THE ETHICS OF MISSION AND MARGIN

BY NICOLE D. VOGES
The appropriate application of that oft-repeated adage requires that healthcare executives maintain a high standard of conduct and adhere to ethical obligations. Those standards and obligations served as the underlying theme for ACHE’s program “The Ethics of Mission and Margin,” held in conjunction with the San Antonio Cluster in May.

Led by Richard A. Culbertson, PhD, professor and director, health management and policy, Louisiana State University Health Sciences Center, New Orleans, and funded in part by the Fund for Innovation in Healthcare Leadership, the program presented fundamental ethical precepts and referred to resources such as ACHE’s Code of Ethics as guides for healthcare executives in navigating the myriad difficult situations that impact both their organization’s financial margin and their mission of providing high-quality healthcare services.

Defining Healthcare Ethics

Culbertson began the program by grounding contemporary decision making in “classic” ethical concepts. He described the following precepts as the foundation of ethical decision making in healthcare management:

- **Beneficence:** The obligation to benefit one’s institution and those it serves, including the staff, patients and community
- **Nonmaleficence:** The obligation to bring no harm to one’s institution or to those it serves
- **Respect for persons (autonomy):** The obligation to protect and preserve the individual autonomy of those affected by administrative practices and managerial decisions, particularly the autonomy of patients and staff
- **Justice:** The obligation to act in a fair and impartial manner in making administrative decisions that affect one’s institution or any party it serves
- **Utility:** The obligation to balance beneficence, nonmaleficence, respect for persons and justice in order to maximize the greatest utility in administrative decision making

Culbertson, who has served as both a hospital CEO and a health system board chair at Kaiser Permanente’s Los Angeles Medical Center and Aurora Health Care, Milwaukee, respectively, noted that many of the precepts also serve as the core values of

“**NO MARGIN, NO MISSION.**” It is a simple expression, but for those in the healthcare management profession it involves sophisticated thinking that moves beyond financial collateral and purpose statements.
contemporary medical ethics, although some of the related concepts have evolved.

He used a fictional example from the Tennessee Williams play “Cat on a Hot Tin Roof” to illustrate one such shift. The story’s patriarch, Big Daddy Pollitt, had been diagnosed with cancer, but doctors only shared the diagnosis with family members other than Big Daddy and his wife. At the time the play premiered in 1955, Culbertson said, “the conventional notion of medical ethics was that we would hide—or shield—diagnoses when it was in the patient’s best interest to do so.”

That theory, he said, was replaced in the 1970s with one providing for the respect for persons in the form of “full disclosure, including sharing of diagnoses and complete clinical information with the patient whenever and wherever possible.”

One concept in medical ethics that has not changed, but that has received much more attention in recent years, is justice. Culbertson said many care-related scenarios that come into opposition center around the idea of justice. He cited the lack of acute psychiatric services in post-Katrina New Orleans as an example. He noted the

The Fund for Innovation in Healthcare Leadership

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An article on the second of two Fund programs for 2012, “Palliative Care: Impact on Quality and Cost,” which will be held in September at the Atlanta Cluster, will appear in the January/February issue of Healthcare Executive.

The Fund was established in 2006 to bring innovation to the forefront of healthcare leadership by developing and enhancing its focus on future healthcare leaders, ethics in healthcare management and healthcare management innovations. In its commitment to developing future leaders, the Fund also has provided scholarships for the Foundation of ACHE’s Senior Executive and Executive Programs. Since the Fund’s inception, more than 1,200 generous donors have made contributions. This support has enabled the Fund to strengthen the field of healthcare leadership by providing educational opportunities on important trends and issues.

For more information on the Fund, including ways to contribute, please visit ache.org/Innovation or contact Laura J. Wilkinson, CAE, vice president, Development, at (312) 424-9305 or lwilkinson@ache.org.
impact of the stark and sudden absence of these key services, and he prompted attendees to consider what becomes of the individuals who would have received those services in the hospitals that offered them had they not closed.

“The tension between mission and margin is probably nowhere more acutely reflected than in the concept of justice and how we choose to apply it,” Culbertson said. This imbalance is at play as leaders become increasingly aware of resource constraints and the need to make management decisions that will advance certain individuals or groups, but potentially disadvantage others.

Duty-Based Ethics
To effectively manage these conflicting needs, Culbertson suggested healthcare executives look to resources such as ACHE’s Code of Ethics when facing concerns. The Code has been available to healthcare executives since 1941, but much like the evolving concepts of medical ethics, it requires periodic review and revision as the healthcare management profession evolves. ACHE members are surveyed periodically in regard to the Code, and ACHE’s Board of Governors adopted the latest version in 2011.

The standards of conduct detailed in the Code are built on duty-based ethics, Culbertson said. “Within the ACHE Code of Ethics, we as executives undertake certain duties—we have a duty to the profession that we are individually accountable as outlined in the Code and are expected to adopt and value the behaviors that the profession has adopted.”

Culbertson listed four groups to which healthcare leaders have duty-based ethical responsibilities:

- **Community**: Executives are held publicly accountable for respecting community values and protecting the public’s health and well-being
- **Patients and families**: Executives foster the institutional policies that achieve maximized benefits accrued by services provided, including quality and patient safety, for the patient, and they are accountable when they do not
- **Medical staff**: Executives are accountable for ensuring that the medical staff are able to benefit their patients by providing the necessary resources to achieve the delivery of safe, quality medical care
- **Employees**: Executives are bound to make certain that individual staff members fully realize their abilities and talents within the ethics of their professional group and that they are directed toward the provision of safe, quality care to the patient

“There are also duties that fall on the so-called owners of the organization, typically embodied through the board of trustees,” Culbertson said. “They have an obligation to establish the organizational mission and priorities and hold executives accountable for attaining that mission and thus ensuring the fiscal solvency of the organization.”

**Market Justice or Social Justice? Some Vignettes**
Healthcare leaders face pressure from other stakeholders as well. Culbertson cited the 2008 *JAMA* commentary...
The Ethics of Mission and Margin

During the program “The Ethics of Mission and Margin,” a panel of healthcare leaders shared experiences related to the ethical challenges of balancing mission and margin. The panelists describe how they put the program’s concepts into practice.

Beryl O. Ramsey, FACHE, CEO, Methodist Willowbrook Hospital, Houston, believes the best way to balance ethical precepts while operating within the fiscal pressures of today’s economy fall squarely on following her organization’s mission, vision and values. “When healthcare organizations clearly define and communicate these key foundations and operate in concert with them, the balance and difficult decisions that we face as healthcare executives become more manageable and in less conflict,” she said.

Ramsey also emphasized the importance of respect for persons. Methodist Willowbrook defines respect as treating every individual as a person of worth, dignity and value. “We must hold to this principle and value in healthcare because patients put their trust in us and our organizations, and employees look to us to provide a safe work environment. Healthcare executives are always faced with allocation of resource issues and must stay focused on making the correct and best decisions in providing safe, quality care, and operating with this core value has made a difference for me,” she said.

Scott B. Ransom, DO, FACHE, FACS, FACOG, FACPE, president/CEO and professor, obstetrics, gynecology, health management and policy, University of North Texas Health Science Center, Fort Worth, believes that while there are many challenges to running a healthcare institution, there are certain ethical lines that are not acceptable to cross. “My institution has a very specific mission, vision and values, and that’s the way we behave. Not some of the time; all of the time. There are just certain things that absolutely must be. It’s a nondebatable issue,” he said.

Ransom suggests that healthcare leaders prioritize the ethical concerns that come up often in order to be prepared. “Where do things like beneficence and autonomy stack up on your priority list? Every executive needs to figure out where they fit because there will be times when those things are challenged and you have to be ready to compare. Which one wins—beneficence or revenue? For me, it’s beneficence,” Ransom said.

As president and CEO of the Texas Hospital Association (THA), Austin, Daniel B. Stultz, MD, FACHE, faces public health ethics issues regularly. He recalled an ethical issue that has to do with utility and, to a degree, justice. “We have a law in Texas going into effect Sept. 1 that physicians will testify that they’ve been vaccinated against preventable illnesses. Some CMOs don’t like it, but THA backed that legislative issue. I think it’s indefensible to argue that a doctor should not have to have his vaccination current on things like the flu and pertussis,” he said.

He likened the policy position to THA’s defense of physicians who choose not to work with pediatric patients who have refused vaccinations. “A physician doesn’t want to take the legal or moral ground of taking care of someone who dies of pertussis. We defend that right, so why should we allow any physician to take the opposite course, which is that he doesn’t have to be vaccinated when he could contract a disease? That’s a no-brainer, no question.”
Panelists and attendees considered the ethical concepts, discussed the limits of financial resources and shared their own experiences in an effort to reach sound decisions about the dilemmas presented in the case studies.

Achieving Ethical Balance
After the panel-led deliberations were concluded, Culbertson commented that “achieving balance” was his main takeaway from the vignette discussions. “It should come as no surprise that the executive inhabits a role that requires judicious balance of the above principles and forces, recognizing that they are often in direct or subtle conflict with each other,” he said.

Healthcare leaders, Culbertson said, should pay attention to “the effect of ethics on the conundrum of ‘no margin, no mission.’” He continued, “I think margin has been pretty well looked after in the past decade, and as we move into a new health reform era, I would put in a plug for looking at the role of mission—seeing how we can sustain mission in the face of economic challenges.”

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— Richard A. Culbertson, PhD, Louisiana State University Health Sciences Center

“Market Justice and US Health Care,” by Peter P. Budetti, MD, JD, when pointing out the uncomfortable position healthcare executives are put in when considering market justice and social justice. According to Budetti, deputy administrator and director, Center for Program Integrity, Centers for Medicare & Medicaid Services, physicians, patients, suppliers, insurers, public officials and others have diverse, and sometimes contradictory, viewpoints on market justice.

Market justice considers healthcare an economic good, and it views access to care as an economic reward for personal effort, while social justice allocates healthcare as a societal resource where receipt of care is not linked to ability to pay, Culbertson said.

With that added ethics component in mind, following the presentation three ethics panelists (see sidebar, page 36) led attendees through case studies meant to further explore the healthcare executive’s duty to community, patients, the organization and employees. The vignettes represented real-world operating scenarios healthcare executives have encountered, such as the following:

• A regional health system faced the decision of whether to close one of two remaining major emergency departments and a full-service hospital in an inner-city area due to a decade-long span of annual losses. The city’s mayor pled with the hospital system to stand firm and keep its locations open. (Ethical considerations: justice, beneficence, utility.)

• A hospital was compelled to consider an employee benefit program that calls for assessing lower premiums for those who participate in a health screening program. (Ethical considerations: justice, respect for autonomy.)

• A healthcare organization considered a request from community officials to hastily reopen a facility after an “unprecedented catastrophe.” (Ethical considerations: beneficence, justice, utility.)