The Third Face of Medicine: Ethics and Business

Mary V. Rorty

Introduction:

In this paper I focus on one aspect of biomedicine, health care delivery, and some recent changes in how it is done which are brought to the fore when we talk about the 'business' of medicine. I use the title of this conference to call attention to several paradigm shifts in the way medicine has been regarded—or at least, described—in the several centuries of its recorded history, looking most carefully at the most recent shift of paradigm between last century and this.

I point to some dangers of the new rhetoric of medicine as business, and some of its advantages. I ask how medicine is addressing the changes in the ways in which healthcare is delivered, and whether those changes require a change in the traditional ethics of medicine. In conclusion I return to the title of the conference, and ask whether 'ethics' and 'business' are enemies or allies as medicine faces the 21st century.

I: Context: Changes in the form of care delivery

The context in which health care is delivered in the United States is changing, and the direction is toward greater integration. The number of physicians practicing alone or with one partner has declined from 89% in 1965 to 66% in 1995, with increasing numbers in either larger practices or practicing within larger organizations. The number of medical interventions available to physicians that require expensive technologies, institutional resources or in-patient care rises with innovations and advances in medical science and technology. Even death, to say nothing of improved health in life, occurs with increasing frequency in institutional settings: 80% of deaths in America occur in some health care institution. An eminent health economist has dubbed this transition 'the corporatization' of medicine.[1]

If we go back further and contrast medical practice at the end of the last century with medical practice at the beginning of that century, the tendency is even more readily visible. The physician of the early part of the century was a small businessman; he was in individual practice in an office, access to which defined his patients. He may have visited some of those who sought his services in their homes. Compared to those available to his counterpart a hundred years later, the number of interventions he was able to offer his ill or disabled patients was limited. His primary relationships were dyadic patient/physician encounters, and his interactions with his patients, his local hospital, the nurse that assisted him in his office, were all direct relations very much under his own control. He determined the cost of his services, and collected the fees himself. He had a very strong say in the operation of the hospital. "Hospitals were doctors' institutions, and

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[1] The examples cited in this section are instances of a trend well chronicled by several authors, including Paul Starr, *The Social Transformation of American* Medicine (1982) and James C. Robinson's excellent 1999 book, *The Corporate Practice of Medicine* (University of California Press). The statistics cited are from P.L. Havliceck's 1996 AMA survey of Practice Characteristics. The citation of number of deaths that occur in institutions I don't have a cite for; for all I know it's urban legend, but it is probably one of the most cited urban legends in all the medical literature.

the hospital was seen as a normal extension of the realm of influence and responsibility of the physician."[2]

Compare his situation with that of the physician of the 21st century. Professional activity, especially if s/he practices a medical specialty, requires coordination with other physicians, may take place in a clinic or hospital with shared access to up-to-date technology, which enables interventions of greater complexity (and at best, with greatly improved results) than were possible to his predecessors. To practice in a hospital means 'team' medicine: working with the nurses, consultants from other specialties, chaplains, social workers, therapeutic specialists and unit directors, coordinating care. And very importantly, many of the physician's relations are mediated, rather than direct. The agents of mediation are various. Insurers or the government are co-determinants of reimbursement. The health care organization may limit through its formulary what pharmaceuticals are available for in-patient treatment. A physician in a large practice or in a clinic may have less individual discretion about his panel of patients or use of his time. And for those physicians who are involved with Managed Care Organizations, a large and growing number, there are more limitations on the range of decisions for which any given physician has sole authority.

'OLD' medicine	'NEW' medicine
Individual	Team
Home/office	clinic/hospital
Small business	corporate
Limited clientele	populations
--my practice	--encashment area
minimal intervention	maximum intervention
atomistic/ dyadic	organic
direct	mediated
--professional	--third party payers
	--government
	--MCOs

In his introduction to his 1999 book, *The Corporate Practice of Medicine*, Berkeley health economist James Robinson remarks that "in the waning decades of the twentieth century…the basic structures of the health care system began to lose their uniqueness and came to resemble those in the mainstream of the economy."[3] Referring to the acceleration of some of the differences between the 'old' and the 'new' medicine that I sketched briefly above, he comments "…[S]uddenly in the 1990s the storm of change broke upon the profession, sweeping away the illusion of continuity [with solo

[2] Spencer et al, 2000, *Organization Ethics in Health Care,* 102. Chapters 6 and 7 of that book tell this story in greater detail, as does Starr's 1982 book, *The Social Transformation of American Medicine*.
[3] Robinson 1999 p. 1

practice and fee-for-service payment] along with unquestioned clinical autonomy, unconstrained practice income, and unparalleled cultural authority."[4]

II: Rhetoric and the three faces of medicine

If the context of medical practice is changing, the language we use to talk about it is also changing. For most of its history medicine was an ART, a craft or trade like stained glass or carpentry, practiced by members of an often-hereditary guild and operating within a tradition of ethics, the Hippocratic tradition.[5]

As advances in science and in technology combined to make it possible for the practitioners of this art to gradually address widening areas of the human condition, it became more popular, in the beginning of the last century, to start speaking of the SCIENCE of medicine. The "art" aspect did not disappear, but medicine began to be considered an art AND a science. This appreciation of increasing knowledge of human health and disease was noted and encouraged by the Flexner reports in the early 20th century, and the 'scientization' of medicine, if we can be excused for calling it that, was accompanied by a professionalization as well, as the 'guild' and 'craft' aspects of medicine were replaced by demands for licensure, credentialing, consistent medical education and many of the professional precursors of medicine as we know it today. The professional ethics of the art and science of medicine kept many of its Hippocratic associations and ties to the older tradition. But it also accommodated to the changes of environment, capacities and requirements.[6]

The Janus-face of medicine:

I think of the transformation of image or model or association that took place at the beginning of the last century in terms of an image drawn from Roman coinage: the image of Janus, god of the doorways.

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[4] Ibid., p. 2.

[5] One of the histories I looked at—Douglas Guthrie's *Janus in the Doorway*, (Charles Thomas, 1963) traced it back to magicians, then to priests, and eventually to philosophers—a pleasing conceit. Hippocrates and Galen are counted among the philosophers. Steven H. Miles' 2004 book, *The Hippocratic Oath and the Ethics of Medicine,* is the most recent in a series of thoughtful evaluations of the Hippocratic tradition.

[6] To be fair, I must admit that the perception of medicine as a science dates to its earliest recorded history. The text from the Hippocratic corpus quoted on the slide accompanying this text speaks of the "science"of medicine in its next sentence. I'm not sure what greek word is translated as "science" by Lloyd , but most histories agree that however limited the range of treatments available to them, most early practitioners thought of themselves as commanding a specialized area of knowledge.

The two faces on this Roman coin look to the past and to the future. For the physician of the 20th century, the two faces represent two values or objectives for which the physician is responsible: the traditional value of the well being of the present individual patient, and the forward looking value of the advancement of medical science, for the sake of the future patients.

The professional ethics of medicine is clear about the priority of the two values, of course, and most physicians manage to construct lives of professional integrity that balance these two faces of medicine—but the Janus image reminds us of the potential conflict of commitment between these two values—and recalls cases where this potential gradually became an actual conflict. In the late 20th century one physician called the attention of the wider public to research abuses by his professional colleagues when the drive to advance medical science led to inadequate regard for the welfare of the patients who were the subjects of medical research.[7] This audience of course recognizes the reference to Beecher's bombshell, his 1966 Article in the NEJM, "Ethics and clinical research," calling attention to research abuses in 22 contemporary articles in medical journals—an article which is frequently cited in connection with the so-called 'birth of bioethics' in the 1960s and '70s.

It seems clear that the shift in the image or model of medicine as it added a scientific obligation to its humanistic image laid the foundation for the ethical dislocations of mid-century medicine, a *fata moragana*, the temptress of medical

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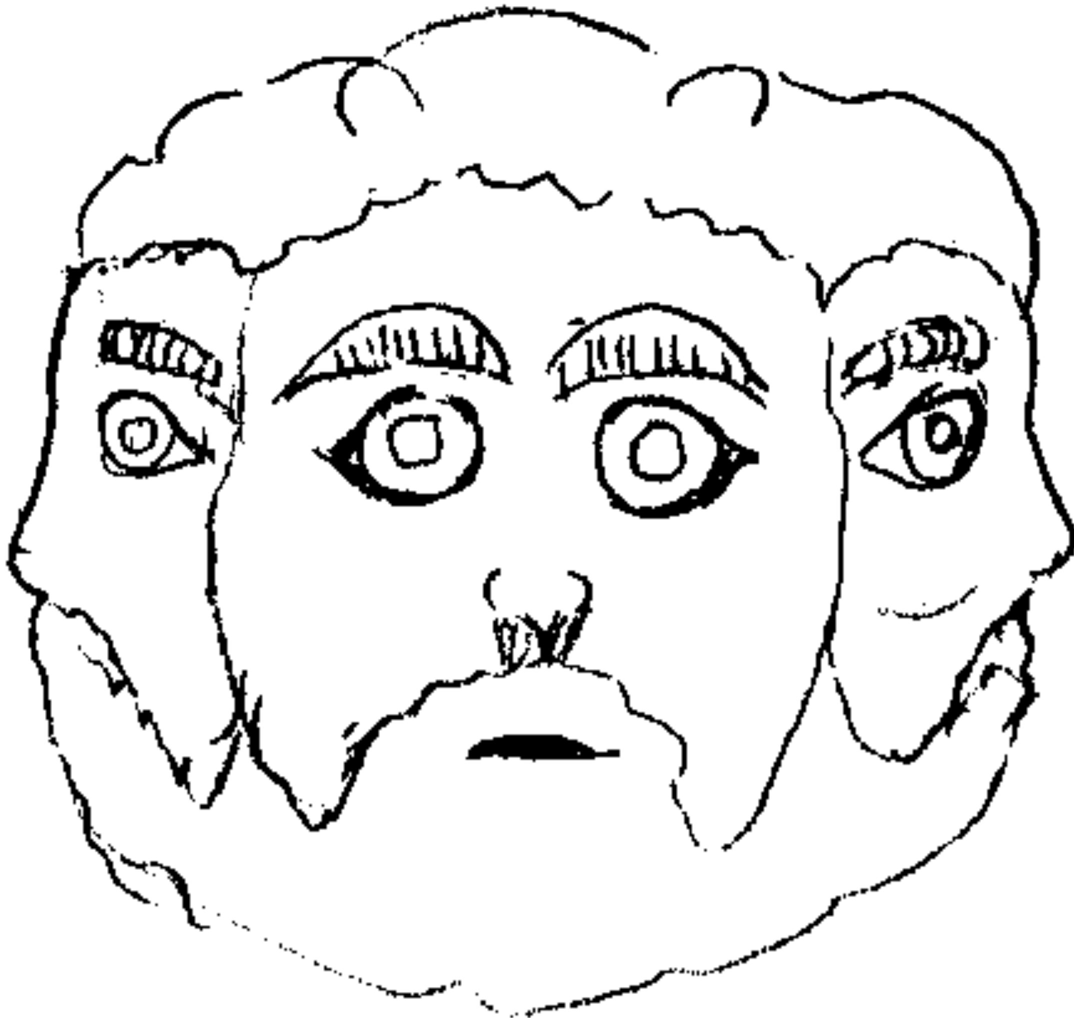
[7] Henry Beecher (1966) Ethics and Clinical Research, *NEJM* cited in Jonsen, *Birth of Bioethics*, pp 144.

progress, leading some of the finest medical minds of their generation into ethically problematic behavior—behavior toward the people in their care that transgressed their own professional ethics. Bioethics, but even more, concentration on and regulation around research ethics, represent ethical counterweights to bring the practice and the profession back into balance.

The third face of medicine:

By the end of the last century another image or model or association with medicine was becoming obvious—in the literature and in the lives of practicing physicians. Medicine is adding a THIRD face: and that is the association illustrated by the title of this conference: medicine as BUSINESS. Medicine is now an art, a science, **and** a business. The third face that is being added to medicine is an explicit responsibility for the COST of medicine, an obligation to be responsible custodians of the resources of the society.



> The three faces of this Gaulish jar represent art, science, and business.[8]
> The three associated responsibilities: the welfare of the individual patient; the advancement of medical science, and responsible stewardship of social resources

To add a third face to our image of medicine is to add another possible area for conflicts of interest and commitment. It does not seem unreasonable to expect medicine to deliver care of high quality for a reasonable cost. But when financial considerations are incorporated into our understanding of the ethical obligations of the profession, it raises the possibility of ethical dislocations comparable to those that led to professional scandals toward the end of the last century.

The changes in the conditions of practice of medicine discussed above are not enough on their own to explain the greater prevalence in media and the public consciousness of the rhetoric, the metaphors and models of business. The failure of the Clinton health reform and the subsequent influx into health care delivery of for-profit corporations, media discussions of the percentage of the gross national product that goes to health care, demands for cost constraint (not only by for profit corporations with an eye to their profits, but also by the government, the payer of about 45% of the costs of health care in the US), and awareness of the rising costs associated with improved but often very expensive technologies, all bring business and market exchanges inevitably to mind.

Medicine in our new century, then, is dealing with rapid and recent changes in conditions of practice, and has as one of its tools and obstacles a new rhetoric that suggests new commitments and obligations, as well as new hurdles.

III: Implications: Five uses (and abuses) of the new rhetoric of medicine

1. *Talking about the business of medicine reminds us that medicine is a business.*

Medicine is a business, and has always been a business.[9] One does not need to deny the financial aspect of any service in order to make clear that some businesses are different than others. One of the differences between the old medicine and the new is the change of model of what kind of business it is, from that of the small businessman or craftsman to a more corporate model, and a more mediated, less direct one—where the physician has less control over all aspects of care delivery.

The term ‘business’ does have a neutral, **descriptive** sense: A business is a *system of production that satisfies needs*. My business (according to dictionary.com) is my specific occupation or pursuit, the occupation, work or trade in which I am engaged. A profession, which is what we think of medicine as being, is one subset of business, a special kind of occupation with specific requirements, including its own internal ethic.

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[8] Images of three-faced gods are hard to find. This image of a ‘gaulish jar,’ like the preceding image of a roman coin featuring Janus, was copied from google images. I hope I have not breached any copyright laws by reproducing them here.

[9] G.D. Lundberg, 1997, The business and professionalism of medicine, *JAMA 278* (20) 1704. One has only to read the sentence to realize that of course that is true. But at the same time its obviousness only became clear in a certain historical moment, when professionals had to distinguish between the honorific, pejorative and descriptive senses of that term.

Of course there is a **pejorative** sense of the term 'business' as well, carrying associations I would like to bracket while we explore some of the implications of this new way of talking about medicine. Those pejorative associations are most vividly illustrated by the character of Smallweed in the film version of Charles Dickens' *Bleak House* on PBS recently. Phil Davis did a superb job of creating a truly appalling character—"an old evil moneylender, entirely consumed by selfishness and greed," as he is described on the BBC website--whose most frequently repeated line is "I'm a businessman!"[10]

I'd like to think that we can acknowledge our compunctions about some of the 'business practices' associated with recent changes in reimbursement for HC in the US today—and still accept the premise of the conference, that medicine is a business—(1) that it costs money; that it is (2) a process of production (3) that provides a (sometimes costly) service, (4) that fills an important social need, and (5) must be financially sustainable.

Why medicine is a business:
• It is a financial exchange and investment of resources • It is a process of production • It provides a (sometimes costly) service • It fills an important social need • It must be financially sustainable

2. *Talking about medicine as a business can be reductionistic of medicine.*

Medicine is not just any business, but is a business which is a profession. Societies assume some responsibility for the health of their members, and the profession of medicine has traditionally served as the designated agent of that responsibility. Professions hold to a specific code of ethics, and members are almost universally required to swear some form of oath to uphold those ethics, therefore "professing" to a higher standard of accountability. To ignore the Hippocratic tradition in medicine and consider it only a business would be inadequate to some of the central elements and values of medicine, both as an individual enterprise (where the physician/ patient relationship has a special status) and as a socially supported activity in the public interest. In international documents, access to a basic level of health care is often included as a human right.

Talking about medicine as a business does not and should not mean excluding or compartmentalizing ethics. Businesses have ethical responsibilities as well, as the growth and phenomenal success of our sister applied-ethics, business ethics, shows. To

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[10] This description of Smallweed is taken directly from the PBS website advertising the series. I did my best to copy the image of Phil Davis' Smallweed as well, figuring it would make a fabulous slide, but my computer savvy wasn't up to the task.

assume that businesses have only financial responsibilities distorts the social role of business and does an injustice to many visionary business leaders.

Example: *Managed Care*. Looking only at the financial aspect of health care delivery has been disastrous to some of the early entrants from other social sectors into the health care arena. Students of the literature on managed care know that the assumption of some managed care organizations that they were responsible for cost containment regardless of its impact on access to care and quality of care led to public outcry, professional outrage and regulatory response. This blindness to the ethical implications of the social context in which they were beginning to operate was very disruptive to medical practice, and self-destructive as well.

3. *Emphasizing the commonality between medicine and other social institutions makes accessible to medicine some of the methods and technologies developed in those sectors.*

As we start thinking of medicine and healthcare delivery using the language and rhetoric of business, we can better recognize its commonality with and integration into the rest of society. One effect of the 'corporatization' of medicine is to make accessible to medicine many techniques, strategies and innovations developed in other institutional sectors that can improve health care delivery.

Example: One example of fruitful exchange with other sectors has been the growth of **organization ethics**. Expanding considerations of ethics in medicine beyond the level of the individual practitioners has been necessary because of the increasingly important role organizations play in contemporary health care delivery. The development of organizations ethics as an intersection of professional, clinical and business ethics is both an example of widening the context to take account of the increasingly collaborative nature of health care, and an occasion to draw on some of the insights and resources of business ethics.

Example: Another important exchange has been the incorporation of mechanisms of **quality improvement** from other industries—including some production industries. A detailed discussion of the impact of new "quality "movements in health care is a subject for another entirely different paper (some of which has been addressed in work with my collaborators Ann Mills and Patricia Werhane[11]). Let me only briefly note here that those importations have been varyingly successful. If quality improvement is a compartmentalized effort, addressing process improvement at the cost of attention to outcomes, it has only a temporary effect. Some of the Six Sigma or TQI/TQM imports have failed to thrive, while others—benchmarking (as described by Daniels and Light), best practices (cf. Sabin and Emmanuel, *No Margin, No Mission*) or balanced scorecard (J. Meliones, 2000) have taken a wider perspective and been more successful.[12]

To be fair, we have seen much more in the literature lately of more attention to outcomes (instead of just processes), and to quality models which, even though they may occasionally derive from the latest 'management fad of the week,' often incorporate more global attention to the variety of factors that can contribute to improving quality of care. In the literature, at least, there is more of a tendency to factor in as quality measures

[11] Cf. eg. Mills and Rorty (2002) "TQM and the Vanishing Patient," *Business Ethics Quarterly 12*(4) 481-504.

[12] Norman Daniels, Donald W. Light and Ronald Caplan, *Benchmarks of Fairness for Healthcare Reform* (1996); James Sabin and Ezekiel Emmanuel, *No Margin, No Mission* (2003).

considerations of patient satisfaction and empirical data on outcomes. The managed care organizations that assumed they were responsible only for costs, and that they could cut them without consideration for the impact of their mechanisms on quality of care have been driven out of business or have gradually retreated from intervention into treatment decisions and are restricting their activities more to insurance. Models of compartmentalization and mechanization are being replaced by models of contextualization, integration and organicism.

Although medicine has an ethical obligation to deliver care of the highest quality, there is still work to be done on the integration of the languages of ethics and quality improvement. Too often the two functions are still compartmentalized within institutions, and we still see verbal duels between management and clinicians in hospitals: "When she talks about 'improving quality' I reach for my professional ethics."[13]

4. *Describing medicine as a business suggests some misleading commonalities between medical exchanges and market exchanges*

The traditional relationship between a person who provides a service and the person who receives it is in many businesses described as "customer service," and many of us have watched with horror as this rhetoric seeps into health care. This market model is a problem when applied to healthcare because of the inappropriateness of the traditional model of "customer."

If you are the customer in a paradigmatic market exchange, you are both payer and consumer. You can choose between lots of lower quality ball bearings or a smaller number of higher quality ball bearings for the same cost. Your supplier can beat out competitors by either lowering the price or improving the quality of the goods he offers for that price. You as an informed buyer can judge both cost and quality, and can freely order your priorities between them. Competition of this sort is the ideal market model.

This market model does not work in healthcare because the payer is not identical with the consumer of healthcare services. The literature on healthcare is littered with the term "customer," but you have to read really carefully to figure out who the customer is in a given context. There is no single "customer" who can balance cost and quality, and can take responsibility for that choice. The buyer is the **payer**, the employer or government agency, who contracts with the HCO or MCO to deliver care to enrollees, and thus is "customer" of the MCO, if the person who gives you money for a product or service (eg a ball bearing) is your customer. But it is the patient, the enrollee (or that subset of the enrollees who actually gets sick) who is the **consumer**. The market model is structurally inadequate to accommodate this bifurcation of the healthcare "customer."[14]

Because of these associations, to focus on the 'business' aspects of medical practice runs the risk of shoving medicine out of one box, and into another, where patients are analogized with customers, or viewed as 'consumers' of health care as a

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[13] One of my too-long postponed projects is to develop a Rosetta Stone for organization ethics which states the same institutional and practice objectives in each of the two different languages of quality and ethics.

[14] I was really pleased with myself for seeing this problem with the market model. But it turns out the same point was made much more elegantly and clearly in 1995 by Haavi Morreim (*Balancing Act: The New Medical Ethics of Medicine's New Economics,* p. 22.) She uses the term "purchaser" instead of "customer" to make the same point.

product. We need to think about contemporary medical practice in a way that acknowledges some of the business aspects of medicine without thereby implying that seeking medical care is a free choice, an optional and entirely voluntary transaction comparable to choosing between a latte and a cappuchino (when you aren't that thirsty anyway).

***5.** Talking about health care in the language of business reminds us that costs matter.*

Many of us long for some version of a national health plan that will address more equitably access to care and just distribution of health care resources. Until that day, we are left with a health care system in which cost matters and economic differences are reflected in differences in health care and health outcomes.

This fifth point returns us to consider again the 'third face' of 21st century medicine, the recent changes in conditions of health care delivery, especially in mechanisms of reimbursement; and the associated demand that medicine be a 'responsible custodian' of health care resources. Does this demand represent a call for a 'new' ethics for the new medicine?

Talking about medicine as a business:
• Points out that medicine IS a business • Although describing it that way can be reductionistic • Encourages importing new management techniques • But suggests misleading commonalities with commerce • Reminds us that cost matters

IV: What's new: How is medicine adapting to the new circumstances?

(a) One of the challenges is countering the emphasis on cost with a balancing attention to quality. We spoke of the two sides of quality improvement technologies—the need to balance attention to processes with attention to outcomes.

One of the ways organized medicine is adapting to the altered situation of the 21st century is by adopting new 'mental models'--ways of talking about—and sometimes, new techniques of dealing with—health care delivery.

Recent publications from the Institute of Medicine acknowledge the mutual implication and interpenetration of cost and quality, and of the levels of individual encounter, organizational structure, and social expectations of the health system as a whole—and the folly and futility of hoping to solve the problems on only one level without acknowledging the effects of any change on all the other levels.

In particular, the IOM: report on quality improvement (*Crossing the Quality Chasm*,2001) introduces a useful model in its introduction (especially in the appendix by Plesik) of complexity theory and the acknowledgment that health care is a complex adaptive system—that changes or interventions at any level resonate throughout the system, often in unpredictable ways. Its recommendation is that we use organic mental models, rather than mechanical ones, in helping to understand and improve health care delivery.[15]

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[15] Cf. Mills, Rorty and Werhane (2003), Complexity and the Role of Ethics in Health Care, *Emergence*5(3) 2003, 6-21.

(b) Another area in which adaptation is taking place is in medical education. In academic medical centers medical students are allowed—encouraged—to sit in on courses in the sociology of organizations, business school courses, engineering school courses on systems analysis—as well as medical economics and policy and medical humanities.

An interesting recent phenomenon in medical education is found in the outcomes project of the ACGME. The fifth Competency on professionalism states that residents are expected to "demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and *business practices*. (my emphasis) The sixth Competency addresses systems-based practice, calling explicit attention to the 'larger context and system of healthcare,' and requires residents to demonstrate an ability to effectively call on system resources to provide care of optimal value. They are called upon to 'practice cost-effective health care and resource allocation' that does not compromise quality of care.[16]

These two accommodations have some things in common: an organic, rather than a mechanical, approach; emphasis on interrelations, not isolation; an expansive and inclusive approach, expanding, rather than narrowing, the range of focus; an approach that is adaptive, and flexible, acknowledging mutual interactions between the profession and the environment of practice, working against compartmentalization.

Does the expectation that new physicians pay attention to business practices represent a fundamental change in professional ethics?

V: A 'new ethics' for the 'new medicine'?

Changes in health care delivery are increasing the usefulness of more integrated, relational and collaborative ways of thinking about the processes and agents of health care delivery.

Physicians are wrestling with diffusions and mediations of their earlier absolute (or at least greater) control of the apparatus of healthcare delivery. The mediation of their control includes the recent entry into the health care arena of 'managed care'—intermediaries between the providers of medical care and the payers, which are themselves outside of the 'Hippocratic matrix'—with a constrained responsibility only for the costs, not the quality, of the care delivered. With cost constraint mechanisms introduced by third parties imperiling the adequacy of medical care in the US, medicine has acted to accommodate considerations of cost, on the assumption that adequate care for a reasonable cost is in the patient's best interest. Insofar as the balance between cost and quality of care is subject to professional expertise, the assumption is that some business considerations are compatible with the core value of traditional medical ethics, that the interests of the patient are paramount.

The absolute autonomy associated with the earlier history of medicine in the US may be irretrievable, but the profession has adapted quite successfully to change in the past. Furthermore, I'd like to suggest that absolute autonomy of practice is not necessary for professional ethics of the highest quality, as is shown by the sterling example of

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[16] Cf. Mills and Rorty, "Business Practices, Ethical Principles and Professionalism" *Organizational Ethics 2*(1), 2005, 30-43, reprinted in *Professionalism in Tomorrow's Healthcare System*, ed. Mills, Chen, Werhane and Wynia, Hagerstown, Md: University Publishing Group, 2005, 101-124.

nursing—a profession with as long and as admirable tradition as medicine, a profession that, certainly within the last century, has accepted as a condition of their practice some external control and has operated predominantly within the constraints of organizations.[17]

If we were to draft a new ethics for the new medicine, it should have some of the following characteristics:

The system as a whole should be justified in terms of its beneficiaries: directed toward the maintenance and improvement of the health of the recipients of care. Cottage industry, small-business or medical-industrial complex, health care is for the sake of the cared-for. Thus the emerging system should be "Hippocratic" in its dominant value, and this expectation should extend to all the participants in the arena—not just the physicians.

But physicians, however virtuous, can't be the only determinants of what that requires. This is not only because they have a history of failing at this task, but because the conditions of healthcare have changed since the physician hegemony was initially established. The physician should, and can, and will, take more responsibility for the cost component of the cost/quality ratio, not only for what they recommend but for what that recommendation will require.

Other voices, especially the hospital's voice, needs to be heard. One of the suggestions for a new way of thinking about the new medicine is that physicians and institutions are moral co-fiduciaries of patients; and that they can, and should, be economically disciplined co-fiduciaries.[L. B. McCullough 1999] This suggestion has two advantages. It acknowledges the extent to which responsibility for care has expanded past the individual physician, and it accepts the appropriateness of responsibility for cost containment at the provider level of the healthcare system.

VI: Ethics and business: enemies or allies?

At the beginning of the last century the ancient art of medicine began to accommodate itself to the opportunities and demands of the vigorous science of medicine. That accommodation seems on the whole to have been successfully navigated. Few physicians today would pronounce themselves threatened by, or be willing to renounce, what I have called the second face of medicine, medicine as science.

The goal of healthcare, the obligation of the healthcare system, is to deliver healthcare of good quality for a reasonable cost to people who need care. The ethical justification of the healthcare system has to be in terms of the health outcomes of the recipients of care, not the distribution of resources. Of course an excellent healthcare system will manage the resources of that system, the essential means to its ends, well and wisely. But resource management is a means to the ends of medicine, not a substitute for it. The distribution of resources determines health outcomes. And the distribution of resources is the consequence of business decisions. So if we justify the healthcare system in terms of its outcomes then it becomes the responsibility and obligation of everyone involved to ensure that business decisions reflect this justification.

The ACGME competencies point out the necessity for physicians to scrutinize the business practices that impact their professional practice for ethical congruence and appropriateness. But this does not mean that physicians become ONLY or mere

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[17] I'm not claiming that a strong professional identity and ethics makes it EASY to operate within organizational constraints, and the turnover in nurses and the number of people who leave the field rather than continuing practice under current conditions does not make the analogy unqualifiedly positive.

businessmen, abandoning professional responsibilities in order to internalize the demands of the cost watchers. The Institute of Medicine reports assume, with justice, that change has to happen on the system level. Unless it does happen, we end up holding responsibility for change to people who do not have the power to change. The business practices that imperil ethical care are often imposed upon the individual physician by the systems—the HCOs, the clinics and HMOs, even the physician alliances and PPOs—within which physicians practice. These organizations themselves are impacted by the requirements of the larger health care system within which they operate. The conditions of practice imposed by that larger system cannot with any justice be governed purely by 'business ethics' or business models—but must be scrutinized by all agents at all levels for professional responsibility. The entire health care system needs to be informed by a Hippocratic sensibility, a Hippocratic model. This demand represents a marriage of systems thinking with professional ethics—a systems-level ethic that like organization ethics incorporates clinical, professional and business ethics in a way appropriate to delivery of health care of high quality.

If the Janus-image suggests obligations pulling in opposite directions, we need only remind ourselves that each face represents a value; that few enterprises worth pursuing have only one value, although most successful ones have a clear priority among their values. It does not seem inappropriate to expect of the health care system care of high quality for a reasonable cost. Nor will we want to exempt from that responsibility the most qualified judges of the requirements of high quality care. It is not merely tradition, but education, experience and skill, as well as their professional responsibility, that decrees that physicians, nurses and other clinicians should determine what care is appropriate for their patients.

But medicine is responding to new realities – and this reality is moving us in the direction of "systems" of care. So professional responsibility becomes an expanded notion both for physicians and for those other agents involved in the health care system who make resource decisions. If we navigate this expanded notion of professional responsibility successfully, with the justification for health care in mind, there is every reason to hope that the third face of medicine will eventually seem as natural and appropriate an ally for the art of care as science has become.

The danger that we are reminded of by the pejorative uses of the term 'business' is not care for the allocation of resources: it is greed, and there are some signs that this is not an unrealistic fear.[18]

If bioethics and regulation are the flying buttresses to support ethical practice in the science of medicine, it may be that organization ethics and the federal sentencing guidelines are the flying buttresses that will help support ethical practices in the business of medicine. We fear the integration of the third face of medicine because of the situation that opened the new century, with a division of labor within the health system: One group, the providers, were responsible for quality, another group, the managed care

[18] 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 embarking on an aggressive strategy of horizontal and vertical integration all for the sake of growth, increased revenue, and of course, massive salaries and other benefits for organization leaders.

organizations, were custodians of cost. As provider organizations have begun to assume some of the tasks of utilization and cost management, the division surfaces within organizations with clashes between clinicians and administrators. Perhaps the contrasts are necessary to make the stakes clear; but it will be necessary to move past adversarial relationships in order to find a common ground.

VII: A 'system' ethics for healthcare

What direction should that move past conflict and division of labor take? Half of the literature I've been reading for this paper recommends incorporating cost control into an expanded notion of physician responsibility, and the other half recommends incorporating quality consciousness into administrative responsibility. If a "new ethic" can be found, it will be one that posits "high quality care for a reasonable cost" as the common objective for physicians and hospitals, for clinicians and managers—for the sake of the patients.

There's been a lot of paternalism and reverse paternalism (=abandonment) with respect to the recipients of care. Sometimes they are told that because they are sick they are vulnerable, they need to be told what's best for them, they can't be expected to understand what their health plans allow for, they wouldn't recognize quality care if they encountered it, they have to be given whatever they want, they have to be taught what's good for them. Sometimes they are told they are greedy, they are exploited or victimized, they are spoiled rotten. Doctor knows best; your health plan knows best… Mainly what they need is to be treated as ends of the healthcare system, not raw material to be processed through the system in order to justify payment.

To get to system ethics we need, it will be necessary to align our business practices with the values that justify our traditional and continuing social support of the health care system. To do that, we need to align our values throughout the system. Until we have a system-wide consensus on values, and allocate responsibility for implementing those values throughout the whole system, we will not be able to progress. The whole reason for the conflict between the system and professional ethics is because of business practices based on values are inappropriate for responsible medical care. Of the ethical models available in the current system, the old Hippocratic medicine has the best hope of granting recipients of care their appropriate respect. But it is not just the physician's responsibility and office to reconcile ethics and business, nor is it his only professional responsibility. It is an obligation of the whole system.

We need to improve it, and in order to move forward, we need a consensus on values in the system as a whole.