patient; the equality of opinion of each member of the moral community; the goal of making clear recommendations and not the imposition of obligatory mandates" (Dawson Derr, pp. 21-22) [7]. The most important goal of these ethical objectives consists in offering support for medical personnel, patients and their families, in order to help them to make informed decisions regarding the proper health care process, thus contributing to the prevention and handling of ethical biomedical dilemmas (Hogstel and all, 2004) [12] and of difficult cases by supplying educational resources, by keeping awake the ethical conscience and by putting out policies and guiding procedures for practices in necessary situations (McCurdy, 1998) [19]. In a single word, this general goal means focusing on moral aspects regarding the healthcare process of patients (Steinkamp and all, 2007) [33].

The multidisciplinary dimension involves a relationship with the medical services supplier's representatives (doctors, nurses, managerial staff), representatives from local communities/authorities, non-medical professionals (ethical thinkers, professors, writers, social workers, lawyers, priests, etc.). These attend meetings where they debate on ethical issues related to healthcare and the rights of the patients, they deal with consultation and recommendations in medical clinic, formulation, development and revision of institutional ethical policies and procedures, mediation of disputes, educational programs for staff and public (Powell & Bluestein, 2006, p. 2; Dawson Derr, 2009, pp. 21-22, 26; Hackler & Hester, 2008, p. 6; Klugman, 2012) [28]-[7]-[11]-[14]. These members are both organizational resources for clinical services and communication channels for the functional units of the institution concerning controversial issues, with ethical implications (Collier and all, 2006, p. 332) [5]. The committees are more efficient, the more they have an interdisciplinary dimension and a diversity based on ethnicity, religion, culture, experience, abilities and knowledge (law, religion, business, cf Hackler & Hester, 2008, p. 14) [11], but also stability (Powell & Blustein, 2006, p. 2; Dawson Derr, 2009, pp. 21-22; 26) [28]-[7]. Many times, ethics committees supply the litigations between hospital establishments, patients of their families. The latter frequently have much higher expectations from medical services supplied by the institution, and in the case of them not being fulfilled, they appeal to the ethics committee (Dawson Derr, 2009, p. 20) [7]. Per ensemble, the utility of these committees is assessed form the point of view of four basic functions: recommendations concerning institutional policies, consultation, education, mediation. Unanimously, the most important is considered to be the consultation function. The final decision in solving a medical ethical dilemma is ultimately taken by the medical staff directly involved, by the patient and the family.

Valentin Mureşan (2009) [23] differentiates between ethics committees and ethical bureaux. In his opinion, the former are interdisciplinary groups made of experts and are responsible with the formulation and the application of the ethical code, with the staff's counselling, the public's education, the lobbying of parliaments. Ethical bureaux (made of an executive director, secretary, and auxiliary staff) are services of a managerial nature, responsible with the projection, implementation and monitoring of the ethical program. In this article, we will use in a generic manner the term ethics committee, without taking into account this double meaning.

Regarding the number of the members in an ethics committee, there are various, divergent opinions: between 15-20 (Dawson Derr, 2000), 10-30 (Collier and all, 2006) [7]-[5]. In accordance with Romanian legislation (Law 95/2006, art. 185), an ethics committee must have 5 members (from which four have a right to vote). A big number of

members has, nevertheless, disadvantages, because it is hard to have all the members present in case of emergency and the responsibility is diluted between them. The extension of the group has a negative effect on the diversity of points of view, and the opposed ideas of the majority might be crushed. "Group thinking" may ensue, exactly in virtue of the pressures exercised for a quick consensus, in virtue of the lack of verified information and of interests and value conflicts (Lo, 2009, p. 133) [16]. Personal ethics being different, conflicts arise, and even in consensus cases, there is a tendency of imposing the personal belief in the detriment of the organization standards related to ethical problems. Consequently, it matters the way in which the members of the committee understand their role and function (O. C. Ferrell and all, 2012, p. 202) [9], but also their availability to learn about clinical ethics, when the education in this domain is missing (Lo, 2009, p. 133) [16].

3. The European experience of ethics committee

France was the first country in Europe which created in 1983 a national ethics committee for the sciences about life and health, a permanent and multidisciplinary institution which was adopted as a model by other countries. But only in 2002, the existence of these ethics committees at a local level was legally recognised. In 1990, they were also legally created in Lithuania and in 1997 in Croatia (Steinkamp and all, 2007) [33]. In Belgium, they were legally instituted at a national level, and by the Royal Decree from 1994 they were accepted at the internal level of hospitals or groups of hospitals, in a mixed form, putting together the two functions: the function of the research ethics committees, and respectively the function of the clinical ethics committees (Carbonnelle, 2002, p. 19) [4]. In 2005, there were in the United Kingdom only 78 clinical ethics committees. In Poland, in 2007, they were not even regulated. In Holland are regulated only the research ethics committees, although they exist already since 1970 in the form of mixed committees, responsible with the identification of the tendencies regarding moral issues in healthcare institutions (Steinkamp nd all, 2007) [33]. In the case of Denmark, although the country did not exactly found these committees, there is a powerful legal and ethical framework for the addressing of ethical matters in hospitals, and it is considered that there is already an ethical regulation very convenient for all the parties involved; all the more, the patients are not actives and, consequently there is no public pressure in this regard (Rendtorff, 2002, pp. 10, 17) [29].

The American model differs from the European one, the latter being based on post factum analysis and decisions (there is deliberation about the possible infringement of the ethical principle and then the sentenced is passed), with the unique exception of Sweden (Anghel and all, 2009) [1]. In this regard, in "Ordinance 1209/2006 for the approval of competences and prerogatives of the ethical counsel which functions in public hospitals" (published in the Official Gazette 854/2006), in the 4th article[2], it is noticeable that the prerogatives of the ethical counsel in Romanian hospitals are based essentially on the analyses of the cases in which the legal rights of the patients were breached, and this is very different from the functions, through which the committee establishes ethical policies, consultation and education. Consequently, the European model of ethics committees plays a more restrained role in the prevention of ethical risks and of conducts which break ethical principles.

4. The Role of ethics committees and of organizational ethics

In spite of a rich literature which highlights the beneficial output of ethics committees, there is the problem of their efficiency or of their restricted role regarding medical clinic, and the lesser attention paid to organizational ethics. The syndrome "fail to thrive" is indicative of their lack of clinical relevance, of the fact that the staff does not know of their existence or about the way to access them, that the committee meetings are inconsistent or even that their members are only there because of vested interests and not in virtue of their education and professional preparation (McCruden & Kuczewski, 2006) [20]. The study realised by Anghel and all (2009) [1] shows that, in Romania, these committees have a "bobby's" role, a penalising role, and thus being neglected the consultative and information role in the sense of rendering aware about matters of ethical nature. There is a lack of transparency in their functioning, as if they were a close system and any information about their activities was inaccessible. The author's conclusion is that the

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[2]"The prerogatives of the ethical council are the following: a) analyse the infringements of norms of conduct in the relationship patient-doctor-nurse, of behavioural norms, of discipline in the healthcare unit; b) verify whether, by his conduct, the medical and auxiliary personnel does not infringe the patients' rights specified in the legislation in force; c) refer to the competent authorities of the state those situations in which there are infringements of the medical deontological code, of rights of patients, as well as of the norms related to professional conduct, stipulated by the law; d) analyse the complaints concerning the informal payments of the patients towards the medical or auxiliary personnel, or concerning the conditioning of the performance of the medical act by extorting benefits; propose, on a case-by-case basis, measures of compliance with the law; watch for the respect, in terminal cases, of the human dignity and propose professional measures for the administration of all the necessary health care."

existence of ethics committees in Romania is due exclusively to the prerequisites of law (Law 85/2006, art. 185, which states that an ethical council is obligatory in every hospital), their activity being visible only when serious and grievous cases are debated. The ethics committees are not structurally and divisionally independent and they do not influence the ethical culture of the organization because they lack ethical instruments. Members are appointed by the director committee, they are not chosen on the basis of specific competences related to medical ethics or to the management of ethics.

Because of the downplaying of their function (and of their internal structure) by the legislation in force in our country, these committees might be included in the category of the committees which "do not have any clear conception about what they have to do, about the way a moral problem is defined and about the methods which might be used in ethical decision-making" (Mureşan, 2009) [23].

5. Good practices for the support of ethical programs in hospitals. The role of ethics committees within these programs

Few good practices can serve as an example regarding the implementation of ethical programs in hospitals and regarding the role addressed by ethics committees for their support.

For example, Calvary Hospital Palliative Care Institute (Cassidy, 1998) [3] set up an ethics committee in 1991 in order to "promote excellency through education in the health-caring of the patient". In 1997, so as to continue developing this initiative, but also to boost the awareness degree of ethical issues, the same hospital founded the Functional Committee of the Patient's Rights and of Organizational Ethics, as a consultation and educational body for the medical and administrative staff of the hospital, subordinated to the committee for the evaluation and the improvement of quality. Within the structure of this committee, another organizational ethics sub-committee was set up, with representatives in all the organization's units, with the objective to "improve the comprehension of ethics, consolidate institutional policies, to improve the communication between members of staff, to clarify the roles of and the championship of activities congruent with ethical principles." Another step further envisaged the carrying out of an audit of values for every department and their comparison with those included in the declaration of mission of the hospital. On the basis of these findings, an educational program for the area that needed improvement is put in place. Along with this educational initiative, there is made an elaborated declaration concerning organizational ethics - "Organizational Ethics Statement", in order to transpose the concerns for ethics in everyday activities. Two consultancy teams were available 24 hours for the staff, patients and families.

Baggett (2007) [2] recommends more factors for the evaluation of an ethical program. First, the implementation of ethical programs moulded after ways of conduct specific for the organization, and not after some general principles, is strongly required. The process must create "an open culture", must identify those regions of "adequate behaviour" and formulate procedures, must give employees a chance to ask questions and to request analysis on ethical issues. There can be organized role-plays for a better comprehension and grasp of reality. Management has to put in place a monitoring system which intercepts whether employees act responsibly and whether they take steps to remedy their mistakes. There is needed, for the efficiency of the program, training programs for the employees, based on particular aspects, so as they can find a solution to the ethical dilemmas that confront them and to know how to react while noticing an infringement of ethical principles in their organization. These training programs must reveal to the employees positive examples of ethical conduct, either from their colleagues or other persons, with a similar amount of experience. The trainers must review the good behaviour learned by the participants and to consolidate them positively through appreciation, "verbal persuasion". Moreover, they must help them to experiment and to learn how to deal with the stress generated by ethical problems and how to choose the adequate conduct, through evaluating the emotional and physical state of the participants. The general principles of the ethical conduct code must be an integral part of the strategic planning process in order to become consistent and a base for everyday operations.

Another example of good practice regarding ethical programs is offered by The Center for biomedical Ethics at the University of Virginia Health Sciences Center in 10 hospitals from Virginia and West Virginia (Neft-Smith, ş.al., 1997) [25], a project initiated in 1990 with the aim to help and consolidate the existing programs. The proposed program was developed in four directions: 1) ethics committees with many functions: forum where can be debated or studied clinical ethics issues; identification of hospital policies concerning ethical matters which might surface in the context of healthcare for patients; monitoring and duly providing, when requested, consultancy for ethical problems in dealing with patients; sponsorship of educational programs concerning clinical ethics and specific legislation for personnel or staff and community; 2) educational programs in clinical ethics and specific legislation in the healthcare domain, addressed to the personnel involved in ethics committees, to the staff of the organization, to patients and their families. The programs were offered by persons from the internal structure of the organization without direct implication in ethics committees. 3) Granting ethical assistance/consultancies by formed trainers to the persons directly involved in certain cases or who are confronted with certain ethical matters. Depending of the case and location, the consultancies are granted by the entire ethics committee, by a sub-committee of the first, or by a specialized consultancy service or an individual specialized service (as it is the case with the academic medical center). 4) Two

persons – resource – with an high-standard ethical and legal preparation, were chosen to ensure and to guide the auto-education of the ethics committee, to ensure the clinical education within the system, to be the spoke-person in emergency cases and to provide consultancy or to act as resource for consultancy counsellors. It was added to these the evaluation Process of the efficiency concerning the already mentioned directions.

6. The findings of the research. Discussions

Our qualitative research supports and complements the previous, mentioned study and consists in a prospection of the websites of 144 hospitals, classified in Romania (from a total of 461), grouped in the first three levels of competence (from a total of five), in accordance with the list published by the Health Ministry (http://www.ms.gov.ro/?pag=53). These levels of competence indicate to patients the degree of performance of the hospital, but they serve as well as criteria for authorities for a better assignment of resources. The overall objective of the research consists in the attestation of the existence of information about ethical involvement and of the instruments and organizations available. In this article we present only the results on the presence of information about hospital ethics committee (ethical council).The analysis of the information published on the website revels that only eight from the hospitals included in the first three categories have an ethical council (presented at the Hospital Management section): three hospitals from Moldavia – the Emergency Hospital County from Vaslui, the ones from Piatra Neamţ and Deva, the Emegency Hospital County "Sfântul Spiridon" from Iaşi, The Academic Municipal and Clinical Hospital from Cluj Napoca, the Emergency Hospital County "Dr. Constantin Opriş" from Baia Mare and the Clinical Institute Fundeni from Buchares), two of them dispose of an code of ethical conduct for the personnel (the Emegency Hospital County "Sfântul Spiridon" from Iaşi and the Institute of phono-audiology and functional surgery O.R.L. prof. dr. Dorin Hociota and the Emegency Hospital County Victor Babeş, both from Bucharest), one of them presents data about its ethical commission (the Emegency Hospital County "Sfântul Spiridon" from Iaşi).

The findings show that the classification criteria of hospitals monitor the competences which fulfil the general and technical expectations of stakeholders: the geographical degree of coverage, the assurance of a certain number of specializations, the number of doctors on duty and medical care in ambulatory for these specializations, a minimum quantity of medical apparatus, a number as small as possible of readmissions and transfers.

The third component of all three mentioned by García-Marzá (2005) [10] is downplayed so as to fulfil certain moral expectancies. Obviously, because they are to serve the patient, ethics committees should enjoy as much publicity and visibility as possible, in order to better seize the occasions where their intervention is necessary. Patients do not have the possibility to found out about their existence and consequently they do not make complaints, although there is dissatisfaction with the quality of the healthcare processes and with the way in which the doctors are treating them (conform to the research conducted by Ristea and all, 2009) [31]. The study made by WHO (2012, p. 81) [34] revels that two thirds of Romanian patients (from Walachia, Moldavia and Transylvania) do not know about websites, and that a little over half of them do not know about the existence of an address online for complaints. Therefore, the consolidation of the educational role of ethics committees is very welcome, a change proposed by McCruden & Kuczewski (2006) [20] as a response to the debates concerning their implication in the support of organizational ethics.

Other information about the ethical councils of hospitals in Romania is visible in the press releases of district councils concerning the appointment of local representatives on their board, concerning the set-up of the ethical council in hospitals, or the display of their internal regulations of organization and functioning. Just three cases were presented in the press about the activity of these councils (the one concerning the orderly from a hospital in Timişoara, accused of bad treatments applied to a little baby (according www.tion.ro), the other one regarding a nurse from a neonatology clinic in a hospital from Constanţa, who accused a doctor of incompetence (according www.telegrafonline.ro), and the case brought forward by a doctor on his own blog (medicalnet.ro), dissatisfied with the limits and "imperfections" of the legal prerogatives of the committees and their application in the solution to his own situation.

Paradoxically, even the mode of organization and the activity of ethics committee produce ethical dilemmas. Such is the case of Romanian committees, which according to laws, must have on their board a representative of the authorities (local or district county) or, depending on the case, a legal adviser. When the first alternative is in place, the appointed member is more often than not also a doctor. Moreover, those on the committee come predominantly from the internal staff, they are appointed by the executive committee of the hospital, and the committee's chief executive is the doctor with the highest rank. All this might eventually generate conflicts of interests, "comradely spirit", especially in a case where doctors are involved or abuses of power are committed while on duty. This is more possible, the more the society at large is one with a high degree of collectivism (the relationship between members of the group could be more important than the job's requirements) and more distanced from the centres of power – such is the Romanian society (Nica & Iftimescu, 2007) [27]. Even if the medical professional expertise played a part in the choice of the members of the committee, one must not forget that the multidisciplinary dimension and the objectivity are also important parts of the approach of the ethical problems (not always of a clinical nature). This is more so, because generally the members are not appointed according to their ethical training.

Another problem is the fact that the ethics committees from Romanian hospitals must have four appointed members with the right to vote: this might create a "tie vote" while adopting a sanction. In this case, "the law has the potential to limit ethics and ethical considerations" (McDaniel, 2007) [21]. These are only some of the problems related to organizational ethics.

7. Conclusions and final reflections. The need for a complex and systematic ethical program

Our study reveals that very few hospitals in Romania are making efforts to show how much they care about ethics management. Information provided on the hospitals web site about their ethics committees are totally insufficient.The main conclusion is that there is a need for greater visibility of the activity of ethics committees, which would be on the benefit of patients but also of the other categories of stakeholders.

The role of ethics committees is still restricted, so that they cannot respond to all the challenges that confront regularly a hospital unit, and it is all the more so, the more their prerogatives take into account especially aspects from clinical ethics, based on the monitoring of the way in which the patients' rights are respected. Various studies show that the presidents of the ethics committees understand that their primary role must be founded upon issues like "end-life care, palliative support and the fulfilment of patients' desires" (Magnus, 2009) [18].

Many times, demotivation of staff might be caused by a working climate or an unethical leadership, situations which do not enter traditionally in the attention of an ethics committee. Another important aspect concerns the decisions of allocation of resources, which might produce diverse conflicts of interests and which might exceed the sphere of competence of the ethics committee. Moreover, the handling of limited resources in the context of requirements for providing a high-standard medical service might generate ethical dilemmas within the decision-making process. Equally, other ethical problems might appear when dealing with recruitment, selection and promotion of staff, protection of the environment, acceptance of diversity, unfair competition.

Also, numerous ethical risks (from receiving and giving gifts within the organization and handling the information and resources in one's own interest, to slowness in activity) may be present in a latent state and could affect the entire functioning of the organization.

Organizational ethics comprises the ethical values and principles adopted by the organization, and the efforts and mechanisms required for their transposition in the institution's activity and relationships with internal and external stakeholders. According with the definition given by the Joint Commission on Accreditation of Healthcare Organizations (1998, p. ix) [13], ethical organization includes the identification of the organizational mission and of the values declaration, of the policies concerning conflicts of interests, professional conduct codes, the daily operations which have an impact on the moral leadership and on the decision-making process. For Magill & Lawrence (2001) [17], organizational ethics comprises the values related to mission, vision, sponsorship, leadership and governance, which will guarantee together the building of a "virtuous organization", "the principles of which will inspire the process of decision-making and the moral behaviour of the employees". In the same vein, Nelson & Gardent (2011) [26] make mention of the fact that the governance factors of an ethical organization are the mission and the vision strongly shared among the employees, a kernel of strong values and culture, ethical practices and an ethical leadership, etc. To these it must be added declarations of values, implemented effectively, which guide the decisions and the behaviour of the employees.

The proper involvement with the organizational ethics demands a management of values based on an ethical program extended at the level of the entire organization, in order to bring answers to ethical dilemmas which might confront the institution from within (the fulfilment of professional obligations towards patients and institution, relationships with the employers, those with the members of the staff, the exercise of authority), or from outside, from handling the relationship with the stakeholders (patients, clients, suppliers, authorities, competitors, community in general). An ethical organization is permanently alert and attentive to ethical issues and establishes standards for their approach; moreover, taking into account that they are provisional, they can be renewed in time (McCurdy, 1998) [19] depending on the new ethical dilemma to which the organization must face up. This permanent alert avoids ethical risks and abusive behaviour.

An ethical organization needs an ethical program that is coherent, systematic, with multiple branches which depend one on the other. This ethical program must address two sides: administrative ethics, and respectively, patient-related professional ethics. It is moulded on the organizational learning and on the employees training in order to facilitate for them the solving of ethical dilemmas and the avoidance of breaching moral principles. In the context of the transgression of their traditional limits, ethics committees can have an important role in the initiation concerning the framework for the functioning of such a values program (forms, sanctions, training and development); or, they may become part of such a program by offering the necessary training, evaluation and audit (Rendtorff, 2002, p. 182) [30].

Any ethical program presupposes a management of ethics, an ethical infrastructure, based on planning (the identification of the mission, the formulation of policies and procedures, the elaboration of ethical codes), on organization (the identification of prerogatives and responsibilities, of the necessary components of the organizational structure and of the hierarchical rand collaborative relations, the appointment of the person in charge), on coordination

(the synchronization of actions), on leadership (awareness, communication, training, support, motivation) and on control (monitoring, evaluation and collective actions – improvement).In view of its importance and of its costs, this program must be included in the strategic planning process of the organization and in the decision-making process as well. Resource allotment and support are needed from the leadership team. Also, the leadership must be ethically-oriented. It is common sense reality nowadays to admit that the leaders must be sensible to moral obligations towards the entire society, including stakeholders, clients, employees, suppliers, authorities, local community (Mendonca, 2001) [22]. A high-standard leadership from an ethical point of view is all the more important for the management of organizations that hold an impact on the healthcare and welfare of the community (Dolan, 2004) [8]. Ethical leadership lacking, there is no vision, action and coordination.

A key-factor is the determination of the performance rate/index, the permanent monitoring and evaluation of the fulfilment of this performance rate/index. The organization is a live organism, which evolves, and, consequently, this ethical program must be malleable and improvable according to the changing of needs, especially under the impact of the working environment (new employees with new values, new regulations, new tendencies recorded at both national and international level due to globalisation, to international mobilisation, to scientific discoveries and technological advances). Equally, the progress of the program must be based on strategies and instruments that ensure its proper implementation (the creation by the managers of an powerful ethical culture, founded on a strong system of values and on ethical leadership, an adequate and fair system of rewards and sanctions, training programs, ethical lines – hotline ethics, circles of ethics, monitoring programs of the ethical climate, ethical audits).

Another element which ensures an efficient functioning is the employment of a manager (officer or ethical counsellor), with prerogatives detailed in the job description, full-time program, who possesses an ethical formation and whose activity might be awarded. Ethics committees "suffer" because of the fact that they function "as a whole", its members do not have specific, "continuous" tasks, or responsibilities at an individual level (but in common).

The "availability" of the team for a period of only 3 years, as it is the custom for the ethics committees in Romanian hospitals, constitutes another problem related to the building of a powerful organizational ethics, particularly as the whole responsibility is devolved on their task. The continuity and the permanence of a person in charge with being an ethical counsellor or officer presents the advantage of longitudinal knowledge about the strong and weak points of the organization, values, conducts and way of reaction, and of the training needs of the staff. This leads in time to the "welding" of the team formed by the person in charge with ethics and the other ones, on the basis of reciprocal knowledge, developed precisely in time, which would facilitate the signalling and solving of ethical dilemmas.

Consequently, in view of the competition from the private sector of the healthcare system, but also of the challenges raised by limited resources, in view of the reforms started in situations of generalized economic crisis, of the intensification of the adjustment demands to the institutional framework at an international level and in view of the rise of community's exigencies for a quality service – in view of all this, ethics committees are confronted with the challenge to improve and grow out of their initial role and to integrate ethics in the health care provided for the patients, in the forms of business ethics and professional ethics. Starting from here, specialists think that "there is little doubt that the organizational ethics will be, under such form or another, part of the operations of an ethics committee and of the healthcare system (Spencer & Mills, 1999) [32].

The two good practices already referred to, show that the willingness to implement organizational ethics was manifest way before the imposition of accreditation standards by the Joint Commission.

The question arises as to why there were not similar proactive initiatives in Romanian hospitals. The answer needs for many factors to be taken into account. First, there is not an "ethical culture" amidst the hospital's leadership team. The managerial performance index/rate is rather elaborated in accordance with the matter of dealing with the budget within the established limits and in accordance with the requirement that medical assistance be assured. Secondly, although the legislation stipulates certain mechanisms (as is the case of the ethics councils), there is not any control over their activity (Anghel and all, 2009) [1]. The standards imposed by the National Accreditation Commission of Hospitals from Romania – CoNas (http://www.conas.gov.ro/norme.html) comprise the evaluation of ethical activity, but only at an fact-finder level (for example, how many times did the committee meet), and, consequently, its relevance is not a major one because it does not say much about the impact of their activity on the improvement of the organizational climate or even of the quality of the medical service. Nevertheless, the ethics committees will be only a few from all the mechanism with the help of which the ethical programs will be implemented or supported (through the formulation of policies and procedures and through the encouragement of education).

Mureşan (2009) [23] indicates five 5 functions for them: input in the formulation and development of the deontological code, in monitoring the adequacy of ethical policies, support in the creation and the sustaining of an ethical culture, organizing training ethics, moral counselling of the leadership and the protection of the organizational reputation.

There is, firstly, the need for vision and the championship of an ethical leadership from the organization's executives, based on respect and sympathy towards the employees. The managers must set an example for the employees by their own conduct, to "set the tone for ethics", to promote every day ethical values and to create the necessary infrastructure for receiving and passing the information further (the assurance of a strong communication

system, in a working state, with various channels, adequate to the technological progress, the ethical department/bureau/service/committee/council/officer for managing and monitoring ethical problems, which is integrated in the organizational structure, a system of awards and sanctions).

Ethics addresses herself to people; they come to know policies and procedures in order to apply them in everyday activities. If they are not properly motivated, fairly awarded and appreciated for what they are doing (including when they set up examples for the others), they will not react to institutional requirements. They must be educated and guided (trained and for this resources must be allocated) in what organizational ethics means, which are its beneficial effects on everybody involved, and what everybody must do in order to sustain an organizational ethics. For the formulation of ethical procedures and policies, a thorough familiarisation with the real problems of the organization is needed, as well as diagnosis and audits, and other viable instruments for their application. Otherwise, the organization will receive a false treatment, for diseases that not affect it and nothing will be resolved in this way.

Obviously, the organization must really be willing to make these policies function. It is useless to set up a policy of the alarm signal, but the working climate to be inhibitive towards the need of expression of the people, to instil in them fear, if they observe an unethical behaviour in their workplace. The decision-making process must show that the organization is not only concern about the resource allocation and the pursuit of its objectives, but also about the moral consequences of the decisions upon the stakeholders. Finally, leaders with a strong moral fibre are needed, who to love the organization that they are in charge of, and to identify themselves with its needs (implicitly with those of the stakeholders), to manifest strong will and good faith. In this context, the good practices and experience of other countries could serve as a viable guide.

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