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The “Ethics” of Organizational/Institutional Ethics in a Pluralistic Setting: Conflicts of Interests, Values, and Goals

Roberta Springer Loewy*

I. INTRODUCTION

As the leadoff panelist and author for the symposium, I assume several duties beyond providing a set-up for discussion of my particular topic. We are an interdisciplinary group, committed to interdisciplinarity as the best way to gain the widest range of perspectives towards inquiry into a problematic issue. However, interdisciplinarity is not immune to a prominent drawback whenever individuals come together to discuss a knotty problem: the tendency to assume that, despite their differences, everyone is on the same page concerning basic concepts. For that reason, I offer *provisional* definitions of the key concepts I will be presenting, so that we all have common reference points from which we can more effectively pursue and refine our discussion of them, even if those reference points are ultimately rejected or abandoned. To that end, here are my provisional definitions¹:

1. Personal morality: the sum total of one’s beliefs concerning right, wrong, good, bad, obligation, etc. One’s personal morality is
 - often tacit, reflexive, and uni-perspectival within a given enclave;
 - based on one’s experiences in the light of one’s upbringing (social, that is cultural or spiritual); and
 - defended by appeal to a commonly recognized and accepted authority, such as religion, parents, culture, other authority figures, etc.
2. Ethics: the study of right, wrong, good, bad, obligation, etc., concerning behavior towards others who may or may not share one’s own personal morality. Ethics
 - aims to be explicit, reflective, and multi-perspective and
 - requires a broader defense than one’s personal morality because it must ultimately be persuasive to those who do

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1. Unless otherwise noted these provisional definitions are my own.

not recognize/accept the same authority, such as religion, parents, culture, other authority figures, etc.

3. Professional ethics: the study of the ethical obligations entailed by belonging to a profession. These obligations exist over and above those obligations that attach to being a person.
4. Bioethics: the study of the ethical relationships and obligations between humans and the rest of their environment. This study subdivides into various branches, for example, environmental ethics, political ethics, veterinary ethics, medical (or healthcare) ethics, etc.
5. Medical (or healthcare) ethics: the study of the various bio-psychosocial relationships and obligations between those seeking and those supplying healthcare.
6. Business ethics: the study of ethics as it relates to the marketplace. Business ethics concerns the quality of the relationships of a business to both its internal and external constituencies.²
7. Organizational (or institutional) ethics: the study of the ethical analyses of decisions and actions taken by organizations/institutions.³ Organizational ethics is widely presumed to be a form of business ethics.⁴
8. Organizational healthcare ethics: the study of the ethical analyses of decisions and actions taken by healthcare organizations/institutions. Organizational healthcare ethics is increasingly presumed to be a hybrid of business and healthcare ethics.⁵

The other aforementioned duty is to list the various criteria for “profession” introduced by our guest speakers (Robert Solomon, Michael Davis, and Mike W. Martin) and discussed within our small group sessions at last year’s inaugural symposium. Those criteria, early identified and discussed in the medical literature by Eliot Freidson,⁶ can roughly be divided into four categories, as follows:

1. Exclusive service-oriented expertise
 - Exclusivity given by society to the profession and no one outside the profession may practice it

2. See Kenneth E. Goodpaster, *Business Ethics*, in 1 *ENCYCLOPEDIA OF ETHICS* 111 (Lawrence C. Becker ed., 1992).

3. ROBERT T. HALL, *AN INTRODUCTION TO HEALTHCARE ORGANIZATIONAL ETHICS* 4 (2000).

4. *Id.*

5. *See id.*

6. *See* ELIOT FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* (1970).

- Public accountability in return
 - Practice has ethical ends (goals) over and above the usual material ends (goals) associated with either personal reputation or private reward
2. Special body of knowledge
 - Generated largely from within the profession
 - On-going discussion/improvement of field and practice standards through robust exchange in research, literature, seminars, continuing education, peer-review, etc.
 3. Self-governance
 - Control over structure, educational requirements, admission, standards of practice, licensure, regulation, censure, etc.
 4. Fiduciary obligations
 - Generic obligations: those generated by virtue of belonging to the class, “professional” in general
 - Specific obligations: those generated by virtue of belonging to a particular type of profession, such as medical, legal, etc.
 - Public obligations: “Profess”ionals must profess their commitment to those ethical ends (goals) connected to the exclusive expertise granted by society—often marked by public swearing of an oath
 - Private obligations: bind professionals to be “client-centered”—that is, to do the best they can for the individual directly soliciting their expertise

A summary definition of profession suggested to us last year by Professor Davis drew the attention of a number of his audience.⁷ I include it here, followed by the reconstructed version that would result by adopting my distinction between personal morality and ethics. I think the changes, while slight, reveal the different senses of the variations of the root words “moral” and “ethics,” just in this brief definition alone. Adhering to this distinction in general would, I think, considerably reduce the sort of equivocation that occurs (for the most part innocently) in discussion and argumentation in both ethics and personal morality.

Davis’s provisional definition:

A number of individuals in the same occupation, voluntarily organized to earn a living by openly serving a moral ideal in a morally permissible way beyond what law, market, morality, and public opinion would otherwise require.

7. For more detailed information about the 2006 symposium, see SIERRA HEALTH FOUNDATION, *TOWARDS A COMMON GOAL: ETHICS ACROSS THE PROFESSIONS* (2007).

My provisional reconstruction:

A number of individuals in the same occupation, voluntarily organized to earn a living by openly serving an ethical ideal in an ethically permissible way beyond what law, market, morality, and public opinion would otherwise require.

So with these provisional definitions stated and last year's discussion of criteria for profession briefly reviewed, I turn to the focus of my remarks, which are intended to open the discussion about mediating between professional ethics and organizational interests.

II. TOWARDS A MODEL OF ETHICAL DECISION-MAKING FOR ORGANIZATIONAL HEALTHCARE ETHICS

This article attempts to bring some clarity to the relatively recent phenomenon of organizational ethics—also known as organization or institutional ethics—in the healthcare setting. To that end, I will review its “pedigree” (that is, its relation to ethics, business, and healthcare) and then examine some of the uncritical assumptions often made about that pedigree. I conclude the article by offering several reasons why, especially in the healthcare setting, organizational ethics—at least as it is currently envisioned—is deeply problematic.

The relatively recent, but profound, changes in the delivery of healthcare—especially the growth of intermediary organizational structures, such as health maintenance organizations (HMOs) that increasingly influence how patients are treated—have given rise to increased public scrutiny of the interests of organizations in general and of healthcare organizations in particular.⁸ To address this issue, the American Medical Association's (AMA) Institute for Ethics convened a National Working Group on Healthcare Organizational Ethics.⁹ The working group examined systems of ethical reflection that might be brought to bear in determining “what should count as ethical conduct for the present

8. See, e.g., *HMO's Cancel Coverage When You Get Sick* (KTLA television broadcast), http://www.youtube.com/watch?v=_Bxh9W_wyc4 (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*); Smart Money, 10 Things Your HMO Doctor Won't Tell You, <http://www.smartmoney.com/consumer/?story=200008301> (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*); Sharon Lerner, *Managed Care Changeover: Bad Rx?*, VILLAGE VOICE (New York, N.Y.), Nov. 16, 1999, at 34, available at <http://www.villagevoice.com/news/9946,lerner,10056,5.html>; Pituitary Network Ass'n, HMO Horror Stories, http://www.pituitary.org/news/hmo_horror_stories.aspx (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*); News Release, Rand Corporation, Rand Study Finds Backlash Against HMOs Caused Few People to Bolt from Their Health Plans (Mar. 24, 2005), <http://www.rand.org/news/press.05/03.24.html> (on file with the *McGeorge Law Review*).

9. DAVID OZAR ET AL., AM. MED. ASS'N, ORGANIZATIONAL ETHICS IN HEALTH CARE: TOWARD A MODEL FOR ETHICAL DECISION MAKING BY PROVIDER ORGANIZATIONS 4 (2000), <http://www.ama-assn.org/ama/upload/mm/369/organizationalethics.pdf> [hereinafter ORGANIZATIONAL ETHICS] (on file with the *McGeorge Law Review*).

generation of healthcare organizations” that provide direct patient care.¹⁰ It is interesting, and I think of no small import, to note that the working group specifically excluded from their examination organizations in healthcare that “do not provide direct patient care”—almost as though there was some tacit, self-evident ethical distinction between direct and indirect patient care.¹¹ Thus, their list specifically excludes insurance companies; some managed care organizations (MCOs); many governmental agencies (federal and state); all producers and distributors of healthcare goods; and the various associations of healthcare professionals.¹²

Published in 2000 and still featured on the AMA’s website,¹³ the group’s report identified and examined, among other things, existing sources of models of ethical decision-making, drawn from traditional western ethics literature. These sources were divided into the following four categories:

- Business ethics;
- Professional ethics;
- Law; and
- Social policy.¹⁴

The working group ultimately concluded that the differences between the perspectives of these four sources were so significant that they could not be combined to yield any useful guide for ethical decision-making, even when limited to only those healthcare organizations that provide direct patient care.¹⁵ Despite this daunting conclusion, the group suggested that there are a number of priorities for healthcare organizations that are in the business of providing direct patient care, and that these priorities can be generated from the four sources listed above.¹⁶ Listed in no particular rank or order of importance, these priorities include:

- Patients’ healthcare services;
- Health professionals’ expertise;
- Public health;
- Unmet healthcare needs;

10. *Id.*

11. *Id.*

12. *Id.*

13. The report is one of the choices on the AMA’s completed research projects page. See Am. Med. Ass’n, Completed Research Projects, <http://www.ama-assn.org/ama/pub/category/7518.html> (last visited Mar. 23, 2008) (on file with the *McGeorge Law Review*).

14. ORGANIZATIONAL ETHICS, *supra* note 9, at 4-8.

15. *Id.* at 8, 17.

16. *Id.* at 9-11.

- Advocacy for social policy reform;
- Relationships with clinical staff, management, employees, and affiliated professionals;
- Organizational solvency/survival; and
- Benefit to the community.¹⁷

After re-examination of and much discussion about the mission statements and public commitments of healthcare organizations employing these various models, the working group concluded that these priorities could reasonably be ranked in the following order of importance:

1. Patients' Healthcare Services
2. Professionals' Expertise in Clinical Matters
3. Remaining six (variable, depending on context):
 - Public Health
 - Unmet Healthcare Needs
 - Advocacy for Social Policy Reform
 - Relationships with clinical staff, management, employees, and Affiliated Professionals
 - Organizational Solvency/Survival
 - Benefit to the Community¹⁸

After surveying a variety of empirical data, including these organizations' choices of ethical decision-making models as well as their own publicly stated commitments, the working group rejected the now-classic claim, argued by Milton Friedman, that "there is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud."¹⁹ They also seemed willing to set aside serious discussion of an alternative position that some things are simply too important to be trusted to the market.²⁰ Rather, the working group

17. *Id.* at 9-14.

18. *Id.*

19. Milton Friedman, *The Social Responsibility of Business Is to Increase Its Profits*, N.Y. TIMES MAG., Sept. 13, 1970, at 32, 126 (quoting MILTON FRIEDMAN, CAPITALISM AND FREEDOM 133 (1962)).

20. See NORMAN DANIELS, JUST HEALTH CARE (1985); HENRY SHUE, BASIC RIGHTS (2d ed. 1996); ERICH H. LOEWY & ROBERTA SPRINGER LOEWY, TEXTBOOK OF HEALTHCARE ETHICS (2d ed. 2004); David T. Ozar, *What Should Count as Basic Health Care?*, 4 THEORETICAL MED. 129 (1983). This position was articulated early on by Arthur Okun. See ARTHUR M. OKUN, EQUALITY AND EFFICIENCY: THE BIG TRADEOFF (1975).

endorsed something more akin to a “stakeholder”-type position, which assumes, among other things, that organizations and institutions may properly be characterized as moral agents,²¹ an assumption that Friedman clearly and quite adamantly rejected. The working group essentially accepted the centerpiece claims of stakeholder theory as follows:

- business decisions and activities affect many individuals, not simply shareholders;
- these affected individuals (including employees, managers, customers, clients, and the wider community) are all, therefore, stake-holders; and
- ergo, businesses have a social responsibility to include all of the interests of the various stakeholders when deliberating about which decisions and activities to support.²²

The working group then proceeded to emphasize that the first priority of the above rankings should, in fact, out-rank the various interests of all other “stakeholders,” including the organization’s bottom line and the well-being of financial stakeholders.²³

About this, their first priority, the working group concluded that “[p]rofessionalism should function to protect moral vulnerabilities that cannot be safeguarded through either the government or the private sector.”²⁴

In their somber conclusion of the first section of the report, the working group cautioned:

At the present time . . . the law (to some extent) and social policy (to a great degree) have given ambivalent or even contradictory guidance to provider organizations. By encouraging market competition and organizational accountability for individual patients’ care, instead of responsible cost containment across the entire population, priority has been tacitly given to enhancing the health of some, especially the well and wealthy, rather than meeting the health needs of all, including the sick and poor. In such a system, the patient and community stakeholders appear to be ranked lower in priority, and the investors, employees, suppliers, and insurers higher, in spite of the conflict of this ranking with the priority of health.²⁵

21. R. Edward Freeman, *Stakeholder Theory of the Modern Corporation*, in *ETHICAL ISSUES IN BUSINESS* 247 (Thomas Donaldson & Patricia H. Werhane eds., 6th ed. 1999).

22. See EDWARD M. SPENCER ET AL., *ORGANIZATION ETHICS IN HEALTH CARE* 56-59 (2000).

23. *ORGANIZATIONAL ETHICS*, *supra* note 9, at 10.

24. *Id.* at 6. This assumption seems to have long found acceptance in the fields of medicine and bioethics, at least here in the United States. I have yet to see compelling evidence that, in a well-functioning democracy, the government cannot serve this purpose—perhaps even more equitably.

25. *Id.* at 8.

It is unfortunately too often the case—especially in the United States, it seems to me—that once such a careful assessment of a problem identifies a “system” to be a significant part of a problem, there is too often a sense of resignation about ever being able to find “live options” that map onto the full range of alternatives that are actually possible, given a truly humane and malleable social system that is fundamentally people-centered rather than merely power-centered. In our overly individualistic society, rather than “take on the system” (which must include discussion about how the system that the problem is embedded in affects the realistic options available as solutions to the problem), there is the tendency to throw up one’s hands and blame the system. This serves merely to “preserve one’s moral chastity”²⁶ by allowing one to retreat to a position that treats the current system as though it were simply an impenetrable social “given.” But a social system is not a “given”; it is purposely created, and it can be purposely changed. Such creation or change nearly always requires coordinated effort, not simply the isolated efforts of individuals.

After offering a brief sample case of decision-making based on the priorities outlined above, the working group concluded their paper by calling for more active dialogue between organizational decision makers, health professionals, and the community at large to come to consensus about some fairly foundational matters.²⁷ This includes not only a clearer understanding of what constitutes health, the aims of healthcare, and just how these might be ranked, but also of how to articulate appropriate standards not just for organizations providing direct patient care, but—one would fervently hope—for those indirectly involved as well.²⁸

III. SOME WORRISOME ASSUMPTIONS WITHIN THE ORGANIZATIONAL HEALTHCARE ETHICS DEBATE

Over the course of my professional career, which lies at the intersection between medicine and the humanities, I have witnessed a rather rapid rise of two especially troubling phenomena that, I would argue, most discussions and deliberations about this issue have, as yet, failed to address adequately:

1. The spread of marketplace language and values to areas beyond what traditionally has been considered the marketplace.
2. The erosion of medical professionalism.

The first phenomenon is intricately connected with the rapidly increasing—and increasingly defended—commodification of goods and services. What was traditionally thought of as public space, public property, and the public “good”;

26. ERICH H. LOEWY, *THE MYTH OF MORAL CHASTITY* (forthcoming 2008).

27. ORGANIZATIONAL ETHICS, *supra* note 9, at 17.

28. *See id.*

body parts and persons; pregnancy surrogates; politicians; and the personae of sports' teams are increasingly discussed as though they are legitimate commodities to be bought and sold in the marketplace.²⁹

The second phenomenon, the erosion of medical professionalism, has been significant and has a number of contributory factors. An obvious one is the demise of "private practice." Increasingly physicians have decided, for a variety of reasons (partly economic, partly because of the "managed care" environment) to become employees of some type of an organization, whether for-profit or not-for-profit. Another factor is the proliferation of "practitioners" outside of the medical profession. This includes not only of nurse practitioners, psychologists, emergency medical technicians, even chaplains, but also of healthcare organizations (health maintenance organizations, preferred provider organizations, etc.) and insurance companies, which increasingly constrain the way medicine is practiced by physicians. Yet another factor is related to the spread of marketplace values and assumptions. It is the growing tendency of patients to cherry-pick the services of medical professionals, almost as though they were shopping from vending machines: if they don't like what one of their medical professionals suggests or prescribes, they will simply try to get what they want from the next.

As a result, the once weighty and carefully protected fiduciary relationship between patient and medical professional has come under assault from various corners and has been greatly diluted. I consider these two phenomena—the ever increasing commodification of goods and services, and the erosion of medical professionalism—to be especially troubling because they are accepted either too hastily or with too little critical reflection. When this occurs, such assumptions take on an unwarranted legitimacy that becomes exceedingly difficult to reverse. Included among these worrisome assumptions are the following:

- "that it is proper to characterize organizations as moral agents," "at least to the extent that decisions and actions taken on their behalf can be evaluated as ethically right or wrong";³⁰
- that organizational ethics is an internal and, often times, top-

29. See, e.g., NOT FOR SALE: IN DEFENSE OF PUBLIC GOODS (Anatole Anton, Milton Fisk & Nancy Holmstrom eds., 2000); Milton Fisk, *A Case for Taking Health Care Out of the Market*, in NOT FOR SALE, *supra*; Patrick Bond, *Commodification of Public Goods: Critique and Alternatives*, Paper Presented to World Council of Churches Dialogue with the World Bank and International Monetary Fund (Feb. 14, 2003), http://www.queensu.ca/msp/pages/Project_Publications/Reports/goods.htm (on file with the *McGeorge Law Review*); Sarah Gilmore, *Commodification of the Body and Corporate Discipline*, 8 ELECTRONIC J. RADICAL ORG. THEORY (2004), http://www.mngt.waikato.ac.nz/ejrot/Vol8_1new/Gilmore.pdf (on file with the *McGeorge Law Review*); Clive Seale et al., *Commodification of Body Parts: By Medicine or By Media?*, 12 BODY & SOC'Y 25 (2006); Karen McGarry, *Mass Media and Gender Identity in High Performance Canadian Figure Skating*, SPORT J., Winter 2005, <http://www.thesportjournal.org/article/mass-media-and-gender-identity-high-performance-canadian-figure-skating> (on file with the *McGeorge Law Review*).

30. HALL, *supra* note 3, at 4.

down project³¹—the emphasis being on “decisions and actions taken by organizations”;

- that the claim that the internal or external members of an organization’s “constituencies” must be taken into consideration somehow prevents inequitable distributions of benefits and burdens resulting from decisions and behaviors of the organization;³²
- that unanimity of interests, values, and/or goals is sufficient to warrant decisions, behaviors and outcomes as ethical; and
- that the language of services and products (consumerism) appropriate to marketplace organizations/institutions is equally appropriate to healthcare organizations/institutions.

While each of these assumptions merits considerable discussion far beyond what this article will admit, I will limit my remarks to the last assumption which, in the face of this country’s burgeoning lack of access to basic healthcare for all members of our society, I consider to be the most profound of our ethical defects. In the interim, because of the brief time we have for discussion, I raise only the following interrelated topics:

1. One of the most popular approaches in organizational ethics is to try to bridge the significant differences between the perspectives of business ethics, professional ethics, law, and social policy by framing the discussion in the language of stakeholder theory. Can this approach succeed? In principle? In practice? And if not, why not?
2. Even if the answers to the first topic are, on the whole, positive, can a market model of ethical decision-making adequately speak to allocation and distribution when the goods and services in question are necessary for persons to be able to participate?

IV. THE (RELATIVELY UNSUNG) BURDENS OF STAKEHOLDER THEORY FOR HEALTHCARE

In most basic introductory courses to business ethics, the definition of stakeholder theory is fairly uncontroversial: viz, that all stakeholders in an organization have a fundamental right to respect and, therefore, an organization’s management has a responsibility to treat all stakeholders—in the language of Immanuel Kant—“*always as an end and never as a means only.*”³³ The initial

31. See Simon Zadek, *Balancing Performance, Ethics, and Accountability*, 17 J. BUS. ETHICS 1421 (1998).

32. See Goodpaster, *supra* note 2, at 111.

33. IMMANUEL KANT, *FOUNDATIONS OF THE METAPHYSICS OF MORALS* 46-49 (Lewis White Beck

problem comes, not surprisingly, in identifying who are to be counted as legitimate stakeholders, and this depends on whether one adopts a narrow or wide definition of stakeholder. If a narrow definition is adopted, a stakeholder will be defined as “[a]ny individual or group vital to the survival and success of the corporation.”³⁴ Whereas if a wide definition is adopted, a stakeholder will be defined as “[a]ny individual or group whose interests can affect or are affected by the corporation.”³⁵

Clearly, the AMA’s working group assumes this wider definition in their report. However, most organizations, even if they adopt this wide version in principle, simply do not take it seriously in practice. For example, the American College of Healthcare Executives’ code of ethics specifically affirms that

1. healthcare executives’ responsibilities to patients must include demonstrating “zero tolerance for any abuse of power that compromises patients”;³⁶ and that
2. healthcare executives’ responsibilities to community and society must include working to
 - a. “identify and meet the healthcare needs of the community”³⁷
 - b. “support access to healthcare services for all people.”³⁸

From my own experiences and the experiences of those around me, these sections of their code are cynical, hypocritical, the product of organizational self-deception on a grand scale, fabulous fiction, or some combination thereof.

But I am hardly the only critic of stakeholder theory; there are critics from across the political spectrum. Examples on the right include the likes of Milton Friedman³⁹ or Elaine Sternberg, both of whom argue that, in Sternberg’s words, stakeholder theory is “intrinsically incompatible with all substantive objectives, and undermines both private property and accountability.”⁴⁰ Examples on the left include not only proponents of classic Marxist thought but also more moderate thinkers whose concerns run the gamut from corporate paternalism;⁴¹ to lack of

trans., Bobbs-Merrill Co. 1959) (1785) (emphasis added).

34. An Introduction to Business Ethics, Chapter 3: Corporate Social Responsibility, www.cbu.edu/~pmaloney/Phil323/IBECh3.ppt (last visited Mar. 21, 2008) (on file with the *McGeorge Law Review*). Philip J. Maloney, an Associate Professor at Christian Brothers University, provides these definitions in a presentation for one of his classes. *See id.*

35. *Id.* (emphasis added).

36. AM. COLL. OF HEALTHCARE EXECUTIVES CODE OF ETHICS § I.I.E (2007), http://www.ache.org/ABT_ACHE/ACHECode_Ethics-2008.pdf (on file with the *McGeorge Law Review*).

37. *Id.* § V.A.

38. *Id.* § V.B (emphasis added).

39. *See* Friedman, *supra* note 19.

40. Elaine Sternberg, *The Defects of Stakeholder Theory*, 5 CORP. GOVERNANCE 3, 3 (1997).

41. *See* Christopher Stoney & Diana Winstanley, *Stakeholding: Confusion or Utopia? Mapping the Conceptual Terrain*, 38 J. MGMT. STUD. 603 (2001).

effective channels of communication for truly effective “consumer” negotiation, especially when it comes to unilateral changes by organizations of the terms of the relationship;⁴² to the coerciveness of the oftentimes extremely limited offerings of third parties (e.g., an employer’s “choices” of healthcare coverage for employees).

V. WHY THE MARKETPLACE PARADIGM IS ETHICALLY INAPPROPRIATE FOR ALLOCATING AND DISTRIBUTING HEALTHCARE

Professor Erich H. Loewy, my husband and professional colleague, has argued for decades that, in order for there to be a marketplace, there are some foundational benefits and burdens that must be equitably borne by members of a society.⁴³ The most important of these are having one’s basic bio-psycho-social needs (as opposed to *mere* wants or tastes) met.⁴⁴ While basic biological needs are fairly similar across widely disparate cultures—and so, one might say, are relatively context-independent—basic psychosocial needs (what Loewy calls “second-order necessities”: e.g., education, healthcare) will vary considerably, depending on the relative peculiarities and complexities of the society in question.⁴⁵ Thus, what is meant by basic needs, here, is those things that are essential for the possibility of sustaining both a primitive biological existence (and its goals) and a psychosocial existence that actively nurtures individuals to maximize their talents and to pursue their interests and goals. Absent having such basic needs met, individuals cannot participate in the marketplace.

For example, having a car in a technologically advanced society committed to a well-functioning public transportation system would not be considered a basic second-order need (one might even consider it a liability). Here in the United States, where public transportation is both spotty and poor, one could argue that lacking a car is an inequitable burden. On the other hand, having access to a cardiac by-pass may be considered an exotic luxury and not a basic need in a technologically unsophisticated society that has no cars, relies on manual labor, lots of physical exercise, etc. Loewy’s contention, then, is that the more complex the society, the greater may be the extent of what are considered to be basic needs.⁴⁶ The ethical corollary to his contention is that when their basic needs go unmet, individuals are stultified in profound ways and, thus, unnecessarily suffer. In the face of such unnecessary suffering a decent society

42. See James A. Fitchett, *Buyers Be Wary: Marketing Stakeholder Values and the Consumer* (Univ. of Nottingham, Int’l Ctr. for Corporate Soc. Responsibility, Research Paper Series No. 19-2004, 2004), <http://www.nottingham.ac.uk/business/ICCSR/pdf/ResearchPdfs/19-2004.pdf> (on file with the *McGeorge Law Review*).

43. ERICH H. LOEWY, *FREEDOM AND COMMUNITY: THE ETHICS OF INTERDEPENDENCE* 92-97 (1993).

44. ERICH H. LOEWY, *SUFFERING AND THE BENEFICENT COMMUNITY* 87-100 (1991).

45. *Id.* at 98.

46. *Id.* at 94-95.

will feel it ethically incumbent to arrange its institutions in such a way as to guarantee that a certain level of basic needs—both first-order and second-order necessities—will be met for all of its members.⁴⁷ This brings us back to the marketplace and those things necessary for it to flourish. According to Loewy, the success of the marketplace depends upon the broadest possible base of consumers who

1. “have sufficient funds to enter [and compete in] the market”;
2. “are sure of what they want and need”;
3. “are able to judge quality and price according to a standard”;
4. have sufficient “time to deliberate, compare and ‘shop around’”; and
5. can safely assume that, if they make a “bad” choice, it will not kill them.⁴⁸

Generally speaking, when such minimal conditions are met, not only will the marketplace function well, but also it will tend to maximally benefit all. However, it is far from clear that any of these minimal conditions can be met within any healthcare setting. Consider the following:

1. A large and growing segment of our population here in the United States does not, in fact, have sufficient funds, individually, to enter and compete in the healthcare market.⁴⁹
2. While an individual may be quite sure of what she wants and needs when it comes, for example, to a good pair of shoes, she is incapable—even if she had the relevant medical expertise—to decide how she should be treated for a serious (or even not so serious, I would argue) illness. While she certainly may be quite capable of articulating her long-term interests, values, and goals, it is highly speculative whether she can determine the biomedical means most likely to support her pursuit of them.⁵⁰

47. *Id.* at 121-24.

48. Erich H. Loewy, *Of Markets, Technology, Patients and Profits*, 2 HEALTH CARE ANALYSIS 101, 105-07 (1994) [hereinafter Loewy, *Of Markets*].

49. See ACCESS PROJECT, PAYING FOR HEALTHCARE WHEN YOU'RE UNINSURED 1 (2003), http://www.accessproject.org/paying_for_healthcare_when_youre_uninsured.pdf (on file with the *McGeorge Law Review*); Erik Siemers, *Study: Duke City's Uninsured Charged Higher Fees for Meds*, ALBUQUERQUE TRIB., July 11, 2006, <http://www.abqtrib.com/news/2006/jul/11/study-duke-citys-uninsured-charged-higher-fees/> (on file with the *McGeorge Law Review*); Liz Pulliam Weston, *A Survival Guide for the Uninsured*, MSN.MONEY, June 20, 2007, <http://articles.moneycentral.msn.com/Insurance/InsureYourHealth/AsurvivalGuideForTheUninsured.aspx> (on file with the *McGeorge Law Review*).

50. Loewy, *Of Markets*, *supra* note 48, at 105-07.

3. The average patient does not have the ability to judge the quality and price of healthcare.⁵¹
4. It is entirely unrealistic to suppose that consumers would have sufficient time to “shop around” for the best healthcare “deal” they could get—even if they could satisfy the above three conditions.⁵²
5. Lastly, patients cannot assume that they would survive a “bad” choice.⁵³

In addition to these five differences, there is another significant difference between the marketplace and the healthcare setting: in the marketplace, the buyer and consumer of an item are ordinarily (unless the item is a gift) one and the same person. Today, the buyer of a healthcare plan is rarely the same person as the actual “consumer.” Rather, the buyer (for example, the employer) is in the market to get the “product” at the lowest price; whereas the “consumer” (the patient) would presumably hope to get the best “product.” This is hardly the usual marketplace scenario.

Bluntly speaking, “[t]he empirical data strongly suggest that the implicit ‘*caveat emptor*’ strategy of the marketplace—viz., ‘let the buyer beware’—is clearly an inadequate method of exchange for at least some social goods and services.”⁵⁴ This brings me back to one of the most worrisome assumptions of the working group’s report: the priority ranking of unmet healthcare needs.⁵⁵ My question is who are the people with unmet healthcare needs? In this country, I fear, many of them are not even recognized as “patients” since, without the “proper credentials”—in the language of stakeholder theory—they are not customers, they are not clients, they are not stakeholders, they cannot get by the non-professional clerk at the front desk in order to draw the attention of a professional’s clinical expertise. When, in the course of their routine day, professionals end up “seeing” only those persons who have already been pre-qualified as patients, any chance of professional expertise serving as a brake on the economic priorities of the marketplace is quite effectively foreclosed.

51. *Id.*

52. *Id.*

53. *Id.* at 102-07.

54. Roberta Springer Loewy & Erich H. Loewy, *Playing the HMO Language Game: Repatriation, Extradition, or Deportation?*, in *CHANGING HEALTH CARE SYSTEMS FROM ETHICAL, ECONOMIC AND CROSS CULTURAL PERSPECTIVES* 127, 138 (Erich H. Loewy & Roberta Springer Loewy eds., 2001).

55. To jog your memory, the group’s reconstructed ranking gave top priority to patients’ healthcare services and second priority to professionals’ clinical expertise. Unmet healthcare needs was listed with the remaining six, to be prioritized variably, depending on context. See *ORGANIZATIONAL ETHICS*, *supra* note 9, at 9-14 and accompanying text.

VI. CONCLUSION

In closing, I would like to offer a final set of definitions from Avishai Margalit—a set that I fervently believe is more than provisional. I offer also an admonition from Hans Jonas which, while it deals with technology in general, has relevance for all modern organizations and institutions today. So, first I quote Margalit's definitions and their corollary:

A civilized society is one whose members do not humiliate one another, while a decent society is one in which the institutions do not humiliate people.⁵⁶

And,

[T]here is something outlandish about the idea of a market society as a decent society: in a democratic society political institutions are justified precisely by the fact that they are meant to protect the members of the society from humiliations generated by the market society. This includes safeguards against poverty, homelessness, exploitation, degrading work conditions, and the unavailability of education and health services for those "sovereign consumers" who are unable to pay for them. In developed societies, the market society is the problem rather than the solution.⁵⁷

And, finally, I speak to Hans Jonas' admonition. Throughout his career, and culminating in his 1984 text, Jonas warned of a grave, new responsibility facing humankind: the responsibility of finding a workable ethic for this truly novel age of technology—where for the first time in human history our decisions and actions could actually result not just in the disadvantaging of others, but in the destruction of our world.⁵⁸ Jonas argued that to survive, we must resist our current focus on our theories of rights, unbridled autonomy, and individualism, and concentrate on developing, instead, a workable, practical theory of personal and social responsibility.⁵⁹ Such a theory, according to Jonas, would be one that would take seriously and address the need for organizations and institutions, when determining what would constitute legitimate versus illegitimate goal-settings, to take into account the long-term and widespread costs of their decisions and actions.⁶⁰

56. AVISHAI MARGALIT, *THE DECENT SOCIETY* 1 (Naomi Goldblum trans., 1996).

57. *Id.* at 22.

58. *See* HANS JONAS, *THE IMPERATIVE OF RESPONSIBILITY: IN SEARCH OF AN ETHICS FOR THE TECHNOLOGICAL AGE* ix-x (Hans Jonas & David Herr trans., 1984).

59. *Id.*

60. *Id.*

In a pluralistic, democratic society, the best way to ensure that such a theory of responsibility is taken seriously requires, at the very least, complete transparency of organizations and institutions to public scrutiny. This would help to assure that the long-term consequences of their decisions and actions (which could be irrevocably life altering—for good or for bad) be distributed in such a way as to preserve the ground for the possibility of continued existence and well-being for everyone and everything affected by those decisions and actions. So, consistent with a workable theory of responsibility, perhaps it would not be too much to expect that healthcare organizations and institutions also commit to the notion that their fundamental obligations must at least include taking into account the long-term and widespread costs of their decisions and actions. This would help to minimize the loss of well-being and self-respect of all individuals even remotely affected. This would go a long way towards approximating both Margalit's definition of a decent society and Loewy's conception of the beneficent community.