The Role of Bioethics and Business Ethics

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Managed care represents a profound transformation in the architecture and process of health care delivery. Whether motivated by the economics of health care and the widely perceived need for cost containment[1,2] or by the quality improvements that a systems approach potentially permits,[3,4] managed care organizations represent a new level of organization in health care delivery. Formerly the fundamental unit of health care delivery was the individual clinician whose focus was principally the individual patient. Now the fundamental unit is a health care organization, and its focus is its covered population. Thus, an organizational perspective is being created alongside that of the individual, with considerable potential for conflict.

Health care organizations manage care by a variety of mechanisms, including financial incentives and the regulation of utilization. These organizational policies can have a powerful influence on the behaviors and the experiences of clinicians and patients as they interact. Because health care is essentially a moral enterprise, it is necessary to assess the emergence of integrated health care organizations and their processes for managing care from an ethical perspective and not merely from an operational one.

The potential conflict between organizational and individual perspectives requires new ethical principles and policies for health care organizations that address the triadic relationship of patients, providers, and organizations. The relationship between patients and clinicians is the traditional province of bioethics. Building on the ancient Hippocratic tradition of fealty and beneficence, recent formulations of bioethics have followed modern movements in political philosophy regarding self-determination and the rights of individuals. By contrast, business ethics has focused on the relation between the organization and the manner in which it produces goods and services for its clients. In this article, we seek to examine the potential for these two complementary disciplines to serve in constructing an ethical framework for delivering health care in the next millenium. We attempt to illuminate how a synthesis of these two disciplines can inform the development of a code of professional medical management in the new era of industrialized health care delivery.

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BIOETHICS

Over the last three decades, American bioethics has strongly emphasized patient autonomy as its prevailing value.[5,6] Other bioethical principles, such as beneficence and nonmaleficence, have received somewhat less emphasis, while the principle of justice has been reserved for discussion of macro-allocation of resources and rarely invoked in individual cases. In the past, bioethics has emphasized the moral agency of individuals through emphasis on autonomous choice as a means of eschewing the endorsement of a particular value system in a pluralistic society.[7] The emphasis of bioethics on impersonal, rights-based obligations and individual entitlements may reflect the reliance on case law for implementation of bioethics policy in many jurisdictions or reflect prevailing contractarian philosophical theories.[8] This individualistic, contractarian approach probably helped prepare the terrain for the industrialization of medical practice. By constricting the domain of clinical moral authority while elevating individual choice, it left open a realm of macro-level policy decisions that business enterprises could claim as their domain.

Bioethics has been instrumental in implementing the policies of informed consent for both clinical and research purposes. Although practice often falls short of the stated objectives, the emphasis on disclosure in health care decisions and involvement of patients in the decisions affecting them stands in contrast to some common business practices. For instance, some health care plans restrict their providers' discussions of more costly alternative care approaches, creating policies in direct conflict with the fiduciary responsibility of the clinician to disclose options. The uproar, both public and professional, over "gag" clauses has led to a number of organizational and legislative initiatives to abolish such clauses.[2,9–11] However, the chilling effect of the health plans' interests persists as long as physicians can be dropped without cause. The development of a substantive code of organizational conduct for health care plans will need to limit excessive discretionary authority. Accountability between plan and provider must flow bidirectionally. Business ethics can contribute to the development and implementation of such a code as well as inform the process with its experience of problematic aspects of corporate codes.[12]

In discussions of justice in bioethics, a minimum level of care is often considered due all patients. Commercial managed care plans avoid the societal issue of just distribution of medical services. In some jurisdictions, the Medicaid minimum benefits package is set so that costly high-technology treatments such as liver transplants are covered, while routine or preventive care is inadequately supported. Resource allocation under risk capitation is likely to differ dramatically from the open-ended entitlements

under indemnity plans. Whether a just distribution will be more or less likely in arrangements in which a limited amount of capital underwrites the health care costs of a predefined population of patients is not yet clear. Expenditures in this setting compete among all parties for a restricted pool of resources, e.g., a limited number of magnetic resonance imaging studies. This is somewhat analogous to the global caps that national health care plans, such as those of Canada and Great Britain, have had for years; however, greater limitations of resources have existed there than exist, as yet, in typical American health care plans. Clearly the perspective under capitation favors the population over the individual, and this may favor a form of distributive justice.

Wherever there is a fixed global budget to serve a population's medical needs, conflict will arise between the interests of individual patients and the total plan membership as well as between individual patients. The outline of a bioethical perspective that fully and concurrently addresses both individual and communal needs is only beginning to emerge. It will be a challenge for bioethicists, clinicians, and other interested parties to develop the framework for a consensual code of conduct to deal with the tensions between the individual and the group needs. This will require the engagement of citizens and policy makers with a level of understanding of the inevitability of limited resources and competing claims for them. Such a level of awareness of the issues was not attained during the debate over the Clinton health care plan and will doubtless be difficult to obtain. Expectations of all parties in health care delivery remain very high, and realistic objectives need to be discussed and agreed upon.

Although it has not yet risen sufficiently to these challenges, bioethics can have a vital role in delineating the responsibilities of managed care organizations as providers of health care. How do the concepts of fidelity, advocacy, and beneficence apply to provider organizations? How are the specific components of a system of health care invested with an organizational ethic? For example, safeguarding electronic medical records requires both technical and operational effectiveness and the moral commitment to expend the requisite resources to maintain patient confidentiality.

BUSINESS ETHICS

Organizations understand their fiduciary responsibilities differently than do professionals. Physicians have understood their responsibilities predominantly in terms of individual patients, whereas organizations are responsible to groups, populations, or parties representing groups. Of note, the individual patient-centered focus of medicine contrasts with the sociologic view of professions having a societal responsibility. Organizations, particularly publicly traded for-profit ones, have priorities that emphasize short-term fiscal concerns. "No money, no mission" is a business phrase that physicians are reluctantly learning in this era of cost consciousness and market competitiveness. The bioethical tenets of autonomy, beneficence, and justice may be overwhelmed by the values of market competition and fiduciary accountability to capital investments. In medicine, the primacy of ethical conduct is fundamental, despite the reality that it is sometimes practiced in the breach. In business, there had been in the first half of this century a presumption that morality was a nonprimary social good that must compete with other social goods within the business realm.[13] Moreover, the marketplace, by its very nature, is more likely to emphasize return on investment than enhancement of social goods, and the primary fiduciary responsibility is to the shareholder.[14] Business ethics is not an oxymoron, but its grasp is tenuous because of the primacy of economic interest in the marketplace and the decline of public consensus on socially acceptable norms of conduct.

Business ethics has called attention to the importance of the role of specific corporate leaders in valuing and championing ethical corporate conduct.[15] Corporations usually reflect the values and character of their leaders, and naturally these vary with the specific parties involved. The health care industry is certainly no exception. One witnesses variable conduct of managed care and other health care organizations with differing sensibilities to the ethical imperatives of health care delivery. However, it has recently been noted that the hypercompetitiveness of the current market has narrowed the differences and heightened a bottom-line focus.

Integrated managed care plans, because of their influential role in the delivery of health care, have converted the dyadic patient–physician relationship into a triad. Moreover, the impersonal and contractual nature of the corporation–client relationship represents a considerable change from the interpersonal, trust-based physician–patient relationship. Yet a systems-based approach offers some apparent benefits for patients through greater performance monitoring and feedback, more emphasis on preventive services, and evidence-based medical practices. It is too soon to determine whether the patient–physician-organization triad compares favorably with its predecessor, but all parties are experiencing the uncertainties and stress that such upheaval brings. Population and individual perspectives are likely to differ. A code of business conduct alone is not likely to resolve such inherent conflicts completely.

Businesses are ostensibly managed to efficiently produce goods and deliver services, but, as business ethicist William Frederick has pointed out, power aggrandizement is a competitive business "value" that often reduces the efficiency of production.[16] It is unreasonable to expect power-aggrandizing values to spare health care plans (even nonprofit ones), but perhaps we can minimize this phenomenon by developing explicit codes of professional conduct concerning managed care. By this means the values of bioethics and business ethics can provide substantive inputs that are heard in health care boardrooms across the country.

Can corporations care about individuals? Can the values of medicine endure corporatization? The many instances of dissatisfaction recounted in the lay and medical presses bespeak serious difficulties in the transition, but do not answer whether, on balance, the new system will be more or less equitable or accountable. Several authors argue that greater oversight of health care plans should include committees involving providers and patients as well as administrators in policy decisions.[17–19] Such oversight measures are necessary if the recently reconstituted clinical triad is to be truly relational and accountable, and able to assume the difficult charge of adjudicating conflicting needs and goals of the individual patient and insured population.

Interestingly, these calls for greater participation in health care delivery have recent parallels in business ethics in the stakeholder concept, which recognizes that corporate responsibility extends beyond the shareholder to the client, the workforce (internal clients), regulators, and the community-at-large.[20] This contrasts with Friedman's amoral theory of business that holds financial return on the investment as the only corporate fiduciary concern.[21] This approach has had considerable influence in American business but has limited the societal obligations of business. Public good is still low in the hierarchy of business values. A narrow financial focus will not work in the health care industry because of the vital importance of health care, the demands of justice, and the imperfections of the health insurance market.

Changes in business ethics such as stakeholder theory that are under way could lend support to morally sound medical enterprises. Stakeholder analysis holds promise because it is helping businesses rethink themselves as more than profit-generating entities, but rather as a responsible component of an interrelated society. Difficulties, however, persist in how to adjudicate competing claims of various stakeholders; the forces to perpetuate the existing power structure are great. Thus, stakeholder analysis represents a beginning to address competing claims, but much work remains on how to balance the legitimate competing claims and on creating the appropriate accountability process with the health care industry.

Robert Solomon notes that stakeholder analysis is limited by the vagueness of the concept. He contends that an Aristotelian ethic of business virtues such as integrity, fairness, and a toughness that transcends self-interest is essential to placing business ethics on a sounder footing than stakeholder theory can by itself.[22]

ACCOUNTABILITY AND MEASURABILITY

Corporations construe accountability in terms of measurable quantities. "If you can't measure it, you can't manage it." In managed health care, surveys and profiling have produced data on physicians' productivity, utilization, and outcomes. Such devices are rarely statistically validated; hence, the meaning and utility of such profiling is uncertain. Nevertheless, an ongoing process of scrutiny and feedback may yield some quality improvement and cost savings.[23] Patient satisfaction surveys have renewed interest in interpersonal communication skills, which may strengthen the clinician-patient relationship.[24] The nature of clinical practice remains personal and individualized, and emphasizing standardized measurements could be problematic. If corporations respond only to measured criteria, limited in scope, the immeasurable in the clinical encounter may suffer. The emphasis on productivity is likely to further depersonalize the clinical setting to the dissatisfaction of patient and physician alike. Mediating the competing claims of corporate efficiency and the professional values of individualized attention is a serious challenge that needs to be addressed.

This may be helped by the development of a consensus-based code of health care management, which unlike existing codes fully involves the multiplicity of stakeholders. An approach that involves the various stakeholders, informed by the crucial implications of their choices, promises to provide a broader-based rationale than exclusively market-based decisions.

EVIDENCE-BASED VERSUS MARGINALLY BENEFICIAL THERAPIES

Coordination of care, case management, and gatekeeping by the primary care physician are cornerstones of managed care.[3] They, in some cases, have helped reverse the fragmentation of health care that occurred with the growth of specialization. From a corporate viewpoint, gatekeeping provides accountability in a single professional who should know the patient best. The economic charge, implicit or explicit, in gatekeeping has raised ethical concerns that beneficent care may not be as readily dispensed as it had been. There is already evidence suggesting that trust has been undermined.[9] Companies that emphasize evidence-based medicine will counter that no treatment that is documented to be beneficial would be denied, but conceivably some beneficial therapies are yet to be so proven.

The categories of "probably beneficial" and "marginally beneficial" therapies prove most contentious. For example, patients with symptomatic pharyngitis or bronchitis (often viral) seek physician contact with strong expectations that an antibiotic will be prescribed. Such expectations often influence prescribing practice by physicians whose healing powers are frequently invested in providing a prescription.[25] When patients have expectations for marginally beneficial interventions, physicians may acquiesce following a path of least resistance. Of course, more expensive and invasive procedures and treatments also may fall into these categories, and patient expectations have not changed regarding them. The physician is placed in the position of contending with the hostility between patients who expect that even marginally beneficial care is due them and the health care plan that expects to

pay only for treatments of proven efficacy. Clearly the latter's agenda is concerned with costs in a way the former's is not, while the clinician becomes a reluctant mediator. This is not to say that patient input and expectations are not legitimate elements of clinical encounters.

Developing principles and policies of gatekeeping based on professional ethics could help rectify some of the imbalance that currently exists in the clinical triad. The exact nature of such procedural ethics requires further work, but it could clarify the duties arising when marginal care is the expectation, as in some types of cost sharing.

BUSINESS ISSUES AND METHODS

As medical practice becomes industrialized, physicians are challenged to understand business perspectives and methodologies. Although many physicians have been involved in the business aspects of medicine previously, others will need to increase their knowledge and awareness of business and corporations, so that they can function in the "re-engineered" medical milieu. At the same time, a fundamental recommitment to the moral nature of medical care will be necessary in order to preserve the medical profession's fiduciary responsibility to its patients. As the medical profession needs to learn a systems approach to health care, managed care corporations need to recognize and support the ethical substance of medical practice. Moral vigilance, while essential, will not suffice. The development and implementation of a code of business conduct in health care will be a necessary vehicle to move ethical concerns into the boardroom. A standard of health care business practice, like a standard of medical practice, can be a powerful influence on actual conduct.

CONCLUSIONS

The industrialization of medical practice has proceeded at a vigorous pace in recent years. Economics has been the driving force in this process, which has had broad implications for the nature of clinical practice. Two different ethical disciplines are relevant to this enterprise; both require a resynthesizing for organizational change. Bioethics has traditionally dealt with individual moral dilemmas of modern medical practice, while business ethics has been concerned with how corporations can incorporate an ethical perspective into business practices. While bioethics has taken in large measure an individualistic tact, emphasizing autonomy and entitlement, and failed to anticipate the development of a corporate approach to health care delivery, business ethics has struggled with a narrowly defined vision of its applicability in the business world.

The rapid development of the managed health care industry creates the compelling need and opportunity for a greater interplay between these two disciplines. Bioethics must deal with both the theoretical and practical aspects of the health care industry without turning all decisions into matters of individual preference, clearly an unsustainable practice for a system in which individual and group interests sometimes conflict. Business ethics must be informed by the moral ethos of medical practice, particularly beneficence and justice, if it is going to deal with health care industry issues in an honest and forthright fashion. What is lacking is a substantive social ethic to energize this process of synthesizing a new code of mutual responsibilities between plans, providers, and patients. In this society in which mercantile values predominate, we need a renewed articulation of the core health care values of beneficence and access.

Moreover, these values will need a substantive vehicle in order to engender new policies that protect the vital interests of patients, providers, and plans. However, given the power-dominated legislative process, another method of consensus development may be required to create ethically derived codes of health care business conduct to guide this process. At times competing interests will conflict, and difficult choices will have to be made. The hardest work that awaits us is to craft policies that restore a balance so that all parties can thrive albeit with compromises that they might not have preferred. For example, plans may need to reduce profit margins in order to provide for all beneficial interventions. Physicians may need to yield autonomy and moderate profit margins in order to keep care cost-efficient. Patients and their surrogate decision makers may need to yield their autonomy to demand nonbeneficial or marginally beneficial interventions. There is already some evidence that these changes are commencing, but we cannot rely solely on market forces to address all the needs of these parties. The collaboration of bioethicists, physicians, and other providers, health plan leaders, and patient groups will be necessary. The Oregon health care decisions process could serve as a useful model of how to incorporate the perspectives of a variety of stakeholders into such a deliberative process.[26] A group in Colorado is using a related process to develop a code of ethics specifically for managed care.[27]

Medical decisions concerning treatments and diagnostic procedures in the "probably or marginally beneficial" will sorely challenge the consensus-developing process. Yet, a new consensus on the nature of responsibilities in this area will need to be worked out for a fiscally and ethically sound future for health care delivery through health care plans. These responsibilities must be grounded in ethical values and not merely mercantile ones. Cost efficiency and clinical caring must meet in a newly created, morally sensitive framework for health care in the 21st century. This is not the first time in our history that health care delivery has been reorganized. Each reorganization installs a new hierarchy of values.[28,29] The reorganization now under way, however, needs to be guided by the fundamental values of beneficent caregiving and not dominated by market values. This will require a new synthesis of bioethics and business ethical analysis that produces a practical yet principled code of health care management

and delivery. This process must proceed at societal, professional, and legislative levels in order to accomplish the goal of superior health care for our society.

For this synthetic process to be truly dynamic, physician leaders and educators will need to engage business leaders and educators in a serious and disciplined dialogue. Carefully focused ethical analysis should precede policy changes. Even well-intentioned compromises may have unforeseen consequences. Change has occurred very rapidly in health care delivery, and we have not had time to analyze and comprehend fully its meaning. The very essence of medical professionalism is at issue, and this should be of concern for parties inside and outside of the medical profession. We must clarify and articulate these issues before we can communicate to physicians in training a lucid accounting of their profession for the 21st century. When we do communicate it to them, it must be fully integrated into the well-established formats of medical education including case rounds and clinical conferences. The challenges to ethically based medical practice are substantial, but many interested parties working collaboratively can create the needed solutions.

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