Ann E. Mills, Mary V. Rorty, and Patricia H. Werhane, "Clinical Ethics and the Managerial Revolution in American Healthcare," *The Journal of Clinical Ethics* 17, no. 2 (Summer 2006): 181-90.

Clinical Ethics and the Managerial Revolution in American Healthcare

Ann E. Mills, Mary V. Rorty, and Patricia H. Werhane

Ann E. Mills, Msc (Econ), MBA, is an Assistant Professor in the Center for Biomedical Ethics at the University of Virginia, Charlottesville, *amh2r@virignia.edu.*
Mary V. Rorty, PhD, is a Clinical Associate Professor at the Stanford Center for Biomedical Ethics in Stanford, California, *mvr2j@stanford.edu.*
Patricia H. Werhane, PhD, has a joint appointment as Wicklander Chair of Business Ethics and Director of the Institute for Business and Professional Ethics at DePaul University and Ruffin Professor of Business Ethics and Senior Fellow of the Olsson Center for Applied Ethics, Darden Graduate School of Business Administration, University of Virginia *pwerhane@depaul.edu* or *phw2m@virginia.edu.*

INTRODUCTION

The healthcare industry, particularly healthcare delivery organizations, is awash in "quality" movements. Because the techniques, initiatives, and mechanisms associated with the quality movements affect delivery of care, they affect clinical encounters.

This essay will spell out why clinical ethicists and other clinicians should take a closer look at how quality initiatives are implemented in their institutions. To do this, we briefly review important aspects of the American quality movement, its potential impact on the processes of healthcare delivery, and its relevance to clinicians and clinical ethicists. We discuss some of the obstacles to developing quality improvement programs — obstacles that may prevent the appropriate introduction of quality initiatives in healthcare organizations. When these obstacles are ignored in the design of quality programs, the roles and relationships surrounding clinical encounters may become distorted, and impede delivery of quality care. We conclude by suggesting that, in the absence of a fully functioning organizational ethics program, the clinicians and individuals associated with institutional ethics committees should develop or enhance their skills to recognize, understand, and address the potential effects of quality programs on patient care.

Problems in clinical care come to ethics committees in the form of specific impediments to providing care to individual patients. While some ethical issues result from personality clashes or faulty interactions, others stem from misaligned goals within the healthcare organization. Patterns of consults — repeated consults from the same unit, or consults that indicate the same structure of problem — can alert clinical ethicists to structural problems: processes, policies, or procedures that systematically thwart providing excellent care.

Our attention is directed toward quality improvement strategies that may be introduced by healthcare organizations to improve the processes of delivering healthcare. Strategies and mechanisms that prioritize efficiency over effectiveness may degrade or interfere with human relationships, the exchange of information, and interactions that are central to excellent healthcare.

THE AMERICAN QUALITY MOVEMENT

Quality initiatives, either in manufacturing or service industries, make two key assumptions.[1] The first is that *quality* is defined through customers' expectations. The customer is profiled, so that expectations can be derived, depending on the customer's socioeconomic background. These expectations can then be defined and measured and translated into specific aspects of the product. This definition gives management the tools to develop the accountability mechanisms that are associated with outcomes, that is, answering the question, "Were the customer's expectations met in purchasing the product?"

The second assumption is that, by concentrating on the processes by which a product is produced, and perfecting those processes in light of expectations for it, the quality of the end product will be improved or its cost lowered. In a service industry, often the process is part of the product. For instance, the diner's experience depends as much on the service received as it does on the excellence of the food. Nevertheless, process improvement is a key element in both the manufacturing and the service industries. Expectations give management a precise product to deliver, and so the job of operations management is to continually review processes, and the components of the processes, so that the processes can be improved, and the product will conform to an appropriate standard of quality.[2]

Quality initiatives are often explicitly or implicitly associated with various philosophies of management. Most initiatives are implemented to effect some sort of change in the beliefs and behaviors of the stakeholders of the organization (that is, employees, administrators, managers, consumers).[3] When consistency, uniformity, precision, reliability, standardization, and predictability in performance are the characteristics of excellence in a product, improving processes of production is an engineering task. Deviations can be identified and appropriate corrections made. Because the organization has a precise idea of customers' expectations, by using the techniques derived from the two key assumptions discussed above, an organization can presumably increase its market share by retaining the loyalty of old customers and attracting new customers.[4] It is important to note that these advantages accrue in the context of "free" market competition, in which informed customers may select among competing products whose quality they can judge using their own prioritizations regarding cost and quality — priorities that are known to the producer.

In some service industries, consistency, uniformity, precision, and standardization are also strong criteria for the excellence of the service provided, such as banking or other financial industries. Their application can effect improvements in process, which, in these industries, cannot be divorced from the product. But "quality" is a relational term in several respects: it applies to comparisons with other products that have been designed or intended for the same purpose, and in terms of the adequacy of a product in respect to filling the human needs it is designed to fill. If the criteria and context are carefully enough spelled out, "quality" can become a descriptive term, but it is remarkably uninformative as a descriptive term outside this context.

QUALITY INITIATIVES IN HEALTHCARE

Although some leaders in the healthcare industry have urged the industry to apply quality initiatives to the processes of healthcare for some time,[5] the report, *To Err is Human,* by the Institute of Medicine (IOM), made importation of quality initiatives inevitable.[6] The report ended any debate about the quality of healthcare delivery in the American system by revealing the magnitude of medical error, as well as the variation in treatment patterns in different localities. Even when the quality of healthcare is poor, its cost is still high, and quality initiatives promise to reduce costs while enhancing quality.[7] Interestingly, and entirely congruent with the philosophy of many quality initiatives, the IOM report was not interested in assigning individual blame for the ineptness of some of the current processes of healthcare delivery.[8] Rather, it noted that much of the variation in quality could be attributed to systemic causes, not human error. It stressed the need for the development of initiatives to highlight, measure, and identify deviations from appropriate care, which was ultimately identified by the IOM as a matter the under use, overuse, or misuse of resources.[9] The use of resources is precisely what quality initiatives promise to control.

It is a truism that the healthcare delivery organization hosts a daunting array of different processes. Some of these processes are mechanical. For instance, billing procedures are expected to proceed in much the same way, time after time. Packing surgical kits, deriving requested lab values and conveying them rapidly and precisely to the requester, scheduling utilization of medical devices or operating room space, are all processes that profit from attention to their efficiency, and we are not concerned with the application of quality initiatives in these areas. In fact, their application, depending on the circumstances, should be encouraged, as efficiency and standardization are characterizations of "quality" services of this type.

But not all healthcare processes are equally mechanical. At the patient-clinician interface, mechanical processes must yield to human interaction, with all the complexity, variability, and unpredictability that characterizes human relationships, exacerbated by a context that is often characterized by uncertainty and vulnerability.

The role of clinical ethics in case consultations is to facilitate the making of difficult decisions. Often consults result from poor communication or the delivery of care that is not in alignment with a patient's values and preferences. Initiatives designed to inhibit communication, or essentially disregard the patient's values and preferences by requiring adherence to a strict process, are of concern to us, as clinicians and as ethics consultants.

Quality improvement initiatives are designed to change the processes through which care is delivered. Since the "product" in healthcare includes the process through which care is delivered, this means that quality initiatives promise to change the clinical encounter, by affecting the roles and relationships that are the context of care. Quality initiatives come in many varieties, of course, and some quality initiatives promise to support these roles and relationships.[10] Others do not. These other initiatives are often rationing devices, "dressed up" as quality control,[11] and their introduction may result in care that is not appropriate.

For instance, a quality initiative may be implemented in the emergency room — ostensibly to reduce waiting time and increase appropriate access. The design of the initiative may include mechanisms that are calculated to measure and control the time that each clinician spends with each patient. But the implementation of such an initiative may be disastrous without backup routines that are designed to accommodate those patients who represent a "deviation" from the usual services provided. Moreover, the role of clinicians and their relationships with both their peers and patients become more automated — controlled as they are through rationing and measurement. Bottlenecks may develop when clinicians do not adhere to a predetermined schedule, and communication between patients and clinicians may become tense, limited, and imprecise.

Or consider the implementation of a quality initiative that supplies a benchmark for treatment, and that includes measurement and accountability mechanisms that are designed to hold the physician accountable for deviations from the benchmark. Even though routines for exceptions may be provided, physicians are confronted with a disincentive to weigh patients' values and preferences when they recommend treatments — especially when such accountability mechanisms can be used punitively.

One fundamental premise of the quality movement is that an excellent production process will be both effective and efficient. *Efficiency* is a characteristic of a process, and describes how it is done — how safe, rapid, or precise it is. *Effectiveness* is a characteristic of the result of a process or activity. It refers to how satisfactory the result is, whether that result is a product or a service. It is effective if it fulfills the goal of the activity, and its effectiveness is measured in terms of how well it satisfies the recipient or beneficiary, and meets some independent standards of excellence.

There is little doubt that an effective process or service will be even better if it is efficient as well, and all stakeholders in healthcare delivery processes can agree upon this common goal. It is not as obvious that efficiency alone can serve as a criterion of effectiveness. The judgment of the effectiveness of a process or service may be open to more dispute, as the evaluative criteria on which the judgment is made depends, in healthcare, on the place of the evaluator in the system.

HEALTHCARE IS AN ANOMALOUS INDUSTRY

Organizations introduce quality improvement mechanisms to improve healthcare delivery, and care of high quality for a reasonable cost may fairly be seen as an appropriate goal for such an organization. But healthcare organizations are complex, and different stakeholders in the organization — administration, staff, financial directors, physicians, and patients — may have different responsibilities, and thus may prioritize their criteria for what "counts" as "improvement" differently.

Those responsible for the financial viability of the organization must look to cost-control, and many quality initiatives in healthcare were initially borrowed from other industries and introduced on the assumption that improving care processes will automatically reduce costs, without imperiling quality. But, as we noted above, the advantages of balancing the cost/quality conundrum by improving processes accrue in many industries in the context of free-market competition. The challenge of introducing quality initiatives in healthcare is particularly difficult, because of some of the idiosyncrasies in the kind of service industry that healthcare is. It is these idiosyncrasies that may produce ethically unacceptable processes and outcomes in the delivery of care if not allowed for in the design of quality programs. First, there is an imbalance of knowledge between patients and careproviders. Second, there is a split in the "customers" in healthcare (payers and patients), as well as a split in the "providers" (physicians and healthcare delivery organizations).[12] Third, the beneficiary of health services and the raw material of the process of healthcare is the patient, and each patient may have some idiosyncratic characteristics that preclude a uniform approach to the treatment of illness. Fourth, healthcare organizations often do not control their environments.[13] These sources of possible variation create radically different, and sometimes incompatible, criteria in what it means to provide care that is of good quality; and the quality of care may be measured differently, depending upon the evaluator's place in the system — as payer or provider, patient, purchaser, or enrollee.

1. KNOWLEDGE IMBALANCE

The criteria by which physicians or other clinicians judge the effectiveness of a treatment or intervention are subtle and demanding, as is appropriate, considering the difference in knowledge between professionals and their subjects. It is exactly that difference in the knowledge base, inculcated by education, honed by experience, and assured by professional self-regulation, that explains why people seek professional care. An effective intervention is one that achieves the intended outcome. An intervention that fails to achieve the intended outcome may be satisfactory to me as the patient (the staff was courteous, the doctor listened attentively, the tonic tasted fine), but unsatisfactory to the more demanding judgment of my physician or his or her peers. Thus, the patient and the clinician may evaluate the effectiveness of a clinical encounter from totally different perspectives.

2. SPLIT IN CUSTOMERS AND PROVIDERS

The bifurcation of the "customer" is particularly important, because of the role of customers' expectations in quality initiatives. The typical market model decrees that the savvy customer — who both pays for and consumes the object purchased — can freely choose whether to purchase an excellent product at an appropriately high price, or a lower quality product for a lesser price, with the desired priority between cost and quality to be determined by the customer. If the payer for the process or product is not its beneficiary, the market mechanism is disrupted. In healthcare, the payer is the one who finances the health plan; typically, financing is through the employer or the government; and it is the patient who receives the care.

This calculation is further complicated, since, on one understanding, the enrollee in a health plan is one of the payers, if not the sole or major payer. The status of the enrollee as the customer of a given health plan is bifurcated as well, since the healthy enrollee might well prioritize cost, while the enrollee as a patient who is actually in need of the care that the plan represents, will have different priorities.[14] It is worrisome to note that some structural constraints — restrictions in a patient's particular health plan, or variation in the skill-base and service constraints of the primary physician — often cause patients to become a captive consumer

base, rather than a group of informed individuals who are free to make informed deliberations between cost and quality that represent actual "choice."[15]

Although it is common to speak of "individual and institutional care providers," to lump together the individual and institutional agents in healthcare delivery is to occlude the important differences between them. Patient care in healthcare organizations includes services provided by the institution that are similar to those of a good (or mediocre) hotel, up-to-date (or outmoded) technologies, and competent (or callous) personal attention to patients' expectations. It also includes medical treatments, diagnoses, and interventions by clinicians, whose relation to the hospital often seems to be that of an independent contractor. The criteria for what "counts" as effectiveness or quality may differ between the institution and its clinicians, and the priorities between different criteria may differ as well. The relation between the clinician and the hospital has been described by one observer as "a built-in tension,"[16] with management of treatment modalities — control — as the object of dispute.

3. PATIENTS: RECIPIENTS OF CARE, OR THE "RAW MATERIAL" OF A PROCESS?

The individual enters the healthcare system with a particular question or problem. Patients are individuals, each of whom has slightly different physical characteristics. Patients also have a variety of values and preferences. So patients cannot easily be neatly folded into a one-size-fits-all process — even if those patients present with similar symptoms. In its second report, *Crossing the Quality Chasm,* the IOM addressed how the healthcare system could improve the quality of its delivery processes.[17] That report made "patients' values and preferences" a supporting prong for evidence-based medicine.[18] Our concern is that the processes that are designed to control flows and eliminate variation in treatment patterns are generally more rigid than flexible — for, after all, the intent of process control is control, not flexibility, and it is a truism that it is easier to design for standardization than it is to design for flexibility.

4. THE HEALTHCARE DELIVERY ORGANIZATION: CONTROL OF ITS ENVIRONMENT

Finally, some of the greatest impediments to the appropriate design of quality programs may come from the environment in which healthcare organizations operate. In spite of many conflicting values and beliefs about healthcare and healthcare policies, our society does not yet believe that healthcare is purely a market commodity.[19] However, healthcare organizations have been forced to behave as though it were. They are subject to the competing pressures of their environment, which may, to a greater or lesser extent, depend on the organization's market position. For instance, there may be only one large employer in a geographic allocation — and several healthcare organizations. Or there may be only one healthcare organization that dominates the competitive landscape in a region. In addition, most healthcare organizations rely on some reimbursement through federal and state agencies. Conflicts between various elements of an environment may cause healthcare organizations to be exposed to simultaneous, conflicting imperatives: "improve quality, at whatever cost," and "reduce costs, no matter what effect that has on quality."[20]

All of the above idiosyncrasies make it difficult to design quality initiatives that produce outcomes that are desired and evaluated as "quality" by all associated stakeholders. Conflicts among stakeholders' values often lead to ethics consultations, which places those interested in clinical encounters, and the ethical issues surrounding such encounters, in a particularly privileged position to evaluate the ethical implications of quality initiatives.

QUALITY IMPROVEMENT REMAINS AN IMPORTANT GOAL

Despite the difficulties of implementing appropriate and flexible quality initiatives, there are good reasons why healthcare organizations consider the adoption of a flexible, focused quality initiative appropriate. First and foremost is the fact that quality in healthcare delivery has been deemed unacceptable. Processes that can help with decision making, help eliminate unnecessary waste, and contribute to the development of clinical knowledge and skills should be encouraged. All stakeholders agree that treatment should be efficient

and effective. It is when one goal is prioritized at the expense of the other that a process can produce ethically unacceptable outcomes — and, given the emphasis of many quality initiatives on quantification and accountability, without some explicit mechanism to ensure an appropriate balance, efficiency or cost-control will be emphasized at the expense of effectiveness or quality.

Although members of clinical ethics committees are in a position to receive "early warning" of disruptions of patient care by the introduction of inappropriate quality initiatives, the tradition of ethics consultation does not always encourage committee members to look beyond individual cases. Here, we suggest one mechanism and two strategies that may increase the usefulness of ethical oversight by ethics committees.

ORGANIZATIONAL ETHICS PROGRAMS

In 1995, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recognized that increasing pressure to constrain healthcare costs was a growing threat to the quality of healthcare, and urged each of the institutions it accredits to institute a process or program to scrutinize business practices for possible impact on patient care.[21] Such "organizational ethics" programs can provide a mechanism to balance quality and cost.[22] However, not every delivery organization has formed an organizational ethics program, and many extant programs are floundering.[23] To date, there is no consensus on the activities of such programs, let alone the identification of appropriate educational requirements. If the organizational ethics movement does not provide leadership by reminding the designers of quality initiatives of the mission and values of healthcare organizations, it will fall to clinicians and clinical ethics programs to address cases in which the poor design of quality initiatives produces ethically unacceptable outcomes. For this, the designers may need to develop new skills, for they are dealing with systems that are designed to produce the very outcomes deemed unacceptable. Below we discuss the foundations of a skill set that we believe will be needed.

A SYSTEMS APPROACH

Susan Wolf has argued that a systems perspective is needed to think about important issues in healthcare. Wolf used the example of informed consent to argue that merely considering the process of informing a patient of the options of treatment, and getting consent at the point of treatment (a dyadic approach) is an oversimplification of the complex arrangements in healthcare systems and bypasses many elements that affect patients' consent. As our healthcare system is presently configured, it is necessary to have information concerning patients' subscription to an insurance plan, insurance and healthcare coverage, information sharing and transfer, rationing, and other points of care. It is precisely in this network or web of relationships that patients become ill informed, and the degree to which patients are actually able to provide "consent" becomes problematic. To consider informed consent only in patient-healthcare professional one-on-one encounters does not take into account how the patient is insured, how the professional and the healthcare center are reimbursed, limitations on capitation and rationing (which may be prescribed by the employer of the patient, the insurer, the state, Medicare, or Medicaid, or by other criteria), patients' and physicians' options in treatment (many of which are financially constrained), and whether the patient has the option to go to another healthcare center. Obligations to inform patients run all the way through the healthcare system, and not merely at entry or before treatment. And it is not merely the physicians' duty to inform patients, since that places an undue burden of knowledge on healthcare professionals. Moreover, many clinical ethical issues arise because disclosure and full information have not been disseminated at every stage, not merely at the point of treatment.[24]

Wolf goes on to argue, "A truly systemic view [of current healthcare] . . . considers how [this set of individuals, institutions, and processes] operates in a system with certain characteristics. The system in-

volves interactions that extend over time, a complex set of interrelated decision points, an array of [individual, institutional, and governmental] actors with conflicting interests . . . and a number of feedback loops."[25]

Quality initiatives can be thought of as system initiatives, in that they are designed to change processes or components through which a prescribed outcome is anticipated. The outcomes from these initiatives cannot be understood in isolation from the processes or components that produce them. To understand, and effectively address, the ethically unacceptable outcomes that arise from quality initiatives, clinicians and clinical ethicists should take a systemic view in analyzing them, and put them in their context. They may have to understand how management issues, financing, costs, capitation guidelines (and other regulations), patient information (as well as patient autonomy), professional standards, and the quality of healthcare delivery are affected by the design of the process under consideration — any of which may represent different criteria for judging quality for different stakeholders or groups of stakeholders.

A systems approach acknowledges that most of our reasoning, experiencing, practices, and institutions are interrelated and interconnected. Almost everything we experience or think about exists in a network of interrelationships, such that each element of a particular set of interrelationships affects the other components of that set and the system itself, and almost no phenomenon can be studied in isolation from these relationships.

Ramo notes, in a systems approach, "concentration is on the analysis and design of the whole, as distinct from . . . the components or parts."[26] Systems thinking requires conceiving of the system as a whole with interdependent elements, subsystems, and networks of relationships and patterns of interaction. Studying a particular component of a system or a particular relationship is valuable under this rubric, but one needs to acknowledge that the component under consideration is also embedded in, and affected by, other systemic considerations. Mitroff and Linstone note, because "the fundamental notion of interconnectedness or nonseparability forms the basis of what has come to be known as the Systems Approach, every problem humans face is complicated and must be perceived as such."[27] Thus, each system or subsystem, because it is complex and entails a multitude of various individual, professional, clinical, managerial, and financial and sometimes even political relationships, must be analyzed, and must be analyzed from multiple perspectives.

ACKNOWLEDGING MULTIPLE PERSPECTIVES

We noted above that quality improvement strategies are typically introduced on the organization level, rather than by individuals. But individuals within the organization have a central role in maintaining the quality of the clinician/patient interaction, and a responsibility to scrutinize the strategies and mechanisms that further the important goal, common to both organizational and individual providers, of providing care of high quality for reasonable cost. By acknowledging the importance of this shared goal, clinicians can best contribute to its achievement. But this may involve adopting, for purposes of analysis, a multi-perspective method to evaluate and improve quality improvement strategies.

A multi-perspective method postulates that problems arising for or within a system should be dealt with from a number of perspectives, to maximize the values represented by the alternatives. Each perspective may illuminate a different value, which will challenge other values in dynamic exchanges of questions and ideas. In a healthcare delivery organization, one needs to look at problems from a technical or fact-finding point of view, from an organizational and financial perspective, from the perspective of professional expertise, and from the perspective of individual patients and their values, priorities, and particular illnesses. Then one can rank problems, perspectives, and alternate solutions and evaluate a problem and its possible resolution from the multiple perspectives.[28]

While it is never possible to take into account all the factors involved in a particular case analysis, to consciously attempt a multi-perspective approach forces us to think more broadly, and to look at particular problems from different points of view. This is crucial in present day clinical dilemmas, because, as Mitroff and Linstone note, each perspective usually "reveals insights . . . that are not obtainable in principle from

others."[29] This is also invaluable in trying to understand other points of view. A multi-perspective approach is essential to understand the limitations that financial pressures and guidelines place on healthcare delivery, what is at stake for the uninsured, or what is at risk when professional staff are overburdened with efficiency requirements or their numbers are decreased. This can explain how medical errors might occur, as well as help provide fresh insights to their prevention. Such a process does not require clinicians and clinical ethicists to be experts in all these fields. Rather, it helps clinical ethicists to contextualize the issues, to become more informed, and to figure out where to look for outside expert assistance, when needed.

Clinicians are familiar with the idea of a multi-perspective approach. In the clinical encounter, clinicians often evaluate a plan of care from several perspectives, such as whether or not a family can accommodate the care required by a patient. Clinical ethicists also know the importance of considering the interests of all persons who have a stake in a given case. Indeed, most methodologies that outline how case consultations should proceed stress that facilitating the making of difficult decisions requires considering all relevant facts and the perspectives of all concerned.[30] We suggest that this same approach should be brought to bear on the processes and relationships that form the context of care, outcomes as well as processes.

CONCLUSION

We have discussed some of the obstacles that may preclude the appropriate implementation of quality initiatives in healthcare institutions and suggested that if these obstacles are not considered in the design of quality initiatives, this may produce outcomes that are ethically unacceptable. *Quality* is a relational term. In healthcare, quality depends on the place of the evaluator in the system and the differing criteria through which the evaluator judges the effectiveness and efficiency of the product or service, and which stakeholders have their expectations met through the initiative. A systems approach, combined with a multi-perspective view, may be useful in designing or modifying such initiatives.

A warning, however; there are two provisos to using a systems approach. First, because we are talking about clinical ethics programs in healthcare delivery organizations, the values of patient care, patient autonomy, and professional expertise are the core, primary values. Prioritizing the best interests of the patient is, and must be, the first consideration. This is obvious, but it is sometimes in danger of being overlooked when decisions that involve cost are at stake.

Second, a systems approach does not mitigate individual professional, managerial, organizational, or patient responsibilities. A systems approach should not be confused abdication of individual responsibility. As individuals, we are not merely part of or determined by the systems and relationships in which we are involved. Each of us is a byproduct of, character in, and author of the organizations, institutions, and systems in which we live; thus, each of us bear responsibility for the quality of healthcare delivered and its weaknesses.

Use of a systems approach indicates that clinicians and clinical ethicists should become aware of the complex dimensions of the healthcare system in which they and their organization are operating, and that they should bring those considerations into play when necessary in ethics consultations. This may require evaluating roles, relationships, and the context of a quality initiative, and working to make changes that improve the system. This is an example of what Patricia Werhane has called *moral imagination:* "the ability in particular circumstances to discover and evaluate possibilities not merely determined by that circumstance, or limited by its operative mental models, or merely framed by a set of rules or rule-governed concerns."[31] In healthcare delivery, the clinical setting requires such moral imagination, operating on the organizational and systemic levels, as well as within specific clinical settings.

ACKNOWLEDGMENT

This work was supported by a grant from the Batten Institute of the Darden Graduate School of Business, University of Virginia.

NOTES

1. R.W. Grant, R. Shani, and R. Krishnan, "TQM's Challenge to Management Theory and Practice," *Sloan Management Review* 35, no. 2 (1994): 25-35.

2. R. Garrison and E. Noreen, *Managerial Accounting,* 8th ed. (Boston: Irwin McGraw-Hill, 1997), 200-2.

3. J. Detert, R.G. Schroeder, and J.J. Mauriel, "A Framework for Linking Culture and Improvement Initiatives in Organizations," *Academy of Management Review* 25, no. 4 (October 2000): 850-63.

4. W.E. Deming, "Improvement of Quality and Productivity Through Action by Management," *National Productivity Review* 1, no. 1 (Winter 1981-1982): 12-22.

5. G. Laffel and D. Blumenthal, "The Case for Using Industrial Quality Management Science in Health Care Organizations," *Journal of the American Medical Association* 262, no. 20 (November 1989): 2869-73.

6. Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000).

7. See notes 1, 2, 4, and 5 above. Also see R. J. Bringewatt, "Making a Business Case for High-Quality Chronic Illness Care," *Health Affairs* 20, no. 6 (2001): 59-608.

8. Quality initiatives are "system initiatives," as they look at each component of production or service processes, and many purport to eliminate fear of blame or mistakes in the workplace by empowering workers to identify problems in processes and suggest improvements. See note 2 above.

9. M.R. Chassin, R.W. Galvin, and the National Roundtable on Health Care Quality, "The Urgent Need to Improve Health Care Quality," *Journal of the American Medical Association* 280 (1998): 1000-5.

10. Quint Studer used a modified version of a management tool, the "balanced scorecard," to improve the relationships of hospital clinicians and staff with each other and their patients. There is some evidence that he has been successful in supporting these relationships — and this has resulted in improved performance, as measured by management indices. *Modern Healthcare* has published a number of essays on his accomplishments.

11. M. Bailit, "Ominous Signs and Portents: A Purchaser's View of Health Care Market Trends," *Health Affairs* 16, no. 6 (November/December 1997): 85-8.

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

13. J.D. Kleinke, *Bleeding Edge — The Business of Health Care in the New Century* (Gaithersburg, Md.: Aspen Publishers, 1998).

14. A.E. Mills and M.V. Rorty, "Total Quality Management and the Silent Patient," *Business Ethics Quarterly* 12, no. 4 (2002): 481-504.

15. See note 13 above.

16. R. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1998), 12.

17. Committee on Quality and Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System For the 21st Century* (Washington, D.C.: National Academy Press, 2001), see the executive summary.

18. The IOM definition of evidence-based medicine is supported by three prongs: best evidence, clinical expertise, and patients' values and preferences, derived from D.L. Sackett et al., "Evidence Based Medicine: What It Is and What It Isn't," *British Medical Journal* 312 (13 January 1996): 71.

19. R. J. Blendon and J. M. Benson, "Americans' Views on Health Policy: A Fifty Year Historical Perspective," *Health Affairs* 20, no. 2 (March-April 2001): 33-46.

20. See note 14 above.

21. JCAHO, "Patient Rights and Organization Ethics," *Comprehensive Accreditation Manual for Hospitals* (Oakbrook Terrace, Ill.: JCAHO, 1995), 95-6.

22. A.E. Mills and E. M. Spencer, "The Healthcare Organization: New Efficiency Endeavors and the Organization Ethics Program," *The Journal of Clinical Ethics* 13, no. 1 (Spring 2002): 29-39.

23. A few programs seem to be flourishing: see A.E. Mills, E.M. Spencer, and P.H. Werhane, ed., *Developing Organization Ethics in Healthcare: A Case-Based Approach to Policy, Practice, and Compliance* (Hagerstown, Md.: University Publishing Group, 2001). See "Appendix C," J. West and E. White, "The Development of the Sentara Healthcare System's Ethics Program"; "Appendix D," C. Myser, P. Donehower, and C. Frank, "Bridging the Gap Between Clinical and Organizational Ethics in a Newly Merged Healthcare Organization"; but, in general, most programs we are familiar with are floundering.

24. S. Wolf, "Toward a Systemic Theory of Informed Consent in Managed Care," *Houston Law Review* 35 (1999): 1631-1749.

25. Ibid., 1647.

26. S. Ramo, *Cure for Chaos* (New York: D. Mackay, 1969): 11-2.

27. I.I. Mitroff and H. Linstone, *The Unbounded Mind* (New York: Oxford University Press, 1993), 95.

28. Ibid., see chapter 6.

29. Ibid., 98. For further development of a systems approach to healthcare, see P.H. Werhane, *Moral Imagination and Management Decision-Making* (New York: Oxford University Press, 1999), 93.

30. For example, J.C. Fletcher and E.M. Spencer, "Ethics Services in Healthcare Organizations: Insuring Integrity and Quality," in *Fletcher's Introduction to Clinical Ethics,* 3rd ed., ed. J.C. Fletcher, E.M. Spencer, and P.A. Lombardo (Hagerstown, Md.: University Publishing Group, 2005), 297-326.

31. Werhane, see note 29 above.