Business Practices, Ethical Principles, and Professionalism

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INTRODUCTION

Whether in single practice, research organizations, government facilities, or complex hospitals or clinics, physicians practice in organizations. They are influenced by, and influence, the internal business practices of the organizations with which they are affiliated, as well as the business practices of other organizations that are part of the delivery system. It has always been true that the way in which care is delivered involves business practices. Healthcare delivery, whatever the model, is a business that involves costs and reimbursement issues. If there was earlier some hope that professional business practices did not require constant ethical reexamination because of the relative autonomy of the physician as professional, the radical restructuring of the healthcare system and the way healthcare has come to be reimbursed in the last two decades has brought into greater salience the impact of systemic business practices on professional practice.

The Accreditation Council on Graduate Medical Education (ACGME) acknowledges in its standards the interrelation of professionalism and business practices.[1] In the fifth and sixth competencies listed in the ACGME Outcomes Project, ethical professional practice is placed in the context of the larger system within which the physician practices. If ethical professional standards are reflected in appropriate business practices, then the outcomes of the healthcare system as a whole may also be professionally responsible. But professional goals and the business practices designed to achieve them are not necessarily correlated throughout a healthcare system. Individual professionals may not have enough control, either of the institutions in which they

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practice or in the healthcare system as a whole, to assure ethically appropriate results. Furthermore, in any business practice, there are design characteristics that must be considered. If we want physicians to commit to standards that have been associated with professionalism, then the systems within which they work, and the business practices that are designed to achieve the goals of those systems, must support their activities as professionals. This can be achieved only if we design systems that are responsive to professional values and are characterized by some degree of flexibility. Business practices are not static, and the healthcare delivery system is fragmented. Each component, on each level—individual physicians, healthcare organizations, the payers and managed-care organizations that interact with them—has a plurality of values and goals that are supported by their own business practices. The more responsibility that is entrusted to professionals, the greater the temptation may be for other components of the delivery system to design intersecting practices that may corrupt or be perceived as corrupting professionalism.

In this essay, we look at the fifth and sixth competencies of the ACGME, consider the goals and values that they presuppose and the practices associated with them: the means by which organizations or individuals achieve their corporate or individual ends. We concentrate on business practices, defined broadly as *relationships, processes, or procedures designed to meet some goal or produce some outcome.* We demonstrate that each component of a business practice—its goal, the relationships or interactions which it encompasses, as well as the outcomes it produces—should be scrutinized for the ethical principles on which it relies as well as its effects on the other components. We focus our remarks at the organizational level of the delivery system, but they can apply to the micro-level of the individual practitioner, and to the macro-level of the objectives of the system as a whole. We address questions of what business practices are, how they are linked to goals and outcomes, and how they are designed in order to understand how threats to professionalism may arise through them. While business practices are a necessary condition for professional activity, they may be a source of problems as well. The problems faced by an ethical individual within an unethical system are not new or unique to medicine, but they do call attention to the impropriety of holding individuals responsible for systemic failings. We conclude that enlarging the concept of professionalism to include greater consideration of cost will not be enough for physicians and the organizations with which they are affiliated to achieve the goals of the sixth competency. For this, we may need to require that the system as a whole to commit to the same goals.

THE ACGME COMPETENCIES

The fifth competency provided by the ACGME invites this reexamination. It states:

> Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
>
> - demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
> - demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, *and business practices* [authors' italics]
> - demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.[2]

The requirement of the ACGME that physicians "demonstrate a commitment to ethical principles pertaining to . . . business prac-

tices" as a condition for professionalism is a demand that physicians run their practices or operate their clinics or perform research in a way that is consonant with their professional ethics, and that they resist practices that prevent or distort their professional judgment. This competency calls for residents and other physicians to make a commitment to the ethical principles that pertain to medical ethics, clinical ethics, and "business practices." It is a three-pronged approach that acknowledges business practices are related to professionalism, and so may influence the way in which care is delivered.[3]

> The sixth ACGME competency states:
> Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:
>
> - understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements of the system affect their own practice
> - know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare costs and allocating resources
> - practice cost-effective healthcare and resource allocation that does not compromise quality of care
> - advocate for quality patient care and assist patients in dealing with system complexities
> - know how to partner with healthcare managers and healthcare providers to assess, coordinate, and improve healthcare and know how these activities can affect system performance.

The sixth competency complements the fifth by emphasizing the integration and interconnections between different levels of the healthcare system and various sites of care. It recognizes that physicians practice at every level of the delivery system and that physicians are constrained to act as patients' advocate within that system. Differences in requirements, procedures, regulations, or business practices in the organizations with which practitioners interact affect their ability to exercise their professional judgment on behalf of their patients.

In the sixth competency, the ACGME reiterates the overarching professional goal and desired outcome for physicians and whatever system within which they practice: to deliver care of optimal value. The fifth competency requires that professionalism include a commitment to the ethical principles of business practices, and the sixth competency supplies the goal toward which those business practices are coordinated.

WHAT ARE BUSINESS PRACTICES?

Business practices are the way in which people, resources, and technology are brought together to try and fulfill the values and goals of an organization. Interactions—relationships or procedures, processes or systems, policies or activities—can be examined as "business practices," depending upon the context in which they occur and the role they play in the operations of an organization or physician practice.[4] Business practices may be formal or informal, simple or complex, but they exist only to fulfill the organization's goals. (An organization leader would be hard pressed to justify any business practice that does not in some way fulfill a goal associated with the organization.) They are designed and implemented to produce desirable organizational outcomes by affecting the behavior and decision making of internal or external stakeholders, either individuals or other organizations.

ETHICAL PRINCIPLES AND BUSINESS PRACTICES

Business practices are linked to organizational goals and have normative content. Most

organizations produce either a product or a service for an identified customer or population of customers. Even government agencies can be so described, if the customer is seen as society as a whole. Many organizations want to keep their existing customers and add new customers, which they can only do if their products or services meet the standards expected by their customers. As a matter of course, they expect to be reimbursed for their efforts.

In the process of producing goods and services, maintaining and adding to their customer base, and collecting the revenue associated with the delivery of goods and services, organizations accrue costs, which, if not controlled, may threaten their viability. From this perspective, the business practices employed by any organization that wants to remain viable over the long term can be said to support three important organizational goals: *product or service excellence, customers' satisfaction, and cost control.* These goals are appropriate for healthcare organizations. Costs must be controlled, professional excellence must be maintained, and care must be delivered that is adequate or at least in some way satisfies the needs and expectations of patients and the community served by the healthcare organization.[5] These goals are all associated either directly or indirectly with the long-term financial viability of the organization, as are the business practices that support them.

Each of these goals reflects ethical principles, insofar as they are associated with values that are endorsed by society. But the business practices associated with them may not reflect commonly accepted ethical principles, or may result in unethical outcomes. We believe it is unethical to produce goods under "sweat shop" conditions in order to control costs, but sweatshops do exist.[6] We do not believe it is ethical to allow known safety hazards in the production and supply of goods and services, but unsafe products have been known to be used or marketed.[7] Nor do we believe that unethical business practices should be used to achieve customers' satisfaction; for instance, clients are not allowed to dictate their wishes to auditors, regardless of the desirable effect on customers' satisfaction, when the practices they recommend are illegal or improper.[8] In the healthcare context, we question the conditions under which some professionals have been known to work,[9] we believe it is unethical for professionals to claim knowledge or skills they do not possess,[10] or for healthcare organizations to use unsafe practices, such as reusing needles.[11] Further, medical professionals are obligated not to harm their patients—whatever patients may wish.

Just as goals and business practices may not be correlated with ethical principles, goals and outcomes may not be correlated with ethical principles. This will depend on the design of the business practice in question and on the appropriateness of its use. For instance, a rigidly designed business practice that is employed in the manufacturing sector may be unethical if it employed in a professional setting. A tightly controlled quality initiative that employs detailed rules to govern every aspect of behavior and decision making may be inappropriate and reduce the quality of outcomes when it is implemented in an emergency room setting, which requires a great deal of individual discretion and professional judgment for success.

We have said that the goals of an organization may not reflect ethical principles when they are not associated with values endorsed by society. This very much depends on the form and function of the organization and society's expectations of it. For instance, although both for-profit and nonprofit healthcare organizations must remain viable, we have different expectations of the two types of organizations, and are disconcerted if we encounter behaviors accepted in the one in the other. We do not expect nonprofits to endorse the goals that are more commonly associated with for-profits, such as excessive profitability or market dominance.[12] The collapse

of the Allegheny Health, Education, and Research Foundation (AHERF) is a case in point. Not only did it highlight the need for attention to roles and responsibilities of the various actors involved in the collapse, it raised questions about the appropriateness of those responsible for a community asset that embarked on an aggressive strategy of horizontal and vertical integration.[13]

But ethically questionable goals that are endorsed by an organization may be associated with ethical business practices and ethical outcomes. A nonprofit healthcare organization that seeks market dominance may employ ethically appropriate business practices that deliver ethically appropriate outcomes. For instance, market pressures have forced many nonprofit religiously affiliated healthcare organizations to merge or consolidate with secular organizations to maintain their financial viability, or vice versa. Such combinations provide challenges for institutions that have been historically unwilling to provide services offered by their new partners. But while there has been controversy over the provision or discontinuation of specific services, centering on abortion and birth control, there is wide recognition that many mergers that involve Roman Catholic institutions have succeeded in improving the quality of care for the communities they serve.[14]

Equally, ethically questionable business practices and ethically questionable outcomes may be associated with ethically questionable goals. For instance, some question the ethical principles associated with the goal of Myriad Genetics, which is to obtain a worldwide monopoly on information pertaining to the BRCA1 breast cancer gene.[15] Just as questionable are Myriad's business practices and the outcomes associated with this goal. Myriad can command monopoly prices associated with tests for this breast cancer gene. This has resulted in the province of British Columbia discontinuing the use of the test because its healthcare system can not afford the $3,850 (Canadian dollars) price tag, which deprives women of a potentially important diagnosis option. So when we think about business practices, we have to think about the organizational goals they are designed to support, the way the business practices are designed and implemented, and the outcomes they produce and whether they are in alignment with community expectations. This leads to a matrix of possibilities in terms of the ethical principles associated with goals, business practices, and outcomes (see figure 1).

For physicians, the extent to which the goals, practices, or outcomes of the organizations with which they are affiliated support or contradict their professional values is crucial. Any of the three may constitute a possible threat to practitioners' professionalism and must be scrutinized by physicians regarding their influence on physicians' decision making. Physicians understand the need to maintain the financial solvency of their prac-

Matrix of Possibilities

Ethically acceptable = A
Ethically unacceptable = U

Goals	Practice	Outcomes
A	A	A
A	A	U
A	U	A
A	U	U
U	A	A
U	A	U
U	U	A
U	U	U

Figure 1.

tices, or of the hospitals to which they admit. But physicians, with respect for their excellence of practice, may hesitate to associate their personal reputations with a healthcare organization that blatantly ignores the quality of care it provides in favor of high profits or one that consistently ignores patients' dissatisfaction.

ADDITIONAL COMPLICATIONS

There are further complications in trying to disentangle the ethical principles that are associated with organizational goals, the business practices that are meant to support them, and the outcomes they produce. Organizations, like individuals, typically have a pluralism of values and goals. Further, some practices that are appropriate to an agent at one level of a healthcare system may be perceived as inappropriate if exercised by other agents.

Most organizations or individual practices are committed to more than one goal. But these goals can conflict. Business practices that are designed to maximize potentially competing objectives require ongoing balance and prioritization to achieve their objectives. For instance, most organizations, including healthcare organizations, endorse both quality (meeting customers' expectations through product or service excellence to maximize customers' satisfaction) and cost-constraint as goals to be achieved. The potential for conflict between quality and cost is well known. Improved quality is often, although not always, associated with increased costs. Similarly, lower costs are often, although not always, associated with decreased quality. Many organizations assign priorities to the achievement of their goals. For instance, many organizations will place customer service or product excellence before cost, in the belief that profits depend more on these factors than on cost-control.[16] (Many organizations, including healthcare organizations, codify their priorities and the values they represent in mission statements, ethical codes, or value statements.) But it very well may be the case that two ethically acceptable goals, when reprioritized, produce ethically unacceptable business practices or outcomes. Or, it may be that the goals themselves, when reprioritized, are perceived as unethical, depending upon the wider social expectations of the business in question. For instance, we do not expect healthcare organizations to prioritize cost-control over adequate care, and when they do, we perceive it as unethical.

An additional complication is associated with the source of a business practice that might cause it, or its goals and outcomes, to be perceived as ethical or unethical. For instance, utilization review that is instigated by third-party insurers and used to control physicians' decision making is widely perceived as unethical.[17] But if the utilization review is instituted by a hospital with its residents and physicians, it may be viewed as a nuisance or irritant, but may not be perceived as unethical by physicians. If it is done by peers, physicians might perceive it as an attempt to educate them concerning new evidence about specific diagnosis and treatment options. This is the case, even when utilization review purports to support the quality and cost goals of organizations. So, the exact same mechanism, used for exactly the same purpose, may be perceived as ethical or not depending on its source.

Business practices may also be subtle, with outcomes that are not tightly linked in time to the practice or the organizational goal they support. For instance, one well-known practice is the intrusion of drug company representatives who may attempt to endear themselves to residents or other physicians with invitations, goods, or services of various sorts.[18] A midnight pizza party may be harmless, but its intended outcome may not be so harmless, if the object is to capture the attention (and the gratitude) of the recipient, to be reciprocated by prescribing from the representative's company. So what may be perceived as a harmless business practice may

not be so harmless, but rather subtle and invidious.

DESIGNING BUSINESS PRACTICES

Business practices, even when they are aligned with organizational goals that reflect generally accepted ethical principles, may be themselves unethical or may produce unethical outcomes. This will depend on how the practice is designed and whether or not its design is appropriate for the context in which it is implemented. Some tasks demand a great deal of precision, with little scope for variation. Others can be specified best in terms of their goals and some behavioral parameters, leaving the processes for their accomplishment up to the particular agent. An organization of any size that is designed to deliver healthcare must coordinate the actions and services of a number of different skilled and less-skilled workers, so the business practices that are associated with various organizational tasks must be appropriate to the demands of those tasks. So there is an important characteristic when considering the design of business practices: *the amount of rigidity or flexibility they possess.*[19]

An important distinction in the design of any business practice is whether or not it is largely mechanical (rigid) or naturally flexible. This distinction is fundamental and describes how a business practice is designed and how it responds to external or internal stimuli. In mechanical systems, we can predict in great detail the interaction of each of the parts in response to a given stimulus, since, in a purely mechanical system, pre-specified responses are always correct and a correct response is always expected. For instance, an organization might use mechanical assembly lines as part of its business practices. If all parts are working correctly, when it is turned on, the line begins to function as it was designed. When deviation occurs (for example, the line does not turn on) it is unexpected and generally provokes study (is a fuse blown?) and action to prevent recurrence (replacing the fuse). Another example is a tightly controlled quality control technique that requires exact measurements or very specific interactions among its components. These components may or may not be human beings.

It might well be the case that tightly controlled business practices do not have to be closely monitored for the production of potentially unethical outcomes. If the practice is ethically designed and it produces ethical outcomes, then it will, barring unforeseen events, always produce ethical outcomes. For instance, a tightly controlled and ethical billing process will always produce the same outcomes, and if it is designed to produce ethical outcomes, it will always produce ethically acceptable outcomes. But the context in which it is used may vary, and it is not always appropriate to use tightly controlled practices.

Other business practices must have more flexibility in their design. For instance, most healthcare organizations employ teams of personnel to evaluate, treat, and monitor individual patients. These teams are composed of administrators, case managers, doctors, nurses, social workers, chaplains, and others who work within the business practice of "case management" to produce one or more goal. Persons who are associated with the team must have some flexibility in how to best achieve the goals of case management, because each patient and her or his circumstances are unique, and it would be inappropriate (and probably disastrous) to try and rigidly govern the interactions of the team. Thus, we can think of business practices as falling somewhere on a continuum between the poles of extreme rigidity and extreme flexibility. This characteristic is important, not only because it is central to the design of a business practice, but also because the degree of flexibility of a business practice may determine the propriety of the business practice itself and its outcomes. For instance, when physicians set up practice, they must allow enough flexibility in time and other resources to accommo-

date patients with varying needs. When a hospital requires the use of evidence-based medicine in clinical decision making, rigid adherence to guidelines may itself be unethical, and may also produce unethical outcomes, depending on the values and preferences of the individual patient.[20]

Flexible business practices are needed when human judgment is required. But it should be noted that the flexibility of a business practice may allow its components, including human beings, through their interactions, to change either the practice itself or the goals it is intended to achieve.[21] Because either the goals or the practice can change through the interactions of its components, the ethicality of the practice or its outcomes cannot be guaranteed.

The characteristic of rigidity or flexibility will also determine whether or not additional business practices, such as incentives, are perceived to be needed to influence decision making. In our earlier example, if all parts of an assembly line are working correctly, as they are expected to do, desirable organizational outcomes will be produced. There is little need to provide additional incentives to produce these outcomes. But if an application requires more flexibility in the design of a business practice—if it requires the exercise of judgment, of skill, of intuition, of the interactions of varying individuals or groups—positive or negative incentives might be needed to align decision making with desirable organization outcomes. And, of course, incentives themselves can be flexible or not, depending on how closely linked they are to expected outcomes and how rigorously they are enforced.

PROFESSIONALISM

Professionals are expected to exercise their judgment on behalf of individuals or organizations. Their judgment, based on rigorous, esoteric study, and experience,[22] is expected to benefit the individual or organization with which the professional is associated, and also society as a whole. Engineers are expected to prioritize safety in the design of new products so that we, as members of society, can purchase and use these new products without undue fear. Physicians, lawyers, and priests are expected to have relationships with their patients, clients, and penitents that are based on trust, so that we, as a society, can believe that the sick, the legally challenged, and the sinner can find a safe haven where the individual's interests are ascertained, respected, and advocated through the judgment and the activities of the professional.

To practice the profession for which they have been trained, physicians will constitute themselves as, or associate themselves with, an organization that is in the business of delivering healthcare. Such an organization can be a sole practice, a partnership, or a clinic of several physicians; a healthcare organization; a research organization; a multi-practice clinic; or other entity, including government service or research institutions.[23] That organization will have goals, practices, and outcomes. Organizations that are constituted to facilitate the practice of medicine are not identical with the person of the practitioner. Practitioners are bound by the codes of the profession, but the organizations that physicians constitute or join as the context and the medium of their practice are the means through which physicians exercise their professional expertise in the service of patients. Organizations are "medical providers" or professional agents, but they are so in a secondary or derivative way, by association with professionals.

Healthcare organizations themselves do not have a "professional ethic," but, since they are organizations of and for professional practice, they should be structured in a way that facilitates rather than impedes professional practice. Thus, practitioners must be conscious of, and scrutinize, the extent to which their sites of practice, healthcare organizations, will be appropriate means for the exer-

cise of their profession—an efficient and effective means—one that facilitates the exercise of their professional obligations without presenting obstacles to ethical practice.

WHY AND HOW DO THREATS TO INDIVIDUAL PROFESSIONALISM EMERGE?

In this context, threats to the professional judgment of an individual emerge because the outcomes that are associated with professional judgment are deemed undesirable from the perspective of some individual or organization who is affected by it. Either they are undesirable in themselves or they may conflict with other desirable outcomes or organizational goals. Threats can emerge from both the internal and external environment, and they can take the form of either a business practice or an incentive (which has, as we have said, is another form of a business practice.) Either or both can be associated with either the external or internal environment.

The larger society has been conflicted about the rising costs of healthcare in the United States, while it has been generally satisfied with the level of care available. In the late 1990s, a period now being called the "era of managed care," various business practices that were associated with reimbursement were introduced by payer organizations, on the assumption that the costs of care could be controlled without reducing the quality of care. Various restrictions and incentives were introduced in hopes of altering physicians' behavior. Some produced undesirable results because they attempted to externally constrain physicians' judgment.[24]

But professional judgment is perhaps the most important service offered by healthcare organizations. Because professional judgment depends on a number of different factors, some of which may be outside the organization's control, supporting it requires flexible business practices. If business practices are inappropriately rigid, such that professionals' judgment is constrained, inhibited, or influenced, these business practices can be seen as a threat to professionalism. In the above example, a tightly controlled quality technique, when applied in an emergency room setting, might be a threat to professionalism if rules are substituted when professional judgment is required. Other threats to professionalism can emerge through the use of incentives.

All incentives appeal to individuals' self-interest, and many incentives are quite straightforward. Individuals are rewarded by enhancing their performance within prescribed parameters. Enhancing individuals' performance is linked with enhancing an organization's performance. So there is a direct relationship between individuals' goals and the organization's goals. But because of some anomalies of healthcare (particularly the fact that the consumer of healthcare goods and services is not generally the payer),[25] excellent professional judgment may produce undesirable organizational outcomes: costs that are associated with preserving professional judgment may be perceived as excessive. Moreover, because healthcare systems include these kinds of anomalies, more than one stakeholder generally has a stake in the outcomes of professional judgment. Therefore, incentives in healthcare that are designed to affect professional judgment are more complex than they might be otherwise. Supporting professional judgment might mean increasing the likelihood of additional organizational costs. Thus, incentives may be designed that pose a conflict of interest or commitment for the professional—who is perceived to be the gateway to the costs incurred by the healthcare system and its components, and also the gateway to the profits to be made.

A *conflict of interest* refers to situations in which one's professional judgment or professional code is in conflict with other demands or influences that, if acted upon, would compromise professional judgment. An organizational demand that questions one's pro-

fessional judgment or conflicts with a professional code creates the potential for one such type of conflict.

Conflicts of interest occur in every part of life, as various roles conflict with other roles, when professional integrity is at question, when there are professional biases concerning judgment, or when demands for financial rewards, cost-cutting, or greater efficiency challenge one's professional decision making. Having a conflict of interest itself, however, is not necessarily unethical. It is only when one acts on a conflict in ways that break acceptable rules for sound professional decisions, that jeopardize professional judgment, or that cause harm, that the conflict raises ethical issues.

Conflicts of interest are usually distinguished from conflicts of commitment, although they often overlap. According to Werhane and Doering, "Conflicts of commitment are those sets of role expectations where competing obligations prevent honoring both commitments or honoring them both adequately."

All physicians face the possibility that the demands of care of one patient will threaten the care of the other patients for whom they are responsible. The profession of medicine itself incorporates care of the patient and advancement of medical science as possibly competing commitments. As a professional with limited time and resources and a variety of professional demands, physicians are often faced with conflicting demands of their profession that are impossible to honor simultaneously. Conflicts of commitment also arise as role conflicts. In a complex society, each of us has a number of roles, and inevitably they clash. One simply cannot honor all one's commitments as a parent, spouse, citizen, professional, manager, and employee satisfactorily, all of the time. Unlike conflicts of internet, one can neither avoid the existence of conflicts of commitment nor avoid acting on those conflicts unless one simply abrogates all one's duties altogether. In all cases, however, the ability of professionals to ignore the conflict and base decisions purely on professional judgment depends on the amount of flexibility and the strength of incentives built into these practices.[26] But if outcomes are not expected to be affected by the conflicts raised—and if enough flexibility allows professionals to ignore them and if incentives are diluted so that they are ineffective—why go to the time and trouble of creating them?

Organizations too face conflicts of interest and conflicts of commitment. One of the criticisms most frequently made of for-profit managed care is that the obligation to serve the patient, constitutive, and definitory of the social institution of healthcare, is in possible conflict with the need to make profits for shareholders. As the conversion of previously philanthropic foundations to for-profit healthcare institutions in the U.S. accelerates, the discussion grows more heated. What is not questioned is the requirement of fiscal responsibility: any healthcare institution must remain economically viable to fulfill its mission of delivering healthcare to the individuals and population for which it undertakes responsibility. The strategies, systems, or processes it uses to maintain that viability—in changing circumstances—present a shifting array of moral questions to committed practitioners.

EVALUATING BUSINESS PRACTICES, GOALS, AND OUTCOMES

Before individual physicians can commit to the ethical principles that pertain to business practices, they should evaluate the suitability of those principles for their practices, from the perspective of the goals of their organization, the priority of these goals, the design of their practice, and whether or not the design of the practice produces ethically acceptable outcomes. Therefore, physicians must have standards that can be used for purposes of evaluation. For this, physicians have traditionally looked to the standards that are associated with professionalism.

The traditional professional ethics of medicine has defined the duties of its practitioners in relation to activities that advance the best interest of the individual patient, within the context of a relationship based on mutual respect and trust. If we assume that the best interests of patients lies in the ability of physicians to exercise their professional judgment to deliver adequate care to patients, then business practices that prevent the exercise of professional judgment or inhibit it can be perceived as a threat to the professionalism of physicians—which we cannot ask physicians to support. But if the goal of physicians is to deliver care that is cost-effective, then we have added a new dimension to the concept of professionalism and to the professional obligations of physicians and hence to the evaluation of a business practice, its goals, and outcomes. It may be that when the provision of cost-effective care conflicts with the traditional obligations of physicians some decisions should be made on the basis of cost-effectiveness.

Quality care (or at least adequate care) and cost-effectiveness are goals endorsed by society as ethically appropriate—with one caveat. Society deems the quality of care, which must include some aspects of professionalism, as more important then the cost of care. It views a reprioritization of these goals as ethically unacceptable.

But we know from our discussion of business practices that goals, the business practices that support them, and the outcomes they produce, may not reflect ethically desirable characteristics. We know from our discussion of the design of business practices that accommodating professionalism will require some degree of flexibility, and we know that flexibility cannot guarantee the achievement of specific goals. We also know that flexibility may invite interactions (business practices) from other components of the system that may not share the same goals or may prioritize them differently. How do we prevent these goals from becoming reprioritized or distorted? How do we align business practices with outcomes so they reflect ethically desirable characteristics? Will expanding the obligations of physicians to consider cost-effective care be enough to ensure that they are able to deliver quality care at optimal value?

A SYSTEMS ETHIC?

The ACGME's fifth competency emphasizes the individual physician's responsibility for professional practice, and the sixth competency contextualizes this responsibility to the various organizations and practice options that constitute the larger healthcare system. Since most, if not all, medical practice occurs within some organizational context, individuals must be alert to possible conflicts of interest and commitment that can arise because of the plurality of goals that any organization must have in order to survive. But because of the fragmentation of the healthcare system as currently constituted, it is possible that individual responsibility alone will be inadequate to prevent or avoid professionally undesirable outcomes.

Elsewhere we have advocated the formation of an organization ethics program that, at least at the mid-level of the system—the organizational level—might be helpful as a mechanism of intervention when a practitioner perceives the threat of inappropriate reprioritization or distortion of the goal of care of optimal value.[27] We have suggested that it is important that any healthcare organization's business practices should be aligned with its essential values and goals, and that conflict be resolved by appeal to those goals and values. The healthcare organization exists to provide care, and since care of high quality must reflect some degree of professionalism, there is no necessary or intrinsic conflict between the professional responsibilities of the individual physician and the organizations within which he or she practices. However, we also know that the business practices of the various components of the system interact to-

gether in ways that might reprioritize or distort these goals. If we want to achieve the goal of quality care of optimal value, if we want business practices to support professionalism, and if we want to achieve appropriate outcomes, then we must start at the system level. This will require that the system, as a whole, commits to the same goal, as well as to principles that govern the way in which business practices interact and the outcomes they produce. Even then, this might not be enough to ensure the system achieves the results we want.

Supporting professionalism requires flexibility in business practices. The system as a whole must have the ability to react to unforeseen events, to negotiate when appropriate, and to problem solve in a creative way. But flexibility in business practices, although a precondition for professionalism, cannot guarantee appropriate outcomes, nor can it guarantee that the practices themselves will not change. Therefore, even when the delivery system and all of its components commit to the same goal and to the same principles, its outcomes and its practices must be continuously reevaluated.

A persuasive argument could be made that implementing a code that governs the goals, interactions, and outcomes of a system, and a mechanism that monitors its implementation in delivery of healthcare services, system is desirable both because it opens the door to increased efficiency and effectiveness and because it is the right thing to do. However, this is unlikely in the short-term. In the short-term, systems will remain fragmented and open to abuses.

CONCLUSION

The fifth and sixth competencies of the ACGME Outcomes Project combine to enlarge the professional obligations of residents (and by extension, all physicians) to greater consideration of costs in the delivery of care. That obligation may be enough to deliver some kind of care of optimal value, but it does not guarantee the preservation of professionalism as it has been traditionally understood. It may put residents in an untenable position relative to their patients. It may also further undermine the trust and respect that we as a society have for our physicians.

Quality in healthcare requires the provision of professional care, and this requires the ability of a system's professionals to exercise their judgment. Compromising that judgment through badly designed business practices or inappropriate financial incentives will not produce the results we want, if they compromise the patient-centered ethos that is central to good medical practice. The challenge to professionals, to the organizations with which they are associated, and to industry leaders, is to design business practices that are capable of achieving cost-control goals while still standing the test of being evaluated against professional standards. This will require an integrated perspective that recognizes the legitimacy of organizational cost-control goals while it simultaneously gives priority to the quality goals of the practice or the healthcare organization.

The development of an integrated ethics for a healthcare system, as a whole, is a daunting task. In the short-term we can ask professionals to be aware of and to scrutinize an institution's goals, business practices, and outcomes for their effect on professionalism. We can endeavor to teach residents the importance of personal and professional integrity and can call their attention to the intricacies of the wider delivery system. We can urge attention to organization ethics for help in resolving issues that healthcare organization can control. These are the first steps toward the development of a successful delivery system. This, however, will not be enough for the future, unless the system as a whole is explicitly committed to these same principles. The alignment of values of individual and organizational agents, at all levels of a system, is the task to which leaders in medicine are com-

mitted. The ACGME competency standards on professionalism that require individual physicians to commit to the principles of medical ethics while they simultaneously commit to the ethical principles of business practices, represents a step toward developing such an integrated perspective among physicians.

NOTES

1. See *http://www.acgme.org/Outcome/* and retrieve the competencies under "Project Outcomes."

2. Most business practices can be investigated as systems. A "system" has been defined as "a complex of interacting components together with the relationships among them that permit the identification of a boundary-maintaining entity or process." See A. Laszlo and S. Krippner, "Systems Theories: Their Origins, Foundations and Development," in *Systems Theories and a Priori Aspects of Perception,* ed. J. Scott (Amsterdam, the Netherlands: Elsevier, 1988), 51.

Systems are connected in ways that enhance the fulfillment of one or more goals or purposes. Systems may be micro (small, self-contained, with few interconnections) or macro (large, complex, consisting of a large number of interconnections and purposes). A system may be rigid and function mechanically, or it may be what Paul Plsek calls an "adaptive system," because it consists of individuals and organizations that have the liberty to interact with, respond to, and change the system. See P. Plsek, "Redesigning Health Care with Insights from the Science of Complex Adaptive Systems," in *Crossing the Quality Chasm: A New Health System for the 21st Century,* (Washington D.C.: National Academy Press, 2001), 310-33.

3. E.M. Spencer et al., *Organization Ethics in Healthcare* (New York: Oxford University Press, 2000) chap. 12, pp. 200-10.

4. See *http://www.corpwatch.org/article.php?list=type&type=108* for a definition of sweatshops and a list of articles detailing recent cases.

5. See *http://cc.msnscache.com/cache.aspx?q=81476974579&lang=en-US&FORM=CVRE7* for the infamous Ford Pinto memo in which costs to repair the back end of the Pinto were compared against anticipated deaths. See also G.T. Schwartz, "The Myth of the Ford Pinto Case," *Rutgers Law Review* 43 (1991): 1013.

6. Arthur Andersen's role in the collapse of Enron is especially notorious. For example see J.D. Glater, "Last Task at Andersen: Turning Out the Lights," *New York Times,* 30 August 2002 .

7. H.S. Berliner and E. Ginzberg, "Why This Hospital Nursing Shortage Is Different," *Journal of the American Medical Association* 288 (2002): 2742-4. See also S. Veasey et al., "Sleep Loss and Fatigue in Residency Training: A Reappraisal," *Journal of the American Medical Association,* 288 (2002): 1116-24.

8. S. Rosenbaum, "The Impact of United States Law on Medicine as a Profession," *Journal of the American Medical Association* 289 (2003): 1546-56.

9. R. Voelker, "Eradication Efforts Need Needle-Free Deliver," *Journal of the American Medical Association* 281 (1999):1879-81.

10. L.E. Singer, "The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status," 23 *American Journal of Law and Medicine* 23 (1997): 221.

11. L.R. Burns et al., "Business of Health Care; The Fall of the House of AHERF: The Allegheny Bankruptcy; A chronicle of the hows and whys of the nation's largest nonprofit health care failure," *Health Affairs* (January -February, 2000).

12. J.M. Kellhofer, "American Pluralistic System: Mergers between Catholic and Non-Catholic Healthcare Systems," 16 *Journal of Law and Health* 103 (2001/2002), available at LexisNexis.

13. L.B. Andrews, Biotechnology Symposium: The Gene Patent Dilemma: Balancing Commercial Incentives with Health Needs,"

Houston Journal of Health Law & Policy 65 (2002). See also J. Paradise, "European Opposition to Exclusive Control Over Predictive Breast Cancer Testing and the Inherent Implication for U.S. Patent Law and Public Policy: A Case Study of the Myriad Genetics' BRCA Patent Controversy," *Food and Drug Law Journal* 59 133 (2004): 133. See also S. Gad et al., "Identification of a Large Rearrangement of the BRCA1 Gene Using Colour Bar Code on Combined DNA in an American Breast/Ovarian Cancer Family Previously Studied by Direct Sequencing," *Journal of Medicine and Genetics* (2001): 3888.

14. The idea that quality in the production of goods and services is paramount is the basis for the whole "quality" movement. The central idea is that if producers consistently examined their processes then costs would fall as quality rose. See W.E. Deming, "Improvement of Quality and Productivity Through Action by Management," *National Productivity Review* 1, no. 1 (Winter 1981-1982): 12-22. Also see R.W. Grant, R. Shani, and R. Krishnan, "TQM's Challenge to Management Theory and Practice," *Sloan Management Review* 35, no. 2 (1994): 25-35.

15. M.K. Wynia et al., "Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place," *Journal of the American Medical Association* 238 (April 2000); 1858-65.

16. See Jerome P. Kassirer, *On the Take: How Medicine's Complicity with Big Business Can endanger your Health* (New York: Oxford University Press, 2005), for a description of this and many other business practices that are designed to influence physicians' judgement.

17. Plesk, see note 3 above, pp. 310-33.

18. A.E. Mills and E.M. Spencer, "Evidence Based Medicine: Why Clinical Ethicists Should be Concerned," *HEC Forum* 15, no. 3 (Fall 2003): 231-44.

19. Plesk, see note 3 above.

20. E.M. Spencer et al., *Organization Ethics in Healthcare* (New York: Oxford University Press, 2000). See chapter 5 for a discussion of professionalism, pp. 69-91.

21. J.C. Robinson, *The Corporate Practice of Medicine* (Berkeley, Calif.: University of California Press, 1999).

22. J.C. Robinson "The End of Managed Care," *Journal of American Medical Association* 285 (2001)): 2622-8.

23. This anomaly of the healthcare system was noted in 1995 by E. Haavi Morreim, who writes, "in this sense the term purchaser is systematically ambiguous; we could be referring either to patients or to payers." See E.H. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics* (Washington DC: Georgetown Press, 1995), 22.

24. P. Werhane and J. Doering, "Conflicts of Interest and Conflicts of Commitment," *Professional Ethics* 4 (1005): 47-82.

25. Spencer et al., see note 20 above, pp. 73-8.

26. Ibid.

27. Ibid.