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Towards action oriented ethics policies for Health Care Organizations.

A normative exploration.

Summary
In Dutch healthcare ethics is automatically associated with professional care. Initially healthcare ethics is especially understood as medical ethics. Thereafter other dimensions of morality have been introduced, for example in relation with the transformation of Health Care Organizations (HCO’s) into business models. In the Netherlands this evolution of healthcare ethics has been interrelated with the intention to support professionals to make their own choices and to reflect critically on the values of their practice. This development towards a more practice oriented ethics is interesting, certainly when it is associated with actual processes of deprofessionalization. Leading question of this study therefore is how ethics policy in healthcare organizations should be defined. It asks for a normative investigation of practice, with the intention to define a meaningful concept of ethics policy for HCO’s. This normative investigation has three directions. The first focuses on the condition of this policy as ethics policy. The second and most important, pays attention to the character of activity, central in the professional practice: individual health care. The third investigates the organizational context of this practice.

Ethics – the first specific dimension of this policy – is studied through three different points of view. The term ‘discomfort’ characterizes the first. On one hand it reflects the feelings of uneasiness uttered by ethicists and philosophers about the use and meaning of applied ethics. On the other hand it refers to an actual evaluation of developments in health care which influence the professional character of this practice. Beginning with critical observations of two Dutch philosophers, Zwart and Ten Bos, some pitfalls are identified, threatening the critical function applied ethics ideally has. Applied ethics tends for example to become too instrumental, although this narrow scope will be welcomed by some practitioners and managers, in this way ethics looses its critical function. Applied ethics therefore needs to respect its philosophical origin. At the same time it is necessary that ethics stays close to practical experiences and the associated discomfort. This experience of discomfort or embarrassment is an important base for applied ethics. Regarding modern developments in health care, embarrassment is related with two aspects. First attention is given to the experiences in medicine that formed the cause for the development of modern bioethics itself. The observation made by
medical doctors and others – that health care practice is interwoven with the counterproductive exercise of power is of great interest. It asks consciousness of the limitations and risks of professional healthcare. Professionals should therefore be aware that the meaning of their professional care never can be estimated by the professional view alone. Patients also have to be in the lead. The result of this movement is a more dialogic practice.

However, a plea for a more dialogic, professional practice can no longer be sufficient. The influence of system features that inflicted healthcare has created another ambivalence of modern healthcare practice: this time it is no longer the power of the professional but rather the opposite that endangers the quality of care. Instead of too much power it is a lack of professional power that has originated uneasiness and discomfort amongst the professionals. In Dutch it is called ‘beroepszeer’ (professional sore). It is a multisided phenomenon: not only industrial and bureaucratic rationality has caused anomalies in healthcare practice, intraprofessional processes of practice rationalization formed another cause. It is difficult to give these features sufficient attention in ethical reflection. Nevertheless it’s necessary, the more because of the changing definitions of professional care they support. Instead of the traditional moral inclination of professional occupations, professionalism is more and more defined in connection with amoral attributions of expertise. So, deprofessionalization becomes a challenge for practice oriented ethics.

The second point of view for an investigation of ethics is formed by current possibilities for development as seen in ethics as well in healthcare practice. The first perspective - of ethics – pays attention to general views on applied ethics, but also to opinions of ethicists about the process of deprofessionalization as an interesting subject for reflection. Some ethicists, acknowledging that it takes place, do not regard this process as an item in need of a theoretical response. Others take the opposite position, though the ways they react differ. Their reactions, however, show an increasing involvement of the professionals. First there is a proposal for a new theory of professional care. The second solution proposes to make explicit the logic of care, embedded in practice. The third solution emphasizes the necessity to support the professionals in investigating the moral dimensions of their own practice.

In the metaphilosophical discussion on applied ethics these theoretical positions on deprofessionalization are reflected. Some ethicists stress the material expertise of the ethicist regarding healthcare matters, others acknowledge an own expertise of professionals in the ethical identification of the moral dimensions of their practice. The arguments for this recognition are different. Some ethicists reason from a hermeneutic perspective, others from a more political philosophical view. The first group emphasizes that the view from inside cannot be missed for an adequate ethical evaluation of practice. The second group says that a just form of ethical theory naturally prefers a participatory view of practice above the distant view of the observer. Applied ethics therefore should be contextual and
practice oriented. According to some of these ethicists ethics should naturalize. It is not surprising that representatives in the Netherlands of the last mentioned perspectives are also involved in implementing professional oriented ethics policies in healthcare institutions. This way of ethics not only concerns theorizing practices of care but also changing them.

A practice oriented ethics policy seems very dependent of these theoretical positions: especially the political philosophical, because more than the hermeneutic perspective it gives attention to the reflective aspects of professional practice itself: ethics does not start this view with the theorizing activities of ethicists, but with the reflection of the practitioners in performing the practice itself.

Although the direction of a practice oriented ethics, inspired by hermeneutic and political philosophical interpretations, is clear, much has to be closer specified. For instance the themes and subjects of such practice oriented ethics. Chapter 4 tries to formulate some answers to these questions from a perspective that connects ‘professionalism’ to ‘reflection’ and ‘responsibility’. That is the third point of view for exploring ethics as a basic element of ethics policy in HCO’s. Starting with the Kantian idea of practical judgment, ‘professionalism’ is connected with a specific interpretation of action oriented ‘reflection’. In action the practitioner moves between the experience of the situation and the practical and ethical knowledge he has in mind regarding this specific situation. At first to consider what is going on, what can and has to be done and secondly to give better form to his capabilities of practical judgment in reflecting former practical experiences. So ethics is connected with critical professionalism. Inspired by Hannah Arendt two important topics for this kind of critical reflection are identified. In the first place professional caretakers should reflect on experiences, that inflict their personal ideals about professional care. Next to this focus on personal loss of identity as starting point for self referential critics, they should reflect their professional routines: in order to improve them corresponding with their ideals of good practice. This perspective - making professional routines subject of ethical reflection - can be connected with a Socratic approach of practice, while the first interpretation, focusing on loss of personal identity, is inspired by Kantian ideas of autonomy and morality.

Next to this sketch of material content, there is a sketch of sources to give shape to this kind of ethics in a more practical way, for instance the forms of moral deliberation nowadays used in clinical settings. More specific forms are suggested: first there is a proposal to borrow some qualitative methods from social sciences, especially ‘action research’ and more specific ‘living theory.’ Also a plea is done for a classic method known from the history of ethics, casuistry, because this method supports an active role of the practitioner in ethics. However, a practice oriented ethics has to pay attention to more dimensions of practice than the reflections and choices of individual professionals alone. According to ethicists as Walker and Verkerk attention in reflection should also be given to patterns of responsibility in healthcare.
With this sketch of practice oriented ethics, taking self referential action critics as starting point, the exploration of the first subject, ethics, comes to an end. Nevertheless in relation to this sketch, there are serious questions to answer: how risky is choosing for self referential critics as starting point for ethics policies in HCO’s? Can we really trust that professionals have a capability of self-regulating reflection? Is an external limitation of values and norms not more adequate? It is suggested that these questions can be met with a reference to the nature of care. Understanding the nature of care, we can prevent that a form of ethics, starting with self referential critics, becomes inadequate. This theoretical position about the nature of care needs a solid basis: what form of action is professional care for someone’s health anyway? That becomes the leading question for chapter 5 and 6. Chapter 5 investigates how care can be defined. Therefore we use a typology of action of Hannah Arendt, derived from classic Greek philosophers especially Aristoteles. This typology gives attention to qualitative differences between human activities and to the historical development in evaluating these activities. According to this typology care can be understood as: labour, work and action. While the definition of care as labour stresses the day by day activities that need to be done to keep life going on, the definition of care in terms of work pays attention to purpose oriented, linear processes with a beginning and an end. Thought of as work, the outcome of the process can be set apart from the process itself. Of old, medical acts are most associated with work as a linear activity, but not totally: from ancient times medicine is also understood as action: an activity that takes place between people; that confirms people as they are, part of society. In that way medicine is also important for the construction of society. Not in a modern economic sense, but in a sense of meaningfulness. According to this classic interpretation medicine can be understood in a political and therefore ethical way: it takes place in the ‘polis’ and helps it to survive. Therefore medicine asks personal qualities belonging to political action, especially ‘fronesis’: prudence. Pointing at medicine as a form of social-political action, it also gives direction at the morality of medical care. Labour and work do not have these strong moral meanings: thanks to their situation in the sphere of the private household, they precede the political realm. Thereby and by its instrumental character labour lacks full moral meaning. Chapter 6 gives a nearer explanation of care as a form of action. It starts with the recapture of Arendt’s typology in actual debates on care to underline the potential meaning of this typology. Especially attention is given to the way two Dutch philosophers use the typology to make clear that care cannot be reduced to the realm of the marketplace. On the one hand Achterhuis who deduces the special character of care from the relational sphere of the household (‘oikos’). On the other hand Van Heijst who stresses that care is special because of its character of action. Although both views can be used to stipulate the special character of care and to set care free from the marketplace, I prefer the vision of Van Heijst. In my opinion Achterhuis neglects the feature that modern professional care does not fit the special relational dimensions of the private household. Moreover he overestimates
the classic boundary between private and public. By doing so, day by day care is devalued to an irrelevant form of social-political work. A definition of care as action as given by Van Heijst, guarantees a qualification that gives more justice to the special and social character of professional healthcare. This interpretation also fits a vision of professional care best as taking personal responsibility for action. But it does not give an answer to the question, what exactly makes care, even when it looks like labour, into a form of action.

There are various arguments to underline the action character of professional, day by day caring activities. The circumstance that from old nursing activities are acknowledged as medical activities is rather a weak argument. Other arguments are stronger. In the first place the argument that day by day care is given to strangers as well. Therefore there are no certain patterns of care, the professional can trust on. Secondly there is the argument that day by day patterns of care loose their stable character when illness and handicaps occur. In that case day by day knowledge is not sufficient anymore. Instead there is need of special knowledge and expertise. This kind of argumentation is already used in the Corpus Hippocraticum. Both aspects implicate that caring for the health of another citizen can be estimated as action, even when it looks like labour. The next argument accentuates the circumstance that professional care takes place between people. It is an argument that Van Heijst brings forward in her recapture of the typology of Arendt. She stresses the interactive character of care as step to a dialogical interpretation that makes not only the caregiver but also the recipient an active co-designer of the process. Van Heijst pronounces this interpretation referring to the theories of Tronto on care as a relational process between people that cannot be completely reduced till the initiative or the actions of the caregiver.

However, will care be confirmed as a social practice of acting people, such confirmation demands special organizational arrangements. That is the third dimension of ethics policy. Just considering the process of socializing healthcare, it is a dimension that needs attention: the way healthcare is organized in our society has increasing meaning for the definition of care itself. Chapter 7 illustrates this process on the basis of two Dutch studies on healthcare developments: a study of Becker on developments in care for the elderly and a study of Pols on developments in the same sector and also in psychiatric care. Becker’s study is taken as example for a vision on the organization as a construct, while Pols’ study is used as an example for an interpretation that views the organization as spinoff of a social process starting in caring practice itself. A central point in the view of Becker is the way the culture of organization, fixed by management and expressed in corporate stories, is steering the partial processes that take place in the organization. A crucial point of the vision of Pols is that care - independent the way care is expressed - is made true in practice and nowhere else. This position implicates a confirmation of professional activities as action. In the interpretation of Becker professional care is reduced into a performance of organizational arrangements, whereof
the rationality is no longer a case of the professionals. Strictly spoken the professional occupation in this concept is defined as labour.

To explicate these two different visions at the HCO, there has been made use of a typology of De Geus, borrowed from the philosophical tradition. The image of an HCO as indicated by Becker, is linked with a Platonic interpretation of organizations. Pols’ view of an HCO approaches a more Aristotelian concept. Instead of emphasizing the totality of organization, just as it happens in a Platonic interpretation, the Aristotelian concept emphasizes the meaning of the relationships between the participating individuals: every individual actor is held responsible for his actions. When we want to confirm professional care in terms of a practical affirmation of the uniqueness and morality of patient as well as caretaker, adoption of a more Aristotelian view is inevitable.

Of course, such a representation of the organization has implications for thinking about management as a relevant organizational activity. In chapter 8 and 9 this perspective is elaborated in line with the former presentations of the two mentioned opposite organizational models. Next to an interpretation of management in terms of constructing and ‘making’, comes an interpretation of management in terms of process: management then is understood as action. Chapter 8 describes the difficulties to perceive managing as a form of (inter)action. The influence of modern social science has given managing a technical rational appearance. Change management therefore is dominated by an utopistic approach with little room for normative reflection. Organizational changes are represented in a way that makes change invisible as change. It transforms the manager into an impartial observer of the developments and also leaves space for putting forward indisputable, factual rules. That background gives reason to the view of MacIntyre of the manager as an amoral character. Although continuously serious attempts are made to escape from the totalitarian claims of technocratic management forms, most attempts seem to fail. What could possibly help is a radical break involving scientific paradigms as well. Therefore, some authors propose a change to a more esthetic and intuitive management style. Instead of technical rationality intuition and esthetics should guide managerial moves. While such a turn towards more intuitive management could compensate shortcomings in practical knowledge and skills, it is the question if it is sufficient to affirm the central activities of HCO’s as action, as a moral and political practice of its own.

For why, as an affirmation of care as action, one would not choose for a more ethical definition of managing for constructing and leading HCO’s? How would such a style of managing look anyway? Those questions are answered in chapter 9. Choosing for a management style, different from ‘making’, is a strange, but not impossible affair. It starts taking the caring practice in HCO’s seriously. It is also necessary to ascertain that leading in a professional practice is not primarily a separated function but a part of professional practice itself: it starts as a way of professional self steering. Those ideas not only underline a definition of care as acti-
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on, and views on professionalism in terms of critical self reflection. They are also confirmed in modern concepts of organization that are associated with democratic forms of management, for example networks. According to these perceptions management commences as embedded leadership, and is part of practice itself. Such a presentation fits the interpretation by Pols of caring practices well. But even when practice oriented management models fit such an Aristotelian management concept, the question is if vertical elements of steering can be missed in such kinds of organization. Because professional care stays human, its moral quality cannot be guaranteed completely. This circumstance makes, even in an Aristotelian organization, vertical steering elements necessary. Moral quality of acting in care cannot be sufficient guaranteed with a reference to its professional character. Steering is necessary. But what kind of steering should be used?

Management can be performed in very different ways. Using a distinction, made by Arendt, between utility and meaningfulness, explicated further with the famous distinction of Weber between ‘value’ and ‘goal rationality’, a management description is elaborated that could be supportive for action oriented developments in healthcare. Next to a goal rational orientation, focusing on questions of utility, there is room for the meaning of care as experienced by them who are practically involved in the caring process itself. Such attention focused on meaning and value, makes the estimation of processes of rationalization not only dependent of utility or productivity but also of the intrinsic logic of care itself. In relation to organizational developments it is therefore necessary to make a difference between the HCO and other kinds of organization respecting the crucial processes in practice.

Some critics will remark that the same processes of development and rationalization can be put through in any type of organization, without making a difference between them on the basis of crucial processes in practice. Nevertheless such an approach carries the risk that it does no justice to the meanings people give to their activities. And neither to the people self involved in those activities.

Managers of professional healthcare institutions should, in their deliberations about formal processes of rationalization, be guided by the question what kind of reinforcement the proposed rationalization process promises, for the practice involved, conform the specific values and norms of that practice. Acting in such way transforms managing an HCO as with professional care, into an interactive and moral practice itself.

Chapter 10 transforms the results of the explorations on ‘ethics’, ‘care’ and ‘organization’ into a coherent normative concept for ethics policies of HCO’s. In addition to an image of ethics beginning with the critical reflection of practitioners about the normative form of their practice, a number of terms is described, almost naturally belonging to that image. Next to the crucial concept that directs the way the other concepts have to be understood - ‘action’ - comes ‘care’, ‘professionalism’, ‘ethics’ and ‘organization’. As far as this conceptualization has some original me-
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aning, it is indicated that not the operational elaboration of ethics policy has this quality, but the broadening of the perspective in the direction of organization and management.

Subsequently the consequences of this concept for the concerned parties are described, not only for ethicists and practitioners, but also for patients and citizens. Practice oriented ethicists should display for example less expertise in material questions of care, but more in sustaining the faculty of practical judgment and in learning programs for the practitioners that enforce this faculty. This consequence demands adaptation. Another element that demands adaptation is that not only the practitioners but also ethicists and managers are addressed as persons involved in moral practice. According to an Aristotelian view of organizations the democratic design of HCO’s is another matter that deserves attention: it asks explorations into the involvement of patients and citizens in policymaking processes.

Because the presented concept is theoretical, the described consequences are hypothetical. Decisions about the implementation of action oriented ethics policies, are therefore made in local care practices and nowhere else.