Institutional Practices, Ethics and the Medical Professional

Introduction

Recent changes in care delivery mean that excellence of practice must involve a wider range of considerations than were involved when most professional codes were developed. In order to exercise their profession, physicians practice in organizations. The institutional sector of health care involves organizations of varying size and role, from individual practice associations of sole practitioners or several physicians operating within a particular community, to healthcare systems composed of many hospitals, all of which relate to other organizations within the sector, including their suppliers, payers and regulators (Robinson 1999). Today the decisions made by organizations with which physicians are associated inevitably impact their own professional practice and their relationships with their patients. To protect professional integrity, the contemporary physician must carefully scrutinize the business practices associated with the delivery of medical care for possible threats to ethical medical practice.

In this chapter we focus on the ethical implications for physician practice of decisions which are made on other levels of the health care system and are thus often out of the individual's control. We instance several ways in which organizational decisions impact the professional functions of physicians. The organizations we consider are of two sorts: practice and delivery organizations, the hospitals or health care systems in which much of physician practice occurs; and payer organizations, public and private insurers and the managed care organizations or systems that increasingly determine how the physician is reimbursed for services. The cases we present incorporate three

perspectives which may also be considered tools for analysis: professional ethics, organization ethics, and stakeholder thinking.

Professional ethics has a long tradition as one of the major pillars of health care. Physicians acquire a particular ethical perspective in the course of acquiring their professional knowledge, experience and skill. The mainstay of professional ethics is the physician's commitment to the best interests of the patient. The Hippocratic tradition of medical ethics has influenced the professional ethics of other healthcare workers, including nurses, hospital administrators and members of the allied health professions. *Clinical ethics*, addressing ethical conflicts arising at the bedside, is a compartmentalized function of health organizations, and ethics committees have been a condition for accreditation of U.S. hospitals since the 1990s..

Organization ethics: It would be a mistake to think that ethical issues for physicians arise only on the individual level. Organizations too set goals, institute processes and procedures to attain them, act according to articulated values and decide how to prioritize them in particular situations. Physicians practice medicine in and through healthcare organizations, and the way those organizations operate furthers or impedes their own professional activities. Organization ethics focuses on the extent to which the organization is to be counted as a moral agent, and the mutual implications in healthcare organizations of professional, clinical and business ethics (Spencer et al., 2000). It is concerned with the alignment of interests and values within organizations, and with the implications of individual decisions for the organization's vision and culture. The organization and the individual physician in one sense share common values and have a common social role. In another sense they have different values, because they

fill those obligations in different ways, have different priorities, or specify the situation differently. Our hypothetical cases illustrate how decisions driven by business considerations can have professional and clinical implications for affected parties.

Stakeholder thinking: Recent work in healthcare ethics has depended heavily upon a tool developed in business ethics for understanding organization decision making. Under the stakeholder model it is important to consider the implications of an organizational decision on all the individuals or groups that will be affected by it. The stakeholders of a business include not only the stockholders, as in the traditional business model, but other affected organizations, payers, employees, the consumers of the product or service delivered by the organization, the local community and the larger society. In health care, stakeholders include care providers and patients, payers and suppliers, the local community and the larger society that supports the social institution of health care.

Stakeholder theory assumes that the relations of the organization with all its stakeholders are to some extent reciprocal, and represent normative claims which need to be taken into consideration in calculating the consequences of a course of action. It requires evaluating and prioritizing various stakeholder claims, taking into consideration relationships between organizations and the various stakeholders whose interests are affected by organizational decisions. (Elms, Berman & Wicks 2002) Our hypothetical examples illustrate organization-level decisions, often driven by business considerations that have ethical implications for medical professionals.

II: The Physician and the Provider Organization

Case I: From a Local Hospital to a Health Care System

Markson Valley Hospital is a 300 bed tertiary care hospital in a mid-sized city in a rural region of the northwest. It has served the area for 60 years but was running into financial difficulties because of changing demographics and competition from the academic health center in the state capital.

When they were beginning to worry that they might have to close the hospital, their recently appointed Chief Executive Officer suggested that a merger, a strategy proved successful in many other industries, might be a solution to their financial problems. By merging, hospitals can eliminate excess capacity, increase efficiency, and boost market share, as well as increasing their ability to bargain with insurers.

Markson arranged financing to purchase three other hospitals: two small urban hospitals that were also facing financial difficulty—one of which was quickly closed—and one thriving suburban hospital. The combined organization was renamed the Markson Valley Health System (MVHS).

Dr. Abrahmson is a gastroenterologist who practices in the Markson Valley. The hospital that was closed was the one most proximate to his office. He wonders what the impact of the merger will be on his practice. The success of the transition is a test of the organizational culture of the new Markson Valley Health System.

Hospital mergers have been a common phenomenon in recent years. Considerations of economies of scale drive many mergers: by combining facilities and

potential patient populations, institutions may be in a better position to negotiate cost savings with suppliers or obtain better reimbursement rates from insurers. Mergers can address problems like low census, turning competitors into allies, and may make it possible to better utilize available facilities by reallocating beds or services to better meet demand.

Often mergers are not successful. One source claims that the failure rate is as high as 65% (Ruocco, 2005). For instance, a merger between two northern California health systems that was expected to save $100 million over three years incurred losses of $173 million, leading to a hasty termination of the arrangement (Kastor, 2001, Blackstone & Fuhr 2003). Even when a merger is financially successful, other stakeholders may be adversely affected. There may be a price to pay for the physicians practicing in a hospital that has been sold. Consolidating services may cut costs for hospitals, but increase costs and inconvenience for the physicians who practice in them, who may have increased travel time, reduced access or decision-making power, or face greater competition for operating rooms or beds,. (Blackstone & Fuhr, 2003).

The hospital that was closed by Markson Valley Health System may have provided services to a group of patients that will now have no comparable facility available to them. The capacity that is eliminated may be the unit upon which Dr. Abrahmson's practice depends. Bed reduction might mean that fewer patients are able to be served or that some may be sent home prematurely. Increased purchasing power may come at the cost of a reduced formulary or reduced control over equipment purchases.

The success of the new organization depends upon the support and trust of the community it serves, and that is based on the historical characteristics of its once-separate

constituent institutions. In order to reap its hoped-for benefits, the integrated Markson Valley Health System must consider the perspective of the increasing number of individuals and organizations that are stakeholders in the expanded system. Combining their operations in a way that will preserve that historical advantage and further the financial security of the unified system will require forethought and a balancing of considerations.

<h2>**The Organization's Culture and Climate**

One of the most frequent reasons given for failure of health care mergers is incompatibility of the cultures of the merging institutions (Blackstone & Fuhr, 2003). The way an organization operates, the pattern of its behavior, is its culture. It includes the goals it pursues, and the rules, processes, and norms for behavior by which it seeks to attain those goals. Often expressed formally in mission statements, value statements, and codes, the organizational culture expresses what the organization does and how it does it (Victor & Cullen, 1988). The ethical climate of an organization is its morale-- the perception of the organization's members, its employees, and those associated with the organization, of the extent to which the expressed values are actually implemented in its daily operations.

A positive ethical climate has at least two important characteristics. First, the mission and values of the organization, which inform its expectations for professional and managerial performance, are implemented in the actual practices of the organization. Second, a positive ethical climate requires that the organization operate in the way society expects it to-- the manifest organizational culture is appropriate for the organization's social role. Morale is low in an organization that is behaving in ways not

in accordance with society's expectation of it, and its stakeholders' trust in the organization can be damaged. Culture and climate are particularly important in health care, an institutional sector with a particularly sensitive and strongly defined social role. Two health care organizations that share the same socially sanctioned values but prioritize them differently in their operations might fail to achieve successful merger, even if the financial preconditions are adequately met. The changes brought about by the combination of separate institutions into one system may present difficulties that have not been anticipated by MVHS's new administrator. [1]

At the high point of its expansion Markson Valley offered to buy Dr. Abrahmson's practice. He was tempted to accept the offer, but wondered if the sale would limit his ability to refer patients to outpatient facilities in the neighborhood that were unaffiliated with Markson Valley Health System.

The decisions made by the hospital closest to Dr. Abrahmson affect his ability to refer patients to that facility, and new the system's decisions about which of their services to invest in or to upgrade affects the quality of the care he can offer his patients. If the expanded Markson Valley is going to close its facilities to non-affiliated physicians, there may be some advantage for Dr. Abrahmson in accepting the offer of purchase. But as he is aware, such affiliation may preclude referrals outside the system.

The size of the organization in which a physician practices can be very important to his ability to meet his professional ethical expectations. In Independent Practice

Associations (IPAs) —organizations of a small number of partners in community primary or specialty practice—close integration between professional, clinical and business considerations may be possible. New contracts, new insurance company or governmental regulations, may be able to be accommodated between partners. New support staff can be added to handle administrative details as insurance plans proliferate; admitting agreements can be shifted from one local hospital to another as the healthcare organizations in the community close, consolidate or change their target populations. The number and mix of patients in the practice can be adjusted to meet changing conditions.

If Dr. Abrahmson accepts the offer of purchase of his practice, he may lose some of that flexibility. Markson Valley Health System may impose utilization quotas that determine how many patients Dr. Abrahmson should have in his practice. If the number is higher than his present practice, he will have less time to spend with each. If it is lower, he may feel some relief from financial pressure that will allow him to pay more attention to each encounter. The conditions of the contract will determine the effect on his clinical encounters. For the physician who is an employee or whose area of practice is becoming tightly tied to a large organization, the practice situation can be very different than that of the individual practitioner. Depending upon the size, degree of compartmentalization, and the organizational culture of a large organization, the integration between clinical and administrative functions can be cooperative and flexible or almost non-existent.

As has been noted by many commentators, any arrangement has incentives and disincentives, and physicians must scrutinize any suggested arrangement for explicit or tacit threats to professional practice (Rodwin, 2004).

Case II: From Non-profit to For-Profit

Marymount Hospital is located in the heart of New England in what was at one time an important mill town. It was founded in the early part of the century by a local philanthropist, the wealthy owner of a majority of the mills, with a charter that charges the hospital with primary responsibility for the health and well being of the community in which it is located. Its benefactor left a healthy endowment to sustain the hospital, devoted primarily to supporting unreimbursed care, and it thrived for a number of years, developing an excellent reputation for a number of specialty services.

Unfortunately it has recently fallen into financial difficulties and was purchased by Aleph, a large for-profit hospital corporation based in California. The parent corporation has determined to narrow the scope of several of its hospitals, including Marymount, concentrating on developing centers of excellence for specific services to attract national and international patients. They have increased the number of pediatric cardiologists and expanded their transplant services, and downsized the maternity ward and emergency room.

Local physicians are finding that there are no beds available in the intensive care units for emergency admissions, since all the beds are full of scheduled surgical patients, and Dr. Wilkinson, a local obstetrician, is

worried that the nearest maternity ward with a Newborn Intensive Care Unit is 40 miles away across the state line.

The community is a stakeholder in its hospital, and the consequences on the larger community of Marymount's acquisition remain to be seen. The conditions under which it will be able to continue to use its endowment for its designated purpose are subject to conditions out of its control. Few have suffered the fate of one of the hospitals purchased by the Allegheny system, which found its endowment emptied to meet shortfalls in other hospitals in the system (Massey 1999), but "studies have demonstrated that investor-owned hospitals will not commit to providing the same level of charity care… as non-profits" (Kline, Stephan, & Holbrook 2004, p. 354).

The history of this hospital is a snapshot of the history of the transitions across the country. Non-profit to investor-owned conversions have increased in frequency in the last few decades. Many once-charitable foundations have been forced to close, and others have been absorbed or transformed into for-profit organizations. Hospital conversions have been described as "the largest potential redeployment of charitable assets in the history of the United States" (Kline, Stephan, & Holbrook 2004, p. 352). Historically, nonprofit hospitals have been committed to the mission of providing charitable health care to the communities in which they are based. However, recent emphasis on cost constraint and the entry of for-profit enterprises into the business of health care delivery have transformed this expectation. All healthcare organizations are now under demands for efficiency and cost constraint that are increasingly incompatible with the way they used to provide services for the indigent and uninsured of their communities.

The mandate to be competitive and the mandate to be compassionate are in some ways simply incompatible. "We can't ask non-profits to be more like for-profits in the ways that we like—efficient, responsive, aggressive—without expecting that they will also become more like for-profits in the ways that we don't: rapacious, hardheaded and yes, sometimes selfish" (Jacob Hacker, quoted in Cohn, 2004, p.51).[2]

In the short term Wilkinson's conditions of practice have become much harder, and his (and everybody else's') community patients, for whom there is no room at the hospital, will suffer as well. The decisions that influence their practice are not made on the individual level, but impact the individual physicians because of their position within the larger system. Financial considerations have led the hospital to change its business practices in the broad sense. The mission of the hospital and its prioritization of values have changed, so what is done in it changes, and the physicians and patients who don't fit with the new model will be excluded.

Case III: The Incredible Shrinking Unit

> **Dr. Kim is the director of a 20 bed surgical ICU in Marymount hospital. Shortly after the purchase by Aleph, she received a memo announcing that two new cardiologists were being added to staff in order to increase the prominence of Marymount as a national and international center of excellence in cutting-edge cardiac surgery. As of next month ten of the beds of her unit were to be designated for the scheduled surgeries of cardiac patients.**

Because Dr. Kim practices entirely within the hospital, the impacts of organizational decisions on her professional practice are much greater than upon Dr. Abrahmson's. In this instance, the organization suffered severe disruption of the alignment of values within the organization. The coordination between the administrative decision and the clinical staff was almost non-existent. The speed of the change, the lack of consultation with affected units, and the lack of preparation for the shift in emphasis, sent ripples of consternation throughout the unit. Nursing staff clamored for re-training to deal with the expected onslaught of seriously compromised patients, but were going to have very little time to get it. Dr. Kim was losing control of half of her beds, and had to scramble to find alternate sites of care for some of the patients now in her unit, many of whom required a level of care unavailable in other units of the hospital. She now dreads the monthly meetings of the county medical association, of which she has been an active member; because she faces the unpleasant task of telling her community colleagues that there is suddenly 'less room at the inn' for their local patients. Morale within the hospital has plummeted; community trust in the institution, she fears, will soon follow.

Marymount, driven by decisions in the head office of Aleph, has handled this transition badly. The health care professionals who are at the crucial interface between patients and the institution have been disrespected and disregarded. Low morale in this crucial unit, often one of the central fee-generating dynamos of the hospital, will have implications throughout the organization as the word spreads and each internal stakeholder wonders if his unit will be the next to be downsized. The commitment of the organization as a whole to the primary value of excellent patient care, as trumpeted in its

mission statement, has been called into question, creating a negative ethical climate. It will be bad if clinicians doubt the commitment of the organization to clinical care. It will be worse if they shrug and dismiss it as 'business as usual'—no better than they have learned to expect of institutions under control of the Aleph corporation. Apathy is dangerous for the patients, and contempt is dangerous for the system.

Individual and Organizational Moral Distress

Dr. Kim is a physician whose area of practice is within a large complex organization with many goals and objectives, not all of which are easy to reconcile. A hospital is a site for the exercise of professional services, and the professional integrity of its practicing physicians can be either supported or impeded by the decisions made in furthering the hospital's various needs for financial stability, patient satisfaction and care of high quality.

If moral *dilemmas* arise when a caregiver must choose between incompatible courses of action, each of which has ethical justification, moral *distress* arises when the agent is clear about the ethically appropriate course of action but institutional constraints make it difficult to implement. Conceptualized in the mid-1980s in the nursing literature (Jameton 1984, p. 5), moral distress is applicable in many realms of health care. Much of the literature on moral distress focuses on the individual psychological consequences of frustrated agency: loss of self esteem, demoralization and guilt in individuals, reduced efficiency, lowered quality of care and increased turnover in staff in organizations. All caregivers, physicians as well as nurses, are increasingly torn between conflicting commitments: their accountability to their patients and their accountability to the

institutions in which they practice. Of particular concern to both individuals and organizations throughout the healthcare system is the current pressure for cost containment and continuing pressure for quality improvement. An organization committed to excellent care for reasonable cost may institute policies oriented toward cost containment that are perceived by internal constituents as constraints upon the quality of care required by their professional clinical judgment. Working conditions that impede, rather than supporting, actions required by the professional ethics of healthcare providers can be a source of moral distress.[3]

Case IV: Cost over Quality?

Dr. Pearson recently completed his residency in a nationally recognized transplant program. In looking around for placement he chose Marymount because of their expressed intention to expand their transplant services. But last year one of the transplant patients spent 260 days in Marymount's ICU, at a total cost of over $4 million dollars, much of which was not able to be recovered from any source. Marymount's board is now looking again at their transplant program, and has established an internal oversight committee to evaluate any proposed surgeries that are both high-cost and high-risk. Furthermore, a recently developed anti-rejection drug that Dr. Pearson had good results with in his residency is not on the hospital's formulary for reasons of cost. He is wondering if he chose wisely when he opted to come to Marymount.

In Dr. Pearson's case the provider organization is crucial to his practice. The extent to which the services available in that institution facilitate or impede Dr Pearson's practice is an important professional consideration for him. As a practitioner of a specialty with both high risk and high cost, he is particularly vulnerable to institutional mechanisms to control costs. At the stage he has reached in his career, his ability to further hone his own skills and to contribute to advances in transplant medicine may weigh very heavily in his choice of where to practice. The unavailability of a pharmaceutical that improves the chances of his patients for positive outcomes is worrying as well. Dr. Pearson faces a conflict between his personal career goals, his ability to advance his medical specialty, and his loyalty to the organization in which he practices.

Conflicts of Interest and Conflicts of Commitment

Most business practices in the health care sector create the possibility of conflicts of interest. It is considered a breach of professional ethics if a physician recommends an unnecessary procedure or course of action that results in financial advantage for himself. Conflicts of interest can usually be easily recognized and avoided. If Dr. Abrahmson consistently refers patients for diagnostic imaging only to a lab in which he has a financial interest and the quality of their care suffers as a result, this might represent a conflict of interest. Conflicts of commitment involve the distribution of focus and effort between competing professional obligations, rather than a conflict between professional obligations and self-interest (Werhane & Doering 1996, 61). Conflicts of commitment are much harder to avoid and can create moral dilemmas for conscientious professionals.

Dr. Kim has professional responsibilities to her fellow clinicians, her community colleagues and the organization in which she practices. She wrestles with how she can continue to meet those competing commitments in the fact of changing conditions in her unit. Dr. Pearson too faces a professional conflict between his pursuit of professional excellence and the advance of transplantation medicine, and his contractual commitment to Marymount Hospital..

What is the nature of the conflict faced by the institution? Marymount (and its parent company Aleph) have an obligation to both cost containment and care of high quality. Marymount Hospital must maintain financial viability, and may be uncertain how much financial support they can count upon from Aleph, even though it was the decision of the home office that they expand their transplant program. The hospital may be expected to heed their advice, but also to take full financial responsibility for the results. Aleph can shift financial risk to its component units. But those components are then going to have to distribute that risk to their various services—a complex balancing of short- and long-term advantages that is bound to disrupt established expectations. The ability of Marymount to support care is currently influenced by its relation to Aleph, but it may have been equally, if differently, constrained by its financial instability as the free-standing institution it was before its acquisition.

The extent to which necessary accommodations impact the physicians and patients in the hospital may be in large part a function of how the decisions are made. What is the degree of communication between the administrative and professional leadership in the hospital? Does the Board discuss, or only pronounce? Will the oversight committee include representation from the various services? Are there

mechanisms for altering or supplementing the formulary when particular cases need special consideration? Will decisions of the oversight committee rely on available data about outcomes, or will cost be the only consideration? The answers to these questions speak to the organizational culture and ethical climate of Marymount Hospital.

II: The physician and the payer organization

The majority of people with health insurance in the US are covered under some form of managed care. Following the failure of the Clinton Health Plan in 1993, managed care has become the primary business model for reimbursement for medical services. Managed care organizations have as their major rationale the containment or reduction of health care costs. Methods of cost constraint vary by plan, but usually involve some combination of the following strategies: selecting and limiting the number of providers who are authorized to provide care for plan enrollees; monitoring what services are available, requiring pre-certification for treatments or referrals, and restructuring how individuals and institutions are paid. Only 8% of insurance offered through employers resembles the traditional indemnity coverage of the past, and 80% of the insured U.S. population is now covered by some form of managed care. (Voss et al 2005, quoting Fletcher 1999).

While fee for service medicine has been accused of having the potential for encouraging overtreatment, its replacement model has the potential for encouraging undertreatment. One of the major criticisms directed toward the financial incentives introduced by some managed care contracts is that they constitute a conflict of interest for providers between their professional concern for their patients and their concern for their own financial advantage. Another concern is the dominance of for-profit entities in the

field, whose commitment to profit for investors competes with their commitment to care of high quality.

Case V: Whose costs? Whose problem?

Dr. Abrahmson's practice serves patients covered by several different insurance plans, a few reimbursing on a fee-for-service basis, the others by capitated payment with several different capitation rates. He frequently sees patients presenting with gastroesophageal reflux, a problem for which there are several diagnostic procedures. Depending upon which he chooses, the costs to the patient, the costs to his practice, and the cost to the medical system as a whole will be different.

The benefits of the payment mechanisms adopted by different payers accrue differently to providers, patients and the society at large, depending upon the circumstances of each patient that Dr. Abrahmson sees (Voss, 2005). To whose interests is he most immediately committed? As citizen, proximate agent of the wider healthcare system, partner in a practice and a physician committed to the ethics of his profession, Dr. Abrahmson faces complex decisions, all of which have ethical implications. If he had decided to sell his practice, some of the decisions he faces may have been pre-empted by the conditions of his relationship with the Markson Valley Health System. But even absence of choice is freighted with ethical implications.

Balancing professional obligations is not new to medicine. Physicians have obligations to their individual patients, but also obligations to the population of patients for whom they are responsible, and to the support and advancement of medical science. The most recent claim has to do with resource allocation. Insofar as they are designated or appropriate custodians of communal resources, physicians need to consider cost as well as the quality of medical care. Recent focus on cost containment as well as changes in the patterns of reimbursement have prompted a heated dialogue on how, when and whether physicians should be involved in bedside rationing (Weinstein 2001).

Case VI: To Refer, or Not to Refer?

Dr. Simms is a family practitioner in Markson Valley. She is in practice with three other doctors and her practice has a contractual relation with Markson Valley Health System. Dr. Simms has just seen a patient with a painful mass in her abdomen and she thinks an ultrasound examination is necessary for diagnosis. The Health System refuses to reimburse for out of system referrals, and the Markson Valley facility has no appointments for ten days. She wonders what she should do.

If Dr. Simms decides to send her patient to an ultrasound facility that is outside the Markson Valley network in order to get timely information about the cause of her inflammation, she may suffer individual financial loss or threaten the financial viability of her partnership, depending upon the conditions of her contract. The practice may have contractual provisions that penalize them for out-of-network referrals, or the additional

expense might cause the contract to be cancelled. Her commitment to her patient may conflict with her commitment to her practice association.

If she decides to recommend that the patient wait for the next available appointment with the Markson facilty, she runs a risk of a different sort. While providers are held responsible for quality of care, payers are held responsible only for cost. Current law regulating health insurance (ERISA, the Employee Retirement Income Security Act of 1974) exempts many insurers for care decisions, without acknowledging that some managed care organizations deliver care as well as providing insurance. In the Pegram case that went to the Supreme Court, a patient for whom delayed diagnosis led to a ruptured appendix, peritonitis and a prolonged hospitalization filed suit for negligent care against both the physician and the health maintenance organization with which she contracted. While it was arguably the HMOs rules that led to the postponement of the diagnosis, it was only the doctor, the proximate agent, who was held liable. While the doctor was sued for malpractice, it was decreed that the HMO could be held liable only for the cost of the benefit that was initially denied. (Applebaum 2000, Bloche 2000).

Dr. Simms dilemma arises because Markson Valley Health System's strategy for financial security included purchasing practices and restricting referrals outside of the network. While there may be no specific policy of reducing the number of services available, the waiting list for a service like ultrasound serves as a tacit dissuader.

<h2> New forms of insurance and the 'end of managed care.'

There is good reason why early forms of managed care directed their attention to physicians, developing complex strategies to persuade physicians to prescribe less, refer less, utilize fewer expensive diagnostic technologies, discharge patients earlier or admit

them to less expensive facilities. Physicians remain the gateway to medical treatment, controlling access to pharmaceuticals, hospital admissions and specialist referrals. But there is a wide consensus that these strategies cost more in good will than they reaped in cost savings. As one of its more sympathetic observers noted, "the managed care system has achieved considerable economic success but has proven itself a cultural and political failure." (Robinson 2001). Narrow physician panels offend patients and disrupt long-term physician-patient relationships, while pre-admission authorizations, coverage denials and any risk-shifting mechanisms that imposed third-party judgments between physicians and their patients were vehemently rejected by both patients and providers. As a result there has been less of a tendency in the last few years for the intermediaries between physicians and the purchasers of health plans to combine insurance and delivery. Instead, insurers stick to the area they know best, and the mechanisms of managing care—utilization review, gatekeeping, capitation—are more often mediated by the provider organizations (Robinson 1999, 2001).

There is some question whether this actually represents the 'end of managed care' (Robinson 2001) or just its perpetuation in a new guise. In practice, Dr. Simms is as likely to have some 'management' of her referral and utilization of services by her immediate practice, even if she and her partners decided to dissociate themselves from MVHS. But from her perspective, such reviews done by her practice might be less threatening to her professional integrity than utilization reviews done by agents less proximate to and less knowledgeable about the particulars of her patients.

III: Dealing with Systems

Although we have been speaking of payer or provider organizations, there is a sense in which it is the health care system as a whole that is both payer and provider. In almost all its dimensions health care is imbedded in a complex set of systems and subsystems, a complex network of interrelationships. To deal with ethical issues in health care either from a dyadic or even an organizational perspective often belies what is really at issue and thus ignores a number of elements that are related to the issue in question. Proper evaluation may rather require what the organizational and scientific literature calls 'systems thinking,' or a systems approach. (Werhane, 2002, p.293, Mills Rorty & Werhane 2003).

***Systems thinking**:* The physician-patient relationship is where the social institution meets the recipients for which it exists. But to focus only on that micro level is to exclude from view many factors that explain and determine the content of that dyadic relationship. Individuals as a source of choice, decision and action are embedded in a complex set of networks and interrelations. The micro-level of the individual, the meso-level of organizations, and the macro-level of the larger society are interdependent, and decisions on any level affect and are affected by decisions on other levels.

The importance of a systems-approach to health care in the US is becoming obvious to many people in the health care system. The prestigious Institute of Medicine has approached the problem of quality in medicine with a systems-approach (Institute of Medicine, 2001; Plsek, 2001) and recent reforms in resident education are also paying increasing attention to implications for professional practice of decisions and policies on organizational and system-wide levels (ACGME 1999, esp. Competency 6).

These considerations do not preempt individual professional decision making, but do affect those judgments and their outcomes. "A truly systemic view of current health care [in the United States] considers how this set of individuals, institutions and processes operates in a system involving a complex network of interrelationsips, and array of individual and institutional actors with conflicting interests and goals, and a number of feedback loops." (Wolf, 1999). Because of the interrelationships of the various units and levels of the healthcare system, the factors that combine to produce an ethically troubling situation have their source in distant as well as proximate decisions.

Acknowledging the interdependence of the various levels of the healthcare system, from the dyadic relation of the physician and the patient to the macro-level of the role of the social institution of health care in the larger society, has several benefits. For one thing, it mitigates simplistic analysis and inappropriate "victim" blaming, and raises the possibility of more appropriate allocations of accountability within the system (Emanuel & Emanuel 1996) . The element of the system that is most proximate to an ethical issue is not necessarily the cause of the problem. It is not Dr. Kim's fault that there are no free beds in the ICU, and Dr. Wilkinson did not choose to close the maternity ward.

Further, it facilitates the ability of the stakeholders in the system to weather the unpredictable and strategize for optimal outcomes. Some things can be resisted, some changed, and some only endured. A cultured and honed sensitivity to morally problematic situations, and the moral imagination to address them, will be useful, if not always comforting, to the medical practitioner in the 21st century (Werhane, 1999).

IV: Conclusion

This chapter has focused on the impact of organization level decisions on individual professional practice, with particular attention to ethical issues raised by business decisions. Physicians practice their profession in and with organizations, within which they are not always the sole decision maker. Decisions of those organizations have ethical import in their own right and also have ethical implications for the physicians affected by them and their patients. Some ethical conflict in medical practice is a function of the degree of alignment of values between physicians and their associated organizations, between different components of those organizations (e.g., management and clinicians), and between the health care system and the larger society. Hospitals are complex institutions, involving divergent objectives and multiple actors linked in fluid and ambiguous power relations. Because of compartmentalization, hierarchical organization and bureaucratization, integration of goals and alignment of values among various stakeholders can be hard to achieve (Denis, Lamothe & Langley 2001).

It is no accident that the sub-field of organizations ethics, representing the intersection of business ethics, clinical ethics and professional ethics, has grown up at the same time as some of the changes in the conditions of individual physician practice instanced in our examples. When the Joint Commission for the Accreditation of Health Care Organizations introduced the term as a requirement for the continued accreditation of health care organizations in 1995 it did so to emphasize the obligation of health care organizations to manage their business relationships in an ethical manner, while recognizing the primacy of patient care (JCAHO 1996). Organization ethics directs attention to the ethical implications of the relationships health care organizations have,

not only to individuals affected by or implicated in their operation, but to other organizations and to the larger society of which they are a part.

We do not consider organization ethics a replacement for professional ethics. Rather, an effective organization ethics program should protect and foster the professional ethics of its professional stakeholders, as well as serving as a forum for prospective discussion of decisions, structures, strategies, policies or contracts that members of professional groups judge to be threats to their ethical practice (Spencer et al. 2000, p. 161). The more intimately professional practice is implicated in organizational structures, the more important it is that organizations have some mechanisms for addressing the integration of clinical and business decisions, mechanisms that allow clinical professionals a voice in organization-level decisions.

We need to address the confusions created by the changing model of health care delivery in the US on several levels. On the level of the individual provider, the professional ethics of the physicians needs to include an imperative to deliver cost effective medicine. On the level of the organization, we need to strengthen the support for high quality medicine—to balance the forces within the society that are pushing for cost control without attention to its effect on quality. We cannot perpetuate a split such that one component of the provider organization, the clinician, is responsible for quality, while another component, the administration, is responsible for cost. All stakeholders need to consider both.

On a national level, healthcare system is in rapid and rocky transition, driven in part by commercial interests that are foreign to the Hippocratic tradition of medicine. We commend the professional who is also an active citizen. The health care system as a

whole is responsible for providing care of high quality at a reasonable cost to the population, but faces many structural impediments. It has never been more important that physicians include among their professional obligations a commitment to improve a fragmented health care system and advocate on local, regional and national levels for their patients. While the obstacles are daunting, the objective should be achievable—but not without the active participation and advocacy of those who have the most invested in the adequate care of their patients.

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[1] The dangers of overexpansion due to merger activity are nowhere better exemplified than in the story of Allegheny General Hospital. Under the leadership of an ambitious Chief Executive Officer it underwent rapid expansion in hopes of consolidating and improving its financial position. Ten years later the expanded Allegheny Health Education and Research Foundation had 14 hospitals, two medical schools, 'hundreds' of associated physician practices, and over 20,000 employees. But many of its strategic decisions, and some of the problematic means by which they were implemented, failed of the desired intent. In 1998 the Allegheny System declared bankruptcy, having incurred $1.4 billion in debt. At the time of its collapse it was the largest medical care provider in Pennsylvania and the largest non-profit physician-hospital organization in the United States. The collapse of the system marked the end of a blind belief in expansion as the answer to fiscal viability (Burns et al. 2000).

[2] **The logic of expansion decrees that services will be consolidated when a hospital joins a larger organization. Conversions have often resulted in increases in administrative costs, staffing cuts, and, as in the case of Marymount, reduction or discontinuation of vital community health services. One economy may be the outsourcing or consolidation of collection services, and thus treatment of uninsured patients can be problematic in hospital conversions. There have been reports of some hospitals requiring up to 50% pre-payment from uninsured patients seeking non-emergency care, and some hospitals are facing litigation for charging uninsured patients up to four times more than the same hospitals charged patients with private insurance for the same procedures (Cohn, 2004, Patient Care Law Weekly 2004).**

[3] **Organizations too can suffer a form of moral distress, when external pressures from other organizations or social factors impede their capacity to fulfill their social function (Mills & Werhane, 2005). Several well known court cases provide examples of organization demoralization. In the Baby K case in Virginia in 1993, caregivers were concerned about the propriety of and professional responsibility for continuing to treat an anencephalic baby. The institution concurred with the professional judgment and took the case to court. When the courts ruled against the hospital the morale and reputation of the hospital were called into question (McCarthy, 1993). A different alignment of values occurred in the Maryland case of A.C. When caregivers wished to honor the wishes of a terminally ill pregnant cancer patient to let her die without a cesarean section to save her premature baby, the hospital's lawyers, acting on behalf of what they believed to be extramural social values, injudiciously forced an un-consented cesarean section. Mother and child died, and the resulting court case went against the institution. (*In re A.C.* 1990) Here too the morale and reputation of the institution suffered.**