Business Ethics, Stakeholder Theory, and the Ethics of Healthcare Organizations

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Until recently (before managed care), business issues in healthcare organizations (HCOs) were relatively insulated from clinical issues, for several reasons. The hospital at earlier stages of its development operated on a combination of charitable and equitable premises, allowing for providing care to be separated from financial support. Physicians, who were primarily responsible for clinical care, constituted an independent power nexus within the hospital and were governed by their own professional codes of ethics. In exchange for a great deal of control over their conditions of practice, they took almost complete responsibility for patient care. Thus clinical and professional ethics could to some extent be compartmentalized from the business issues—a much easier feat when, as in much of the last few decades, virtually all care was reimbursed from some source or other. In addition, many HCOs were not categorized or treated as businesses, although of course they were presumed to be governed by the same expectation for good management as any other organization.

Today this separation of powers and of issues is less possible. Still, in analyzing ethical issues for healthcare organizations there is a temptation to separate out business issues from clinical or professional issues. Ethical issues in the management of the HCO are often distinguished from those that face its clinical practice, and those, in turn, are distinguished from the challenges experienced by the professionals who carry out that practice. But this is a misperception. In the contemporary HCO, financial, clinical, and professional issues are all so interrelated that one cannot neatly separate out, say, the cost of an MRI from a patient's need for it or from the professional expertise that determines the desirability of that protocol. Thus there is a need both for studies in organization ethics for healthcare and for those studies to take into account the interrelationships among clinical, professional, and financial aspects of those organizations.

To begin to address these issues, in this paper I will make four points. First, I will argue that the misidentification of business ethics with a libertarian Milton Friedman perspective can be reinterpreted to contribute to the thinking about the ethics of healthcare organizations. Second, I will suggest that it is not the profitability of healthcare organizations that is the danger, it is the priori-

This paper is an outcome of collaborations with Ann Mills, Edward Spencer, and Mary Rorty of the University of Virginia Medical Center and from work done with the AMA Ethics Institute with Linda Emanuel and Jessica Berg. Debts to my colleague R. Edward Freeman, the "father" of stakeholder theory, are also obvious. Parts of the paper will be reprinted in revised form in Chapter 3 of *Organization Ethics for Health Care* by Edward Spencer, Ann Mills, Mary Rorty, and Patricia Werhane, New York: Oxford University Press, 2000.

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tizing of profits as the first order of business in healthcare organizations that is questionable. But this is true in garden variety non-health-related for-profit enterprises as well. Third, one prevalent theory in business ethics, stakeholder theory, has much to contribute to organization ethics for healthcare delivery organizations. Stakeholder theory provides understanding of organizations and organizational accountability that best integrates financial issues and other considerations. Stakeholder theory assumes that the organization and all its stakeholders form a shared moral community, and it appeals to moral minimums or principles of fairness when evaluating organizational decisions. I will conclude, however, that even though business ethics contributes to our thinking about the ethics of healthcare organizations, these organizations have distinguishing characteristics that make them worth considering apart from other business or charitable enterprises.

To facilitate these arguments I will make the following assumptions. By healthcare organizations (HCOs) I will mean medium and large sized provider organizations that have a defined management structure. I will also make the rash assumption that the purpose or mission of healthcare organizations is, by definition (because they are called *healthcare* organizations), patient or patient population healthcare or well-being. Third, I will assume it makes sense to say that organizations are moral agents and can be held morally responsible, although they are not moral agents in the same sense as, say, individuals.[1]

Friedman Economics

I will begin with a myth. There is a myth that business ethics is primarily focused on libertarian views defending laissez faire capitalism and competitive, unfettered free markets except in cases of egregious harms, particularly harms to liberties. This myth is perpetuated by a reading of the Nobel Prize economist Milton Friedman,[2] who some time ago declared:

> 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. (p. 126)

This often misquoted statement does not advocate that "anything goes" in commerce. Law and common morality should guide our actions in the marketplace just as they guide our actions elsewhere. Nevertheless, given that qualification, which is an important one, Friedman places primary importance on profit maximization as the role of business. Thus managers' first duties and fiduciary duties are to owners or shareholders. Ordinarily, these duties are to maximize return on investment, although in some companies the mission statement directs managers to other ends as well.

Friedman's conclusion is based on a neoclassical economic model of rational choice theory. Rational choice theory is grounded in the assumption that human beings act primarily from interests of the self, that is, in their own self-interests, broadly conceived. For example, Mother Teresa could be described as acting in her interests, which were to help poor, ill, aging Indians to have decent treatment and a dignified end to their lives. She could be called a rational utility maximizer since all her work was directed toward maximizing her interests.

According to most proponents of this view, it is rational to maximize your interests, even when these are interests in oneself. Or at a minimum, it is irrational to harm yourself or otherwise lessen your opportunities or devalue your own interests, all things considered.[3] When one acts rationally (and no economist assumes that any of us does most of the time), one acts to maximize one's interests, or long-term chosen preference, all things considered.[4]

Rational choice theory has often been interpreted as egoism. But this is probably erroneous. There is a trivial sense in which all my interests are self-interests; I am the subject of my interests, so they are interests *of* myself. But I am not always the object of my interests; that is, not all my interests are *in* myself. I have other-directed, altruistic or benevolent interests, and can cherish disinterested values.[5] The organizational analogue of rational choice theory would be an organizational rational utility model: that organizations act, or should act, if they are rational, primarily in their own interests. The assumption by economists such as Friedman is that what is in the "interest" of a commercial enterprise is maximization of profit. If we understand business organizations on this model, what is ethical is the maximization of shareholder interests since shareholders are the owners of the enterprise. Any activities that do not work toward this end are unethical since they violate the considered preferences of shareholders and question the fiduciary duties of managers. Notice that if managers are themselves rational, and thus interested in their own utility, corporations must provide the proper incentives to motivate managerial interests to align with those of the company and its shareholders. Despite this alleged introverted organizational focus on itself and its interests, it is further argued that in a climate of free enterprise, when the playing field is relatively level, competition among businesses may act to regulate economic interests, increasing well-being by producing competitively qualitative goods and services at low cost.

Rational choice theory, and Milton Friedman's version in particular, has been influential in changing the model of contemporary healthcare delivery. The promise of managed care has been that self-interested commercial competition between providers and insurers will be a sufficient mechanism to improve the efficiency and reduce the cost of healthcare, without imperiling quality. Yet there are a number of difficulties with this argument even as it applies to the practice of commerce or business, and even greater difficulties when applied without qualification to healthcare delivery.

The difficulty when applied to business is that, in fact, many of the best for-profit corporations do not operate under Friedman's philosophy. A case in point was the reaction of Johnson & Johnson in 1982 to poisoning of Tylenol capsules. The CEO of J&J, James Burke, decided to discontinue the marketing of the capsules, despite the absence of correlation between the J&J manufacturing process and poisonings, against the best advice of marketers and even the FBI, and in the face of the risk of loss of its then-dominant market share in pain medication. Citing J&J's credo, the first line of which states, "We believe our first responsibility is to the doctors, nurses and patients, to mothers and all others who use our products and services," Burke withdrew the capsules from the shelves and Tylenol capsules were never again manufactured or sold.[6] This act alone cost J&J more than ten million dollars.

There is further evidence that the action of this company is not a moral anomaly. In a six-year project, James Collins and Jerry Porras, professors of man-

agement at Stanford University, set out to identify and systematically research the historical development of a set of what they called "visionary companies," to examine how these companies differed from a carefully selected control set of comparison companies.[7] Collins and Porras's interest lay in explaining the enduring quality and prosperity of these visionary companies, but in the course of their research they dispelled a number of myths, including the myth that insists that the most successful companies exist first and foremost to maximize profits.

Collins and Porras defined the visionary company as the premier organization in its industry, as being widely admired by its peers, and as having a long track record of making a significant impact on the world around it.[8] The visionary companies identified by Collins and Porras are 3M, American Express, Boeing, Citicorp, Ford, General Electric, Hewlett-Packard, IBM, Johnson & Johnson, Marriott, Merck, Motorola, Nordstrom, Phillip Morris, Procter & Gamble, Sony, Wal-Mart, and Walt Disney.[9]

Each of the visionary companies identified by Collins and Porras faced setbacks, that is, each has made mistakes. Nevertheless, each has displayed a resiliency, an ability to bounce back from adversity. The long-term financial performance of each has been remarkable. A dollar invested in a visionary company stock fund on 1 January 1926, with dividends reinvested and making appropriate adjustments for when the companies became available on the stock market, would have grown by 31 December 1990 to $6,356. That dollar invested in a general market fund would have grown to $415.[10]

The comparison companies chosen by Collins and Porras are by no means sluggards. They represent some of the most respected organizations in the world. They are Ames, Burroughs, Bristol-Myers, Chase, Colgate, Columbia, General Motors, Howard Johnson, Kenwood, McDonnell Douglas, Norton, Pfizer, R.J. Reynolds, Texas Instruments, Wells Fargo, Westinghouse, and Zenith.[11] But that dollar invested in a comparison stock fund composed of these companies would have returned $955—more than twice the general market but less than one-sixth of the return provided by the visionary companies.[12]

What distinguished the visionary companies from the comparison companies? Each operates in the same market and each has relatively the same opportunities. Still, Collins and Porras state:

> Contrary to business school doctrine, "maximizing shareholder wealth" or profit maximization" has not been the dominant driving force or primary objective through the history of the visionary companies. Visionary companies pursue a cluster of objectives, of which making money is only one—and not necessarily the primary one. Yes, they seek profits, but they are equally guided by a core ideology—core values and a sense of purpose beyond just making money. Yet, paradoxically, the visionary companies make more money than the more purely profit-driven comparison companies.[13]

Having dispelled Friedman's edict as the only acceptable normative framework for organizations, there is one sense in which Milton Friedman's version might be useful in thinking about HCOs. HCOs are, at least in theory, created for one purpose: to minister to the health of patients and patient populations. If their mission is patient or population health, then as rational agents they should act so as to maximize the treatment and well-being of their designated populations. Rewording Friedman,

> There is one and only one social responsibility of an HCO: to use its professional and economic resources and engage in activities designed to treat and improve the health of its patient populations so long as it stays within the rules of the game. . . .

One of the "rules of the game" in the present economic climate might be the proviso that an HCO must be economically viable; that is, minimally, it must break even or create the ability to pay its debts. Even HCOs that depend on charitable contributions or state funds are under such economic constraints. Another "rule" would be the practice of following legal and regulatory mandates. This formulation puts in perspective and focuses the unique feature of HCOs that distinguishes them from other types or organizations, including for-profit, non-health-related corporations, while appealing to a Friedmanesque rationale and justification for their actions. Actions of an HCO that do not maximize patient or population treatment would, on this account, be irrational and indeed morally wrong, given the mission of the HCO. Efficiency, productivity, profitability, economic stability, needs and interests of healthcare professionals, and interests of insurers, government, or the community are important goals only insofar as they contribute to the primary aim of the HCO.

Stakeholder Theory

What Milton Friedman sometimes neglects to consider in his description of a manager's fiduciary responsibility to shareholders is an organization's obligations to other stakeholders, in particular, in business, to employees, managers, customers or clients, and the community. One could not run a business without employees and could not stay in business very long without customers, nor exist at all unless the community accepted commercial activity. These groups of individuals (and there are others), are important, not merely because one could not exist or achieve profits without them, but also because they are individuals or groups of individuals—human beings with rights and interests.

An approach to business ethics that takes into account the rights and interests of the broad range of individuals and organizations who interact with and are affected by business decisionmaking is stakeholder theory. Widely defined, stakeholders are "groups or individuals who benefit from or are harmed by, and whose rights are violated or respected by, corporate actions."[14] In a modern business corporation the primary or most important stakeholders commonly include employees, management, owners/shareholders, and customers, and, usually, suppliers and the community.

Focusing more narrowly, a stakeholder is any individual or group whose role relationships with an organization

(a) help to define the organization, its mission, purpose, or its goals, and/or
(b) are "vital to the survival, and success [or well-being] of the corporation." (Freeman, 1999, 250), or
(c) are most affected by the organization and its activities.

Under the narrowly defined version, stakeholders appear to be those who are instrumental, one way or another, to the firm and its well-being.[15] Figure 1 illustrates these relationships.

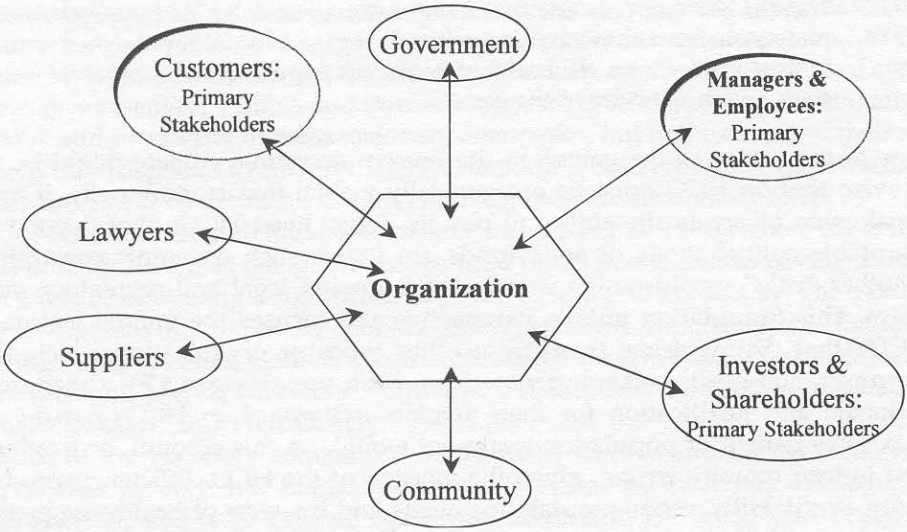

Figure 1. Standard stakeholder "map."

In the first instance, stakeholder theory appears to be primarily descriptive; stakeholder relationships outline organizational role relationships within and outside the firm. Prioritizing stakeholders helps further to sort out and clarify organizational priorities so that not every person, group, or other organization affecting or affected by the organization in question is equally important as a stakeholder. Otherwise the theory is vacuous. One way to prioritize stakeholder claims is to examine an organization's purpose and mission, ranking stakeholders in terms of who has legitimate or appropriate claims, and who is essential to that mission and to the survival and flourishing of the organization.

A finer-grained analysis of stakeholder identification identifies and prioritizes stakeholders in terms of "[(1)] the stakeholder's *power* to influence the firm, (2) the *legitimacy* of the stakeholder's relationship with the firm, and (3) the *urgency* of the stakeholder's claim on the firm."[16] By power the authors mean, most obviously, coercive power, such as that derived from legislation or regulation. But power can also be in the form of utility, for example, access to resources. So an HCO with a large capital base has more power just because it has financial flexibility. Normative power is a third dimension.[17] The recognition of a physician as a professional backed by a strong professional association and a code of ethics gives to that person or group of professionals normatively grounded power.

Legitimacy does not merely refer to legally mandated relationships. Legitimacy also includes relationships or structures that are socially expected or accepted. For example, healthcare organizations are expected to provide patient care, and in some communities provide it to the whole community, including the indigent. The third criterion, urgency, is more situational. A patient in intensive care requires more attention, ordinarily, than an outpatient with an earache.

The instrumentality of the prioritization deals only with part of what is important in stakeholder relationships. It does not take away from the normative claim of stakeholder theory that each stakeholder's interest has intrinsic

value, and in fact, according to proponents of stakeholder theory, the intent of stakeholder theory is largely normative.

> The descriptive accuracy of the theory presumes the truth of the core normative conception, insofar as it presumes that managers and others act [*or should act*] as if all stakeholders' interests have intrinsic value. In turn, recognition of these ultimate moral values and obligations gives stakeholder management its fundamental normative base.[18]

The normative core of stakeholder theory has three aspects: the purpose of the firm, the relationships between the firm and its stakeholders, and, at least in healthcare organizations, the interrelationships among stakeholders. Challenging the position that a manager's primary responsibility is to maximize profits, or that the primary purpose of a firm is to maximize the welfare of its stockholders, stakeholder theory argues that the *goal* of any firm and its management is, *or should be,* the flourishing of the firm and *all* its primary stakeholders. That purpose is identified with stakeholder interests.

> The very purpose of a firm [and thus its managers] is to serve as a vehicle for coordinating stakeholder interests. It is through the firm [and its managers] that each stakeholder group makes itself better off through voluntary exchange. The corporation serves at the pleasure of its stakeholders, and none may be used as a means to the ends of another without full rights of participation of that decision. . . . Management bears a fiduciary relationship to its stakeholders and to the corporation as an abstract entity.[19]

Let us assume for our purposes that all stakeholders in question are individuals or groups (including institutions) made up of individuals. If stakeholder interests have intrinsic value, then, according to R. Edward Freeman, the "father" of stakeholder theory, in every stakeholder relationship, the "stakes [that is, what is expected and due to each party] of each are reciprocal, [although not identical], since each can affect the other in terms of harms and benefits as well as rights and duties."[20] Therefore stakeholder relationships are normative reciprocal relationships for which each party is accountable. Figure 2 illustrates some of those kinds of relationships in a typical healthcare organization.

Obligations between stakeholders and stakeholder accountability notions are derived on two grounds. First and obviously, stakeholder relationships are relationships between persons or groups of persons. So the firm and each of its stakeholders are reciprocally morally accountable to each other just because they are people. One is obligated to treat individuals with respect, play fairly, avoid gratuitous harm, etc. What is distinctive about stakeholder relationships, however, is that these relationships entail additional obligations because of the unique and specific organizationally defined and role-defined relationships between the firm and its stakeholders. For example, an organization has obligations to its employees because they are human beings *and* because they are employees of the organization.[21] Conversely, because of their organizationally defined roles, employees have role obligations to the organization that employs them and to its other stakeholders, *as well as* ordinary moral obligations to that organization and its other stakeholders.

In HCOs these obligations become more complex. For example, an HCO has obligations to its employee-professionals (a) because they are moral agents,

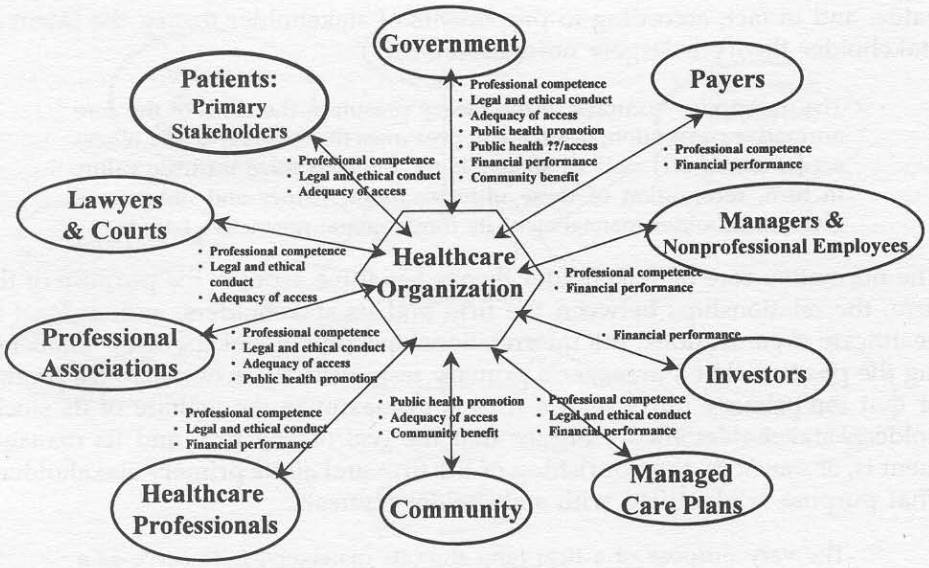

Figure 2. Stakeholder accountability in a healthcare organization. Adapted with permission from E. Emanuel and L. Emanuel, "What is accountability in health care?" *Annals of Internal Medicine* 1996, 124:231.

(b) because they are employees, and (c) because they are professionals and hired *as professionals*. Conversely, healthcare professionals have role obligations to the HCO that employs them and role obligations to patients, to their profession, and to their professional associations. They may also have role obligations to the communities they serve and to healthcare payers, *and* they have ordinary moral obligations to all of these populations by the simple fact of their existence in the community.[22] Figure 2 illustrates stakeholder accountability relations in a typical provider organization.

Acknowledging a plurality of moral agents, their interests, and reciprocal moral relationships, stakeholder theory appears to be immune to some of the objections raised to the Milton Friedman version of a rational choice model. But how does one evaluate various stakeholder claims against each other and against the profitability criterion Friedman and other economists advocate? Even not-for-profit or charitable HCOs must survive, and in the increasingly competitive healthcare climate, economic stability even for the most successful HCOs has become a critical issue. How does one prioritize economic sustainability in HCOs against other claims, in particular, those defined by the mission to foster patient and population health?

In fact, there is a simple method for prioritizing stakeholder importance in HCOs. First, by the fact of being a *healthcare* organization, the primary stakeholders in any HCO are its patients or the patient population it serves. Because the primary value-creating activity of a HCO is excellence in patient care, and because survival in the healthcare industry requires offering professionally excellent service, healthcare professionals are the second most important stakeholders. Third, long-term organizational viability that includes financial stability is necessary for the continuation of an HCO and the quality of its services.

Finally, because health is considered a public good, community, community access, and public health are part of the stakeholder equation.

Stakeholder theory raises another issue. Is a stakeholder analysis, even an instrumental analysis, merely self-referential? That is, could one make a case for an organization that prioritized its stakeholders in terms of its mission and recognized reciprocal accountability relationships between the organization and its primary stakeholders, but engaged in untoward or even evil activities? According to some stakeholder theorists, stakeholder theory is descriptive, instrumental, internally normative, and has another normative dimension as well. In evaluating stakeholder claims Evans and Freeman, two of the initiators of stakeholder theory, initially took a Kantian approach, arguing that because stakeholder relationships are relationships between individuals or groups of individuals, any decision must be one that affords equal respect to persons and their rights, valued for their own sake. A decision or action that used people as means for other objectives would not meet this Kantian criterion. Such prioritization leads to judgments that value corporate material goals over persons, a valuation that would violate this kind of stakeholder approach. In addition to autonomy and respect for individuals, procedural fairness, informed consent, and respect for contractual agreements are means tests for stakeholder relationships. And in a properly constructed stakeholder arrangement, stakeholders should have viable avenues for self-governance and recourse.

Some thinkers, such as Robert Phillips, develop a standard of fairness as the normative basis for stakeholder relationships.[23] This principle, derived from Rawls' theory of justice, argues that

> Whenever persons or groups of persons voluntarily accept the benefits of a mutually beneficial scheme of co-operation requiring sacrifice or conurbation on the parts of the participants and there exists the possibility of free-riding, obligations of fairness are created among the participants in the co-operative scheme in proportion to the benefits accepted. (p. 57)

These formal considerations of such a fairness standard should provide a set of externally derived minimum guidelines or moral minimums for evaluating organizations and stakeholder decisions: for judging some of them morally acceptable and some morally problematic. Decisions that affect various stakeholders must meet these minimum standards of respect for individuals, fairness of procedures and outcomes, informed consent, and availability of recourse.[24]

In summary, stakeholder theory contributes to our thinking about HCOs in the following ways. First, it helps us to prioritize those affecting and affected by the organization, in particular, patients, professionals, managers, and payers, and their value-creating activities consistent with the complex nature of healthcare organizations and without diluting the importance of one stakeholder. Second, stakeholder theory spells out reciprocal accountability relationships that have been written about in the medical literature[25] but have not been connected to organizational accountability. Stakeholder theory provides a moral framework for evaluating not only stakeholder relationships but also evaluating organizations, their missions, and their value-creating activities. Thus stakeholder theory initiates thinking about *organization* ethics for healthcare, while including the stakeholder dimensions of professional, clinical, and managerial ethics.

Business Ethics and Healthcare Organizations

Given the reformulated edict of Milton Friedman and the normative contributions of stakeholder theory to the ethics of healthcare organizations, can we simply subsume HCOs under the philosophical umbrella of business ethics? Several characteristics of the HCO complicate our understanding of the organizational aspects of healthcare and therefore complicate or even preclude such a move. They are the following.

1. *Mission:* Few corporations define their mission solely in terms of profitability, as we discussed earlier. What we learned from Collins and Porras is that the best organizations integrate other missions with the aim of profitability, and that the best (longest surviving, most responsible, and most profitable) business organizations are those that do not focus on profitability as their primary missions. Still, whatever the mission, a goal of any for-profit business firm is the economic flourishing of its shareholders, or of its primary stakeholders. In an HCO there is no such tight relationship between the rationale of the organization's existence and the condition for its economic survival. The difference between garden variety corporations and any HCO (whether a for-profit organization or not) is the primary mission of HCOs, which is always the provision of health services to individuals and populations. This constitutive goal stands in an uneasy relation to economic ends. What is strange is not that an HCO is concerned with efficiency, profitability, or at least sustainability. The trouble begins when an HCO realigns its mission or creates an organizational culture in which efficiency, productivity, and/or profitability become the first priorities.

2. *Patient priority:* In any organization, how one prioritizes value-creating activities determines the nature of stakeholder relationships. Patients, the consumers of the healthcare services provided by HCOs, have a privileged status among the stakeholders. It is true that in many excellent companies profitability is only one of a number of goals, such as integrity, customer satisfaction, employee well-being, respect for community, etc. Nevertheless, no for-profit entity can stay in business very long if it loses money. So while customers may be a set of important stakeholders, they are not the only primary stakeholders. This is not the case in HCOs.

3. *Separation of customer/payer and consumer/patient:* In HCOs, recipients of healthcare services are usually not the payers. The correlation between consumers and payers is very different in this organization from the usual business, and there is a crucial ambiguity in the stakeholder role of "customer." Various forms of insurance, employer-sponsored health plans, or government agencies purchase health coverage for the individuals and patient groups who are the actual and potential patients for a given HCO. This three-way relationship complicates accountability among the parties affected in healthcare delivery. Unlike the typical consumer, the patient may have no choice to go elsewhere or to change providers. Even in those cases where the recipient is also the payer, the consumer/patient is often ill and vulnerable. So, unlike ordinary consumers, patients are not always able to exercise their choices coherently.

4. *Central role of professionals in HCOs:* Healthcare professionals—physicians, nurses, members of other allied health professions—play key roles in the capacity of an HCO to deliver the services central to its definition and mission. It is the healthcare professional, not the manager, who is responsible for delivering care. One cannot gloss over, trade off, or subordinate professional commitments

to patient health. Not only is this morally irresponsible for obvious reasons, it imperils the mission of any HCO, if an HCO is by definition a healthcare organization. Typically, healthcare professionals belong to, and are accredited by, independent professional associations. Many if not all professionals consider themselves primarily bound by the ethical prescriptions of their profession, preeminent among which are their duties to their patients. The necessity of professionals in HCOs complicates stakeholder relationships, particularly when the professional is also an employee of the HCO.

5. *Community and public health:* Despite the ability of HCOs to define and restrict the patient population they will serve, community access and public health are always part of the accountability equation, because of the simple societal expectation that healthcare organizations *should* serve health needs.

6. *Healthcare markets:* There are a number of factors that complicate healthcare markets. There is an obvious information asymmetry between managers and healthcare professionals, and between professionals and customers or patients. Coupled with patient vulnerability, an HCO's healthcare customers are never "fully informed" customers. If "buyer beware" was ever an appropriate slogan, it clearly does not apply to HCOs. There is also an information asymmetry between healthcare organizations. Competitive healthcare organizations do not have access to customer (i.e., patient) information in ways in which they have access to market information in other business enterprises. So ordinary competitive relationships are not possible in the healthcare market. Additionally, there is a supply/demand asymmetry. Healthcare organizations cannot respond to all market demands, in particular, to the demands of the uninsured. Along with that is a pricing asymmetry. Some patients or patient-groups cannot pay for what they consume while others pay for more than they consume.

These six factors (and there are others) give ample evidence that the distinguishing features of healthcare organizations warrant their separate study as a particular set of organizations. Business ethics provides some tools for that study, but this does not merit merely conflating HCOs with other business organizations.

Conclusion

Theories of business ethics, while focusing primarily on for-profit organizations, are helpful in getting at ethical issues in HCOs as well. Milton Friedman's edict about social responsibility, when revised to specify the primary mission of HCOs, focuses attention to what HCOs are or should be about. Stakeholder theory elaborates on the complex relationships among various stakeholders in HCOs, relationships that are sometimes oversimplified in some delineations of HCOs. Stakeholder theory reminds us that stakeholder relationships are normatively reciprocal relationships of accountability prioritized by the organizational mission, roles and role obligations, organizational culture and climate, professional interests and obligations, and societal expectations, and it provides the opportunity to introduce independent evaluative criteria for organizations as well.

In other respects too issues business ethics raises are important to HCOs, particularly as they function as managed organizational providers trying to offer good healthcare as efficiently and productively as possible. Profitability is not always the only priority even in businesses unrelated to health and health-

care. There is no reason, then, to imagine that profitability should be the first order of business even in a for-profit HCO. The most exemplary for-profit corporations think about profitability as at best only part of their mission. Conversely, however, separating out business issues from those raised by clinical ethics or from the responsibilities of healthcare professionals may be detrimental to the HCO, to patients, and to the long-term professional commitment of healthcare specialists. This is because economic issues play a role in providing healthcare in every setting. Even in the "good old days" before managed care, healthcare professionals had to earn a living, and hospitals and clinics had to survive economically even on charity or governmental support. So to bracket economic issues as if economic sustainability had no role in healthcare is not helpful because those issues affect, and have always affected, the quantity, quality, and kind of healthcare that can be provided. What is important for organization ethics of HCOs is not to imagine that economic concerns are the only concerns or that profitability is the first priority, not that these concerns are irrelevant altogether.

Business ethics also reminds us that organizational accountability is as important as individual accountability. As it turns out, the HCO is at the same time a much more explicitly defined organization (in terms of its mission and clientele) and usually a more complex organization (in terms of stakeholder accountability, who delivers services, and how these are reimbursed) than many garden variety corporations. How one deals with the uniqueness and complexity of an HCO should be the subject for further study.

Notes

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4. Hausman DM, McPherson MS. *Economic Analysis and Moral Philosophy.* Cambridge: Cambridge University Press, 1996. Sen A. *On Ethics and Economics.* Oxford: Basil Blackwell, 1987.
5. This distinction is illuminatingly discussed in Adam Smith. See Smith A. *Theory of Moral Sentiments,* ed. Macfie AL, Raphael DD. Oxford: Oxford University Press 1976: Parts I, II. Although the model of a constrained rational egoist is often attributed to Smith, that is simply untrue. He is not an egoist, nor does he place emphasis on the autonomous individual moral decisionmaker; he acknowledges the intrinsically social nature of human beings. See *Theory of Moral Sentiments,* II.ii.3.1.
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7. Collins JC, Porras JI. *Built to Last.* New York: HarperBusiness, 1994:2.
8. See note 7, Collins, Porras 1994:3.
9. See note 7, Collins, Porras 1994:68.
10. See note 7, Collins, Porras 1994:4–5.
11. See note 7, Collins, Porras 1994:282.

12. See note 7, Collins, Porras 1994:5.
13. See note 7, Collins, Porras 1994:8.
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