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INTRODUCTION

On 6 October 2011, individuals from a wide range of backgrounds were brought together by the Víctor Grífols i Lucas Foundation to share a day of reflection on an issue of common interest: ethics in health organizations. The session focused in particular on the relationship between the logic of care and the logic of management. While the pages that follow do not record the full richness of the dialogue that took place, they do seek to reflect the substance of the various contributions.

Our starting assumption when organizing this encounter was that hospital settings bring together two different logical frameworks, each reflecting a set of values, principles and criteria which do not always coincide. As a result of these differences, the decision-making process is often characterized by tension and a struggle to reconcile conflicting priorities. The existence of these distinct frameworks does not mean that either is necessarily incompatible with a commitment to the aims of the health institutions within which they exist. But our starting point was a recognition of the differences between the two approaches, and the fact that these differences may lead to tensions and contradictions, depending on the specific organizational context.

We decided to call these two approaches the "logic of care" and the "logic of management", because the purpose of the seminar was to create a space for shared dialogue and reflection on these two approaches, to better identify how they interact with each other, to identify the main challenges they encounter, to identify a number of typical situations, and ultimately to draw some conclusions which may be of relevance to the training both of health professionals and of health managers.

From the outset, we were only too aware of the existence of a third actor who influences and indeed frames the relationship between these two logics, often in a decisive manner: public policy. This actor is often seen as somehow external to the institutional framework within which the encounter between the logic of care and the logic of management takes place, and is often held

responsible for many of the problems which arise as a result. However, this actor was not invited to our meeting. Although there was clearly a risk that decisions taken in the realm of public policy would thus offer a convenient scapegoat, we were keen to focus directly on the relations between the logic of care and the logic of management on the basis that, while these are obviously conditioned by public policy, they also exist as entities in their own right. In the end, any such fears proved to be unfounded, and the seminar provided the occasion for a lively and enlightening dialogue, which we hope is reflected here.

A number of different questions came up, pertaining both to the relationship between the two logical frameworks, the values which constitute the non-negotiable core of each, and the points or situations where there is the greatest overlap or the greatest potential for conflict. And there was also careful consideration of the issue of how to transfer our conclusions to the sphere of education and training: what those who normally operate within the framework of the logic of care should necessarily know about the logic of management, and vice versa.

While it was repeatedly stressed that the gulf between the two approaches was not so large, upon listening to the contributions it was not always clear whether this assertion was a description of the actual situation, the expression of a wish, the observation of a growing trend, or a normative proposal as to how things should be. In any event, whatever the level of dissonance (in terms not only of principles but of how specific organizations operate in practice), one thing was clear: the need to keep sight of the aims and values of the organization within which the activities take place, and the provision of effective, integrated care for the patient, which should be the primary concern of everyone, whatever their background. It is also important to remember that facilitating communication between the two approaches is sometimes simply a question of ensuring the availability of space and time for meeting, because physical distance and communication barriers are often the cause of differences and conflicts.

A final issue which came out very clearly was the pressing challenge represented by the rapid and far-reaching changes in both the management and healthcare professions in recent years, a clear awareness of which should have an immediate impact on the education and training of both professions.

Readers of the pages which follow will probably reach the same conclusion as the participants: that in order to make further progress in this area, we would need to reflect explicitly on public policy and the need for changes to professional education in this area. However, this would be to get ahead of ourselves, and would also risk undermining the value of the contributions and discussion set out below, which one hopes will be both stimulating in their own right and may serve as a starting point for similar discussions in other places and other contexts.

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Professional ethics and institutional ethics: between collaboration and conflict

Diego Gracia

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Two logics or a single logic? Two sets of ethics or a single set of ethics? While health professionals have always been more or less clear about their ethics and the logic which governs their decision-making, they tend to find it harder to understand that there may be two distinct sets of rationales and that, furthermore, these may be in conflict with one another. The problem is compounded by the fact that this phenomenon is relatively new, and that the literature has little to say about it.

A bit of history

This is not the first time that hospital doctors have had to work with external managers who may not even belong to the health profession. It is worth recalling that hospitals began, in the west, during the Middle Ages as charitable institutions attached to existing ecclesiastical structures, both in towns (episcopal hospitals) and cities (monastic hospitals located at the side of Roman roads). These hospitals were the site for the practice of Christian charity through the exercise of the seven corporal works of mercy: to visit the sick, to feed the hungry, to give drink to the thirsty, to visit and ransom the captive, to clothe the naked, to shelter the homeless, and to bury the dead. Their primary objective was not to attend medically to the sick but to help the poor and the needy. Indeed, the word "hospital" comes from the Latin *hospes*, meaning "pilgrim". In these places, poor pilgrims were attended to (the original name was *hospitale pauperum*), but it is very unlikely that they were provided with medical care. This differentiated them from the *infirmaria*, which did indeed provide medical assistance, but were the exclusive domain of the most privileged layers of Medieval society.

Only gradually did medicine enter the hospitals. And when it did so, health professionals encountered institutions organized and governed not by doctors but by churchmen. It goes without saying that the logic of the church and the logic of medicine were different, and that this constituted a continuous source of conflicts. I will list some of them: the prohibition on human anatomy, so essential for the development of surgery; the impossibility of performing autopsies on dead patients, something which unquestionably delayed the progress of clinical medicine; the insistence on interpreting illness as a punishment for sin, something which completely contradicts medical logic; a different and often opposite approach to everything related to the practice of sexuality, etc., etc.

It is important to realize that it was not until well into the modern period that doctors took control of hospitals. Only in the 18th century did these become institutions organized and run in accordance with professional criteria. Doctors became the managers of hospitals, with churchmen reduced to a secondary role, whose function was restricted to the provision of spiritual support to the sick. As a result, from the 18th century onwards the institution of the hospital was gradually secularized. What had begun as a primarily ecclesiastical institution became a predominantly civil one. And its primary concern with the performance of charitable works was gradually replaced with a focus on providing medical care for patients.

This, broadly speaking, is how things stood from the 18th century until the second half of the 20th. Throughout this entire period, doctors were also responsible for managing hospitals. Since then, and in Spain more specifically since the 1970s, doctors have been gradually replaced by professional managers who are not necessarily doctors and who often have a background in economics. As a result, the new type of organization is associated with the appearance of a new person – the manager – with both medical and nursing directors relegated to dealing with strictly clinical issues. And this is where the conflict between the logic of care and the logic of management arises, given that these two logics often coincide but sometimes do not.

The reasons for change, and its consequences

Why did things change in the 1970s? Because it was becoming apparent that the existing model was not functioning particularly well. In 1973 there was an economic crisis which threatened the welfare state constructed with such evident success following the Second World War. Every western European

country established public medical insurance systems, and throughout this period they ran surpluses. It was only around 1973 that they began to go into the red. At the beginning, it was assumed that this was temporary, as a result of the crisis, and that as soon as this was over the economic boom times would return. However, it soon became clear that this was not the case, and health expenditure rose unstoppably, to the point where it outstripped economic growth. Something was wrong, and it was necessary to take drastic measures to prevent catastrophe.

These measures found expression in policy during the 1980s. Margaret Thatcher took power in the United Kingdom in 1979, and remained until 1990 (when she was replaced by John Major), while Ronald Reagan won the United States presidential elections of 1981 and held power until 1989. At the same time as this was occurring in the west, the communist alternative was crumbling in the east. Gorbachev launched his *perestroika* (reconstruction) in 1986 and introduced *glasnost* (opening, transparency) in 1988. One year later, in 1989, the Eastern bloc disintegrated and, on the night of the 9th and 10th of November that year, the Berlin Wall came down. This was interpreted by the west as a clear confirmation of their policies. It is no coincidence that the following year, in 1990, the neoliberal and monetarist policies of Thatcher and Reagan, typical of the Chicago School (Friedrich Hayeck, Milton Friedman) were exported to the rest of the world by means of the so-called "Washington consensus", which imposed the same criteria on the World Bank and the International Monetary Fund.

In relation to healthcare, this had a number of major consequences. The first of these entailed a shift from a vision of it as a "not for profit" activity to seeing it as a business like any other, that is, one motivated by profit. This was clearest in the United States, where hospitals, which had previously generally been owned by religious or civil non-profit institutions, were acquired by insurance companies or investment funds. Another fundamental consequence was the appearance of so-called *managed care*, which in its most radical manifestations seeks to maximize the economic profitability of health services, regardless of age-old principles once deemed an inviolable element of medical ethics.

This brought with it the appearance of a new concept, the notion of "double agency" by which health professionals, who had before seen themselves as the agent of the patient, fulfilling the role of what legal experts call the "position of guarantor" and under an obligation to seek the patient's benefit, now found themselves obliged to act also as resource agents, with the resultant potential for conflict between the two claims on their loyalty.

All of this is related to a whole range of other issues, including what is sometimes called the "financial engineering" of the 1990s and later, a decisive factor in the current crisis. But perhaps the most decisive factor is one which has generally been ignored: the conviction which has spread throughout the western world since 1980 that the only kind of value is economic or that other value, where it is acknowledged, is deemed to be subordinate to the economic. We therefore need to seek wealth, because everything else will arise as a result, and any other value must be measured in monetary units. Things cost what people are prepared to pay for them. It is precisely during recent decades that this slogan has become a social and cultural cliché.

Value and price

But this is far from being above dispute. In fact, a very interesting literature has appeared in recent years, which attempts to contest this way of seeing things. I will cite two books: the first by Tony Judt, *Ill Fares the Land*; and the other, by Michael Sandel, Professor of Ethics at the University of Harvard, titled: *Justice: What's the Right Thing to Do?* The thesis of both is that, since the 1980s, there has been a massive change in our values system and that this, at the very least, should be addressed. They argue that value and price are not identical.

There is a natural perception that certain things should not be bought or sold. This is expressed in sayings such as, "You can't put a price on health," or "Money can't buy you love." "Human beings have dignity but no price," argued Kant. "The cynic knows the price of everything and the value of noth-

ing," in the words of Oscar Wilde. There are some things which, for most people, are "priceless". And this means not that they have no value but rather that they are extremely valuable. Indeed, they are deemed to be so valuable that they cannot be exchanged for anything else, or for money.

These are what have traditionally been called "intrinsic" or "inherent" values. In the ancient world, these included the platonic ideals of beauty, goodness etc. We no longer think of intrinsic values in this way, either as substantive things, or as their objective qualities. But this should not lead us to the opposite extreme, the one which is currently the most frequent, the belief that they are purely subjective, lacking all rationality, and therefore immune to any coherent logic. "There's no accounting for taste," as the popular saying would have it. According to this view, everyone has their own values, we respect these because we are civilized people, but at the same time we consider them to be mistaken and subjective. This has led to the belief that the only possible rationality is economic, one which assesses value solely in monetary terms, because there is no other way to do so. All values are subjective, but there is a way of making them objective, through the category of price. The price gives us an idea of what things are worth.

This is the situation in which we find ourselves. We are caught between the absolute objectivism of those who are nostalgic for the past, and the absolute subjectivism of those who consider themselves truly modern. It is as if there were no other solution, no third way. But this assumption is quite false. This is one of the consequences of the current economic crisis, one which is forcing us to reconsider issues we believed to have been resolved. One of these problems is, precisely, the question of value.

By identifying value with price, what we have done is to reduce all values to one type or subclass of them, that which is generally described as "instrumental". These are also sometimes called reference, technical or intermediate values. All technical products fall into this category. A car, a plane, a pen, a medicine, have value in so far as they are useful for something else – in the first and second examples, for moving from one place to another, in the third, for writing, and in the fourth, for alleviating a symptom, curing a disease, or saving a life. All these instruments derive their value from something which is external to them: health, life, knowledge etc. If a medicine did not alleviate a symptom or cure a disease, we would say that it was "no use for anything". This is the nature of instrumental values. They are the means by which we achieve other things that we value not as means but as ends. These are what we call "intrinsic" or "inherent" values. Without the latter, we could not have the former.

Some things have a worth of their own, not from reference to something external or other than themselves. The beauty of a picture has a value of its own, such that it cannot be exchanged for the beauty of any other picture. The beauty of the paintings of Titian is not the same as that of Velázquez, and if we lose any of them we will have lost something irreplaceable, its intrinsic value, regardless of whether we still possess the others. And this is the point: intrinsic values cannot be exchanged, while instrumental ones can. Nor can they be measured in monetary units, unlike instrumental values, for which the unit of measurement is money.

This issue is extremely important and would benefit from more detailed analysis, but here we will have to make do with these broad generalizations. From these, we can draw some major conclusions. One, which is fundamental, is that the processes of valuation, which are always subjective because the valuation depends on the judgements of individual people, end up being objectified. The result is what we call "culture". Culture is the repository of values of a society. This means that the value judgements of individuals contribute to the repository of values that we term culture, which is the result of the valuations made by the members of a group. Societies may choose to promote instrumental values or intrinsic values. In philosophy it has often been argued, most prominently by Heidegger, that western society has, since the 18th century, preferred instrumental values, to such a degree that it has tended to view even intrinsic values as if they were instrumental, judging them by the same criteria. I am afraid that this tendency has become even more marked during the last 30 years, since 1980. The result of this conversion of all values into instrumental ones is what the Frankfurt School has termed "instrumental rationality" or "strategic rationality". This is the greatest axiological distortion imaginable.

Professions and jobs

Human beings perform countless, wildly varying roles in society. These include the set of roles generally referred to as "occupational". With the exception of the unemployed, we all perform an occupation within the social network, and this obliges us to perform certain tasks, and to do so in a particular way.

Occupations have traditionally been of two types: "professions" and "jobs". Sociologists have sought to explain this division in various ways. It has been said that jobs are manual, while the professions are intellectual; that one is dedicated to leisure and the other to business, etc. However, I believe that the roots to the distinction lie deeper. We apply the term "profession" to those social roles that deal with intrinsic values, and "job" to those that are concerned with instrumental values. Having said this, I find myself immediately obliged to correct myself. While this distinction may have applied in the past, it is clear that recent years have seen a blurring of the division that matches the change in our attitudes to these two types of value.

The health professions deal with intrinsic values, generally termed "vital values", and which include life, health, pleasure and well-being. To do this, they need to use lots of technical devices, both diagnostic and therapeutic, the value of which is purely instrumental, and which are increasingly complex and costly, a fact which in turn makes healthcare vastly more expensive. In this domain, dominated by instrumental values, it is clear that ethics has to be ruled by the principle of efficiency, that is, achieving maximum benefit for minimum cost. There is an ethics of the management of instrumental values, but this ethics is not the same as the one which applies to the management of intrinsic values. One such intrinsic value is justice. This requires that basic social goods are available to all, despite the fact that this principle often clashes with the "law of diminishing returns". As a result, justice may become inefficient, and inefficiency is unjust. This is a classic example of the conflict between value and price, or between intrinsic and instrumental values.

So what should we do?

Ethics is concerned not with values but with duties. Ethical questions are always practical, consisting of knowing what should or should not be done. In this context, we need to know whether to choose justice or efficiency. It is normal to frame matters in this way, by applying a dichotomous "either-or" logic. One of the two values must prevail over the other, because we cannot apply both at the same time, and in this context we need to know whether to choose justice or efficiency. This is what we call "a conflict of values", with just two outcomes or courses of action, of which one must be chosen.

The usual way to describe this is to say that we are facing a dilemma. A dilemma is a conflict to which there are only two solutions, of which we must select the best. If you look at the literature on ethics and bioethics, it is impossible not to be struck by the vast number of articles and books whose titles include the word "dilemma". Everything is a dilemma, and at times it seems that the function of ethics is simply to guide choices between two courses of action.

My personal opinion is that genuine dilemmas are extremely rare, but that human beings have an innate tendency to convert problems (that is, conflicts in which there are more than two possible courses of action) into dilemmas. This is generally due to intellectual laziness or, in William of Ockham's more elegant phrase, the "rule of parsimony". It is easier to decide between two courses of action than between several, and as a result of this fact we tend to start by artificially simplifying problems and converting them into dilemmas, with the aim of identifying two courses of action and choosing the most appropriate.

However, our first and only moral obligation is to ensure respect for values, and this means all of the values that are in conflict and not just that value which is deemed to be of higher status or greater importance. Any value lost is irreparable, and for this reason we must strive by all means to safeguard all the values affected by the conflict or, at least, to do as little harm to them as is possible. It is a serious error to believe that we are satisfying our obligations by choosing the most important value while damaging others. This could only be justified if it had been demonstrated that no course of action was

available that enabled the values in conflict to be protected or to suffer the least possible injury. Choosing one value to the complete detriment of another is always a tragedy, because one value is then irremediably lost.

Two values and a single logic

Do health professionals and health managers have two distinct logics? I would say no; that they share a single logic. However, their professional roles oblige them to promote two distinct sets of values, in one case the intrinsic values of life and health, and in the other case the instrumental values of efficacy, efficiency and effectiveness. But let us not deceive ourselves; we are all in this together. Values do not exist in abstract; rather, they find expression in people and in things. These are the locus of both intrinsic and instrumental values. It is for this reason that the purpose of ethics is not to prioritize one over the other, but rather to defend both or to infringe them as little as possible. Traditional medical ethics was mistaken in giving primacy to the values with which the medical profession is concerned and disregarding economic values, and by the same token the current approach, which always gives precedent to the principle of efficiency, is equally mistaken. This is playing at dilemmas, something which always leads to disaster. Unfortunately, this is exactly how this issue has usually been approached. What we face is not a dilemma but a problem, and our obligation is not to choose one of the conflicting values to the complete detriment of the other, but rather to seek the best course of action to preserve both values or to infringe them as little as possible. This is our objective, our sole objective, both as health professionals and as managers. This is a shared objective. There are not two logics, or two ethical frameworks, but rather a single logic and a single ethical framework in which there are two distinct types of value: distinct, but inseparable. As a result, it is not acceptable to resolve conflicts by always choosing intrinsic values or by always preferring instrumental ones. Sometimes, for example with respect to the so-called primary social goods, it may be necessary to resolve conflicts in favour of justice over efficiency, while at other times just the opposite will be required.

A final clarification. When a conflict of values arises, any non-optimal course of action is a bad thing. Ethics is concerned not with what is good but with what is optimal. Or, to put it another way, any decision that is not optimal is bad. This clearly distinguishes ethics from law. It seeks not to identify right from wrong, but rather to identify what is optimal. Julián Marías wrote a short book on ethics with the title, *Tratado de lo mejor* (Treatise on what is best). The judge who fails to issue the optimal ruling is acting wrongly, in the same way as the doctor who fails to prescribe the optimal treatment. This is always a problem, and one which is unfortunately far more complex to resolve than a simple dilemma. The method of dealing satisfactorily with moral problems and taking sensible decisions has, since the time of Aristotle, been called deliberation. And it has to be conducted with care.

This is the purpose of ethics, in our case of medical or clinical ethics. To achieve this, health institutions need to create spaces for deliberation. This is what ethics committees can, should and must be. It is their function to be at the service of all: managers, health professionals and service users. Ethics committees should be seen as what they are, quality committees, designed to improve the quality of decisions in the health sphere through better resolution of value conflicts. This is a big challenge, and one which our health system has yet to face up to.

The logic of management

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Handling professionals is one of the most complex challenges faced by management. The term "professional", according to the definition established by Mendoza, refers to the member of "a knowledge-based occupational group, whose members have significant control over their own work and who enjoy a protected position in the market (whether in the employment market or the market for professional services)".

The education and socialization of professionals contributes to the development of their identity, internalizing standards and values that emphasize service to society and altruistic ideals. Professionals claim, furthermore, knowledge that is beyond the reach of those who do not belong to their profession. This is certified knowledge that forms the basis of their autonomy and the control they exercise over their work. The process of embedding the liberal professions in organizations is sometimes referred to as bureaucratization, something which calls into question many of the factors that characterize and identify the medical profession: autonomy, control over one's own work, the relationship with patients, decision-making capacity, status etc.

Professional organizations

During the second half of the 20th century, medicine has increasingly been practised within organizations. The tradition of free, individual practice of the profession has gradually been incorporated into hospitals and health centres, professional organizations that are more than simple conventional bodies designed to achieve specific objectives. The consolidation of health institutions has wrought a profound transformation on the traditional manner of practising medicine. As they have developed, hospitals have gradually exercised more and more control over health professionals, demanding results, as a consequence of which doctors feel that their autonomy is threatened and struggle to understand and accept the demands of a more extensive organization, with more instruments of management and control, and also more bureaucracy.

In the European context, the public sector accounts for the majority of the health professionals working for these organizations, such as university professors or hospital doctors. The management of these organizations is characterized and distinguished by certain features due, precisely, to the presence within them of professionals.

Hospitals reflect the professional bureaucracy described by Mintzberg in which doctors form the operational core, the central part of the organization, have a significant degree of autonomy, have a direct relationship with the patient, and categorize patient needs in order to decide upon and apply a treatment, with this being one of the characteristic features of these professional bureaucracies. In addition, these organizations contain a sophisticated support staff, constituting a parallel hierarchy that does not coexist easily with the hierarchy of the professionals. Managers have the task of mediating between these two structures and hierarchies, limiting themselves to administrative issues without becoming directly involved in professional issues, while at the same time striving to ensure that doctors have the best possible conditions under which to perform their care and research duties, without being encumbered by problems that should not concern them.

The conflict between organizations and professionals

The principles and values of a bureaucratic organization are not the same as those of professionals, and indeed they often clash. As a result, it is often difficult for professionals to fit into organizations, to the point where the conflict between organizations and professionals has generally been identified as a typical feature of such organizations. The repeated demonstration of discontent, demotivation and professional dissatisfaction are generally interpreted as symptoms of this conflict.

However, this conflict is not the same in all professions. This predisposition and how it is manifested vary between professions providing services to people, such as law, medicine or university teaching, or technical-scientific professions, such as engineering or auditing. Not all members of any given profession respond in the same way with regard to their relationship to the

organization, and in this respect Gouldner distinguished, over 50 years ago, between two types of professional behaviour: local and cosmopolitan. Locals were defined as professionals with a high degree of organizational loyalty, aspirations to "make a career in it" and, therefore, more sensitive to organizational instructions and rewards, with strong reference group orientation and less commitment to their professional specialty. He characterized cosmopolitans by their low organizational loyalty, an interest in acquiring new knowledge and developing new areas of specialization, and a wish to obtain the professional recognition of groups outside the organization. These typologies at least help make it easier to understand the simultaneous needs for loyalty and knowledge of any organization of professionals, and the tension that results from this fact.

The causes of conflict are attributed to the simultaneous participation of professionals in two systems – the profession and the organization – and to the fact that the organizational principles of the profession and of the bureaucracy are different. That is, the conflict occurs in organizations of professionals as a result of the difficulties of combining professional standards and values (autonomy, professional standards, ethics, self-governance, loyalty and a focus on the service user) with the requirements and demands of the organization, which emphasize authority and hierarchical control, conformance with organizational standards and regulations, and loyalty to the organization. Reconciling the two calls on loyalty is not easy, because although the objectives of the organization are more precise, in so far as they are explicitly stated and set out in terms of quantifiable results, the objectives of the profession are more diffuse, given the difficulty of agreeing upon a single way of understanding and practising the profession.

The consequences of this conflict for the organization take the form of lost productivity and creativity, increased staff turnover, poor relations with managers, a deterioration of the working atmosphere, loss of interest in updating knowledge, and difficulties in mobilizing professionals around organizational objectives. For professionals, the conflict is expressed as a difficulty in identifying with the organization where they work, depriving the work that they do of meaning, the renunciation of certain of their principles and hopes, and the adoption of an adversarial or negative attitude towards the organization.

The visible expression of the conflict between organization and profession generally takes the form of a conflict between managers and health professionals, due in part to confusion about their respective responsibilities and the different perspective from which they approach problems (a broad one in the case of managers, and a more narrow one in the case of professionals), contributing to distrust between the two. Managers are representatives of the organization, and they tend to distrust professionals and seek to control them because they do not understand or share the reasons why, on occasion, these professionals subordinate the interests and objectives of the organization to their own professional interests and needs. This distrust grows if managers perceive professionals as a direct threat, either as a result of challenges to their authority or due to the difference between the values of professionals and those held by managers or the organization.

Despite this, the relationship between professionals and the organization cannot be understood purely in terms of conflict. Research has gradually revealed evidence of compatibility between professionals and organizations, to the point where some authors describe how bureaucratic structures promote the development of a professional career. This could explain why some professionals have been prepared to give up part of their autonomy in exchange for prestige, security and the advantages of belonging to organizations.

For salaried doctors, autonomy, control over their own work, the relationship with patients, the ability to make decisions, status and professional recognition are a common focus of disputes with the organization and its representatives. The professional perspective assumes that doctors feel committed to the standards, rules and values of their profession, that these are shared with colleagues and applied in professional practice. For its part, an organizational perspective expects that doctors, as salaried employees of the hospital, accept the rules and standards of the organization and share its values.

The reforms that began in Spain at the start of the 1980s, as a consequence of the transfer of responsibility for health to the regional governments, intro-

duced a "management" model designed to ensure that hospitals were run more efficiently. Two different ways of understanding how hospitals function developed, thus entrenching the conflict by setting the increased authority of managers on the one hand against the autonomy of health professionals on the other, establishing the pattern for relations between doctors and managers. The conflict has persisted, although it has been softened by the fact that managers have gradually become "professionalized" while doctors have become "bureaucratized".

Organizational commitment and reconciling different loyalties

Several studies suggest that the best way of overcoming the conflict between organization and profession is by promoting doctors' participation in and commitment to the hospital. These argue that participation, as an explicit, irrevocable, voluntary, public act, is an expression of the commitment of the individual and, as a result, if doctors participate in decision-making this will increase their sense of responsibility towards the hospital and its operation. By the same token, it is assumed that a doctor who is more committed to the hospital will be more receptive to the proposals of management, will be more supportive of the institution's strategic objectives, and will be more willing to work harder and to make more efficient use of the resources at his or her disposal.

Of all the aspects that contribute to professionals' commitment to their work, the one which has received most attention from researchers has been the issue of commitment to the organization. This commitment is seen as a psychological state in which the individual identifies with the organization and, as a result, the individual will be more loyal, less likely to take time off work or to leave the organization, and more productive and receptive of instructions; in summary, that the professional will respond more positively to management's proposals.

The model of organizational commitment referred to is that of Meyer and Allen. This is based on three components:

- affective commitment to the organization
- recognition of the costs associated with leaving it, and
- the moral obligation to remain in it.

Commitment to the organization reflects different levels of commitment in each of these three components and is defined in terms of the degree to which each of these is valued.

The most important factor in generating organizational commitment is what is called "perceived organizational support", understood as the perception of employees as to how highly their contribution is valued, and the attention paid to their welfare by the organization. Studies have found a correlation between the discretionary powers associated with jobs and the level of perceived organizational support, something which has great relevance for hospitals. And there is also evidence that the perceived support of the immediate supervisor or line manager contributes to an improved perception of organizational support.

It has also been found that it is difficult for an individual to identify with the organization as a whole when this, in turn, is made up of multiple groups, each with its own objectives and values, which may or may not be compatible with those of the rest of the organization. As a result, organizational commitment may be better understood as a set of multiple commitments, and in this regard particular importance may be attached to the specific entities within the organization to which the individual may feel committed. This is not a minor question, particularly for doctors who experience the hospital through the service to which they belong and which constitutes the basic organizational unit of which they are a member as a result of their professional specialism, and to which they are generally far more closely committed than the hospital as a whole, an entity that is often perceived as abstract and remote. Another important focus of the doctor's commitment is the head of service, a pivotal figure in the relationship between doctors and the hospital. The head of services establishes the general framework and also guides the professional work of the doctors in his or her unit, contacts other groups of specialists and supplies administrative information to doctors. However, the reality is often that heads of service act more as representatives of the medical staff

in their service, and are not usually regarded as part of the hospital management.

Research that has looked at the level of commitment of doctors to the hospital and the compatibility between this commitment and their loyalty to the profession suggests, in general terms, that the majority of doctors combine organizational and professional commitments. Commitment to the hospital is constructed, developed and reinforced throughout the doctor's professional career. However, within the medical profession there are different notions as to the nature of the profession, and not all health professionals understand the practice of medicine in the same way, with the result that doctors do not constitute a homogeneous, uniform group.

In this regard, research has identified different types of doctor, different clusters typified by different ways of understanding, experiencing and practising their profession. As a consequence, any human resources policy aimed specifically at the medical profession requires the identification, in any given organization, of these clusters in order to ensure that any policies or actions are tailored to each group. Managing doctors and the potential conflicts between the organization and professionals requires that any actions taken be adapted to the demands and needs of each cluster.

Institutional governance and institutional autonomy

If doctors are to reconcile their commitment to the profession and the demand for loyalty to the institution, the hospital itself must have a degree of autonomy that, at present, most of them lack. Institutional autonomy is essential for the development of policies to promote the perception of organizational support among medical staff. In so far as doctors see that the health institution where they work takes an interest in and is concerned about them, that it strives to enable them to practise their profession, to improve the conditions under which they work, to offer them more professional opportunities and to facilitate their professional progress, that it distributes resources fairly, that it recognizes and rewards outstanding contributions, then doctors will perceive and value this organizational support and, as a result, their commitment to the organization will also increase.

It is difficult to raise doctors' commitment to the hospital as a result of improved organizational support if most health institutions lack real management authority as a result of established procedures that regulate the operation of these health institutions and restrict the capacity of managers to resolve day-to-day problems in hospital organizations. Delays in the resolution of operating problems that affect the provision of resources to respond to the increased demands of care provision, to resolve temporary and unstable employment situations, to replace obsolete materials and equipment, together with an inability to identify, evaluate and recognize the different contributions of staff, to give just a few examples, create a strained working environment and contribute to the perception by doctors that they receive little organizational support, something which in turn has a negative impact on their own commitment to the hospital.

However, if the managers are to have the autonomy they need to manage the centre, certain conditions are essential. The first of these is that the health institution itself must have a legal status that allows it to have its own management structures such as to ensure not just its autonomy but its identity. For this reason it is to be recommended that, as a minimum, the board should be chaired by an independent and well-respected individual. Among other functions, the board is responsible for appointing and, where necessary, dismissing management teams, which should be characterized by professionalism and proven ability, ensuring that the management echelons of the institution are not colonized by political appointments.

Management teams are responsible for drawing up and implementing the strategy of the institution, on the basis of which the organizational structure is created and developed, operational management is performed, and a human resources policy designed to promote links between the doctors and the hospital is established. In this context, the figure of head of service, which is of central importance, has been questioned in a number of studies, both by doctors and by managers, due to a perceived lack of trust in them on the part

of the hospital's senior management. Some studies have found that doctors do not have a particularly high opinion of their immediate superiors, either because they are not competent or because they are viewed as the formal representative of the hospital management (in a context where management is not always viewed sympathetically), or because they do not offer the opportunities for personal and professional development that the doctors had hoped for. And service heads themselves face a dilemma: either to do without the institutional recognition associated with any promotion up the hierarchy and continue to work as medical professionals, or to pursue a management career route, concerning themselves with administrative and management tasks, many of which do not interest them and may lie outside their area of expertise.

Ensuring that heads of service are better managers, so that both hospital management and doctors feel reasonably satisfied with those who fill these positions, is no easy task, and entails decoupling the management position from the professional career structure, so that heads of service can be rewarded or dismissed on the basis of their performance, and ensuring that they are qualified and trained to assume the responsibilities associated with their position.

The situation that exists in hospitals is similar to that which exists in other organizations of professionals where middle management positions are filled from the ranks of professionals who play a critical role in the operation of the organization. The problem tends to be very similar in all such situations: ensuring that professionals who are promoted to management positions are able to perform their tasks competently, that they are committed to the goals of the organization, and that they are able both to manage the professionals in their charge and help them to develop in their careers. If professionals feel committed to management this obviously brings significant benefits for the organization, and the absence of this commitment makes it very difficult for health institutions to achieve excellence and efficiency.

Contributions from professionals

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From "everything for the patient" to "everything for all the patients"

Thirty years ago, hospital managers were like property managers or accountants. Doctors staunchly defended their independence, proud of their freedom to prescribe, which some saw practically as a right to act arbitrarily. A patient admitted to hospital could be kept in for an extra week just because his doctor was attending a conference. I remember that as house officers we would request tests without much reason, sets of tests that were very easy to select on the request form, sometimes driven purely by scientific curiosity, and only rarely checked by our bosses.

A few years later, the power of management had increased considerably, hospital services began to collect statistics of average hospital stays, and talk of quality policies, care objectives, incentives and the rest began. New developments included pharmacy budgets and the monitoring of prescription profiles in primary care.

Over the years, in Spain we have gradually become aware of the economic implications of care and the limitations on resources, bringing us to the current situation where the economic crisis threatens the collapse of the public health system. We now deal with concepts such as efficiency and opportunity cost, but such concerns remain very much a minority concern when compared to other countries such as the United Kingdom's National Health Service.

In 1999, a Declaration of the Central Commission for Professional Ethics of the Professional Medical Association in Spain called attention to these ethical criteria in the management of resources with respect to the prescription of generic drugs, recalling the ethical duty to be financially responsible when taking care decisions. In my opinion, this declaration marked a turning point, given its status as part of a professional code of ethics, which means that financial considerations are indirectly included in our legal notion of what constitutes good practice.

Of course, as participants in a seminar on ethics and health management, we are in no doubt as to the importance of these concepts, but we must declare in no uncertain terms that these values are not included in the training of doctors in Spanish medical faculties, where these issues are not discussed, or at least not in a systematic, structured manner.

At present the professional practice of a doctor focuses on four areas: a) care, b) teaching, c) research, and d) management. A good health professional cannot ignore his responsibility for managing the resources for which he is responsible or, to put it another way, where he has the power and the responsibility for taking or authorizing decisions: admissions, prescription, complementary tests etc. And this includes, of course, time management, organizing patient consultations and the management of waiting lists.

This requires a revolution in how we train medical students. The classical "everything for the patient" needs to give way to "everything for all the patients", and this represents an added level of responsibility that has to be taught and learned. For this reason, I would question whether we can distinguish the logic of management from the logic of care; it strikes me as obvious that we are part of a single project, which is one with a clear and overarching moral purpose.

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Sensitivity and information about suffering can help facilitate understanding between the two logical frameworks

I agree with the other contributions to this debate. In my opinion, the two logical frameworks – care and management – are destined to reach an under-

standing based on the fact that they share a single starting point and a single focus: the patient. There would be no health professionals (doctors, nurses, psychologists etc.) without patients; there would be no need for managers of health institutions without patients. And it is the health and well-being of patients that provide the *raison d'être* and the motivation of both sets of professionals.

One of the factors that may give rise to differences between the two logical frameworks is the gulf that separates professional and patient. Health professionals examine and treat the patient's suffering and those factors that may contribute to or impede the patient's comfort; the manager, as Manel Peiró so graphically put it, is "trying to herd a flock of cats". And we can ask, what information could bring these two logical frameworks together?

Following on from an example proposed by Diego Gracia, there are minimum standards of care that cannot be ignored: every child has the right to an education, even if he or she has been born on a remote farmstead high in the mountains; and by the same token, no patient should **feel abandoned** however alone he may feel, and regardless of the fact that the disease he suffers from may be rare, untreatable or terminal. Although it is difficult to design an instrument or a strategy for evaluating this (in my opinion, the data provided by so-called satisfaction questionnaires is of dubious value), it is important for us to seek to do so; analysis of the **reasons** for why patients feel abandoned should be included in the information available to the management team in just the same way as data regarding length of stay, rates of surgical infection etc.

At the same time, while health professionals have a more direct relationship with the patient, many of them limit their care and treatment to somatic aspects, forgetting, as Cassell (1982) has argued, that "**it is not bodies that suffer, it is people**".

In my opinion, both health professionals and managers should be particularly attentive to work published in leading scientific journals that uses a methodology founded on evidence-based medicine to consider issues such as the effect of active listening (Lautrette et al., 2007; Lilly and Daly, 2007) or the impact on health of the loss of a loved one (Christakis and Allison, 2006; Hansen et al., 2000).

Often, relieving a patient's suffering does not require greater financial expenditure but more sensitivity (Bayés and Morera, 2000) and better communication skills (Arranz and Cancio, 2000) on the part of health professionals.

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Human rights and care as reference points in the relationship between the ethics of management and the ethics of care

My contribution to this debate on the different logics existing within health organizations will focus on three aspects:

- shared responsibility for respecting human rights
- care as the focus of ethics, and
- providing an environment in which care is respectful of human rights.

Shared responsibility for respecting human rights

I should start by saying that I agree with Professor Diego Gracia that we need to create a set of values that bring together managers and health professionals in a shared institutional commitment: providing the best possible care for the health needs of citizens. For me, the conflict arises from the changes needed to develop an ethical framework that involves both care and management professionals. That is, between a logic focusing on the process of illness, and a logic focusing on human rights. Being a good professional is not just a question of doing what has to be done in specific contexts, applying one's skills and techniques in an appropriate manner. Today, being a good professional means developing an ethical awareness from which to work with the patient as a person and not just as the embodiment of a medical condition. Our macro-ethics recognizes, both legally and ethically, the rights of citizens in the health sphere. In large part thanks to international agreements, which have found expression in regional and national legislation, issues such as information and privacy have gradually been incorporated in our health institutions. Macro-ethics has clarified key values that must be taken into consideration when conducting research with human beings and when attending to their health problems.

Our universities and other educational establishments, to a greater or lesser degree, recognize the importance of considering the values involved in respecting individuals and the diversity of ways in which they understand and live their lives. Universities have also defined their mission and values and, in their continuing professional development programmes, have included sessions and courses on bioethics, human rights, decision-making, the right to privacy etc. However, in most cases this has not been accompanied by the necessary organizational and structural changes. For example, how do you really accompany a person who is dealing with illness, and how do we offer information which is appropriate, accurate and suitable, as required by law? The answers to these questions cannot lie solely with care professionals; managers are also responsible for ensuring that consent is much more than just putting a signature to a document. A number of studies show that a lack of time, staff turnover and workload are seen by service users as negative aspects that obstruct or even prevent outright a satisfactory information and communication process (Busquets and Caïs, 2006). At the same time, we know that an informed patient takes better care of his health, and that a person who feels responsible for his health suffers from less illnesses (see WHO and ICN). It is of the utmost importance that management should be genuinely committed to ensuring that the values enshrined in law are actually implemented by doctors and nurses.

The importance of care and the care context for the logic of management

With regard to the presentation by Professor Manel Peiró, I would like to make two points. One relates to the role of nurses, and the other relates to the support that professionals need as individuals working with people who are in a situation of crisis.

When the issue of health management is raised, it is almost always addressed from a medical perspective. Organization is articulated in terms of medical

processes. From this perspective, the participation of nurses is seen as the role of a participant in the medical process. The team is a medical one, and nurses form part of it in so far as they attend to medical needs and problems. In this view, nurses are necessary for monitoring and controlling the progress of the medical treatment, for organizing daily duties in hospital units etc.

However, there is another way of assessing the nursing contribution to the process of illness and health and this, in my opinion, is more needed than ever before. Nursing knowledge about the needs of people involved in the process of health and illness is necessary because it locates the action within the context of caring for the person. Caring involves working with the essential aspects that help to maintain life in the process of health and illness, and it therefore helps the patient to experience the problem in the healthiest manner possible. When Florence Nightingale laid the foundations for modern nursing, she defined her aims in the following terms: "teaching is to prepare nurses to help the patient to live." The essential aim of care is to help the person to do what he or she would do if able to, or to make up for this lack, to seek to develop the individual's capacity to care for himself, to help him understand the relationship between his habits and his health, to take decisions that are consistent with his personal values. Not in vain do we teach that nursing is one of the advanced disciplines, within the health sciences, with regard to the helping relationship, the communication of information and bad news, of coping mechanisms and the aspects which link human rights and caring for people with health problems.

Nurses have developed models of care based on the person as subject, on the notion of health as a continuum related to the different stages of life, and have stressed the importance of the environment or the context. As a result, rather than by raising ethnocentric demands in order to prise more power away from doctors, the true power of nursing lies in the need for the knowledge it possesses. Nurses and doctors care and cure. For medicine, care is an essential objective, and it is worth recalling that the Hastings Center identified it as one of the goals of medicine, but the essence and experience of professional care are to be found in nursing, just as the essence and experience of curative medicine belongs to the discourse of doctors. As a result, managers can no more renounce nursing knowledge than they can medical knowledge. It is not a question of power, but an ethical question, and all the more so in times of crisis. The essential value of caring for people when they suffer from health problems may be one of the key indicators for determining the type and form of health provision. Nurses want to and can participate in incorporating the values of care into the logic of management, and demonstrating how care is a key element for the sustainability of the system.

Finally, and this too is an idea that derives from care, the logic of management must also encompass the need to care for health professionals and for healthcare institutions. To successfully practise medicine, nursing or any other activity relating to those who are suffering, staff must be provided with a protective and supportive working environment. Professionals must know and feel that they work in contexts which facilitate rather than obstruct their task. In this respect, managers have a huge responsibility: that of creating environments that promote the professionalism and diligence of their staff. Often, the manager is seen not as a facilitator but quite the contrary; they sometimes appear to reach decisions without taking into account the intrinsic difficulties of caring for those who suffer, difficulties which care professionals experience first-hand on a daily basis. This may in part be one of the reasons for the current problem of the lack of commitment or loss of health professionals, in addition to those identified by Manel Peiró. Sometimes, one meets former students who were totally committed to the profession and its values while in training, but whose work in institutions, far from helping to consolidate these values, is a cause of disillusionment, due to the impossibility of putting these values into practice. The personal, subjective, emotional effort entailed by working with those who are suffering is, in my opinion, something which is not given due consideration by organizations. It is treated as if it were just a personal question for each health professional. It is not easy to give bad news, to accompany a person and his family at the end of life, to understand the behaviour of an ill person as a consequence of his suffering, to attend to families with their different dynamics. It is not easy to be a doctor or a nurse, and even less so if one does not feel that there is a shared commitment between managers and care professionals, and a shared awareness that the work being performed involves people who are suffering.

Conclusion

We know that crises also bring opportunities for growth. Perhaps the acceptance of human rights in the sphere of health and the ethics of care can help our organizations to grow towards being organizations which really fulfil their responsibility of being places that generate health instead of being places that attend to disease. What is at stake is no less than the sustainability of our system and with it the maintenance and development of values essential to life and social coexistence. It is not easy, and requires the shared efforts of all who are involved. The logic of management and the logic of care should not be polarized in a struggle as to which should predominate over the other; the task at hand is to work together to find formulae, which will always be partial, in order to ensure that we focus on people, both those for whom we care, and those doing the caring.

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When we talk about ethics in the decision-making process in health organizations, this can be considered from two perspectives that initially appear to be distinct: from *the perspective of the world of management* or *the perspective of the world of care*. Before we consider whether the logic of these two perspectives coincides, we must first consider whether these are really two opposing views or rather two complementary ones. The basis on which decisions are taken may be different, just as the values and principles may not be identical.

We started from the premise that there are two ethical frameworks: that of management and that of care, but perhaps we should consider them not as two distinct sets of ethical conduct but rather *as two distinct levels of work that start from different positions and therefore apply different logics in practice*. A world in direct contact with the patient and another whose contact is only indirect, but both sharing a single goal: to provide the best care given the resources available, including both the material and the human resources.

We can accept that *the two logics are distinct at the level of action, in how they act*, but not in terms of principles and values. As a result, macro-analysis of the situation and the general approach to the use of available resources may produce agreement between the two perspectives. However, at the micro level of decision-making, principles and behaviours may diverge, because specific decision-making will reflect the fact that one decision is taken by a care professional with respect to *a given, named patient*, while another is taken by a manager with application to *patients in general*.

If we look at specific actions, these are very different depending on whether they are taken by managers or care professionals. Management logic is governed by principles which involve providing high quality care while ensuring that expenditure does not exceed income, maintaining institutions that provide an environment in which professionals are able to practise, with observable outcomes expressed in terms of service users and their health, and

actions based on plans which are tested against reality. The principles of the logic of care are, similarly, to provide and guarantee high-quality care, ensuring the efficacy and efficiency of care actions, and confirming the effectiveness of actions. *If resources are limited, then this is something that should inform the perspective of both sets of actors.*

Are some principles more important than others? The answer is yes, although which principle takes priority depends on the situation under consideration. In some situations, resources clearly take priority, while in others this is not necessarily the case. However, we need a conceptual framework which stands above and mediates between the two logics.

Over 20 years ago, Linda Aiken, Professor of Nursing at the University of Pennsylvania, began to study the relationship between the working environment for nurses and the outcomes for patients, and specifically the impact on patient safety of what she terms *magnet* hospitals. She has shown that, when an institution creates an environment in which professionals are happy and the professional level is high, there are better outcomes in terms of patient mortality. Perhaps we can say that there are two different logics and that the principles are not always identical, but that values must be shared; if this is the case, then the final outcome will be the one desired by both logical frameworks.

The values that motivate the logic of management and the logic of care should be the same, and this is the big challenge for all organizations. We must cultivate and promote those values that strengthen the professionalism of all involved; the traditional shared values that should characterize everything we do, such as commitment, transparency, effort and pride in belonging to the organization, are essential.

Likewise, there must be *dialogue between managers and carers*, between the two worlds, as this is the only way of ensuring the change we need to adapt to our present situation, and the economic and social conditions we are currently experiencing. *Only through dialogue, discussion, building consensus, and the search for common ground between the two positions can we achieve the cooperation we need.*

However, there are a number of factors potentially affecting the behaviour of both spheres. *The different views reflect the fact that the two sectors tend to give different answers to questions such as the following:* Are inequalities in accessing the system or the distribution of resources analysed objectively? How are budget restrictions distributed? Are health planning criteria explained and documented? Are decisions based on scientific evidence? Is resource use based on considerations of effectiveness? Is the application of new therapies or surgical techniques evaluated? Does the act of caring contribute to quality of life and, if it extends life, under what conditions does it do so? Do we make good use of modern technology? Are investments planned taking into account the care provision limits of individual centres? These and many other questions require *dialogue between managers and carers; only in this way can we bring the two positions closer together*.

We must *share the analysis and build a common discourse*. Management structures should facilitate real participation, establishing mechanisms and providing instruments designed to help bring together the positions and build the necessary consensus, and care professionals must engage with this participatory process.

A country's economic situation and wealth clearly condition the level of care provision. If less resources are available in the future, we cannot guarantee the existing levels of provision, and this means we have to optimize our use of the budget which in turn means that prioritizing is essential, with all of the difficulties this implies, particularly where individual and group decisions are in conflict.

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Understanding the discourse between the logic of care and the logic of management involves reflecting on the different factors which affect and influence the current development of our health organizations. Below, I seek to

address the elements that explain, at least in part, its development: firstly, the historical process that continues to have a major influence on the current arrangement of health institutions; secondly, the change in our hierarchy of values and the effect of this on social priorities; and thirdly, the challenge posed by so-called caring institutions, as models to be taken into account.

Our knowledge of the history of care and the people who provide it forms a basis for a deeper understanding of the contexts, situations and social responses that come together to create the complex reality of today's health organizations. The history of caring and curing, or the history of the development of the modern health professions, goes back to the Middle Ages and has its roots in the intense spiritual yearnings of western European society at that time. Monasteries, religious orders, monks and nuns embodied the principles of Christianity, and pilgrimage was a well-established means of seeking salvation. Gradually, in response to streams of the poor and sick, these institutions constructed *hospitalarius* next to monasteries to administer care, with the principal objective of saving souls by saving the body (Fernández and Garrido, 2003; Donahue, 1988). Individual salvation was an important motive for members of religious orders, who hoped to attain their goal through the practice of charity (Valls, 2006). As a result, over the centuries, the religious orders gradually acquired practical knowledge both in caring for the sick and managing institutions. This knowledge was transmitted from generation to generation, a process favoured by the fact that these were closed institutions.

The first hospitals were primarily care institutions, marked by the historical and social context within which they occurred. The care they offered to the poor and sick was basic in nature. Over time, these organizations evolved, although they continued to be characterized by a commitment to care, and this care, in turn, was defined by its religious function as an act of charity and an expression of love for God (Domínguez Alcón, 1986). The major change occurred in the 19th century, when advances in medical science led to a new way of thinking about hospital care, and determined that doctors should be a constant presence in hospitals and should assume responsibility for their management. Although this process of transition was far from easy, medical treatment became the prime objective for institutions, with care relegated to a secondary level. Or, to put it another way, the instrumental values of caring gradually gave way to those of curing.

The cultural changes over the centuries can be studied through the lens of the changing weight of different social values in response to new situations, events and discoveries. Over recent decades the analysis of global and European surveys of social values have tracked changing values both in society as a whole and in the specific area of health. The most recent data indicates that society is polarized between one group among whom materialistic values predominate, and another in which social values appear to have more weight (Elzo, 2010). In the logic of care, the different ways of providing a professional service that need to be taken into account and balanced against each other are in general absent. Nobody questions that care treatment contributes to improvements in people's health, although we need to seek to balance intrinsic and fundamental values in order to benefit human beings. We have moved a long way from the notion of a single, causal factor of illness: the many diverse elements that come together in the development of suffering, the unique nature of the process of falling ill (Kerouac et al., 1996) and, in general, the health–illness continuum mean that the demand for care is primary.

I would stress the notion of creating what I would call "caring" health institutions (Ramió Jofre, 2005) in which the organizations are concerned to care for the professionals who are, ultimately, the source of the work they perform. Health professionals are the driving force behind the service that people in need of medical and nursing care require. We need institutions that motivate people and promote reflective professional practice; organizations that seek to articulate the personal and professional values of those who work within them with the values of the institution itself. A commitment to health professionals involves establishing spaces for cross-disciplinary dialogue to generate positive value. The values, and in particular the attitudes and behaviours they articulate, are not always the same and do not always appear of their own accord; teams must work together, reflect and arrive at a consensus, including in situations of crisis. The professional creativity that helps to

limit health expenditure is a factor that tends to be ignored and yet could play a vital role in the current situation. Many times during history provide evidence of this (Valls and Ramió, 2008). For example, during Spain's Civil War, both nurses and medical staff found innovative ways of attending to the civil population and to injured soldiers with the scarce resources at hand.

I should like to conclude by stressing the importance of being attentive to changes in the wider society, and in particular to social values in a range of contexts: in management, in university education, in professional associations, to implement the measures needed in order to ensure that those receiving care are the true focus of health institutions.

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It appears that the focus of the two logical frameworks is helpful from an academic perspective: it has given us a basis for reflecting upon our participation in this seminar, which I imagine was the objective of the organizers. However, it bears little relation to the language used in the corporations that provide health services. If, instead of attending this seminar, those of us here today were attending a meeting of the board of management or the advisory body of a health corporation, one of the questions we would undoubtedly ask ourselves would be, "What can and must we do to motivate our professionals?" Or, to put it more realistically, "What is the best management model to motivate them?"

Asking the question in these terms means accepting two underlying assumptions. The first is that the main asset of these institutions is their professionals, and the second is that the current management model has outlived its usefulness. This problem has been a long time in the making, and the current economic crisis, with its impact on how health care is funded, has only served to make it more evident. However, the current crisis offers an opportunity to encourage and accelerate change.

Health centres in general and large hospitals in particular, due to their complexity, suffer from a management model and organization that is excessively hierarchical and bureaucratic, one which bears little resemblance to business models of knowledge management. The hierarchical nature of hospitals is a legacy of the past that, in its time, reflected a move towards greater professionalism, but which today is a hindrance, the effects of which can be clearly seen at the linguistic level.

It is no coincidence that the word most frequently used to designate the different levels of responsibility is "head". This takes us back to organizations in which the principle of authority is necessary to define and impose the conditions that ensure the productivity of manual labour. But this principle is in contradiction with the performance of knowledge-based work, one of the

features of which is that the task of defining the content of the work and the best way to perform it is the responsibility of the person performing the job.

The values that motivate professionals in general and health professionals in particular have little to do with the values of traditional economic management, concerned as it is primarily with efficiency. While such efficiency is obviously necessary, all the values that are central to a model for organizing and planning work concerned exclusively with the achievement of results, such as control, order and obedience, not only do not stimulate professional performance, but actually demotivate it.

The greater the skill and experience of the professional, the more he values his opinion being taken into account when formulating care objectives. Only he can know if it is possible to improve results in terms both of quantity and quality. With one proviso: that in health interventions, if a previously determined level of quality is not achieved, then the results are not acceptable. The added initiative and creativity that professionals can bring to their task requires a climate of respect and trust which is based on dialogue. The demand for greater autonomy reflects this need to create the best conditions to perform their job. Only when quality is guaranteed can we talk of efficiency.

It is the task of current health managers to promote initiatives that give rise to new organizational forms based on increased autonomy for professionals. And this is where their first problem lies: promoting the self-management of health professionals means delegating functions and losing power, and this is often a source of resistance among those who are not committed to this action. However, although this is the most obvious obstacle, it is not the main one. We have to hope that the current managers share this diagnosis and see that it is in their own interest to support a change in management model. As I see it, there are three main obstacles to change.

The first is the political manipulation of health management. One thing is the legitimate duty of the health authorities to formulate health plans, evaluate the quality of care and exercise budgetary control, and quite another is intervention in the day to day running of care centres. Some politicians are more concerned with their image and so-called "social peace" in centres than with results and the quality of care. And this intervention undermines the moral authority of managers. Management teams should be evaluated on the basis of their results, not changed at the whim of regional health ministers on the basis of political sympathies and a willingness to do their master's bidding. Only if management teams are convinced that their future depends on results and are prepared to account for their work, is it possible to bring forward changes the effects of which will be seen over the medium and long term.

A second obstacle is the lack of information regarding the real cost of processes. How can one delegate the management of a care area if one does not know the cost of the care provided? If there is no participation in drawing up and managing the budget, then management cannot really be independent. We have real information about the cost of professionals, but we generally lack the information we need regarding their performance. And when we have such information it is unsatisfactory, consisting of hours worked without linking these with outcomes. Diagnosis-related groups (DRGs) are an instrument which probably provide an approximate reflection of the cost of straightforward procedures, but I doubt their accuracy in measuring the cost of more complex procedures such as organ transplants which, due to their unpredictability, have a negative impact on scheduled activity that would also need to be quantified.

The third obstacle, although not necessarily the least, is the unwillingness of health professionals to take on management responsibilities. Educated in diagnostic and therapeutic procedures, we focus our interests and energy on updating our knowledge and technological progress in our specialist area. Heads of service know how to organize tasks within their own area of competence, but the reality is that caring for patients with common illnesses such as cancers or transplants requires coordination between health professionals in different areas, and this raises the need for new forms of organization that transcend the current system, based on specific service areas.

Engaging in serious consideration of how to overcome these obstacles is itself part of the process of initiating change. A clear statement of the principles and values underpinning this process is essential if health professionals are

to be included. Indeed, the procedure of defining these values could itself be a stimulus for change. The process of identifying values must be a participatory one. The ethos of the institution must be shared by each and every one of its members. This is what managers and health professionals have in common, and the existence of two distinct ethical frameworks does not help. Whether it takes the form of proclaiming a set of values or of drawing up a code of ethics, this declaration of intentions involves all the members of the institution, and should contribute to the achievement of care goals.

For this reason, the dominant values cannot be exclusively economic; of course such considerations must be taken into account, but they cannot be the main ones. If we accept as valid the goals of medicine proposed by a group of experts from a number of countries, brought together by the Hastings Center, the guiding values of our activity should be to promote and care for people's health. Preventing illness, curing it when possible, caring for those who cannot be cured, and helping those who are dying; all of these processes require compassion and personal involvement.

We treat people whose situation makes them vulnerable. Physical pain, anxiety, uncertain and a fear of death are all caused by and associated with illness. To do this, the core values of the centre's activity, shared by managers and health professionals alike, must embody a commitment to a clinical relationship based on trust and respect. Caring for those who cannot be cured and those who are dying should provide a framework for reflecting upon and identifying the conditions that facilitate such a relationship. And we should start by questioning those health centres that do not have palliative care units. Does caring for the dying not form part of their care objectives? And we must also question the limitations of the measurement of health outcomes. How do we evaluate the efficiency of a palliative care unit? In this context, how do we interpret any additional years of life?

The values shared by managers and health professionals must be those that embody a commitment to providing the best possible care for the patient and creating the clinical relationship that makes this possible. These are relationship values, as intangible as they are essential to the task of caring for those who are suffering. This involves respect for the other, for their values and convictions, but also empathy and compassion. Cultivating such values is well worth the joint effort of all, managers and health professionals alike, without distinction.

It is the job of management committees to promote this engagement with values. To do this, they need to create and support forums where this work can be conducted, whether a values commission or the ethics committee of the institution. Both are joint decision-making bodies, with a multidisciplinary membership and a consultative status, whose purpose is to provide guidance on working with values and dealing with ethical conflicts. It is the job of the values commission to promote procedures whereby the institution's staff identify those values they consider to be most appropriate for guiding their actions. The function of the ethics committee is to draw up a code of ethics for the centre and to ensure this is respected. Both bodies have in common a responsibility for the shared ethos of the institution, providing guidance on how to apply this ethos in practice.

And this task cannot be left to clinical ethics committees, whose duties are restricted to providing guidance on issues relating to patient care. The issues of management and organization, of sustainability and the environment (such as the disposal of waste), a fair trade purchasing policy and any others linked to the social responsibility of the institution, lie beyond its remit.

Just as clinical ethics committees have contributed to and continue to contribute to promoting a care model based on respect for the rights of the patient, so values commissions and ethics committees can and must help by providing advice to management committees and health professionals to promote a new model of care that prizes respect and cooperation to provide the best possible care for the patient.

Joan Viñas Salas

Head of Surgery, Arnau de Vilanova University Hospital, Lleida

To the question of whether managers and care professionals have distinct logical frameworks, I am inclined to answer that they share a single set of

objectives of working together to provide patients with high quality care. However, I believe there is a difference between the sensibilities of the health professional, who is in daily contact with the suffering of patients and their needs, and of managers, who deal with suffering when they receive a complaint or when a problem appears in the media, but not on a daily basis.

Of the various ethical frameworks in our society, the ethics of care has a greater influence on care professionals (and even more so in light of the feminization of the health professions) in comparison to other ethical approaches (consequentialist and utilitarian, Kantian, virtue or character based, liberal individualistic, communitarian, casuistic, principlist, etc.), while the management view tends to be more influenced by communitarianism or consequentialism.

For many years there has been mutual distrust between managers and care professionals. There are managers who have had "traumatic" experiences when they have trusted in doctors (budget deviations etc.), and doctors who have also trusted in managers and been let down. This distrust sometimes leads managers to take decisions on an autocratic basis, without giving doctors full information or involving them in the decision-making process, because managers see doctors as financially irresponsible, and doctors in turn do not involve themselves in management problems, underestimating the importance of the cost of care and acting as if managers should give them everything they ask for. This situation begs to be improved.

I believe there is a lot of common ground, given that we are all working for the good of patients and on their behalf, with priorities that are easy to reconcile, in areas such as how to deal with life-threatening situations, providing effective treatment, research and innovation projects etc. There are other priorities that are more controversial: *a la carte* medicine, alternative therapies, the introduction of new technology or drugs, clinical variability, protocols and the use of complementary tests, among others.

If the health system is not to lose either quality or fairness, and if access to care is not to be dependent on the patient's wealth, creating a two-tier system, then we must make sure that the health system is sustainable. This is the responsibility of all of us, care professionals and managers alike. It is doctors who know whether a treatment is inefficient or futile, that the risk-benefit ratio means it cannot be justified. We must involve ourselves, stress the importance of case history and physical examination, and accept uncertainty as part of our profession, accept quality assessments and cooperate with them, etc. We should not seek to shield ourselves behind the illusion of "zero risk", asking for a whole slew of complementary tests that provide very little and, furthermore, bring their own risks, including that of over-diagnosis.

The *management model* in public health needs to be modified, and this includes promotion, remuneration, management etc. Team management positions cannot be for life, and the selection and removal of staff must be based on ability rather than being subject to political will. Rather than managing, they should lead, and exercise not just power but authority.

The management of centres and teams must put the patient at the centre of everything they do. Those who hold management positions are there to serve in the command chain and facilitate the work of care professionals, who must also treat the patient as their priority, over and above other legitimate but secondary interests (prestige, power, money, career etc.). Those who work best and hardest should be rewarded, and the institution must value and recognize work done well, in order to avoid the uniformity that ultimately rewards mediocrity.

We need to involve health professionals in management activities. Care is not a two but rather a three-sided encounter: health professionals, patients and society, which provides the resources. Management by objectives (MBO) or the proposal for objectives agreed in accordance with the ethical principles and principle of the sustainability of the system are, in my opinion, a good tool for aligning the mission and objectives of the centre.

At a political level, in order to ensure a high quality of healthcare with universal access, there needs to be a pact between the different political forces, as happened with pensions.

The *training* of health professionals and the leaders of management teams is essential if we are to deliver this improvement to the health system. This

training must be incorporated at undergraduate and postgraduate level, and in continuing professional development.

At undergraduate level: course contents should include health economics, bioethics and management. There is relatively little experience of this in Spain, such as the course in health economics and another in bioethics, run by the university hospital at the Faculty of Medicine of the University of Lleida for over twenty-five years. However, I am also aware that students imbibe values when they do their clinical practice: the actions and attitudes of care doctors are a major influence on their students.

At postgraduate level: the training of house officers should also include these subjects for all trainees, whatever their specialty. We also have positive examples, such as the Complementary Joint Plan implemented in Catalonia in the 1990s, that included courses in bioethics, care quality and management, which I believe were useful, and were seen as such by interns in all specialties.

Continuing professional development is also fundamental for practising doctors throughout their careers, and not just training in their own specialty, but also in cross-disciplinary issues: bioethics, quality, empathy, management, economics etc., because times move quickly and new technologies bring social changes.

Managers who wish to work in the world of health also need specific training to enable them to understand the language and sensibilities of care professionals, in addition to training in the leadership and management of companies and organizations. It could be a good idea for them to do their practice with other managers in care centres, and even for them to put on a lab coat and accompany doctors as they do their rounds, deal with emergencies, perform surgery etc., living side by side with doctors and nursing staff to ensure that their decision-making will be informed by a better knowledge of the realities facing medical staff.

We need to prepare staff for decision-making in situations of uncertainty, and we need to teach people the need to be service-oriented, to develop the ability to assess situations, to acquire communication skills and empathy, to appreciate the importance of ethics and humanity, to be sensitive to diversity, to have emotional intelligence, to have leadership, teamworking and cross-disciplinary skills, etc. The "code of ethics for the third millennium", published in 2002, already includes these commitments.

Educating society

Users of the health system and patients and their families also need to be educated. This education should start during childhood, as part of primary education, so that children acquire healthy habits. We also need to teach people to make best use of our health system, one which is provided virtually free of charge. The ability to go to the doctor whenever one wishes without any limit needs to be controlled, whether by means of some sort of gatekeeping device, or through the work of monitoring commissions, involving the participation of users. Health may be priceless, but it still has a cost, and must be sustainable. The user must use the system in a way which accepts responsibility for its sustainability.

I will conclude with a brief description of some examples taken from real life, which I believe illustrate the management and care approaches to health management, in response to the request of the chairperson of today's debate.

- Following user surveys and review of complaints received by the Hospital Users' Support Service, management proposed punishing doctors whose performance was below average by forcing them to attend a course on human relations. We convinced them it should not be a punishment, and the proposal was not implemented. If attending courses on human relations is a punishment, then the courses themselves will be pointless.
- A surgeon colleague of mine used to say every Tuesday, "I already operated yesterday, so for what I earn, from today onwards I lose money for every extra patient I operate on." This philosophy rewards inefficiency and undermines the corporate ethos.
- Another colleague, a rheumatologist with a busy private practice, used to say, "In my practice, I put up with whatever the patient and the family want, I even put a smile on my face however much of a pain in

the neck they are. I never chuck them out of my office, I just tot it up in my head: the longer they take and the more they annoy me, the more time I'm clocking up. If they think it's too much and don't come back, they're saving me a problem. In the public sector you put up with less." We need to use efficient management criteria in public health, and establish appropriate quality assessment systems to ensure that patients don't receive differential treatment.

- As a union leader, I proposed introducing a card with a magnetic strip to allow flexible control over doctors' working hours at my hospital. The director rejected it as "a trick" and continued to complain that doctors didn't work their full hours, without doing anything about it, leaving those employees who did work their full hours with the feeling that those who avoided doing so were rewarded, earning as much or even more, if they were older and had more years of service. Identifying, encouraging, rewarding and valuing those who show greater commitment to the institution and work harder is essential to prevent professional burnout and growing disillusionment.
- One health department established a set of targets for reducing the number of complementary tests, and bonuses were established for achieving them. Some health professionals "saved" so much that there were serious complications in some patients. Any system of payment for achieving targets must involve ethical debate and monitoring both at the time and subsequently, to avoid the temptation of "switching sides" and going from being the patient's defender to achieving savings regardless of the cost.

In public medicine, there is a view that specialists are better than family doctors, and, among specialists, those who use the most sophisticated technology consider themselves to enjoy greater prestige. At the same time, the way that professional advancement is linked to management responsibilities (registrar, head of section, head of service) is counterproductive and causes dissatisfaction among staff who feel that they are undervalued. We need to place the patient at the tip of the pyramid and view ourselves as his or her servants. We are all needed, from the director to the registrar or house officer. Every position should be valued in terms of its contribution.

In conclusion, I would like to stress that managers and care professionals are "sailing in the same boat", and in light of the current economic crisis, both nationally and globally, it is more urgent than ever that we work together, that we all give of our best, with the aim not only of safeguarding Spain's high-quality, universal health system, one of relatively few in the world, but also to ensure that we constantly improve the quality, accessibility and fairness of the services we provide, in order to continue improving the health of the population we serve.

Francesc Moreu

Managing Partner of Moreu y Asociados

My contribution to the discussion comes not from an academic but rather from a practical perspective, based on my experience over many years as a manager in the health sector. It has been claimed that there are two "ethical frameworks" existing in opposition to one another, but in my opinion and in the strictest sense there is no discrepancy between the ethics of care and the ethics of management, because both care and management share a single paradigm.

A separate issue is that, in the case of medical professionals, the ethical principles they absorb as part of their training and which then form the basis for their values do not help them to feel comfortable about exercising their profession within the business framework where most of them will operate.

In their traditional formulation the conventional ethical principles of care professionals – beneficence, autonomy and justice – are not sufficient for today's society, which does not consider beneficence (the absence of maleficence) to be enough when what this society demands is excellence.

Autonomy is not a gift of the professional to the citizen, but is rather a right of the citizen and must be managed as such, and doing everything possible for a patient (justice) or taking cover behind the theory of the duty to provide succour (I cannot fail to do something when I know it can be done) is beside the point when what can be done exceeds the means available, and when the

scarcity of resources means that every euro spent on one patient is a euro less for another. As a result, the ethical principle of justice is of no use and should be replaced by the principle of fairness.

Medical faculties are training health professionals for a world that does not exist (not just in this regard, but also in so far as they continue to train health professionals for individual practice as members of a liberal profession when, in the vast majority of cases, they will be salaried employees, working in an interdisciplinary and multidisciplinary context) and it is therefore no surprise that, when they first enter the hospital-enterprise, clinic or primary care service, they clash with the reality of a management that requires them to strike a balance between value and sustainability, and they respond by feeling uncomfortable and refusing management responsibilities.

One more factor: health professionals feel isolated in the face of risk when it comes to reaching management decisions when these involve rationing diagnostic tests, drugs or provision in general in the face of demands from citizens incited by political or social demagogy, when they attempt to combine their role of advocate for the patient and advocate for society.

By contrast, those who dedicate themselves to management either lack training for their role if they come from a medical or nursing background, or, if they come from other areas, do not always understand the peculiar characteristics of the core business in which they find themselves. And all of this is amplified on the one hand by the shortcomings of public law, which covers the majority of health provision and scarcely allows for its adequate administration, let alone management, and on the other hand by the interference of politicians expressed by the rapid turnover in positions filled by "our own" rather than by "the best".

Companies provide the route for solving this apparent dichotomy between the ethics of care and the ethics of management. Let us recall three of the typical strategies used in the business world. The first is to privilege the business over the enterprise. The business, in our case, is handled by health professionals, while the enterprise is in the hands of the managers, and this obliges us to seek a balance of power between professionals and managers in the health business-enterprise.

The second strategy refers to the vital balance between value and sustainability. Value is the guarantee of the future, but without sustainability there can be no future. The search for value is associated with the culture of care, while ensuring sustainability is the task of management.

The third strategy is that all companies want to be knowledge enterprises. Hospitals (and by extension all health organizations) are by definition knowledge enterprises, by virtue of their position as professional bureaucracies.

The challenge is to resolve the dilemma between the ethics of care and the ethics of management on the basis of these criteria, and the point where the two meet (in day to day activity, which is where the dilemma really arises) is in the application of clinical management, which is the proper task of all professionals, whose ethical conflicts must be resolved in the light of the principles of professional ethics.

Clinical management is what happens when clinical practice and management are brought together, and the two share a single paradigm. Clinicians have an ethical obligation to manage their clinical practice, and this involves reducing variability and incorporating cost as one element in clinical decision-making. As a result, excellent clinical practice requires excellent clinical management, and there is no conflict between the two.

Francesc Borrell i Carrió

Member of the Bioethics Committee of Catalonia

Doctors (and, by extension, all health professionals) clearly understand the complexity of conflicting loyalties: to the patient (in the first place), to their organization, and to society. These shared loyalties give rise to conflicts, and these in fact play a vital role in contributing to the moral quality of our society, as Diego Gracia has noted, and indeed to the complex operation of society as a whole. Only fifty years ago, health professionals were not required to administer the provisions offered by the welfare state (sick leave, medicines, prosthetic devices, benefits etc.), and nor were they held to the same standards of liability for their actions; and their activity was not sub-

ject to constant scrutiny (in Catalonia, there are almost fifty regular indicators, including European Quality Assurance [EQA], European Qualifications Framework [EQF], Management Agreement etc.). Although adapting to this increased visibility has not been easy, health professionals have accepted it. An understanding of social values (honesty, transparency) and professional values (integrity, excellence) has been essential for this new paradigm in the public health service (and one which would have been unthinkable only two decades ago). A growing moral awareness (entirely compatible with health economics and bioethics) obliges us, in our professional role, to consider the fairness and efficiency of each of our decisions. It is increasingly difficult to work "mechanically", without thinking. Bioethics is the sworn enemy of sloth.

Professional activity is subject to greater demands, both technical and moral. But this does not eliminate the "moral hazard" which, in our case, to put it bluntly, arises from being "generous" with money that belongs to society as a whole. At times we offer a service (a complementary examination, sick leave etc.) in order to avoid confrontation with the patient. But being a good doctor and avoiding conflict are incompatible. One has to know how to say "no". If this is the individual challenge, then the collective challenge is to create intelligent, learning organizations.

I remember Spain's health and social security department at the end of the 1970s as a very hierarchical organization where the doctor did one's rounds and then went off to "his" office (where he felt like a real doctor). The institution, for its part, was far from accessible: managers scarcely talked to doctors other than to scold or discipline them. During the 1980s, some managers came into the system with new ideas. I remember a meeting of doctors, called by the director of the Hospital of Bellvitge, in which the director drew the following comparison: "I am like an Imperial Viceroy in the Americas. Although it looks as if I have lots of power, if all the Indians got together my head wouldn't stay on my shoulders for more than five minutes. What I am saying is that we need to work together; we can create synergies, listen to each other, and work together on projects." This attitude meant replacing a hierarchical relationship in which a huge gulf separated leaders and led, with a new psychological contract with the organization. That director, Francesc Moreu, is also present here today.

I believe we could do with an approach of that sort at the start of the 21st century. Managers often become isolated, as Francesc José Maria described, protected by a halo of authority that does little to legitimize them. When Manel Peiró talked about herding cats, rather than sheep, he hit the nail on the head. Doctors defend their independence as a fundamental ingredient of clinical practice. Without it, they argue, they could not reach their brilliant diagnoses. For this reason, health professionals are angered rather than deceived when politicians transfer to them responsibility for the reduction in social spending that politicians themselves do not dare to put into practice, or when in the context of across the board cuts, politicians announce new provisions or a financial injection, "so that regional governments have no excuses".

A leadership style alone is not sufficient to achieve the aim of learning organizations. Health professionals are particularly well prepared to work in teams and create organizational intelligence. There is a striking asymmetry between the scientific and intellectual output of specific services and units, and of the large institutions that house them. These institutions have (with few exceptions) been incapable of articulating coherent professional development policies, training programmes, publications etc. The goal of intelligent organizations, with a capacity to learn, does not match the reality of bodies that are scarcely able to apply basic quality standards. Managers are often under too much pressure to meet financial targets, and lose sight of the detail of the organizations in their charge. If they were aware of this complexity, and if they had confidence in the highly qualified staff for whom they are responsible, they would dedicate greater effort to creating knowledge, and not just to adjusting the budget. However, short-termism works against such a process. They take a year to familiarize themselves with the organization they direct, another year promoting initiatives, a further year launching projects, and by the fourth year they are inevitably replaced by another manager (in the best-case scenario). Should we be surprised that some managers are primarily concerned with keeping their immediate superiors happy

rather than with enabling their organizations to progress? Nor does it surprise me that some lapse into a cynicism that recognizes the price of everything without understanding the value of that which is most important, the patient. Often, the intellectual progress of an organization is intangible and not easily expressed in terms of indicators, as a result of which it is not valued by managers. Perhaps this is one of the characteristics preventing organizational maturity: the short-term nature of the political cycles that dominate senior management.

Patient-centred clinical practice could provide a framework within which doctors and managers could come together. This was very clear at the start of primary care, when the same doctor and nurse attended to a given population. This work, performed by Basic Care Units, is now a thing of the past in many parts of Spain where, under the guise of freedom of choice, staffing teams have been rearranged and the role of nursing reduced. We need to recover policies designed to serve patients better, specific policies such as home care, clinical pathways, subjective indicators of well-being that identify inefficiencies etc. (there is a lot of interesting research in this area). Doctors and managers are finding a shared language and shared values in this kind of conceptual framework.

Manel del Castillo

Director of the Hospital Sant Joan de Déu, Barcelona

The starting thesis of this seminar was that there are two different logical frameworks in health institutions: that of health professionals and that of managers. Underpinning the logic upon which health professionals act is the value of justice (doing the best for the patient), while managers are motivated by the value of efficiency. Put another way, doctors are concerned above all with the patient's health, without taking cost into account, while managers are concerned above all with cost, treating health as secondary.

In daily practice in the management of a children's hospital, it is often necessary to reach decisions as to whether a high-cost treatment of questionable efficacy (e.g., compassionate uses in rare illnesses) is indicated. The approach of managers and doctors in such situations is very similar. Both groups are capable of weighing factors of cost and efficacy, and conflicts are rare. What both groups want is for the health authority to establish clear criteria for action and, when necessary, to set limits on the funding of this type of treatment. This would prevent pressure on professionals and centres from family who, logically, wish to obtain for their loved ones whatever is available in the therapeutic arsenal, without reference to any criterion other than clinical efficacy.

In some European countries there are independent agencies that take decisions of this sort on the basis of cost-effectiveness criteria. The best-known example is the UK's National Institute for Health and Clinical Excellence (NICE), whose decisions, taken by independent experts, are binding on the public health system. In Spain there are currently six technology assessment agencies, but their decisions are not binding, they only consider some procedures, and there are no systematic criteria for the analysis of all new technologies before they are incorporated into clinical practice.

To sum up, arguing that conflicts between managers and health professionals stem from different priorities in terms of values is a well-meaning simplification. This may be the case on some occasions, but the origin of the many conflicts between these two groups probably lies in other factors, including the following:

- **Loss of professional prestige**. Medicine has long been practised as a liberal profession based on a relationship of mutual trust between doctors and patients, and with a high degree of self-regulation. The incorporation of doctors into hospitals, a shift to salaried status, teamwork etc. have played a key role in the progress of modern medicine, but these processes have also threatened features such as autonomy, the capacity for self-organization and so on that are an essential element of the medical profession. This situation has made it difficult for doctors to find a role within health institutions, and probably contributes to the problem of demotivation of the group.
  And here there is indeed a clash between two different logical frameworks: that of the professional and that of the salaried employee. The

logic of health professionals emphasizes a commitment to patients, seeing the hospital as a necessary means to the end of providing professional services. Quoting Mintzberg, one might ask: Does the doctor work *for* the hospital, or *in* the hospital but *for* his patients? This professional model requires high levels of autonomy, attributes to doctors a high degree of responsibility for results, and relies upon personalized care, empathy, compassion etc. In summary, autonomy in exchange for strengthened professional values.

- **Managerialism**. Continuous changes in the management of hospital centres, with an average term of two years in charge of organizations, makes it difficult to define credible long-term projects. The constant "reinvention of the wheel" means that professionals who have spent years working for a given organization will have seen seven or eight directors come and go, each with their own projects which, in many cases, seem to involve constantly starting from scratch. Among professionals, it is common to hear the opinion that "directors come and go, but we stick around". This fact gives rise to mistrust, a lack of involvement in shared projects, and a somewhat detached attitude to the internal logic of care teams. In addition, there is often the problem of the politicization of management appointments, accompanied by a lack of professionalism among managers.
- **"Soulless" organizations**. Finally, in many cases public organizations belong to everybody and to nobody, with the result that they behave like organizations that lack a soul, without their own culture, and without the capacity to sustain a project over the long term. Although the majority of health centre strategic plans set out the values of the organization, the reality is somewhat different, and often a change in management team means that even short-term commitments are not respected. It becomes clear that the organization as such does not take on commitments, because there is no organizational logic that transcends the decisions of the management team. In the end, professionals pursue their own project regardless of the organization, and all they ask of management is that they be allowed to work in peace.

These three elements stress the lack of commitment of professionals to their institutions, and ultimately this underlies the conflicts between managers and health professionals. We need to make progress in **governance** (organizations with long-term projects, over which people feel ownership), the **professionalization of management** (professional, stable managers, supported by the governing body) and the **recovery of professionalism** (professionals who are able to develop their professional career on the basis of autonomy and shared responsibility, and who are not merely medical or nursing technicians). If we managed to consolidate these three elements in our health organizations, it would undoubtedly increase the commitment of professionals to their profession and to the organizations where they work. In this case, although there would still be conflicts between managers and professionals, we would probably interpret them more as a clash of opinions and interests, just as occurs in any group.

Pablo Hernando

Director of Customer Care Services, Corporació Sanitària Parc Taulí, Sabadell

I do not believe in the notion that there are two opposing logical frameworks. There are, rather, various logical frameworks – both management and care-based – and these need to have certain shared characteristics if they are to be "healthy": transparency, participation of all the stakeholders, going beyond purely technical aspects, etc. There must be a shared logic that respects the intrinsic values of the health professions and gives weight to instrumental values.

To achieve these, there must be "spaces for mediation" between the two logics. By this, I mean spaces for participation, communication, accounting between the different stakeholders: managers, health professionals, citizens and patients.

What spaces? In health institutions, there are plenty of these: from the various different quality committees (and the ethics committee is one of these)

to traditional participatory bodies. We need to ask ourselves what use we make of such spaces in our institutions. Do we recognize each other as valid partners? Are we honest, truthful and transparent? Do we share values or just interests?

Accepting the above means recognizing that institutions must have a certain character (ethos) that differentiates them from other institutions. If we carefully analyse different organizations, we will see that the opposition between the two logical frameworks varies from organization to organization. The paradox is that, while we assume that such differentiation is based on technical aspects (for example, foetal surgery) rather than on values, in fact such value-based differentiation already occurs. Despite our politico-social pluralism, many organizations seem to be identical either because there is no explicit statement and monitoring of what their values are, or because they only make formal declarations (the typical mission and vision statements) with no practical consequences.

Yes, let's talk about the ethics of organizations. There are organizations whose ethics promote confrontation between the two logics, and others which do not. If we are to avoid this confrontation, we need to formulate, communicate and assess which values the institution promotes. There are minimal, non-negotiable values, which unfortunately often find expression only in formal declarations. These formal declarations must have practical consequences. It is not enough to state a commitment to respecting and promoting patients' rights without asking ourselves, for example, what strategy any given institution has to promote advance planning, how this is evaluated, and what the results are. It is not enough to wish for a balanced budget, without formulating which care objectives we want to achieve and, on the basis of the available resources, where we want to get to and which objectives we may have to sacrifice.

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Introduction

Health institutions are examples of what are called knowledge organizations, and are highly complex for a number of reasons. Among these are the sustainability of the health system, the intangibility of the services it provides, the complexity of the care process, pressure and excessive workloads for health professionals, the demands of working in an environment where issues of life and death are constantly at stake and, more recently, the global economic crisis which is threatening the very existence of the welfare state.

In this context, the management of these institutions is a complex task and the activities it entails do not always revolve around the needs and expectations of patients as the true protagonists of the health system. Although theoretical discourse is dominated by a paradigm of care based on integrated treatment of the individual patient and his or her needs, and those of his or her family or loved ones, the reality in many settings is that medicine continues to be dominated by a focus on treating the condition rather than the patient.

At the same time, health institutions do not always have the kinds of flexible organizational structure designed to motivate health professionals and facilitate their work. Many authors have argued that, in addition to scientific and human knowledge, in order to provide high quality care health professionals must feel committed to the institutions for which they work. They also identify the importance of real channels for participating in the organization's overall decision-making process.

In any case, almost all health institutions have established a mission, vision and values, and in some cases their strategies include ethical principles related to the promotion of patient autonomy. In addition, some institutions have their own codes of ethics.

In this regard, it is important to note the work of clinical ethics committees with respect to the analysis of clinical cases that raise ethical dilemmas and problems, and through the elaboration of reports designed to offer guidance both to professionals and to patients and their families. These committees also draw up protocols to guide health professionals in taking decisions with regard to patients in a persistent vegetative state, assessing patients' decision-making capacity, advance directives and the right to patient's autonomy, among others. And, finally, they act as advisers, drawing up guidelines regarding a whole range of issues related to the policy of the health centre.

Are there two logical frameworks, that of care and that of management?

Having briefly set out what I believe to be some of the key issues regarding the complexity of health institutions, I would echo the distinction drawn by Diego Gracia between *intrinsic values* and *instrumental values* (also sometime termed *reference* or *technical values*), and argue that management is an instrumental value. And following this I would like to focus on two aspects: on management as a necessary instrument but one which does not have value in itself; and on the approach or paradigm of the manager, which may have the result that the logic of care and that of management appear to be different or inconsistent.

One aspect that may give rise to confusion is the fact that the manager ascribes more importance to management itself than to the care process. The manager should be clear that his role is that of a *facilitator*, with the result that he is at the service of care professionals, *facilitating* their work, as it is the latter who are in direct contact with the real protagonist of the healthcare process, the service user or patient and his or her family.

Values such as transparency, accessibility, attentive communication, the use of a participatory management style, the search for consensus when taking decisions about institutional policy, and being at the service of professionals may help to generate trust in the policies of management and to strengthen the commitment of health professionals to the institution. In addition, managers share values that are essential to the provision of care.

It seems unlikely, then, that there are two distinct logical frameworks, but there may indeed be different ways of applying them depending on the values of the manager, and this difference may mean, at certain times and in certain contexts, that a distinct logic exists. For example, if the manager uses a traditional paradigm, focused on illness and bodily systems, then the management criteria will be different than if a care paradigm which focuses on the patient as not just a biological but also a psycho-social being with specific, unique needs is applied.

However, in the context of the current economic crisis the situation becomes even more complicated, as there is the danger that efficiency will take precedence over all other considerations, to the detriment of the principle of justice, creating difficult situations for health professionals. And it is precisely at times such as these that managers must be most aware of the need for care values to prevail. Needless to say, health professionals often find themselves in a position where there are tensions or even divided loyalties between the demands of one's institution and the values of one's profession (Toren and Wagner, 2010).

Clinical management and the management of care

Even if we cannot talk of two logical frameworks, we can certainly talk of two complementary management approaches: clinical management and the management of care. The term "clinical management" and what it implies, which various authors have defined as moving from complementary to integrated management, has for some time been offered as a description of what would constitute ideal health management. Its objectives include: a) promoting the involvement of health professionals in the management of the institution; b) consolidating continuity of care between different levels of the institution, and c) improving the organization of work and increasing the satisfaction of users / patients. Achieving these objectives entails more horizontal organizational structures, decentralization, and strengthening the role of multidisciplinary teams. This sort of management requires a focus on providing integrated care for the whole person, something which requires respect for ethical principles.

With respect to the management of care, I would like to stress some of the aspects linked to the principal objective of caring for a healthy or sick person, the family and the community in an integrated fashion. Firstly, it organizes care in such a way as to enable nursing professionals to provide the best care in a coherent, rapid and appropriate manner, in accordance with the needs of the community and, if possible, its expectations. Its essence lies in providing a high-quality, professional response that promotes the well-being of the individual and the necessary continuity of care required if the care process is to take place in a manner which ensures both the safety and the quality of professional action. Like care management (and for this reason the two are complementary) this requires an organization based on cross-disciplinary processes and support for clinical nursing professionals as leaders of the care process. Secondly, and as some authors have argued (Gordon, 2006; WHO, 2007), the benefits of well-managed care may make a huge contribution to the sustainability of the health system, both by protecting people from the risks that may arise as a result of the state of vulnerability caused by illness, which can make it difficult for them to perform activities of daily living and also, as Aiken has argued in her research, because nursing care makes a significant contribution to reducing morbidity and mortality. Nursing interventions are cost-effective, and investing in nursing leads both to improvements in care and reductions in health expenditure.

And finally, as a nurse I would like to stress the contribution that good health has to make to a country's social and economic well-being, something which should not be undervalued. Everyone wants to be healthy and not to suffer pain, and the government has a duty to establish social and public policies that enable the population to maintain an optimum state of health and well-being. And these objectives have always formed part of the nursing profession.

Conclusions

I have sought to argue that we do not have two distinct logical frameworks: that of care and that of management. What we do have are different approaches or paradigms that, when put into practice, lead to different approaches to management that may bring managers and health professionals closer together or push them further apart. And the further apart they are, the less comprehensive and individualized the care received by the patient and his family will be.

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Towards a shared outlook

In the business world, one thing has become clearer day by day: economic efficiency on its own is no longer enough. An exclusively economic logic, as has been shown so clearly by the present crisis, is not sustainable. We know that we need to change our timeframe, to cease thinking only in the short term, and to take into account a wider range of factors before we reach business decisions. In other words, the logic of money, of management, must be accompanied by a concern for the context, by a logic of service.

In this change of paradigm, health institutions (perhaps without even being conscious of it) could become a reference, a model to be emulated. Their historical origins, as organizations dedicated to beneficence, and their conversion into organizations that, in response to scarcity, have had to concern themselves with the management of resources, makes them the inverse of the classical business model and, if they are able to resolve their internal conflicts, they could show us the path to follow.

Michael Porter, in his most recent article, refers to this path. The recipe is a simple one: we need to work to create shared value. The logic of confrontation that has led governments, companies, NGOs and citizens to live with their backs to one another in the belief that what is to the benefit of one is to the detriment of the others, has exhausted itself. There is just one world for everyone. The well-being and improvement of this world are necessary and

beneficial for all of its stakeholders. We need to work on the basis of the logic of a shared value. We need to abandon the dynamic of confrontation.

If we apply this to health institutions, the lesson is clear: we need to move beyond the confrontation between doctors and managers or, to put it another way, between the logic of care and the logic of management. First and foremost, the doctors, nurses or managers who work in our health institutions are people. And as such they benefit from the well-being of the world, of other people.

Health organizations, like any organization, are a means, a vehicle. In this case, they are a means to a very specific end: improving people's health. And this end is more important than the individual goals of any of the people or groups who make up the institution. For this reason, all the professionals in a health institution should bear in mind that they occupy their position in order to achieve this goal: improving people's health.

In other words, we must leave aside prejudices such as that which assumes that a manager "has a better vision of the complexity of the whole system", or that doctors "have a better understanding of what patients need". The perspective of both groups is useful and necessary for achieving a wider and more detailed view of the problem: of people's health needs and the ability to attend to them. However, this difference must add value to achieving the goals of the organization, rather than undermining this process. The two logical frameworks have an intrinsic value that must be exploited for a common goal.

Although some health professionals struggle to accept it, the logic of management also has enormous value. As Diego Gracia has argued, this logic is the daughter of necessity. If this is true, then the value of the logic of management is in greater need than ever. Whether we like it or not, today it is a central part of the reality of health institutions: resources are limited and must be managed. Once we have accepted this evil (and we say 'evil' because all of us would like to imagine a world without resource constraints) and resigned ourselves to the resulting limitations, we need to find the best and most virtuous way of exercising the logic of management. That is, on the understanding that economic efficiency is not sufficient in and of itself, and that the value is shared. And, in this context, the logic of care has an important contribution to make: the two logics combined help to provide a more complete vision.

If we are to cure the blindness that has afflicted our health institutions over the last decades (affected, one assumes, by the same blindness as the rest of society), to close this gap that separates the two logical frameworks and sets them against each other, we need to build bridges between the two worlds: tools for deliberation, discussion and dialogue, to help improve decision-making processes and put practical wisdom into effect.

Through dialogue we can discover the perspective of others, and bringing these visions together is the best way of finding solutions to a shared problem. In this respect, clinical ethics committees are a tool that derive from the logic of care and which, over the last twenty years, through a process of dialogue, have demonstrated their usefulness in reaching careful decisions on the basis of participation and dialogue.

If we are to bring an end to the logic of confrontation between the two worlds of care and management, then we need a thorough understanding of the need for a joint perspective. Improving the operation of health institutions, then, probably involves incorporating ethics committees into both management and care decision-making processes. Because only an instrument that is based on the assumption that quality requires a shared definition can help to identify this shared perspective. Only by consolidating the care and management processes in bodies of this type can we achieve what we all want: shared value.

If we consolidate ethics committees and apply their methodology to decision-making processes, we will be able to end the logic of confrontation and work to achieve a more inclusive, complex perspective and to create coherent solutions based on shared values; this, in turn, could be a guide and inspiration for the business sector.

Victòria Camps, in her introduction, lamented the lack of courage in our society, and highlighted the need to teach values to future generations to

overcome this shortcoming. Ethics committees could be a powerful tool for putting excellence into practice, creating a culture of dialogue and shared reflection, setting precedents, and leading by example. It is probably not enough to resolve all our problems, but it would certainly offer much needed improvements.

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You have to bear in mind, in the first place, that the patient is the reason why both health organizations and health professionals exist. If we place the patient and his health at the centre of our considerations, then it seems very possible that the two logics can be brought together and perhaps even converge. We are all working for the same goal: to make citizens' rights to health protection a reality.

If we start by listing the ethical principles and values that could, *a priori*, be considered more typical of one group than the other, we will find that the differences are not so great. While it is true that professional autonomy is a key value for health professionals, it is also true that they belong to teams and that these, in turn, work for organizations; this reality is a source of added value, but it also represents a very significant limitation on professional autonomy. For managers, efficiency is a dominant value, but we should not forget that health efficiency is often measured by the capacity to solve health problems and not just by our ability to do more with less. If we look at ethical principles, professionals stress beneficence while managers stress justice and solidarity. But there is also a set of values that, in principle, are shared by both groups: quality, customer orientation, innovation etc.

The problem appears when we try to give content to these values and ethical principles. I will give an example: innovation is commonly understood by the professional as the possibility of applying the latest technology or prescribing the latest drug to be released, in order to provide better support for the doctor's diagnostic or therapeutic work, with the management of resources which are, by definition, always scarce. By contrast, for the manager innovation usually means reengineering organizational or care processes in order to make the financial and clinical management of the centre more efficient, in a way which, when it involves reorganizing functions and working hours, clashes with the interests of health professionals.

This different conception of the content of values and ethical principles gives rise to the confusion which in turns produces tensions and even conflict between the two logical frameworks. There are also tensions between the two logical frameworks because the person who determines expenditure, or at least a large part of it (the professional) is not the person who consumes the resources (the patient) or the person responsible for paying (the manager).

In general, it is fair to say that both managers and professionals lack a systemic overview of the context within which they perform their functions. Such a systemic vision would help both to bring the two logical frameworks together and to formulate an inclusive ethics designed to overcome the differences between the outlooks of the two groups.

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The ethics of organizations: a neglected subject

It is normal for people to be aware of the personal values that govern our lives, and that we reach decisions on the basis of what constitutes a good life. It is also normal that, when choosing a profession, one identifies with the values and mission of that profession or, as a minimum, accepts the code of ethics drawn up by the professional association. In the case both of professional and of personal ethics, we are aware of what is at stake and of the rules of the game.

However, when it comes to civic ethics, the ethics of the basic requirements that every individual should have in order to be able to choose his own concept of a good life, we are not so aware. And this lack of awareness and clarity is part of the explanation for the decision in Spain to introduce the subject of citizenship for secondary school pupils: because we need to distinguish the rules for shared public space; rules which, in morally plural societies, should be impartial and tolerant with respect to choices in our personal lives.

The ethics of organizations in general and of health organizations in particular has been a neglected subject: only those whose job goes beyond practising their profession to exercising a degree of responsibility are generally aware of organizational ethics. The notion that organizational ethics is a neglected subject raises not only the idea that it might be desirable to introduce it into the education of health professionals, but also that it would be advisable to ensure that it forms an integral part of professional practice in organizational settings. That is the real neglected subject: incorporating education about the organizational, team working and management environment into professional training, and covering the other skills that health professionals need to perform their job properly. At the same time, we need to ensure that management training covers the specific nature of the professionals with whom they will be working, and is not simply limited to applying the techniques studied on management and business administration courses.

For this reason, I do not think that the perspective of two distinct logical frameworks, two ways of operating, one associated with care and the other with management as if they were diametrically opposed, is correct; two approaches with loyalties to different people and different categories (the patient and quality in one instance, and ownership of the organization and organizational sustainability in the other). This distorted view explains why managed care is so often viewed critically, as a form of illegitimate interference of management, bureaucratic or even financial values in the legitimate, disinterested, altruistic logic of care. Instead, we should view such managed care as not just necessary but essential, as not just setting limits but also providing the conditions that make the logic of care itself possible. This is the positive reading of managed care, of two overlapping logics that are nothing more than different perspectives on professional practice within organizational settings where it is necessary to manage people, resources and time, a requirement which dictates the need to establish priorities and limitations.

Meeting places to overcome misunderstandings

Precisely because they have no choice but to reach an understanding, we must recover the vision that provides professionals and organizations with their legitimacy. Because they are health organizations, and therefore organizations of professionals, we must recognize the virtuosity of each professional, his excellence in handling his chosen instrument. But at the same time we have to remember that today's professional is not a soloist, but rather that, in order to become and to continue to be a professional, he needs to be part of an orchestra; this is the only basis for training, practice and employment. By the same token we sometimes need someone to conduct the orchestra (in the case of large organizations) or the jazz quartet (smaller, more dynamic units that require continuous improvisation and creativity). One can only feel valued and appreciated in a small unit or team. Such links are more difficult to create when the organization is just a logo, a building or a payslip; or when the guidelines, responsibilities and policies are not made clear. Whatever the size of the musical organization, we need rehearsals, scores, harmonies, rhythms, tempos: that is, coordination, learning, time management, individual roles, professional careers and a sense of rhythm.

All of this is predicated upon the care professional's perception of himself as a member of the group in which he participates, and upon another style of management, one more attentive to consultation and communication with stakeholders, one based on a particular skills base and which understands management as an organizational undertaking. Finally, management must engage with the specific nature of what it means to manage health professionals, and care professionals need to recognize the importance of belonging to a team and an organization, and the vital role to be played by management in professional practice.

And because there are no hard and fast rules in this area, we need to analyse and discuss how to achieve shared goals: it is not a question of applying the

rules of management regardless of the specific care requirements or professionals involved; and nor can we willfully ignore the means and the organizational policies which are a requisite for professional practice. If we are to facilitate such reflection and discussion we need to provide spaces in which to analyse, manage and overcome misunderstandings.

A practical proposal

We need, then, training in how to manage professionals, so that the organization does not exist solely as a coercive entity which makes demands upon professionals, "exploiting" them as means to an end. Such instrumental use does little to build patient trust in the professional and the organization, given that this trust relies upon the existence of trust and confidence between professionals and the organization.

To create this, we must recover a shared mission, the goal of the institution, discuss the care models by which the institution wishes to be identified, and consider how and why these are consistent with justice (guaranteeing the right to high-quality healthcare) and with the efficient use of the resources deployed for this common goal.

If such participation in forums about what to do and how to do it is to be successful, then it must be based on a desire for participation. These spaces for analysis, participation and decision-making must provide an opportunity for sharing knowledge, goals, clear guidelines, and processes, and this requires a balance between professional specialty, interdisciplinary cooperation, good communication, and clear, public exposition of one's case.

We also need policies that reward performance (on the basis of the responsibilities and performance of individual professionals), and this means agreeing upon what the organization aims to achieve, who decides upon this and who evaluates it. In other words, managing and evaluating commitment, both through quantitative measures of efficiency and qualitative ones. (It cannot simply be a question of outcomes; a given care action may be good in itself without expecting any more of it than that.) And efficiency must be more than the mere absence of complaints, the management of waiting lists, or an uncritical cost/benefit analysis (benefit for whom, and why?). Management by values (rather than just by objectives) requires discussion not just of how we put it into action but also of how we evaluate it (if we are not to confuse value with price, and economic values with ethical ones).

This management of differences, rather than of similarities, is more complex and requires participation in management, accountability (of all sorts) and responsible delegation. (Who does what? How? With whom? Do they know how to? Can they? Do they want to? Are they allowed to? What will they stop doing?) And all of this requires us to break with the fatal attraction of power, to overcome our urgent desire to hold onto it at all costs, because this is at worst a negative vision (absolute power corrupts absolutely), and at best simply counterproductive, leading professionals to restrict themselves to following orders (something which is simply inappropriate for professionals who manage knowledge).

Making these mutual expectations explicit is a part of quality management, to overcome the narrow-mindedness both of professionals, who wish neither power nor management and view them as an interference with good professional practice, and of managers, who either out of cowardice or fear of dissent shy away from communication and participation.

Ultimately, focusing care on the patient as a person, rather than on the professional or the system, will require changes of habit, outlook and privileges: something which is impossible without courage, and impossible without enthusiasm.

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This seminar has addressed the relationship between the logic of care and the logic of management, starting from the supposed conflict that may arise between the need for efficiency in the distribution of limited health resources, and the need for this distribution to be fair. It is true that there are many

occasions on which this conflict does indeed appear to exist, and that we are sometimes forced to choose between more efficiency but less fairness, or greater fairness but less efficiency. And I agree with Professor Diego Gracia that in each case we need to weigh these values against each other, rather than deciding that one should prevail over the other in every instance. We need to take wise, prudent decisions that are the product of a deliberation in which both efficiency and fairness are taken into consideration. And we also need to recognize that the sacrifice of efficiency in favour of fairness is justified whenever fundamental values related to dignity, equality of opportunities and social cohesion are at stake.

My contribution is more analytic than normative, and is based on the argument that, depending on the conception of fairness and efficiency we use, we may reduce the number of cases in which there is a conflict between efficiency and fairness. The result is that there is more space for compatibility than might appear at the outset. However, whatever notions of fairness and efficiency we use, the conflict between the two values is not eliminated completely. There is no single vision of the two logics: that of care and that of management. The logic of care, when linked to fairness in health, can be viewed in at least two ways. In the first, the value of fairness requires that we prioritize those who are most seriously ill (A1). According to this notion, fairness means investing whatever resources are required in those patients whose health is worse, regardless of the cost (either economic or to the health of others).

There are two clear problems with this approach. Firstly, it is more difficult to apply in a context in which scientific medicine is often very expensive due to the high cost of the most advanced technology. This is an objective or inevitable limitation. Secondly, it is not clear that the general public is prepared to assume these high costs, either because it requires the sacrifice of other benefits that are also deemed important, or because it requires a level of solidarity that exceeds what people are prepared to display. This limitation is not inevitable but, for many people, excessive health expenditure is not desirable.

In the second notion of the logic of care, fairness in health requires prioritizing those patients who will derive most health benefit from the health resources available (A2). According to this idea, fairness involves investing resources in the most efficient way in terms of health provision for the population as a whole (rather than for a particular patient). Think, for example, of the medicine practised by the army during wartime or by an NGO which, with very few available resources, seeks to optimize the health of a given population. In both cases, dedicating scarce resources to a small number of the seriously ill with an uncertain prognosis is less advisable, morally speaking, than focusing on less seriously ill patients with a far better outlook. These two concepts of fairness in health or the logic of care may, at times, be mutually incompatible. But, particularly with regard to the issue affecting us now, it should be noted that the second view of the logic of care is more compatible with efficiency than the first view.

With regard to the value of efficiency pursued by the logic of management, we can also identify at least two different ways of understanding this. The first involves prioritizing efficiency in the provision of health (G1): its objective is to increase or maximize (optimize) the health of the population (not the health of this or that patient in particular). The second entails prioritizing economic efficiency (G2), either because our goal is to derive the greatest social benefit from a public budget (G2a) or because we aim to increase the financial profit margin of a private health company (G2b). Again, these management logics may be mutually incompatible. But what interests us here is that these distinctions within the logic of management also have implications for a greater or lesser compatibility with fairness.

Prioritizing the most seriously ill patients (A1) and prioritizing economic efficiency (G2) are incompatible in many situations, especially where patient treatment is very expensive and the cost must be met by society. Increasing the financial profit margin of a private health company (G2b) is clearly incompatible with prioritizing the most seriously ill patients (A1), due to the way that the profit motive makes health into a commercial good. At the same time, prioritizing both the most seriously ill patients (A1) and efficiency in health provision (G1), or prioritizing the patients who will derive most health benefit from the available health resources (A2) and also prioritizing economic efficiency (G2), often gives rise to conflict, because the goals being

sought are in contradiction. However, prioritizing those patients who will derive most health benefit from the available health resources (A2) while also prioritizing efficiency in health provision (G1) may be compatible, because they seek the same goal: maximizing the health of the population. Here, it can be argued, justice and efficiency go hand in hand. Although we are seeking efficiency, health is not a commercial good. However, it is one which can be exchanged, and this generates a dual ethical problem. Firstly, it violates the moral separation of individuals, given that the health lost by one individual is compensated for by the health gains of another. And second, those patients for whom treatment is very expensive but not very effective lose out. (For example, those suffering from rare conditions with expensive treatments.) In these cases, we continue to be forced to choose between justice and efficiency or between solidarity and efficiency. Prioritizing this type of patient is not efficient (whichever efficiency criteria we apply) and nor is it necessarily just, if we take into account the equal interest of others in improving their health. However, ignoring them, arguably, displays a lack of compassion. We may argue that a society's compassion is measured, for example, by the treatment it dispenses to children with rare, serious illnesses (if, as tends to be the case, treatment is expensive and relatively ineffective, but there are no alternatives).

To conclude, if efficiency or the logic of management pursues or prioritizes benefits other than those of health, then this clearly represents the commercialization of health and is incompatible with the logic of care, whatever this may be. By contrast, if we seek efficiency in the provision of healthcare, this may be compatible with a logic of care focused on the health of the population rather than on each of its individual members. However, if the logic of care is reduced to prioritizing the most seriously ill, it faces a serious problem, due to the rising cost of medical care (and of technology in particular). If the logic of care prioritizes the health of the population over the health of individuals, then it needs to be complemented by social solidarity, at least in certain cases (such as caring for children suffering from illnesses for which the available treatment is expensive and relatively ineffective) if it is not to become dehumanized.

List of invited specialists

- Sira Abenoza, Associate Professor, ESADE.
- Rogelio Altisent, Coordinator of the Bioethics Research Group at the Aragonese Institute for Health Sciences.
- Ramón Bayés, Professor of Basic Psychology and Emeritus Professor at the Autonomous University of Barcelona.
- Francesc Borrell i Carrió, Member of the Bioethics Committee of Catalonia.
- Montserrat Busquets Surribas, Professor at the School of Nursing, University of Barcelona.
- Victoria Camps, President of the Víctor Grífols i Lucas Foundation.
- Manel del Castillo, Director of the Hospital Sant Joan de Déu, Barcelona.
- Margarita Esteve, Director of Nursing at the Hospital de la Santa Creu i Sant Pau, Barcelona.
- Diego Gracia, Professor of the History of Medicine, Faculty of Medicine, Complutense University of Madrid.
- Pablo Hernando, Director of Customer Care Services, Corporació Sanitària Parc Taulí, Sabadell.
- Francesc José María, Lawyer and Adviser to the Health and Social Services Consortium of Catalonia.
- Josep Maria Lozano, Lecturer at the ESADE Department of Social Sciences.
- Màrius Morlans, Doctor and President of the Ethics Committee of the Vall d'Hebron University Hospital, Barcelona.
- Francesc Moreu, Managing Partner of Moreu y Asociados.
- Margarita Peya Gascons, Professor at the School of Nursing, University of Barcelona.
- Manel Peiró, Director of the Integrated Health Services Management Programme, ESADE.
- Àngel Puyol, Director of the Department of Philosophy, Autonomous University of Barcelona.
- Anna Ramió Jofre, Member of the Management Board and of the Professional Ethics Committee of the College of Nursing of Barcelona (COIB).
- Begoña Román Maestre, Professor of Ethics, Faculty of Philosophy, University of Barcelona.
- Joan Viñas, Head of Surgery, Arnau de Vilanova University Hospital, Lleida.

Publications

Bioethics monographs:

28. *Ethics in health institutions: the logic of care and the logic of management*
27. *Ethics and public health*
26. *The three ages of medicine and the doctor-patient relationship*
25. *Ethics: an essential element of scientific and medical communication*
24. *Maleficence in prevention programmes*
23. *Ethics and clinical research*
22. *Consentimiento por representación (Consent by representation)*
21. *Ethics in care services for people with severe mental disability*
20. *Ethical challenges of e-health*
19. *The person as the subject of medicine*
18. *Waiting lists: can we improve them?*
17. *Individual Good and Common Good in Bioethics*
16. *Autonomy and Dependency in Old Age*
15. *Informed consent and cultural diversity*
14. *Addressing the problem of patient competency*
13. *Health information and the active participation of users*
12. *The management of nursing care*
11. *Los fines de la medicina* (Spanish translation of *The goals of medicine)*
10. *Corresponsabilidad empresarial en el desarrollo sostenible (Corporate responsibility in sustainable development)*
9. *Ethics and sedation at the close of life*
8. *The rational use of medication. Ethical aspects*
7. *The management of medical errors*
6. *The ethics of medical communication*
5. *Practical problems of informed consent*
4. *Predictive medicine and discrimination*
3. *The pharmaceutical industry and medical progress*
2. *Ethical and scientific standards in research*
1. *Freedom and Health*

Reports:

4. *Las prestaciones privadas en las organizaciones sanitarias públicas (Private services in public health organizations)*
3. *Therapeutic Cloning: scientific, legal and ethical perspectives*
2. *An ethical framework for cooperation between companies and research centres*
1. *The Social Perception of Biotechnology*

Ethical questions:

3. *Surrogate pregnancy: an analysis of the current situation*
2. *Sexuality and the emotions: can they be taught?*
1. *What should we do with persistent sexual offenders?*

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