A Deliberative Model of Corporate Medical Management

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Managed care is evolving in ways that pose unique ethical challenges to those interested in the intersection of clinical and organizational ethics. For example, Disease Management (DM) is a form of managed care that has emerged in response to chronic illness. DM is a healthcare management tool that coordinates resources across an entire health care delivery system and throughout the life cycle of chronic disease. Health Maintenance Organizations have reduced some costs in the delivery of acute care, but real cost savings will result only with greater efficiencies in the delivery of costly chronic care. DM is a systematic, population-based approach that identifies persons at risk of chronic ailment, intervenes with specific programs of care, measures clinical and other outcomes, and provides continuous quality improvement. Characterized as a movement to patient-driven services, DM involves a complex web of provider relations. Though the stated goal of consumer empowerment is laudable, some questions remain about the organization of DM programs.

This article examines some ethical issues surrounding the development of DM systems with an eye toward organizational ethics. Specifically, I examine the issue of interprofessional and intraprofessional conflict in the context of this integrated delivery system (IDS). In the first part of the paper, I use political theory and business ethics to offer an interpretation of the nature and scope of authority in medical decisionmaking. The purpose here is to ground professional autonomy and make clear the proper function of authority in corporate medical management. I argue that the concept of authority is integral both to an analysis of the theoretical foundations of an organizational ethic (OE) of managed care in general, and to the resolution of interprofessional and intraprofessional conflict in DM programs in particular.

In the second part, I apply this general theory to DM programs. I argue that, though the goal of DM is above reproach, means to ends involve ethical difficulties for the protection and promotion of both professional and patient autonomy. Those who wish to create DM programs will encounter substantive ethical issues at the intersection of clinical and organizational ethics. These issues exist not only at the individual professional level, but also at the health team level, where they are likely to be a function of differences in orientation to, and mechanisms for, dealing with ethical conflicts.

One such issue is the problem of divided loyalties. Divided loyalties often pit the interests of an individual against the interests of a collective in the allocation of scarce medical resources. This problem is difficult enough for an individual to manage. Interprofessional or intraprofessional conflicts only compound the problem, particularly when such conflicts impact patient care, as in DM team management. DM programs will succeed or fail depending in part on how well team members collaborate to resolve ethical conflicts. The resolution of ethical conflict depends in large measure on whether team members recognize them as such, and whether they utilize deliberative procedures for adjudicating "hard cases." I address these difficulties in an application of organizational ethics to this form of corporate medical management. In conclusion, I build on work by Norman Daniels and in Alternative Dispute Resolution theory (ADR) to offer a model for ethical conflict resolution in the DM team environment.

The term "organizational ethics" gained currency in health care circles with recent publications of standards by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). While new to health care, the study of organizational ethics is a branch of business ethics. In

Journal of Law, Medicine & Ethics, 28 (2000): 125–136.

general, business ethics is divided according to a three-tiered taxonomy: system, organization and individual.[1] At a macro level orientation, business ethics is the study of the relation of business to society. Business ethics in this sense is the study of the ethical issues relevant to the ways in which business entities interact with society. Macro level ethical analysis includes the study of the social, political and economic dynamics that promote or discourage corporate ethical behavior.

At a meso level orientation, business ethics encompasses organizational ethics. Organizational ethics as a domain of business ethics specifically addresses the organizational contexts of thought and action. It is the study of the ethical issues relevant to the ways in which organizations influence their members and to the ways in which these members influence each other and the organization.[2] OE focuses ethical analysis primarily in two areas: (1) the organization/person relationship; and (2) management and employee relations. The first topic includes analysis of the relation of personal *and/or* professional ethics to role obligations. The second includes ethical analysis of the structure of management relations and the problem of conflicting loyalties within organizations. Work in OE centers not only on the obligations of a person in an organization, but also on those structures that are conducive to the acceptance of moral responsibility and accountability.

In its claim that the morality of individuals ought not to be separated from the morality of procedures and structures, OE underscores the relation of authority to moral responsibility. Moral responsibility in an institutional environment refers to ethical accountability for the care, welfare or treatment of others as derived from a specific role. In an organizational ethic for managed care, it is critical clearly to define distinct role responsibilities. Moral responsibility in corporate medical management is a function of the exercise of authority over different aspects of the medical decision making process. Failure to define roles in relation to the legitimate exercise of authority will result in confusion as to who has moral responsibility for what, and therefore who is ethically accountable for possible outcomes in the DM team environment. The concept of authority is therefore central in the development of an organizational ethic for corporate medical management.

The exercise of legitimate physician authority

In the literature, political theorists and philosophers of law distinguish between the analysis of the concept of legitimate authority, and the examination of the exercise of legitimate authority in society. I begin this section with an analysis of the concept of authority.

At the risk of oversimplification, I suggest that the recent analysis of the concept of authority can be summarized in a single proposition: the exercise of autonomy in society makes legitimate authority necessary, while authority makes the exercise of autonomy possible.[3] Though real differences exist at the level of theory on the nature of the mechanisms that establish *legitimate* authority, there appears to be wide agreement on this basic precept. Society must entrust certain individuals with the delegated power to pursue goods that benefit the whole of society. In short, society requires the exercise of legitimate power.

According to received notions, then, society requires the distribution and exercise of power by legitimate authority. Those with Hobbesian sympathies define legitimate authority in narrow political terms as the justified use of coercive power. Thus, someone *in authority* has a "right to command" or power to act for or on someone else. This right to rule, in turn, confers on others a duty to obey. Someone in authority exercises executive power through the imperative character of his or her statements or pronouncements. Others with a duty to obey must "surrender private judgment" in obedience.[4]

The definition of legitimate authority in such narrow political terms, however, excludes other ways that authority and the authoritative emerge in society. The concept of authority involves much more than executive power. For example, we say that a scientist, Professor Gleason, is *an* authority in a particular field of study, quantum mechanics. Although he speaks *with* authority on quantum mechanics, his knowledge does not thereby confer on him a right to command with the power to act for or on someone else. He is not in authority, nor he does hold an official position with executive power that confers on someone else a correlative duty to obey. Others may hold him in high regard as an authority and a source of knowledge, but they do not have a duty to obey his imperative commandments or pronouncements by virtue of such authority. While Gleason does not exercise executive power, he does possess legitimate *epistemic authority*, since he is an authority in a particular field of knowledge.[5]

Where executive authority is a right or power of someone to do something for or on someone else in a certain context, legitimate epistemic authority involves recognition by others of superior knowledge. People are unequal in ability and some people know more than others do about certain topics as a result of their experience or research. Others must rely on the superior knowledge of an authority. The bearer of legitimate epistemic authority, in turn, can serve as a guide or a source of information.

It is in this latter sense that a physician is an authority. Physicians are not in authority. They do not hold *de jure* executive power that confers upon them a right to command, nor do their patients have a correlative duty to obey. Physicians' prescriptions are not commands so much as they are hypothetical statements.[6] Such prescriptions recommend to patients certain courses of action, *if* they desire to get well. Some patients may mistakenly interpret the prescrip-

tion as a command to be obeyed. For such patients, physicians may indeed hold *de facto* executive authority. The fact remains, however, that physicians have epistemic authority and not *de jure* executive authority. The legitimacy of their authority is a function of their superior knowledge and skill and the recognition by others that they possess such knowledge and skill. Physicians serve as guides or as sources of information, and others turn to them for their knowledge and skills.

Patients, on the other hand, are vulnerable. They have neither knowledge of nor experience in the art of medicine. This does not mean that patients must surrender private judgment on the matter of their care, as though physicians held some form of executive power. The possibility of paternalism has been such a serious concern among ethicists, that any mention of the legitimate exercise of physician authority is oftentimes simply rejected out of hand. This reaction may be attributed in part to the identification of legitimate authority with the narrow political view. If executive authority were operative in the physician/patient relationship, then physicians could override patients' actions and judgments justifiably. Since executive authority is not operative in the physician/patient relationship under normal circumstances, then patient autonomy functions at the level of choice in relation to physician legitimate epistemic authority. Physician authority and patient autonomy are by no means incompatible. The choice of care ought to express the values of personal identity. In addition, however, the choice of care also reflects the fact that patients knowingly choose to accept physicians at their word. Patients must therefore trust that their physicians are knowledgeable. They must also trust that their physicians are competent as well, and will pursue their best interests.

The concept of legitimate epistemic authority is closely connected to competence. The idea of competence, however, differs in important ways. For example, when we say that Professor Gleason is a competent scientist, we mean that he has the requisite knowledge. We also mean, however, that he has the necessary skills to perform the tasks that go along with being a scientist, or doing science. Gleason's epistemic authority is a function simply of his superior knowledge, while his competence is a function not only of his knowledge, but also of his ability to perform the sorts of experiments that others can reproduce and benefit from.

In general, the competence of epistemic authority is determined in relation to the judgment of peers. Physicians are members of a profession. Society empowers the profession to verify that a given individual has the appropriate knowledge and skill to exercise their epistemic authority, or practice medicine.[7] Society formalizes this process of verification through certification. Physicians receive certification as legitimate epistemic authorities through state examinations. Society authorizes competent physicians to administer such exams, and then to pass judgment in order to determine who is qualified to become members of the profession. As members of the profession, certified physicians can then exercise their authority in substitutive, essential and perfective ways. [8]

This arrangement between physicians and society is based upon the needs of society. Physicians establish their own standards and accreditation process, regulate entry into the field, and operate with relatively few social constraints. Such powers and privileges constitute a form of monopoly granted by society to physicians. Society as a whole and its individual members, in turn, benefit from a trade-off. In return for professional autonomy, society expects that physicians will exercise their epistemic authority in a manner that serves the public good. Such an arrangement between physicians and society constitutes a kind of implied contract or social covenant. Society grants physicians jurisdiction over the practice of medicine on condition that physicians exercise authority to advance the good of health. In short, physicians are authorized to practice medicine so long as they make available to patients the aid of competent physicians. Moreover, physicians exercise their nonexecutive form of epistemic authority in either a substitutive, essential or perfective way. Physician epistemic authority is essential as a cause of coordinated action in the pursuit of the particular good patient health.

In summary, the analysis of the concept of physician authority shows that physicians exercise a nonexecutive form of authority, i.e., epistemic authority. Moreover, society transmits through certification legitimate authority to physicians to act in the pursuit of a particular aspect of the public good. Professional autonomy is a consequence of a trade-off. The law authorizes physicians to practice medicine, so long as the profession avails citizens of competent physicians.

Sources of ethical conflict in disease management

Healthcare in the United States historically has focused on the individual patient and the delivery of episodic care through a fragmented system of healthcare providers. The model of episodic care delivery is based on the assumption that good health is the usual state of the individual patient and that illness is a temporary aberration. Episodic intervention, in turn, restores the patient to health and thereby validates the success of healthcare delivery. Chronic disease, however, is an ongoing state of illness that cannot be managed as a temporary aberration. A person with diabetes is always more or less in a state of abnormality with respect to excessive amounts of sugar in the blood and urine. Such a person is always either moving into a worse condition or into a better condition than the previous, but never toward a state of disease-free health.

Managed care organizations (MCOs), pharmaceutical

companies and pharmacy benefits programs are beginning to track these chronically ill patients in the community through so-called Disease Management programs.[9] The intention is to focus first on modifying high-risk lifestyles through education and then to detect onset decompensation in these patients at an early stage. The ideal DM program identifies high-risk patients, continually monitors them in the community, predicts when they will reach a critical threshold in the life cycle of their disease, and then intervenes with DM initiatives. Thus, Disease Management is a healthcare management tool that coordinates resources across an entire health care delivery system and throughout the life cycle of chronic disease.

Such initiatives involve a coordinated team approach, sometimes referred to as "share-care."[10] DM teams are designed to provide a full spectrum of care for clinical cases. For example, a patient presents with essential hypertension to a DM team member, usually the primary care physician (PCP). The PCP asks questions about diet, stress, activity, social history, etc. A discussion of the choices ensues and the PCP provides information about various approaches. This usually involves a negotiation of multiple programs/providers. Will they take calcium or beta-blockers? Will they exercise? If so, will they do aerobics or tai chi? Will they meditate or do massage therapy? Do they need counseling for a rocky divorce or work time stress management? Will they change their diet and/or take supplements? Appropriate team staff then follow up with the patient, e.g., an internist, a registered dietitian, an athletic trainer, a massage therapist, a counselor, a psychotherapist, etc.

Advocates of DM contrast an old with a new paradigm. They argue that the future of health care in the United States will be a movement toward patient-driven services. The old provider-driven and payer driven models support a paternalistic structure that places the patient/consumer in a passive position. The patient turns over responsibility for his/her well being to the physician who is expected to possess all the answers to the problem. Patient-driven delivery systems by contrast are said to empower patients/consumers. Patients with chronic diseases select their own treatments based on quality of life, rather than providers or payors. They integrate their own care and are accountable for care decisions, for behaviors that contribute to illness, and for using resources needed to promote wellness. Patients will need to understand treatment options and, through the use of predictive statistical models, be prepared to make choices based on potential health outcomes.

Moreover, advocates of DM programs argue that component management and episodic intervention leads inevitably to an uncoordinated delivery system that lacks care continuity for patients. Many individual decisions in patient treatment entail a fragmented delivery system. On the other hand, a team approach requires coordination of care delivery. Coordination of care, in turn, requires cooperation. Most DM program managers think aligning incentives will solve these coordination problems. Although aligned incentives are probably effective in ensuring that team members maintain a level of commitment to the program, it will take more than just money to solve the coordination problem among DM health professionals. Shared-risk agreements may encourage physicians to provide cost-effective care and to improve quality, but solving the coordination problem will turn more on resolving interprofessional and intraprofessional conflict than on the realization of expenditure goals. Such conflict is of an ethical nature when it is the result of competing ethical principles; in which case, interprofessional or intraprofessional disagreement is on moral grounds and coordination a function of ethical conflict resolution.

Those who wish to create DM programs will encounter substantive ethical issues at the intersection of organizational and clinical ethics. Such issues exist not only at the level of the individual professional, but also at the level of the health team, where they are likely to be a function of differences in orientation to and mechanisms for dealing with ethical issues. Business ethicists have long understood the difficulties inherent in shared responsibility among corporate team members whose differing roles and levels of authority make consensus building extremely problematic. Add to the mix different *professional* roles and professional codes of ethics and the difficulties only increase.

In a corporate environment where team building is essential, individuals must balance their own personal or professional obligations with institutional values. Mutual responsibilities and expectations embedded in team work are an important consideration as the individual weighs his or her own values and attempts to distinguish right from wrong courses of action. The effectiveness of DM programs will in large measure be a function of the ability of team members to recognize ethical issues and to work together toward satisfactory conclusions when faced with difficult decisions about patient care.

A failure to recognize and address such ethical issues represents a serious threat to the success of DM programs. These sorts of programs were devised in the first place as a remedy for a lack of cooperation and coordination among health professionals in a fee-for-service (FFS) environment. However, ethical conflict among health professionals in DM could also result in fragmentation of care. Patients would yet again face a single-episode-of-care environment. With no one to treat the entire patient and coordinate care, patients would be unable to integrate their own care. As a consequence, patient choice and patient autonomy would suffer. DM would not be a so-called "patient-centered service."

Ethical conflict in a DM environment can be analyzed at three distinct levels. The language of business and organizational ethics can be helpful to distinguish among these different levels. According to the literature, ethical issues

can arise in an organization at a micro, a meso (intermediate) and at a macro level. Micro level ethical issues are those that involve individual and/or professional values. For example, in a health care setting, micro obligations would refer to those professional obligations clinicians have toward their individual patients. In a DM program for heart disease, a particular cardiologist would have moral responsibility for the care of his/her congestive heart failure (CHF) patient at a particular juncture in the history of this chronic disease.

Meso level ethical issues, on the other hand, involve team or organizational values. They concern the organization as a moral environment. Such obligations—sometimes called "role obligations"—arise among individuals in relation to an organization as a whole. For example, meso obligations include administering scarce resources. In our example of a CHF DM program, the cardiologist would also have an obligation to steward the resources of the program in ensuring the success of the team.

Finally, macro level issues involve community or cultural values. Macro obligations result from the relation of an organization to society. Such obligations refer to the ways in which business entities interact with society and those environments (e.g., physical, social, industrial, governmental) that society regards as significant. For example, organizations have obligations not to discriminate based on race, or pollute above levels society deems harmful.

Business and organizational ethicists point out that ethical conflicts may also occur among the three levels as well as within each level. Conflicts may be a consequence of competing duties, obligations, or responsibilities among individuals in a corporate or team environment. In the following, I focus primarily on ethical issues that can arise at the micro and meso levels in a DM environment.

The problem of the democratic ideal in corporate medical management

Health professionals acquire an additional set of obligations and responsibilities as members of a DM team. Professional codes of ethics instruct health professionals to consider the patient's interests first in an exercise of legitimate epistemic authority. Duties such as veracity, informed consent, confidentiality, nonmaleficence, etc., are patient-centered obligations. Such micro obligations presume that health professionals will decide how strictly to act according to the best interests of patients. Additional obligations, however, attend new relations in a DM team environment. Meso obligations include ensuring that a budget is well managed, that expenditures are appropriate, and that resources are fairly allocated. These obligations are linked to but do not directly focus on patient care. In fact, newly acquired meso obligations may come into conflict with strictly patient-centered or micro obligations. DM teams will have to learn how to manage ethical conflicts among micro and meso obligations to ensure the success of DM as a movement.

Conflicts of interest constitute the weightiest ethical issue for DM programs. There are two main kinds of conflicts of interest in a health care environment: conflicts between self-interest (often financial) and the interests of the patient; and conflicts that divide loyalties among roles or between moral obligations. Although the first is important, I will not address it here. I focus instead on the problem of divided loyalties (DLs) in the DM team environment.

The problem of DLs is a central ethical dilemma in DM programs. An ethical dilemma involves a choice among alternatives, none of which is particularly desirable. Competing moral principles give rise to conflicted choices, or hard cases. Thus, DLs involve a conflict among ethical principles. DLs often arise as consequence of the need to reconcile the interests of an individual and a collective—a conflict between micro and meso obligations. DLs arise in DM programs in part from an attempt to integrate clinical and managerial roles. On the one hand, health professionals ought to exercise legitimate epistemic authority to promote the health and respect the autonomy of their patients—micro obligations. In a DM environment, however, they are also called upon simultaneously to manage resources and control costs—meso obligations. Thus, health professionals owe loyalty to individual patients and to the program as a whole.

Conflicts among micro and meso obligations involve conflicts among moral principles. The principles of beneficence and autonomy are micro obligations that focus on patient care, while distributive justice is in part a meso obligation that focuses on the fair management of resources. When coping with ethical dilemmas such as DLs, there are few right or wrong, good or bad solutions, only choices to determine the least worst among alternatives. Ethical decision making in DM programs will involve, in some cases, balancing competing moral principles in order to judge what is morally permissible given the facts of a particular case.

For the most part, the problem of DLs is less of an issue in a FFS environment. The moral demands of providers and administrators are largely kept separate. An administrative hierarchy exists alongside a medical hierarchy. This arrangement ameliorates the problem of divided loyalties. Managers handle meso obligations relating to fiscal responsibility and the fair allocation of resources, while health professionals care for patients. Although this separation of powers may shield health professionals from meso level ethical issues and the problem of DLs, ultimately it has proven uneconomical and, some would argue, ultimately unjust. The very means by which health professionals are kept from this form of ethical conflict also results in a failure to hold them accountable for the management of cost and the fair allocation of resources.

DM team management takes an entirely different approach to decision making. Rather than separate hierarchies, such programs flatten the decision making process and rely on collaboration among team members. Although this may have the intended beneficial effect of holding providers more accountable for cost, health professionals are no longer shielded from meso level ethical issues and the problem of DLs. In a FFS environment, the administration bears most of the responsibility for the management of cost. In a DM environment, the DM *team* must bear the responsibility for the creation of its own operational and decision making mechanisms. This means that team members will be required to address both micro and meso level ethical issues, as well as conflicts that may arise between levels. Since the team as a whole must both care for patients and manage the interests of the program, team members will be responsible for mediating competing moral claims. In short, the team will have to develop deliberative procedures to resolve or manage conflicts between the competing moral claims of individual patients and the patient population, or the program in its entirety.

Let's use a case of divided loyalties as an example to illustrate this point: the cardiologist on our CHF DM team argues for expensive, experimental drug therapy in the treatment of a patient with CHF, while administrators argue in favor of a proven effective, generic version to save money for the program. It seems clear that DM teams ought to have a mechanism to adjudicate ethical conflicts of this sort. Teamwork, however, requires direct cooperation. In a DM environment, each team member possesses particular expertise, and each is therefore responsible for individual decisions. The cardiologist recommends an experimental drug therapy for the care of his/her patient; other members of the team recommend a more cost-effective therapy. The success of the team demands constant coordination and communication among members. Communication enables collaboration and consolidation of knowledge, which enables the team to plan action. In a DM team environment, our cardiologist must collaborate with other team members properly to secure care for his/her patient. The effectiveness of the team will depend on the ability of members to make decisions together, even in the midst of value disagreements. How team members interrelate with one another and their patients on a case such as this will determine the manner in which they cooperate, or fail to cooperate, to resolve ethical conflicts among micro and meso obligations. Ultimately, it will determine the quality of the delivery of care to the CHF patient.

Collaboration among DM team members on the problem of DLs is in part an issue of authority and responsibility. In any health care delivery system, the reconciliation of the competing moral claims of an individual and a collective is largely a function of who has authority over and responsibility for segments of the decision making process. In a FFS environment, lines of authority and responsibility are more or less clearly drawn. Clinicians have authority over and responsibility for patient care, while administrators have authority over and responsibility for the collective good of managing cost and fairly allocating resources. In such a FFS environment, however, professional autonomy is assumed on the part of clinicians, harmony on the part of administrators, and seemingly unlimited resources on the part of all.

In a DM environment, on the other hand, there are a multitude of stakeholders who pursue diverse values and goals, including program administrators, medical directors, physicians, case managers, pharmacists, information managers, finance managers, not to mention patients. Various professional groups have an interest in meeting their own professional standards while working in a team context. In our case of the CHF patient, different actors may establish ethical priorities for the care of this patient in a multidisciplinary decision making process, each using criteria that may be more or less explicit and public with respect to his/her care. The question of authority over, and responsibility for, the care of this patient with chronic heart disease is therefore a critical one.

Since each DM team bears the responsibility of creating its own decision making procedure, teams will differ from each other based on how they systemize team member participation. A common assumption is that the democratic ideal is the best model for such collaborative efforts. In our case study, democratic deliberation, then, would serve as a means by which to mediate this "hard case" involving the problem of divided loyalties. The question then becomes what sort of procedural model might prove effective for this kind of deliberation in a DM environment in particular, and corporate medical management in general.

One model, the *aggregative* conception of democratic deliberation, holds that each person ought to be considered one among a community of equals.[11] The application of this model to our case study would mean that each team member would have an equal voice in the adjudication of this hard case. A town meeting approach presumably would minimize inter- and intraprofessional differences in a DM environment. Majority vote would settle ethical conflicts among health professionals and/or program administrators involving competing moral claims at the intersection of micro and meso, or clinical and managerial obligations. In effect, the team would settle by majority vote the course of treatment for our CHF patient.

At first glance, the democratic ideal of the aggregative conception of an equal vote is an appealing one for a DM team environment, particularly in cases where there is no one member who is an expert in a specific problem. For example, team members might be equally competent to make decisions regarding scheduling, materials management, vendor relations, etc. Majority vote might then prove

effective at handling these sorts of circumstances. In medical decision making, however, the aggregative conception is unrealistic for reasons not the least of which include such factors as power, personal desires, and differences in status and educational background. In a health care environment, titles and symbols of medical status are constant reminders that persons are more or less unequal, despite expressions to the contrary.

In addition to the evident sociological issues, there are weighty philosophical issues at stake in such inter- and intraprofessional deliberations. There are reasons why the aggregative of "one person one vote" is misplaced for medical decision making in a DM team environment, e.g., in the care of a CHF patient. While one can argue that individual freedom in a team context becomes secondary to overall team goals, the idea of professional autonomy and the exercise of legitimate epistemic authority militates against the limitation of that autonomy and the exercise of that authority simply for the sake of team success. In effect, the CHF team would require the cardiologist in our case study to compromise his professional autonomy and medical judgment for the sake of overall team success. I have argued that physicians possess and exercise legitimate epistemic authority as a consequence of a trade-off with society. It is not at all clear that the cardiologist ought to waive his authority based on a majority vote.

In what follows, I argue that it would in fact be unethical for the cardiologist to do so. Although an entire DM team is essential to secure the appropriate delivery of patient care for the chronically ill, physicians ultimately must be held responsible and accountable for their DM patients. This does not mean, however, that a DM team ought to be autocratic, with no time given for debate or voting on certain issues. There are, in fact, some issues about which physicians require guidance in the delivery of patient care. Some form of deliberative procedure is essential, if DM teams are to address adequately the problem of DLs and reconcile the oft competing moral claims of individual patients and the collective of the DM program.

Operative authority in corporate medical management

In order to address properly the issue of divided loyalties, an organizational ethic for DM must locate physicians within the context of a myriad of relationships, each with influence on the medical decision making process. It must also take into account the expanded role of physicians in such an environment. Additional responsibilities attend new relationships. In the DM team environment, physicians find themselves accountable for responsibilities that extend over a collective good or the good of a DM program in its entirety.

I have distinguished the concept of executive from nonexecutive authority. The former I defined in relation to a right to command, while I defined epistemic authority in relation to competence and an implied contract or social covenant. Executive authority is subdivided to include the concept of operative authority. As in other forms of executive authority, e.g., political authority, operative authority involves a right to command. Operative authority is distinguished from political authority in that operative authority functions primarily in economic relations.[12] Someone with operative authority possesses authority over the disposition and use of resources. Thus, operative authority is legitimate authority vested in any designated leader or officers of a group that has freely formed for the purposes of achieving some common economic end.

Operative authority is usually allocated to positions within an association or a corporation. Those who occupy such positions have the authority to distribute or use resources. Since operative authority involves a right to command, subordinates have a duty to obey or to surrender private judgment on matters related to the allocation of resources—with this proviso: Such a right to command does *not* extend beyond the legitimate operation of the corporation. Those with operative authority cannot legitimately command subordinates to do what is immoral. Nor can they command outside of the scope of their position or the limits of corporate power. In the assignment of duties, imperatives must be fair and reasonable.

Limits to operative authority become important when we turn to the exercise of legitimate power in corporate medical management. I have argued elsewhere that physicians exercise their nonexecutive form of epistemic authority in three sorts of ways: (1) substitutive; (2) essential; and (3) perfective.[13] Physician epistemic authority is essential as a cause of coordinated action in the pursuit of a particular good—patient health—that benefits a collective. Like physician epistemic authority, the exercise of operative authority is also essential. It is essential, however, *not* in the pursuit of a particular good that benefits a collective, but in the pursuit of the totality of a collective good, in its entirety.

Just as the exercise of operative authority in corporations or associations generally is essential in guiding those subject to such authority toward the collective good of the organization, so the exercise of operative authority in Disease Management is essential in guiding physicians toward the collective good of the team. However, unlike most other kinds of agents of corporations, physicians are bound by decree to exercise legitimate epistemic authority in the pursuit of a particular aspect of the public good. In a process of certification, society transmits legitimate authority to physicians to act in the pursuit of patient health. Thus, society authorizes professional autonomy in the practice of medicine on at least two conditions: (1) the profession must avail the public of access to competent physicians; and (2) physicians must guide individuals toward the good of health

by stemming the progress of an established disease, at the very least.

Can we infer from this that the exercise of operative authority over physicians in a managed care environment is unjustifiable on moral grounds? In short, does legitimate epistemic authority always trump operative authority in Disease Management given the terms of professional autonomy? To use the case study, would the professional autonomy and medical judgment of the cardiologist trump the operative authority of other members of the team who steward scarce medical resources? I don't think that this follows from my analysis of the concept of authority. In fact, I have argued that the exercise of operative authority in Disease Management is essential in guiding physicians toward the collective good of the team. While those in positions of operative authority cannot command physicians to do what is immoral, they can exercise legitimate authority in ways that respect physician professional autonomy.

However, the question remains how can a DM program accomplish a balance among competing claims of particular and collective goods, i.e., resolve the problem of DLs? How can management, on the one hand, exercise operative authority over physicians for the sake of the good of the program without violating the terms of physician epistemic authority? And, on the other hand, how can physicians mediate conflicting loyalties to the particular good of patient health and the collective good of the organization without compromising their professional integrity? In short, how can management and the cardiologist resolve their differences without compromising the success of the team, the cardiologist's professional integrity, and the delivery of quality care to their CHF patient? Part of the solution to this problem lies in the delegation by management of operative authority to individuals already in the possession of epistemic authority.

Toward a deliberative model of ethical conflict resolution in DM programs

The delegation of operative authority in a corporation is a right of individuals in possession of such authority. These individuals have the power within ethical and legal parameters to authorize other individuals to distribute or to use corporate resources. In a managed care environment, this means that those with operative authority have the power to authorize individuals to allocate scarce medical resources, under certain conditions. Ethical parameters place limits on the delegation of legitimate operative authority. Such limits were defined above as the terms and conditions of epistemic authority and/or professional autonomy.

Management in managed care corporations, however, is within its moral and legal rights to delegate legitimately its operative authority over the allocation of scarce medical resources to health professionals themselves. I suggested above that management could exercise legitimate operative authority over physicians in ways that respect professional autonomy and protect patient care, while furthering the legitimate interests of a DM program. One way would be to delegate such authority to physicians themselves. Management can authorize physicians to control the allocation of medical resources. The office of medical director will serve as an example.

Medical directors possess an amalgam of power—both epistemic and operative authority. This fusion of authority entitles physicians so authorized to exercise operative authority over other physicians within a managed care environment. The role of medical director, and other similar positions held by health professionals in managed care organizations, provides management with legitimate means to balance the oft competing claims of the particular good of patient health and the collective good of the organization. Their epistemic authority entitles medical directors to assess performance on the basis of their interpretation of evidence-based, peer-reviewed criteria. Medical directors are then well within their rights to guide other physicians toward the collective good of, for example, a DM program. When management vests physicians with the operative authority to act as medical directors, it thereby creates a function to facilitate in the communication between physicians and management. Medical directors then have the legitimate authority to mediate between the particular concerns of physicians and the collective concerns of management. In this way, management can exercise operative authority over physicians without thereby compromising professional integrity.

The relation on moral grounds of medical directors to physicians is, in part, collegial. When physicians concede to one another on matters related to patient care, they do not surrender private judgment as when subordinates obey orders. Since epistemic authority is vested equally in each professional, it is more correct to say that one physician accepts the professional advice of another. In the relation of medical directors to their colleagues in a managed care environment, when medical directors refer to evidence-based, peer-reviewed criteria to hold colleagues accountable for their actions, they exercise legitimate epistemic authority. Their colleagues do not thereby surrender judgment and/or simply obey orders, but rather accept the peer-reviewed advice of another member of the profession.

Of course, medical directors exercise more than just epistemic authority over their colleagues in a DM team environment. Management empowers them also to exercise operative authority. This does not mean, however, that they can legitimately coerce their colleagues, as in the case of normal superior/subordinate relations in a corporate setting. Medical directors must be careful to respect professional judgment. Nevertheless, operative authority gives rise to an added dimension in collegial relations. As members

of a DM team, physicians have an obligation to respect the operative authority of medical directors. This means at the very least that attending physicians ought to acknowledge the fact that medical directors are charged with the very difficult task of mediating among the competing claims of particular and collective goods.

Conflict is inevitable. It is quite common for those with authority over particular functions to disagree with those with authority over a general good. In certain cases, attending physicians will argue that the particular needs of an individual patient are paramount, while medical directors will argue that the collective good is most important. To return to the case study, our cardiologist will argue that the particular needs of the CHF patient are paramount, and that he/she has a professional obligation to prescribe the expensive, experimental drug therapy in pursuit of the best health interests of the patient. The medical director of the DM team might argue on the contrary that the success of the team is most important, and that the cardiologist should prescribe a proven effective, generic version to steward scarce team resources. Disagreement inevitably focuses on a proper balance among micro and meso obligations. In such cases of ethical conflict, medical directors have a professional responsibility to argue on grounds of evidence-based, peer-reviewed criteria, while respecting a colleague's professional judgment that an individual case may be an exception to the rule. Attending physicians, on the other hand, have an obligation to respect the operative authority of medical directors and consider the collective good of the organization, while entertaining the possibility that the case may not be an exception to the rule. Where there is an impasse, both parties should agree to a deliberative procedure to review the case.

DM programs ought to implement a system of checks to secure a proper balance between the pursuit of the good of the individual patient—a micro obligation—and the pursuit of the good of a patient population, or the entire program—a meso obligation. Such checks would consist of: (1) clearly delineated lines of authority among a proper mix of DM team members; and (2) operational and decision making mechanisms for the resolution of ethical conflict. The former will have more to do with the assignment of responsibilities, while the latter will define the ways in which team members interact to resolve "hard cases." In what follows, I develop an outline of a deliberative procedure to adjudicate hard cases in a DM environment, and then apply it to our case study.

First, DM programs would do well to make use of a mix of "top-tiered practitioners" (physician-specialists) and "lower-tier" health professionals as part of the team, for moral as wells as practical reasons. Different team members should advocate based on either the principles of beneficence and respect for autonomy, or distributive justice. Some team members should be charged with the micro obligation of advocacy solely on behalf of individual patients. These members ought to be practicing physician-specialists in the treatment of chronic disease. Other team members should have as their responsibility to exercise authority properly on behalf of the entire program or patient population. Medical directors manage the program in its entirety.

Still other members would occupy a middle ground between those in charge of the particular good of individual patient health and those in charge of the collective good of the entire DM program. For example, Certified Case Managers (CCMs) are specially trained both as patient advocates and in the management of medical resources. Typically, CCMs are RNs. As such, they have the ability to address the particular needs of chronically ill patients. Additional training in the management of medical resources also equips them with skills to allocate resources efficiently along a continuum of care in the management of disease.

Moreover, physician-specialists in charge of a stage in the evolution of a chronic disease might not be able to discern the relation of one stage to the entire disease process. They cannot therefore manage the entire process. This leads to fragmentation of care and an inefficient utilization of resources. Such fragmentation of care could leave patients uncertain about who is really in charge of their care. Confusion interferes with patient choice and therefore patient autonomy. Patients have a right to be informed, not just about the treatment of one moment in the disease process, but about the entire course of treatment for their chronic ailment. Chronically ill patients should feel confident that someone will be with them throughout the evolution of their care to help them make informed choices and to monitor their progress.

As specially trained RNs, CCMs have the ability to see each stage in relation to the evolution of the entire chronic illness. They are therefore ideally placed to coordinate activities among specialists along a continuum of care. Coordination of care, in turn, both enhances patient autonomy and ensures an efficient allocation of resources. CCMs inform patients about the entire course of their disease and help them manage the transition from one stage of their treatment to the next. In this way, case managers mediate between the particular interests of the physician/patient relationship and the collective good of the program in its entirety. Thus, they also help medical directors make an efficient use of program resources.

Second, operational and deliberative procedures can serve as a system check to secure a proper balance among micro and meso obligations in a DM team environment, particularly in hard cases involving divided loyalties. However, as we have seen, the aggregative conception of democratic deliberation will not suffice as a model for the adjudication of such cases. It fails to account adequately for differences in status, power, and educational background

in the delivery of health care. In a health care environment, persons are more or less unequal given the authority relations consequent upon such differences. One person / one vote is therefore inappropriate for the adjudication of hard cases in a DM environment. An alternative deliberative model for conflict resolution would be more appropriate for health care decision making in DM.

Norman Daniels has done substantial work on the legitimacy and fairness of deliberative procedures in the allocation of scarce medical resources. He argues that platitudes about the general principles of distributive justice are of little value in the adjudication of what I've called hard cases.[14] General principles of distributive justice provide little guidance on how to weigh competing claims. We need fair procedures to supplement general principles. Daniels calls for experimentation among insurers and managed care organizations—a "dialectic between principles and practice"—to determine best practices for making decisions and policies that can be defended on the basis of justifiable weights given to different values.[15] Daniels concludes, however, that such procedures depend upon at least four conditions: (1) a mechanism for dispute resolution; (2) terms of cooperation that are mutually justifiable; (3) clarity about the reasons for decisions; and (4) voluntary regulation.

Applying alternative dispute resolution methods (ADR) to the management of ethical conflicts in a DM team environment could serve to secure these four conditions. ADR is used in a variety of contexts to adjudicate hard cases. It is a consensus process for mediating opposing points of view based on differing values.[16] Participants first work together to design a procedure that maximizes their ability to resolve their differences. For example, ADR mediation is used in family counseling, the civil court system, and in conflict resolution as an alternative to the justice system in labor relations, human resource issues, environmental issues and community development. It is a collaborative problem-solving process to improve communications among interested parties in dispute. As an alternative method of resolving disputes, mediation requires four elements: (1) a facilitator to protect the integrity of the proceedings; (2) good faith from participants; (3) the presence of the parties; and (4) an appropriate site or venue.[17]

The facilitator makes the entire process work. He/she stands in the middle of the conflict and attempts to reduce the tension in communications. Mediation works only if the facilitator is known either to be neutral, or supportive of all parties. Without the trust of the parties, the facilitator cannot help them work collaboratively to reach methods of cooperation that are mutually agreeable. The facilitator helps the parties seek their own long term, best interests by assisting them in finding their own resolution. The focus is on creating lasting solutions. Parties must avoid coercion and manipulation and must be committed to the process of seeking a solution, rather than engaging for some ulterior purpose. The process requires complete confidentiality, the good faith of participants, and a sense of shared responsibility for both process and outcome. Finally, all parties must also willingly interact with the facilitator in order to negotiate a resolution. The intent is to make decisions through consensus rather than by majority vote.

When a DM team faces a hard case, CCMs are ideally suited to serve in an ADR capacity as facilitator. CCMs function every day at the intersection of micro and meso levels to balance the competing claims of multiple stakeholders. On the one hand, as RNs, CCMs are trained to be patient advocates. In a DM environment, this means that they coordinate team efforts to provide a continuum of care for the chronically ill patient. For example, CCMs counsel patients about physicians' instructions, provide education about their disease, make sure they understand their medication routine and try to increase their compliance with the treatment plan. Thus, the micro obligations of beneficence and respect for autonomy guide their actions. On the other hand, the meso obligation of distributive justice also guides their actions as they manage program resources through utilization review. Finally, CCMs have an appreciation both for the epistemic authority of physician-specialists and for the amalgam of authority of medical directors. CCMs are therefore likely to garner the good faith of all relevant stakeholders in ethical conflict resolution among DM team members, i.e., the chronically ill patient, providers and DM team administrators.

Although ADR methodology could prove useful as DM teams experiment with procedural solutions to ethical conflict resolution, I raise one note of caution. The literature in ADR tends to focus narrowly on the four formal elements of mediation above. While the facilitator must act to protect the integrity of the proceedings, encourage good faith from participants, etc., such formal conditions are not enough. In addition, the facilitator would also need to incorporate what Norman Daniels refers to as a "dialectic between principles and practice." While the four elements of ADR establish the formal structure of mediation, ethical principles and rules should set the ethical parameters for discussion.

Let's return to our case study of divided loyalties to see how this model might work resolving the ethical conflict between the cardiologist and the medical director. Recall that our cardiologist argues for expensive, experimental drug therapy in the treatment of a patient with CHF, while the medical director argues in favor of a proven effective, generic version to save money for the program. It seems clear that DM teams ought to have a mechanism to adjudicate ethical conflicts, and that, in order for the proceedings to work properly, all the participants must act in good faith. It also seems clear that the proceedings would benefit from a facilitator to protect the integrity of the process. Additionally, however, as Daniels notes, principles and rules ought

to impose constraints on the deliberations.[18] Thus, while the four elements of ADR should set the formal structure of mediation, the participants ought to adopt terms of cooperation that are mutually justifiable. Not just any preferences will do. Given reasons must reflect the fact that each party views the other parties as seeking terms of cooperation that all can accept as fair and reasonable. In this way, the minority can at least assure itself that the preference of the majority rests on the kinds of reasons that even the minority must acknowledge play an appropriate role in deliberation. The majority does not exercise brute power of preference but must instead seek reasons for its view that are justifiable to all fair-minded people, i.e., to all who seek mutually justifiable terms of cooperation in a given context.

If either the cardiologist or the medical director triggers the DM's deliberative procedures for ethical conflict resolution, then the micro and meso obligations described above should serve as the terms of cooperation. It is not enough that participants express their good intentions, or confidence in the facilitator. All parties should reach agreement that participants will use the principles of beneficence, autonomy and justice as the deep structure of reasons given either for or against the experimental drug therapy. As facilitator, the CCM should strive first to establish mutual agreement on these terms.

Next, the CCM must act to diffuse the perception that either the cardiologist or the medical director is clearly right or clearly wrong. Personality will inevitably play a role in ethical conflict resolution, but participants ought not to succumb to the temptation to reduce the proceedings to a conflict among personalities. Here again the CCM is pivotal. The CCM should make explicit that there are no good or bad people, clear right or wrong answers in an ethical conflict; there are only good people who want to do the right thing for the right—but sometimes different—reasons. Ethical conflicts involve choices, each of which might be the right one from a particular perspective. As Daniel's suggests, it is the job of the CCM/facilitator to work to gain clarity about the reasons for decisions.

Conclusion

The legitimate exercise of epistemic and operative authority in a disease management team environment is necessary both to protect professional autonomy and patient care, on the one hand, and to promote the collective good of the program on the other. An organizational ethic of corporate medical management must provide a framework within which management and physicians are held accountable for the exercise of their authority. Work in organizational ethics must focus not only on the obligations of a person in a managed care environment, but also on those structures that are conducive to the acceptance of moral responsibility.

Additional responsibilities attend new relationships. In the managed care environment, physicians find themselves in relation to specialized agents with responsibilities for a collective good, e.g., the good of a DM program in its entirety. Conflicts between physicians and these corporate agents are to be expected. It is natural for those with authority over particular functions to disagree with those with authority over a collective good. Disagreement will focus inevitably on a proper balance. The experts will argue that their particular function is paramount, while management—specialists in the pursuit of the collective good—will argue that the general good is most important.

The collective good of a corporation in its entirety depends upon the action of particular persons in pursuit of particular goods that benefit the whole organization. But particular functions are by definition aspects of the collective good. It is therefore necessary that there be above those with particular functions, a person or a group of persons with a concern for the whole of the collective good. The proper exercise of operative authority is also essential to guide those in charge of particular aspects of the collective good toward the collective good in its entirety. In fact, it may be said that authority is most essential in the intention and pursuit of the whole of the collective good.

Medical directors stand between physicians and corporate medical management in a DM environment. With their amalgam of epistemic and operative authority, medical directors can guide attending physicians toward the good of a DM program in its entirety, and, at the same time, protect and enhance physician epistemic authority. Nevertheless, conflict is inevitable. A DM program ought to make use of a proper mix of health professionals and Alternative Dispute Resolution methods to resolve ethical conflict among DM team members. Failure to recognize and respond appropriately to ethical conflicts could threaten the success of the DM movement. DM programs were originally devised to remedy a lack of cooperation and coordination among health professionals in a fee-for-service environment. Interprofessional and intraprofessional ethical conflict in DM could result in the "refragmentation" of care. Chronically ill patients would once more face a single episode of care environment. With no one to treat the entire patient and coordinate care, chronically ill patients would be unable to integrate their own care. As a consequence, patient choice and patient autonomy would suffer. Moreover, society would suffer for want of a cost effective means to treat chronic illness.

References

1. K. Goodpastor, "Business Ethics," in L.C. Becker, ed., *Encyclopedia of Ethics* (New York, NY: Garland Publishing, 1993): at 58.

2. C.M. Horvath, "Macro *and* Micro: The Emerging Field

of Organizational Ethics," *Online Journal of Ethics* 1, no. 3 (1997): at 3-17.

3. R.T. DeGeorge, *The Nature and Limits of Authority* (Lawrence, Kansas: University Press of Kansas, 1985); Y.R. Simon, *A General Theory of Authority* (Notre Dame: University of Notre Dame Press, 1980); and J. Raz, "Authority and Justification" *Philosophy and Public Affairs*, 14, no.1 (1985): 7-25.

4. R.B. Friedman, "On the Concept of Authority in Political Philosophy," in R.E. Flathman (ed.), *Concepts in Social and Political Philosophy* (New York: Macmillan, 1973): 3-28.

5. See De George, *supra* note 3, at 34-42.

6. De George, *id.* at 41.

7. R.T. DeGeorge, *Business Ethics* (New Jersey: Prentice Hall, 1995): at 455.

8. B. Barber, "Some Problems in the Sociology of the Professions," *Daedalus*, Fall 1963, 669-688.

9. W.E. Todd and D.B. Nash, eds., *Disease Management: A Systems Approach to Improving Patient Outcomes* (American Hospital Association Press, 1998): at 9.

10. J.P. Hampson, R.I. Roberts and D.A. Morgan, "Shared Care: A Review of the Literature," *Family Practice*, 13 (1996): 264-279.

11. N. Daniels, "Last Chance Therapies and Managed Care," *Hastings Center Report* 28, no. 2 (1998): 27-41.

12. See De George, *supra* note 3.

13. M.E. Meaney, "Authority Relations in Corporate Medical Management: Toward an Organizational Ethic of Managed Care," *HEC Forum* 11, no. 4 (1999): 333-344.

14. N. Daniels, "Justice, Fair Procedures, and the Goals of Medicine," *Hastings Center Report* 26, no. 6. (1996): 10-12.

15. See Daniels, *supra* note 10.

16. C. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* (Jossey-Bass Publishers, 1996); and M.B. Bennett and M.S. G. Sherman, *The Art of Mediation* (National Institute for Trial Advocacy, 1997): at 14.

17. J.E. Beer and E. Stief, *The Mediator's Handbook* (New Society Publishers, 1997): at 24.

18. See Daniels, *supra* note 10.

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