A Social Contract of Foundation for the Professional Ethics of Healthcare Administrators

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LOYOLA UNIVERSITY CHICAGO

A SOCIAL CONTRACT FOUNDATION FOR THE
PROFESSIONAL ETHICS OF HEALTHCARE ADMINISTRATORS

VOLUME I
(Chapter I through Chapter IV)

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
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BY
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CHAPTER I
INTRODUCTION

This dissertation will attempt to define the moral obligations of healthcare administrators as based upon their claim to—and popular recognition of—professional status. It will be proposed that a social contract foundation offers the needed justification for groups such as healthcare administrators to be considered professionals, and for a clear defining of the existence and nature of their professional obligations.

It is important to note that two key presuppositions will be made in this dissertation. The first presupposition is that professions do in fact have moral obligations. The second presupposition is that healthcare administration may in fact be considered a profession.¹

The first presupposition, that professions and their members have moral obligations, is crucial. This presupposition could be challenged by the claim that there are no unique or particular professional obligations; rather, those who claim professional status possess only the normal, i.e., commonly recognized, moral obligations generally associated with all other occupational roles or business positions in

¹The institution of profession will be examined and described in the next two chapters of this dissertation.
society. If no special obligations existed for professions and professionals, then there would be no need to study the professional obligations of health care administrators. However, in general conceptual thinking and common language usage it normally seems to be assumed that a central feature of professions and professionals is to possess some special obligations. Much of the literature found on professions and professional obligations assumes that special obligations do exist for professions and professionals. The claim that professions and their members have moral obligations therefore will not be argued for, but will be presupposed because it is found in popular conceptual thinking and common language usage and is presupposed in much of the literature on professions.

The second presupposition is that healthcare administration constitutes a profession. If this group is not a profession, or if its members are not considered professionals, then the basis for determining their moral obligations fundamentally would be no different than determining the moral obligations for other particular occupational roles or business positions in society.

The question of the status of healthcare administration

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2This dissertation will limit its study to healthcare administration in the United States. The term, "healthcare administrators," will be used to refer to the leaders of healthcare institutions in America. Who I have most in mind are hospital chief executive officers, chief operating officers, and hospital administrative executives in general, but also those same positions held in healthcare networks and healthcare alliances, i.e., systems with multiple institutions.
as a profession has been debated in the literature, but there is now a general recognition, at least within the healthcare field, that it can and should be considered a profession. While some disputes remain in the literature regarding the degree to which healthcare administration may be considered a profession in relation to the "traditional" professions, such as medicine, law, and clergy, those who are actually engaged in healthcare administration certainly consider themselves to be professionals. This perception of healthcare administration constituting a profession arises from the evolved complexity of administrating a healthcare institution requiring what has now become an exclusive expertise, as well as from the common belief that healthcare institutions are not just businesses but are designed to serve the common good.

Historically in our society, healthcare administration originated as a management position needed merely to coordinate the "workplace" of physicians. As surgery was successfully developed, however, hospitals increased in size, technology, competition, and perceived importance to their

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3 This point is developed in Janet Storch, "Hospital Administrators as Professionals: A Study of Occupational Role Identity," Hospital and Health Services Administration 34 (Winter 1989): 507-523.

4 See, for example, Mary MacDonald, "Does Health Administration Represent a New Form of Professionalism?" Health Management Forum 3, no. 4 (Winter 1982): 10-18.

5 See, for example, Jerry Weaver, Conflict and Control in Health Care Administration (Beverley Hills, CA: Sage Publications, 1975): 15-59.
communities, and administrative decision-making was gradually taken over from physicians by specially-trained lay people. In 1933 the American College of Hospital Administrators ⁶ was formed, partially in an attempt to gain recognition as a distinct profession in itself. Medicine progressed with the development of antibiotics after World War II, and through the availability of Hill-Burton funds hospitals grew both in number and size; they developed interests and goals distinct from those of physicians, and the authority of administrators rose along with the managerial complexity and budgets of the institution.

With the growth in health insurance and the development of Medicare and Medicaid funding in the 1960's, hospitals burgeoned into big businesses. For the next two decades not-for-profit institutions expanded and fiercely competed with one another and with the growing number of for-profit institutions and corporations for the market share. At the same time there was a rapid growth in technology, with the corresponding employment of highly skilled and state-licensed personnel, and the emergence of complex information systems. The 1970's introduced managed care, and the 1980's were marked by third-party payer cost-containment measures such as cost caps, fixed reimbursement by diagnosis, and per diem reimbursement. Healthcare institutions responded with cost-cutting measures

⁶This title was changed to the American College of Healthcare Executives in 1984.
through stricter utilization criteria and measurement of productivity and quality. The 1990's have seen hospitals downsizing and merging or networking with other healthcare institutions and networks, initiating various forms of integration and collaboration seeking institutional survival in the face of shrinking reimbursement.\(^7\) Administrating a healthcare institution has evolved into an extremely complex job requiring an unique blend of multiple skills and talents.

Because of the nature of the service provided by healthcare institutions, however, healthcare administrators commonly have not been viewed solely as businesspeople, executive managers, or information analysts. Healthcare institutions have carried great symbolic and social significance in our society, embodying our faith in science, technology, and expertise, and reflecting the values of altruism, social solidarity, and community spirit.\(^8\) Healthcare administrators, by position of their leadership role, have been charged with the responsibility of facilitating institutional response to the fundamental human need of individual health and to the general societal concern for the health of the community.

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\(^7\)For a good overview of the changing role of healthcare administrators, see Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the 20th Century* (New York: Basic Books, 1989)

Because of this responsibility, our society generally expects that health care administrators hold professional status and have professional obligations. In short, healthcare administrators consider themselves to be members of a profession and society treats them as such.

Describing the moral obligations of healthcare administrators is undertaken in order to make an important contribution to the study of professional ethics in general, and to the ethics of healthcare administration in particular. Reflecting the evolving role of hospitals throughout this century, the role of healthcare administration has undergone many changes.

It is not unlikely that the role of healthcare administration will continue to evolve, as currently our country approaches the precipice of some type of healthcare reform, whose values, structure, and delivery have yet to be completely determined as of this writing. The literature in healthcare administration eloquently articulates the problems which have led to the national call for reform and calls upon healthcare administrators to exercise a leadership role in that reform. Unfortunately, however, this literature often tends to represent a defensive posturing, advocating or attempting to salvage the interests of healthcare institutions; furthermore, this literature can be criticized for failing to articulate the professional values of healthcare administrators which would justify and identify their professional
obligations in the face of healthcare reform.

I see this situation existing because the current literature addressing ethics in healthcare administration can be described, at best, as limited in quantity, incompletely developed, and either focusing merely on personal values and institutional standards with no identification of the role-specific duties of healthcare administrators, or offering only generalized descriptions of ethical theories instead of providing a listing and prioritization of this role's central values, i.e., a hierarchy of "goods," to guide how healthcare administrators are to apply those theories when confronted with value conflicts and moral dilemmas. Furthermore, current textbooks used in healthcare administration graduate programs barely mention the subject of ethics or of role-specific professional obligations.

This dissertation will attempt to provide a social contract foundation for the ethics of healthcare administrators. It will be argued that this social contract foundation will help identify and prioritize the role-specific values and

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9This describes the only available textbook on the ethics of healthcare administrators: Kurt Darr, Ethics in Health Services Management (New York: Praeger, 1987). For a similar criticism of the teaching of healthcare administration ethics, see Deborah Tregunno, "Ethics and Hospital Administration," Health Management Forum 7 (Spring 1986): 58-69; Samuel Levey and James Hill, "Between Survival and Social Responsibility: In Search of an Ethical Balance (and Responses)," Journal of Health Administration Education (1986) 4, no. 2: 225-248.

obligations of healthcare administrators, thus offering assistance to the profession when its members are called upon in their institutional leadership role to make difficult moral decisions affecting their institution and the health concerns of their patients and community.

In exploring the ethics of healthcare administrators this dissertation will utilize the seven categories of professional obligation developed by David Ozar. These categories consist of: 1) identification of the chief client, 2) the ideal relationship with the client, 3) commitment to the good of the client, 4) central values of the profession, 5) commitment to competence in the area of the profession's expertise, 6) relationship with co-professionals, and 7) relationship with society at large.

This dissertation consists of two parts with nine chapters. Part One develops the theoretical foundation of professions and professional obligations in general. Part Two applies the conclusions reached in Part One to identify the professional ethics of healthcare administrators.

Part One consists of four chapters. Following this introduction, Chapter II argues that sociological theories fail to adequately define "profession" since they lack conceptual clarification and agreement regarding the meaning

"David Ozar and David Sokol, Dental Ethics at Chairside (St. Louis: Mosby, 1994), 31-35. The eighth category listed here, titled "Education and Integrity," is not utilized in this dissertation.
of the term. Chapter III proposes that a "central instances" approach to defining "profession" is most compatible with the common language usage of the term. Chapter IV argues that the professional status and moral obligations of professional groups in general and of healthcare administrators in particular can be justified only if grounded in a set of mutual commitments of the sort that philosophers have imaged as a "social contract," namely, commitments between society and that group.

Part Two consists of five chapters. Four different models or ways of understanding professions and their obligations which can be found in the literature are examined. The ethics of healthcare administrators is explored in these chapters utilizing the presuppositions of each model. Chapters V, VI, and VII examine what are called the Guild, Agent and Commercial models of professions. In each chapter, presuppositions of the particular model are identified, the concept of the profession of healthcare administrators is developed within the parameters of each model, the moral values and obligations of health care administrators from within the context of each model are examined, and lastly criticisms are raised citing weaknesses and inadequacies in the way each model addresses the professional status and professional obligations of healthcare administrators in light of the proposed social contract between society and this profession.
Chapter VIII argues that only what has been called an "Interactive" model of profession and professional obligations satisfies the requirements of the social contract. Presuppositions of the Interactive model are defined, the concept of the profession of healthcare administrators within the Interactive model is explored, the moral values and obligations of health care administrators are examined, and lastly challenges to the Interactive model of professions and professional obligations are addressed.

Chapter IX serves to summarize and offer conclusions on the main points of this dissertation.
CHAPTER II

DESCRIBING A PROFESSION:
THE FAILURE OF THE SOCIOLOGICAL APPROACH

Undertaking the task of defining the professional obligations of healthcare administrators first requires that an understanding of the nature of profession be articulated in order to grasp the unique character of "professional" obligations. This is necessary so as to distinguish professional obligations from the moral obligations associated with other roles in society such as, for example, the moral obligations normally associated with being a parent or a citizen. Since professionals earn their livelihood by practicing their profession, defining the nature of profession also allows for professional obligations to be distinguished from the moral obligations normally associated with everyday (non-professional) business transactions.

This chapter will explore four different understandings or conceptual models of profession as found in the sociological literature and utilized in the health care administration literature. These models will be briefly summarized and then critiqued. Each model offers a perspective on pertinent characteristics or traits that can be employed in a philosophical analysis of profession. It will be argued that each
model, however, fails in its own attempt to define profession for two reasons.

First, these different sociological "schools of thought" make different assumptions about the nature of profession and ask different questions about the make-up and purpose of professions; this results in a fundamental disagreement over their proposed essential features of a profession. Second, these sociological conceptions of professions are limited to the historical and cultural manifestations of 19th and 20th century occupational groups who were accorded professional status. The cultural context which shapes professions, however, is continually changing. Contemporary medicine, for example, as an occupational group no longer resembles sociology's traditional image of it as a profession, and some groups which are commonly considered to be professions today do not resemble the current make-up of contemporary medicine nor previous cultural manifestations of medicine as an occupational group. Thus, if no occupational groups currently match the professional groups studied by sociology in the past, then it is unclear to what degree a contemporary occupational group must possess characteristics or traits associated with the professional groups of the past in order to be called a profession today, or what traits should be considered essential rather than accidental features or traits of a profession, and what criteria should be used to establish those essential features and traits.
Since sociology fails to conceptualize or define adequately the nature of profession, social theorists are forced to merely adopt a definition of profession and remain faithful to that definition throughout their usage of the term. That approach cannot work here. If it may be assumed that the nature of professional obligation as we find it in health care administration is dependent upon the nature of profession, then arbitrarily adopting a definition of profession would result in identifying specific professional obligations of health care administrators based upon arbitrary group characteristics that not everyone would agree on as the core of what should be considered professional. This would undermine the validity of the conclusions this dissertation will reach. The sociological accounts, therefore, are unable to adequately conceptualize or define the nature of professional obligations in general, and the professional obligations of health care administrators in particular.

Four Models of Profession in the Sociological Literature

The Functionalist Model

Sociological approaches to the study of professions have viewed professions either in a positive or negative light. The positive approach to viewing professions has been called the Functionalist model.¹ In this view professions as

¹This term is used in John Kultgen, Ethics and Professionalism (Philadelphia: University of Pennsylvania Press, 1988), Chapter 5.
occupational groups and professionals as members of those occupational groups are characterized by their special expertise and by their commitment to altruism in unselfishly addressing particular fundamental human needs or social concerns in society.

In the Functionalist model the professions are viewed as enjoying a monopoly of expertise in their domain of authority. Members of society must come to them for help in addressing such fundamental human needs and social concerns as health, justice, and religious salvation. It is the vital importance of these fundamental needs and concerns to individual human life and to society at large, coupled with the exclusive authority of particular occupational groups to address those needs and concerns, which distinguishes professional work from other highly skilled activities. Furthermore, professionals confine themselves to providing means to their clients' or patients' ends. They promise not to exploit their clients' or patients' vulnerability for selfish gain, but rather to devote their expertise to address their clients' or patients' problems. It is also generally understood that all members of society have access to the professions' services. Thus professions serve as the best means to address specific fundamental human needs and social concerns.

In the Functionalist model professionals base their
decisions on rationally grounded scientific principles, yet they are called "practitioners" since their concern is to utilize their special skills and judgments for the solution to practical problems. Professional work therefore requires extensive intensive training and life-long dedication to insure an on-going development in professional skill and judgment. This results in a wide gap of knowledge between the professional and the client or patient. Combined with the profession's pledge to unselfish altruism, this allows professions to be granted monopoly over their knowledge and skill and to be assured of their autonomy in practice.

Monopoly in competence is the foundation for professional autonomy, the primary distinguishing characteristic of professions in the Functionalist model. A profession as a group is autonomous in that it is largely exempt from control by society and is left free to regulate the admission, training, standards, and behavior of its members; individual professionals are autonomous in that a profession's reins of control tend to be slack and the decisions of individual professionals are assumed to reflect their technical competence and professional commitment to unselfishness and altruism. Group monopoly over competence with resulting autonomy is maintained through standards of technical competence or traditions, and their theological perspectives on their religious traditions and the sacred writing associated with their religious traditions.
competence and codes of ethics, and maintaining such monopoly is argued to be the best means of assuring predictable high-quality service in addressing the specific fundamental human needs or social concerns that gave rise to the professions. Professions therefore tightly control membership entry, provide the required extensive formal education, award a professional degree before allowing professional practice, exert control over practice and behavior through professional associations, and restrict evaluation of professional practice and behavior to fellow-professionals since only they possess the needed competence for such evaluation. 3

The Functionalist model characterizes professions in an almost idealized way, and therein lies the weakness of the model. Occupational groups that are known as professions, and their individual members as well, often are not viewed as exhibiting these characteristics of the Functionalist model. What is proposed as a descriptive portrayal of profession comes across to many as more of a normative view of what the literature's authors believe professions should be. In the Functionalist model professions are assumed to be a force for the good and as the best means structured by society to

address specific fundamental human needs and social concerns. But rather than rely upon empirical studies describing how occupational groups with professional status actually constitute themselves and act, proponents of the Functionalist model tend to resort to idealistic descriptions of certain elite members of professions; the ideal characterization thus becomes the public image for all in the professional group.⁴

Criticisms of this Functionalist model of professions abound and arise from society's frequent negative experiences with professional groups and their members. Evidence of collective and individual self-interest within professions in the pursuit of income, status, and power repeatedly refutes the image of altruism and unselfish dedication to the clients' and patients' end as proposed by the Functionalist model. This is not to suggest that some professional individuals and at times some professional groups do not exercise personal disinterest or self-sacrifice, but rather that these qualities often are not present or self-evident. Efforts to preserve monopoly in competence are often perceived as a means to maintain income and status while minimizing competition. It does often seem that both professional individuals and groups tend to overvalue the importance of the service they provide and often appear strongly territorial in protecting and

⁴This position is developed in Jeffrey Berlant, Profession and Monopoly: A Study of Medicine in the United States and Great Britain (Berkeley: University of California Press, 1975).
preserving their role against encroachments from other occupations. Efforts at self-regulation often seem to be self-serving, while codes of ethics lack strong accountability and enforcement and often seem designed to be self-protecting. There is little evidence of peer review of individuals' work. Professional services are maldistributed and are not available to all. There often is not a perceived obligation among professionals to serve those without the means to pay. Professional groups in general seem ineffectual in restraining their members' profit motives. It is also not uncommon to hear charges that professionals associate their technical expertise with a general sense of moral and intellectual superiority, which leads some professionals to exercise paternalistic or exploitive behavior and to advise and direct in areas beyond their field of expertise. In sum, it does not appear that the Functionalist model accurately portrays and characterizes professions as they are perceived by many in society; furthermore, in light of these many criticisms, it is not readily apparent that professions as understood within the Functionalist model are in fact the most effective societal means to address specific fundamental human needs or social concerns.5

Recognizing these weaknesses or discrepancies in the Functionalist model of profession, other sociological accounts

5These points are raised in Kultgen, Ethics and Professionalism, Chapter 7.
in the past three decades have turned to describing and examining professions in a more negative light. Three different approaches critical to the Functionalist account of professions can be identified in the sociological literature. They have been termed the Dominance, Deprofessionalization, and Proletarianization positions.

The Dominance Model

The Dominance position argues that an occupation is able to claim professional status when, for self-serving reasons, it succeeds in its efforts to gain control over the determination of the substance of its own work and subsequent control over the work of others in its domain. Unlike other occupations, a profession believes it may demand autonomy in practice and freedom from control by society because of its exclusive expertise and claim of trustworthiness based on its promised altruistic application of this exclusive expertise. Professions seek to develop institutional structures to protect themselves from external competition, intervention, direction or evaluation. Cultural status and public deference to the profession are promoted by the professions in order to help maintain these institutional structures which safeguard their professional status.6

Because of the financial and sociological rewards accorded to professional groups and their members, other

6This position is developed in Elliot Freidson, Professional Dominance (New York: Atherton Press, 1970).
occupational groups strive to acquire the professional status achieved by the traditional professions of medicine, law, and clergy. These other occupational groups attempt to emulate these traditional professions by demonstrating that they, too, do reliable and valuable work - often establishing educational requirements, specific training programs, licensing procedures, a code of ethics, a professional association - all the "exterior trappings" of the traditional professions. It is the hope of these other occupational groups that society will perceive them as possessing exclusive expertise and an altruistic service orientation and that they alone are best able to address some particular vital human need or social concern, and thereby recognize their claim to professional status and confer upon them through institutional structures some level of autonomy and self-regulation with the accompanying financial and sociological rewards.7

With limited social control over professions, the possibility always arises - and in fact, according to the Dominance model, the possibility should be expected to arise given the primary self-serving motivation of the occupational groups striving to achieve professional status - for professions to misuse their autonomy in practice to promote their own self-interests or personal gain. Most contemporary criticisms of the Functionalist model are examples of this

Dominance model of profession.⁸

The Dominance model's critical view of professions is carried even further, however, by some social theorists who have come to see the pursuit by occupational groups for professional status as the quest for the deliberate abuse of autonomy. These social theorists describe what they term the "professional project" as the effort by an occupational group to organize itself to gain a monopoly over a service and control of the market so as to develop a demand for the service in the form it alone provides. According to this perspective, the earliest professions in the 18th and 19th centuries were occupational groups seeking to attain recognition and to drive rivals from the market place by organizing associations that set exclusive standards, controlling entry into the group, sponsoring schools and standardized training, regulating practice, and all the while seeking to improve their image before their patrons and public for the sole purpose of acquiring and maintaining market control over the services they provide. The "professional project" is thus an attempt to translate scarce resources - special knowledge and skills that can address a specific fundamental human need or social concern - into social and economic rewards. According

to this perspective, professions aspire to portray an ideology of personal disinterest, self-sacrifice, and altruism solely for the purpose of achieving economic rewards and social gain.\(^9\)

The Deprofessionalization Model

Another model of profession found in the sociological literature that is critical of the Functionalist approach to understanding profession has been termed the Deprofessionalization model. This model agrees with the Dominance model that an occupational group is able to claim professional status when it gains control or autonomy in practice over its own work. The Deprofessionalization position argues, however, that the traditional autonomy of professions, idealized in the Functionalist model and criticized in the Dominance model, has eroded in the last few decades and that professions have become subject to the formalized and hierarchical controls imposed by society on all other occupational groups. The Deprofessionalization model argues that even the traditional professions have lost their autonomy due to their loss of monopoly in competence. In medicine for example, this has been brought about by computerization which systematizes diagnoses and allows for close scrutiny of individual physician practice by comparison with group norms or standardized

procedures, a rise in public education and consciousness of health issues which lessens the exclusive expertise of physicians and which leads to greater challenging of their professional authority, increasing specialization within medical practice which makes for more interdependence and accountability between physicians and which creates a whole new group of non-professional technical experts, and the financial cost of medical services which has led to a demand for greater accountability of medical practice and for less reliance upon medical practitioners' professional commitments to disinterest, self-sacrifice, and altruism. The Deprofessionalization model, therefore, argues that occupational groups once granted professional status have in recent times lost their monopoly in competence and thus can no longer justifiably claim autonomy in practice.10

The Proletarianization Model

A third account critical of the Functionalist approach to profession is the Proletarianization position. This model

agrees with the Dominance view of profession and with the Deprofessionalization position that the traditional autonomy of professions has eroded in recent times. The Proletarianization position, however, is distinguished by its portrayal of professions losing their autonomy by becoming employees to large corporations. Increasingly now, according to the Proletarianization view, professionals are forced to "sell" their services and work for others. This model, dependent upon Marxist thinking, sees parallels between the proletarianization of the craft worker in the nineteenth century through the destruction of the guild, the undermining of craft knowledge and skill by new industrial technology and management, and the breakdown of the craft ethos of work, with what has been happening to professionals since the mid-twentieth century.\footnote{This model is developed in Vincente Navarro, "Professional Dominance or Proletarianization? Neither," \textit{The Milbank Quarterly} 66, suppl. 2 (1988): 57-75.} Three structural factors are cited which have led to most professionals now working for others.

First, technological developments leading to the introduction of complicated and expensive machinery in many forms of professional work have made it impossible for individual professionals to raise the necessary capital to own and control their own means of production. Second, with the expansion of professional markets and services, increasing centralized administrative mechanisms are needed to cope with the burdens of mass clientele. Third, large-scale public and
private capital has entered the professional market, reorganizing professional work along the lines of the dominant centralized corporate economy. The result is that professionals have become employees working within a complex bureaucratic division of labor on fragments of projects coordinated and directed by others. Their knowledge is so specialized and narrowed that it no longer serves as a base of power or control. Because of this loss of autonomy, many empirical studies indicate professionals now express dissatisfaction and unhappiness with the evolution of their professional role.\textsuperscript{12}

Some sociologists within the Proletarianization model shy away from Marxist terminology and thinking and describe the growing loss of professional autonomy in terms of "corporatization". They point to forms of corporate control such as utilization and quality review, incentive pay structures, restrictions on practice patterns and the corporate organization of practice, and the restructuring of the marketplace from solo or small-group providers to multi-institutional complexes. They argue that professionals compensate losing control over the product or "ends" of their work by trying to maintain control over the techniques or "means" of their work; what matters is not that one has autonomous control over one's

\textsuperscript{12}See, for example, Charles Derber, \textit{Professionals as Workers} (Boston: G.K. Hall and Company, 1982).
Three Criticisms of the Sociological Models of Profession

The presence of these four contrasting and competing sociological models, i.e., Functionalist, Dominance, Deprofessionalization and Proletarianization models, in effect serves to muddle rather than clarify the sociological attempt to construct one definition or understanding of the nature or profession. Sociology has been unable to construct one paradigm model of profession. Three major criticisms then can be raised against turning to sociology for an understanding of profession.

The First Criticism

The first major criticism is that these four sociological models of profession presuppose that medicine, law and clergy are the "traditional" professions without explaining what structures or features of those occupational groups makes them prime examples of a profession. These three occupational groups are simply assumed to be professions, and their structures and features are then taken to be standard requirements for any occupational group to be granted professional status. But the structures and features vary between these traditional professions, and social theorists tend to value or

emphasize different structures or features in these three professions without offering justifying reasons. As a result, there is lack of agreement between social theorists both within and between each of the four individual models regarding how to identify which other occupational groups are professions, or which traits or qualities need be present in an occupational group in order for that group to be granted professional status.

An illustration of the disagreement between models over the structure and features of profession is the Dominance model, studying what it views to be the "professional project," excludes a number of groups claiming professional status such as European professions where expertise had never been formalized independent of the state, organization-based professions in America such as the armed forces and civil service, and the nursing profession which has accepted a particular subordinate and non-dominant role; these groups do not "fit in" with the position of the Dominance model which espouses that professions are market organizations attempting intellectual and organizational domination in their specific areas of service. In contrast, the Functionalist model and even the Deprofessionalization and Proletarianization models happily include these "excluded groups" as professions since the structure and features of these occupational groups are not at odds with their perceptions of the functional framework of professions.
An illustration of the disagreement within models over the structure and features of profession is evidenced by the various lists of professional features proposed by social theorists within the Functionalist model of profession. One oft-cited social theorist, for example, lists the essential attributes of a profession as consisting of possessing a systematic theory of knowledge with specialized training, formalized organization with group culture, community sanction of group authority, and commitment to altruistic service and an ethical code. As a result, oftentimes members of the "traditional" professions look with disapproval and disagreement at the claims of other occupational groups to professional status because those groups lack such "essential professional attributes," or at least do not have them to the same degree as do the "traditional" professions. For example, despite claims by healthcare administrators to professional status, the medical profession still generally tends to view them as no more than managers with administrative duties rather than possessing professional characteristics, values, and obligations. Yet healthcare administrators continue to insist that they, too, are professionals, and so may appeal to a different social theorist who identifies different "essential" professional attributes to validate or lend greater

credence to their claim to professional status.\textsuperscript{15}

The different social theorists, then, give greater or lesser weight to these above mentioned traits, or include different traits in their lists or even exclude some of those traits. Surveys of sociological attempts to define profession find that hardly any two theorists agree on a same set of traits.\textsuperscript{16}

One result is that such discrepancies in professional trait-identification have led to a "scorecard" approach in what has been termed the "process of professionalization", in which other occupational groups try to emulate the traditional professions through the adoption of some of the features of those traditional professions such as the development of professional standards or a code of ethics. From this we are led to believe that the more features similar to the traditional professions these occupational groups possess, the more they "move up the ladder" from non-profession to semi-profession to full profession. As an occupational group moves through this "process of professionalization" by acquiring features similar to the traditional professions, they expect accompanying increased financial and social rewards whether or

\textsuperscript{15}See, for example, John Stoeckle and Stanley Reiser, "The Corporate Organization of Hospital Work: Balancing Professional and Administrative Responsibilities," \textit{American College of Physicians} 116, no. 5 (1 March 1992): 407-413.

\textsuperscript{16}Such discrepancies between theorists is shown in Morris Cogan, "Toward a Definition of Profession," \textit{Harvard Educational Review} 23 (Winter 1953): 33-50.
not society itself views these groups as possessing professional status. Finally, focusing on an occupational group's features which are similar to the features of the traditional professions ignores the process by which that occupational group obtained those features; there is a failure in such accounts to distinguish between society granting professional status to particular groups as opposed to particular groups claiming professional status because they have taken on the features of other groups commonly considered to be professions.\textsuperscript{17}

The attempts at analysis of professional status and professional obligations in the health care administration literature is also afflicted with the inability to articulate which group-structures or role-features may justifiably be characterized as professional. Various and sometimes differing features are identified or emphasized as exhibiting evidence of professional status. These features include specialized management and organizational skills peculiar to health care administration, development of the American College of Health Care Executives with specified objectives, moral obligations and a code of ethics, personal identification with and ownership of various standards for measuring hospital or institutional success, and so on. Yet there is little agreement within this literature regarding which

\textsuperscript{17}This third point is developed in more detail in Julius Roth, "Professionalism: The Sociologist's Decoy," Sociology of Work and Occupations 1 (1974): 6-23.
features are essential for constituting the professional make-up of health care administrators.¹⁸

Subsequently, much of the literature in health care administration adopts the "scorecard" approach in identifying which traits health care administrators possess which can be characterized as professional (e.g., credentials, association, code of ethics, etc.) and which traits are non-professional (lack of clearly defined knowledge base and skills, standards for entry or maintenance of the right to practice in the field, self-regulation, etc.). The result is that there is admonishment over the existence of non-professional traits with corresponding suggestions for how to better acquire features similar to those possessed by the "traditional professions", or the claim that these "non-professional" traits actually represent a "new form of professionalism".¹⁹

Furthermore, there is occasionally in the literature of health care administration the recognition that focusing on the supposed existing professional traits or the desire to acquire these supposed professional traits may well obfuscate the very reason why health care administration is commonly considered to be a profession today, namely, to administer the provision of health care resources to its own community and to

¹⁸See, for example, James Summers, "Doing Good and Doing Well: Ethics, Professionalism, and Success," Hospital and Health Services Administration 29 (1984): 84-100.

¹⁹See, for example, Mary McDonald, "Does Health Administration Represent a New Form of Professionalism?" Health Management Forum 3, no. 4 (Winter 1982): 10-18.
society in general. In Chapter IV it will be argued that only a social contract foundation in which society benefits from the formation of professions may serve as the justification for an occupational group to be granted professional status. Some of the literature on healthcare administration, therefore, acknowledges that providing a health care system which is sensitive to the needs of those it serves is a more appropriate measure for the criteria of success in healthcare administration achieving professional recognition than the mere acquiring of characteristics or traits commonly associated with the traditional professions.  

The Second Criticism

The second reason why the social theorists have failed in being able to construct one paradigm of profession is that each of the different sociological models of profession make normative assumptions about the institutional function or purpose of professions, and also assume different functions or purposes for professions. The Functionalist model views professions as a construct of society created as the best means to address fundamental human needs and social concerns; the three Conflict models, on the other hand, view professions as attempts by occupational groups to gain economic and social advantage through acquiring a monopoly on particular expertise.

and through a mythic construct of altruism.\textsuperscript{21} These social theorists, therefore, do not approach the study of professions untainted by normative biases concerning the function or purpose of the institution of profession they are attempting to describe. The Functionalist and the three Critical models of profession seem to be adopted by their different theorists not because they match empirical observations or because they lead to empirically confirmed generalizations, but because they provide a framework to articulate the theorists' normative intuitions. When certain value judgments are made, certain conceptual frameworks are adopted and other frameworks are rejected. Social theorists err in adopting a certain conceptual framework for viewing the purpose or function of professions and then arguing that theirs is the only true or objective viewing of professions.\textsuperscript{22}

Assuming different normative criteria for the function of professions contributes to the failure of social theorists to identify the nature of profession. The Functionalist model identifies professions as those groups which help people address fundamental needs like health or justice or religious salvation; the Dominance model identifies professions as

\textsuperscript{21}This point is argued in Lisa Newton, "The Origin of Professionalism: Sociological Conclusions and Ethical Implications," \textit{Business and Professional Ethics Journal} 1 (1982): 33-44.

\textsuperscript{22}For elaboration on this criticism, see Kultgen, \textit{Ethics and Professionalism}, 65-70.
those occupational groups which achieve autonomy in practice and control over their work and the work of others, and successfully obtain market control of their service; the Deprofessionalization and Proletarianization models identify professions as those groups which struggle to control difficult social relations while balancing autonomy in the practice of their work with the expected or dictated outcomes of their work. Whether or not a group can be considered a profession, a semi-profession, or on the road to becoming a profession differs between the four models based upon the perceived or developing function of the group.

The Third Criticism

The third criticism against turning to the accounts of social theorists for an understanding of profession is that sociological studies view the structure and function of professions through the 19-20th century American historical-cultural perspective.

There are two problems with this. First, while medicine, law, and clergy have long been considered the "traditional" professions, the historical-cultural context which shaped the particular structural formation of those occupational groups has now changed such that contemporary medicine, law and clergy do not resemble the traditional image of profession spawned by those occupational groups in the 19-20th centuries. Studies abound within the Deprofessionalization and Proletarianization perspectives exhibiting the many changes which have
occurred in "traditional" professional practice, e.g., group practice rather than solo practice, employment in corporations (with corresponding movements towards potential unionization) due to increased technological costs and to competition for clients and patients and for managed care contracts, increased emphasis upon practice guidelines, cost/benefit analysis, and peer review, and increased knowledge and decision-making by clients and patients. Great care must be taken, therefore, not to draw conclusions about the nature of profession based on outdated presuppositions of what professions are or what they are supposed to look like.

Secondly, some groups that are commonly considered to be professions today, such as healthcare administrators, do not resemble either contemporary versions of medicine, law and clergy or the traditional historical-cultural images of those groups. It serves no purpose to disqualify groups such as healthcare administrators from professional status simply because they do not fit the theories or perceptions by social theorists of what a profession is or should be if these theories or perceptions are based on a different time or

place, when in fact many of these occupational groups are commonly considered by most people to be - and to act like - professions. While the accounts of social theorists on the nature of profession may be of benefit from a historical perspective in understanding the development of particular occupational groups now afforded professional status, they are necessarily limited and inadequate in illuminating the conceptual meaning of profession as used in common discourse today.\textsuperscript{24}

**Conclusion**

Social theorists, therefore, cannot define or identify professions merely by their structures or features since those structures or features may evolve or change - and in fact should be expected to evolve and change - while the groups continue to be considered as professions. Furthermore, sociology lacks the conceptual foundation to distinguish between both essential and accidental features of profession and between descriptive and normative features of profession. This is because sociology largely fails to articulate philosophically the functional premisses that directs the different theorists to focus on and value particular features in their

\textsuperscript{24}This point is argued in Marcus Hollander and Alan Campbell, "Conceptual Models of the Professions and Their Implications for the Professionalization of Health Administration," *Healthcare Management Forum* 3, no. 4 (Winter 1990): 21-27.
The best that social theorists can do, then, is to acknowledge their presuppositions concerning the functional nature or purpose of profession that guides their selection of a list of traits or attributes by which they attempt to define profession. But this will still - and always will - engender disagreement over the inclusion or exclusion and weight of importance given to particular traits or attributes, and will never satisfactorily resolve disagreement over "borderline cases" regarding particular groups and their professional status.

If social theorists are incapable of effectively defining the nature of profession, therefore, then it must be concluded that they will be able to offer only minimal help in the effort to understand the nature of professional obligation in general and of health care administrators in particular.

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This point is developed in Peter Wind, et al., eds., Ethical Issues in the Professions, 1-8.
CHAPTER III

DESCRIBING A PROFESSION: A PHILOSOPHICAL APPROACH

The previous brief analysis of the sociological literature on professions shows that social theorists may offer a stipulative description of profession, but they are unable to provide a conceptual clarification of the term, "profession," such that its meaning can be understood in common language usage throughout changing historical times. It will therefore be proposed in this chapter that a more satisfactory philosophical approach to describing the institution of profession is to identify occupational groups commonly considered in our society today to be professions and declare the popular image or common conception of those groups (and not necessarily those groups themselves as we know them today) to be "central instances" of professions. Even if there is no particular historical time or cultural context in which any of these occupational groups that we commonly accord with professional status perfectly embody the contents of the popular image or common conception of a central instance of profession, nonetheless by working with the popular image of these groups or the common conception of profession which these groups embody in ordinary language use, we can develop a clear and manageable description of a profession that makes sense of the
many and varied common uses of the term, "profession." Adopting this "central instance" approach to the concept of profession will allow for a description of profession flexible enough to encompass most ordinary usage and focused enough to hopefully engender agreement over what will be proposed as the essential features of profession as the concept is used in popular imagery and common language.

**Wittgensteinian Approach to Conceptual Description of Profession**

Now, one possible philosophical approach - an alternative to the one to be proposed here - to describing profession is actually to forgo any hope of identifying essential features of profession, and instead compile a list of traits or attributes which have "family resemblances". Wittgenstein\(^1\) advances this approach, proposing that there need not be any essential features which must always be included in our understanding of a concept, for example the concept of a "game." Instead there can be overlapping sets of characteristics or family resemblances among characteristics such that no one game has all the characteristics and no one characteristic is found in all the games. Applying this approach to the concept of profession, prominent (but not essential) features of occupational groups widely recognized as professions could then be listed as A, B, C, ..., with no one single occupation

displaying all the characteristics. Instead, the features cluster differently for different occupations, such as AB, BC, AC, ....² Thus any given occupational group claiming or attributed with professional status may have many but not all of the characteristics or traits understood to constitute the meaning of profession.

The advantage to adopting this approach is two-fold. First, it offers a means out of the dilemma of trying to determine essential features characterized as necessary and sufficient conditions for the understanding of profession. Second, it explains the view that professions may be considered to be always developing and changing and that a definition of profession should not become solidified around the traditional characteristics associated with medicine, law, and clergy. There is always the potential that new areas of knowledge conjoined with new possibilities for public service in addressing fundamental human needs or social concerns may develop in the future allowing for particular occupational groups to gain professional status while possessing some features or characteristics the same as, and/or some features or characteristics quite different from the traditional professions. It is conceivable that there will always be new contenders, therefore, for the status of profession with new

²This use of the Wittgensteinian approach to the description of profession is also described in John Kultgen, Ethics and Professionalism (Philadelphia: University of Pennsylvania Press, 1988), 58-59.
or different features or characteristics. For example, while surgery is considered today to be a paradigm of a profession, it was not always thought to be so; it emerged from barber shop origins and over time merged with medicine and developed into a profession in popular understanding. Describing a profession according to a family resemblance list of characteristics or traits, therefore, allows for an evolving notion of profession which avoids becoming static and out-of-touch with developing conceptual thought and language use regarding the meaning of profession. ³

Despite the attractiveness of the Wittgensteinian approach in describing profession, it nonetheless seems to be inadequate in two areas. It will be in response to these two inadequacies that a better means for determining the concept of profession will be proposed.

First, arguments against sociology's approach to profession notwithstanding, it must certainly be acknowledged that our popular use of the term "profession" has in fact been significantly influenced by the particular historical and cultural forces in America and in English-speaking countries that shaped and gave rise to the traditional professions of medicine, law and clergy. ⁴ Sociology can be criticized, as


was seen in Chapter II, for extrapolating its conclusions about professions in general from its studies of these traditional professions in a limited historical-cultural period. Yet it cannot be ignored that a satisfactory conceptual understanding of profession must somehow allow these occupational groups to retain their professional status.

To put it another way, if a current group claiming professional status was quite dissimilar in function or make-up from our image of these traditional professions of medicine, law and clergy, it would be difficult conceptually to meaningfully identify that occupational group as a profession. As opposed to the Wittgensteinian approach to conceptual description, this would mean that an occupational group needs to have some cluster of characteristics that bear some resemblance to our popular image or common conception of the traditional professions. Thus some basic or essential features of profession seem to be present in our popular image or common conception of those occupational groups which have been described as the traditional professions.

The possible response to this claim from the Wittgensteinian perspective, however, could be to utilize the charges leveled against sociology and to argue that even contemporary medicine, law and clergy no longer resemble their traditional images, and that some occupational groups commonly considered to be professions today do not resemble contemporary medicine, law and clergy.
While there is some truth to both these claims, it may also successfully be argued that while we may question whether particular occupational groups are in fact professions, no such questioning occurs in regards to medicine, law and clergy. Even the Deprofessionalization and Proletarianization positions, which argue that these groups in their contemporary make-up no longer resemble their traditional structures, acknowledge that these groups are still commonly considered to be professions. It would be difficult to provide justification for medicine, law and clergy to be called professions, for if they are not professions then the concept of profession would seem no longer to carry meaning. Though the current make-up of those groups has changed due to historical and cultural circumstances and their members no longer completely resemble the older image of the benevolent solo-practitioners, medicine, law and clergy are still commonly referred to as professions. Though their structures and features have changed over time, in common language usage they remain "professions par excellence."

These traditional professions, or at least the popular image or common conception of these professions, may then be called "central instances" of the concept "profession", that is, central instances of what is meant by "profession".

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5 This term is borrowed from Revd. Dr. Nigel M. de S. Cameron, "The Seamless Dress of Hippocratic Medicine," Ethics and Medics 7, no. 3 (Autumn 1991): 43-50.

6 Professions and Their Ethics, Chapter 2.
"Central Instances" Approach to Conceptual Description of Profession

All social theorists within the four models of profession as described in Chapter I, agree that the traditional professions of medicine, law and clergy are indeed professions. This is assumed and no proof is offered. All social theorists who attempt to identify characteristics or traits of professions do so by studying these traditional professions. All social theorists who define "semi-professions" do so by placing those groups along a continuum with the traditional professions at one end. Literature in health care administration which inquires into the degree of their professional status also adopts the approach of comparing themselves and the features of their group with the traditional professions. Many other occupational groups within the field of health care adopt this very same approach; they compare themselves and the features of their occupational group to some particular

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sociological appraisal of the significant features of the traditional professions, and place themselves somewhere on the continuum line with those at one end and themselves as being "somewhat like a profession" or a "semi-profession".¹⁰

Presumably, all these social theorists begin their reflections in this way because this is how common usage and the popular image of professions view the matter. Their theories build on these most familiar ways of speaking and thinking, even when the resulting theories change or challenge those familiar ways. In this dissertation, however, the popular image will be more than an unstated starting point. The central instances approach to describing the concept of profession takes this widely accepted pattern of usage and builds on it explicitly.

Medicine, law and clergy will be taken here as "central instances" of the concept "profession." This means that for an occupational group to be considered a profession, it must bear some resemblance to the popular image or common conception of these traditional professions.

To satisfactorily utilize the "central instance" approach to describing profession, however, two issues must be addressed. To what degree must occupational groups resemble the popular image or common conception of the traditional professions, and what aspects of that image are critical for emulation? Addressing these issues leads to the second inadequacy in the Wittgensteinian approach to defining profession. It is conceivable that some occupational group may have the set of characteristics associated with profession of "A,C,D,E,F," yet by failing to have characteristic "B", be subject to serious questions about the justifiability of their professional status. These questions arise because characteristic "B" is always found in the image of the traditional professions, which would thus imply that there are some essential features or necessary characteristics that must be present for an occupational group to commonly be considered as a profession.

The failure of many social theorists and the source of their lack of agreement over identifying essential features or characteristics of a profession has been to concentrate on the structures or features of occupational groups claiming professional status. They focus on such features as possessing particular standards for entry or maintenance in the field, exclusion of competitors, certification from their own schools, a professional association, standards for self-regulation, a journal, a code of ethics, and so forth.
Occupational groups attempting to emulate the traditional professions then seek to take on these visible characteristics. The problem with focusing on these kinds of features is that many occupational groups may take on the external "trappings" of profession and yet still not be commonly considered to be a profession by society.

Returning to the four different sociological models of profession, i.e., Functionalist, Dominance, Deprofessionalization and Proletarianization models, it can be acknowledged that each model does seem to focus on particular features of profession without which a working definition of profession would be incomplete. Though the Functionalist model may be idealistic, the popular image and common conceptual language usage of the term "profession" would seem to include some exclusive expertise applicable to some particular fundamental human need or social concern, and some appearance of selflessness or reputation of promising or providing altruistic service to clients and patients' needs in order that an occupational group may be considered a profession. The Dominance model seems to reflect accurately the idea that professional groups and individuals have not always fulfilled the expectation or promise of selflessness and altruistic service, but rather often have been perceived as abusing their professional status or role for personal gain in income, status and power. Nonetheless it seems true that a working definition of profession would include some sense of relative
autonomy in practice as emphasized in the Dominance model of profession. The Deprofessionalization and Proletarianization models plausibly portray the contemporary lessening of autonomy in the practice of the traditional professions, due to increased knowledge and decision-making input from clients or patients and to increased employment status in place of the traditional solo practice. But there nonetheless remain in those two models some societal and institutional recognition of these occupational groups as professions, and a continued acceptance of some sense of autonomy in those aspects of professional practice where professional expertise is most necessary.

Utilization of the "central instances" approach to describing the institution of profession would therefore best seem to capture the meaning of the term as it is found in popular imagery and common language usage. It also addresses the inadequacies in the approach of the social theorists to describing the institution of profession, i.e., their lack of clarity over the purpose of the institution of profession, and lack of agreement over the essential features of profession. A "central instances" approach to profession would propose that there are particular occupational groups which embody the meaning of profession, and who possess essential features without which those groups would not be considered professions. Central instances of profession, at least in popular imagery and language usage even if not perfectly actualized in
any one specific cultural/historical context, are medicine, law and clergy.

What is proposed here, then, is rather than looking at features or characteristics of the so-called traditional professions, a better approach is to study how society structures exclusive expertise that is addressed to serving fundamental human needs or social concerns such as health, justice, or religious salvation.11 When medicine, law and clergy are treated as central instances of professions, the essential features that constitute them as professions are not those features studied by social theorists, but rather are the features necessary for an occupational group to address fundamental human needs or social concerns in a way that most benefits society. It is from this perspective of understanding the institution of profession that health care administration may stake its claim to professional status.

Defining the Essential Features of Profession

What then, are the necessary or essential features of profession? It is proposed here that there are four such essential features: exclusive expertise which addresses some particular fundamental human need or social concern, (relative) autonomy in practice, societal or institutional recognition, and obligations to clients and patients.

11This way of expressing central instances of profession is adapted from Andrew Abbott, The System of Professions (Chicago: The University of Chicago Press, 1988), 8-9, 315-326.
Exclusive Expertise

The first essential feature of profession is exclusive expertise. It is expertise because it consists of knowledge and skill that is not commonly possessed by most members in society. The special skills of the professional are normally understood to include the theoretical or abstract knowledge justifying the skill as well as the skill itself. This distinguishes the professional from the scholar and from the technician. A scholar may possess theoretical knowledge, but need not know how to apply that knowledge to a craft. She may know why something works, but never be called upon to put that knowledge into practice.\(^\text{12}\) A good automobile mechanic, on the other hand, may know how to fix cars, but would not normally be considered a professional unless he also knew a great deal about physics, chemistry, mechanics, etc., and could not only apply all this theoretical knowledge to his work but explain his work in full relation to relevant physical, chemical and mechanical principles. Then he would know not only that certain things work, but why they work.\(^\text{13}\) Their possession of the theoretical knowledge along with the skill is what prompts us to say professionals "practice" their profession. It is

\(^{12}\)This description is drawn from D.G. Brown, "On Professing to be a Profession," Dialogue 25 (1986): 753-756.

also what enables professions to recognize new problems before they encounter them in practice, to do a lot of the work of defining their own tasks, and to be innovative and creative when problems do arise in practice.¹⁴

This expertise is exclusive in that it cannot readily be learned except from the profession's own members. For example, one must learn how to be a physician from another physician; medicine cannot be taught by a layperson. Educational programs in healthcare administration identify thirty-four distinct areas of specialized knowledge and skill ranging from management, finances, medical and nursing practice, governmental regulations and community relations, all of which are required in the capable administration of healthcare institutions. While lay people may possess similar knowledge or similar skills in some of these areas, it is the combination of both knowledge and skills in all these particular areas and the ability to blend them in practice that distinguishes the unique expertise of healthcare administration.¹⁵

For every profession, this exclusive expertise is valued by society because it is used to address some fundamental


¹⁵See Janet Thompson Reagan, "Practitioner Perceptions of the Knowledge and Skills Required for Successful Practice in Health Administration," The Journal of Health Administration Education 8, no. 2 (Spring 1990): 245-253.
human need or social concern like health, justice or religious salvation. Addressing these needs or concerns is thought by most persons in society to be extremely important, perhaps even essential, to their fundamental well-being, that is, necessary for the fully human and humane life of society and all its members. This exclusive expertise is valued by society to be the necessary means for society to address some particular fundamental human need or other social concern. Professions have not emerged to address all human needs, such as providing food for survival, but rather to meet those more complex needs and occasional crises which laypeople could not master for themselves, such as cure from illness, protection from injustice, or, in some faith traditions, forgiveness of sins.¹⁶

In our own society, healthcare administration until the last few decades was commonly viewed as only a management position charged with "housekeeping" duties, necessary only contingently so that physicians could conduct their vital work. In recent times, however, with the growth in the size of hospitals and with hospitals themselves now being viewed as essential to the delivery of healthcare, and with the corresponding responsibility for allocating large sums of increasingly scarce financial resources for healthcare, the role of the healthcare administrator has not only been enlarged, but

¹⁶This point is developed in Grounding Professional Ethics in a Pluralistic Society, 27-29.
is more highly valued. Healthcare administrators are now commonly viewed as essential actors in the provision of fundamentally needed healthcare to communities in our society.\textsuperscript{17}

The acknowledgement by society that particular professions are needed does not mean that disagreement cannot exist over the best means for professional groups to address the fundamental need or societal concern that elicited their existence. This disagreement may exist within society, between society and a professional group, and within the professional group itself. For example, disagreement exists regarding whether the purpose of the legal profession is - or should be - to assure that justice is best served within society (substantive justice) or to assure that the interests of individuals in society be best served (procedural justice). Professions may also change in character and behavior as differing opinions regarding the best means for them to address some particular fundamental human need or social concern hold popular sway in different historical times.

Many occupational groups also will never be able to claim full professional status because the service they provide is not considered by society to be vital enough or unattainable

\textsuperscript{17}See Marc Hiller, "Ethics and Health Care Administration: Issues in Education and Practice," \textit{The Journal of Health Administration Education} 2, no. 2 (1984): 171. It must also be acknowledged, however, that in the coming years an increasing amount of healthcare delivery will occur outside of the healthcare institutions. This will undoubtedly change the role of healthcare administration, with one potential outcome being a diminishment their professional status in our society.
elsewhere. Historically some occupations gain and then lose professional status based upon the value society places upon their expertise, e.g., medians and fortune-tellers might be said to have professional status in certain cultural or historical settings, but not in contemporary American culture. Clergy may be losing some of their professional status today as religious salvation is less a concern for many people or is felt to be achievable without the particular expertise possessed only by clergy.

Relative Autonomy in Practice

The second essential feature of profession is (relative) autonomy in practice. Social theorists within the Dominance framework argue that autonomy is the most critical feature in constituting an occupational group as a profession, citing control over the determination and evaluation of the technical knowledge used in their work as well as control over the social and economic terms of the work. 18 Indeed, autonomy in practice, with expected accompanying financial and social rewards, does seem to be the desire of many occupational groups who seek professional status. Furthermore, it is undoubtedly abuse of this autonomy by professions in the form of lax self-regulation in areas of competence and moral behavior, and in the involvement in public affairs proposing policies that are not beneficial to society but to the

professions themselves, which is the primary reason why professions in recent times have fallen into public disfavor with accompanying attempts at societal regulation. Yet this is only proper; professional autonomy is always granted by society and is always relative to the benefits which that autonomy will bring to society.¹⁹

Despite the potential for and actuality of abuses, it nonetheless remains true that professions are granted a larger degree of autonomy by society in the forms of control over work and insulation from lay judgment than are most other occupational groups. This can even result in a societally enforced monopoly in the area of their exclusive expertise. Physicians perhaps represent the paradigm of this professional autonomy and societally-enforced monopoly, though even this is changing as society seeks greater regulation in order to contain healthcare costs and to achieve greater benefit from the medical profession. Healthcare administrators exercise remarkable autonomy in their leadership role in the function of their healthcare institutions, yet even this autonomy is being increasingly tempered and conditioned by ongoing feedback from their boards, medical staff, and sponsoring organization.

Professional autonomy traditionally is premised on the profession's exclusive expertise which claims that only fellow professionals understand and so are qualified to assess their

¹⁹This point will be argued extensively in Chapter IV.
peers and to judge what is the appropriate application of their particular expertise. This autonomy resides with the profession and only indirectly with the individual professional. Even though the individual professional claims to be and is certified as being competent to make decisions exclusive to her field of expertise, such decisions are always subject to the standards established by the profession as a whole. It is disagreement over how this autonomy should be interpreted and over the role society ought to play in the determination of those standards which will constitute a primary difference in how the nature of the moral obligations of professionals will be understood within the Commercial, Guild, Agent, and Interactive models.

Societal or Institutional Recognition

A third essential feature of profession is societal or institutional recognition. Many occupational groups in our contemporary society claim professional status. This is often if not always the case because the claim to being a profession carries with it the desired benefits of some measure of relative autonomy in individual and group practice as well as increased rewards in reimbursement and societal status. An occupational group may not just claim professional status, however, in order to enjoy its accompanying benefits; it is society which grants that status to particular groups (with

\[\text{This point is developed further in Camenisch, Grounding Professional Ethics in a Pluralistic Society, 29-32.}\]
its accompanying benefits) when the members of that society believe that doing so is in their own best interests, i.e., when they judge that particular occupational groups are the best means for addressing particular fundamental human needs or social concerns.

Society grants professional status in one of two ways. The most common way is recognizing particular professions to be social institutions. For example, an individual may perform a medical procedure but that would not make him a doctor. Even if he removed an appendix properly, he could be said to have properly performed a medical procedure but it could not be said he was "practicing medicine". That would require a societal recognition that he is a physician, and in our society it has been established that this requires standardized training and recognition of achievement by the profession itself, whose ability to recognize it must itself be supported and confirmed in many ways by the members of that society. One may "hang out his shingle" and call himself a doctor, but he would not be recognized by society as a doctor since he is not part of the social institution of medicine.21

There is a second way that society grants professional status as well. Not all professional groups require a visible formal structure, i.e., possession of many of the common features identified in varying sociological studies as

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21 This analogy is borrowed from Samuel Gorovitz, "Professions, Professors, and Competing Obligations," in Ethics, Trust, and the Professions, 177-178.
properly belonging to the professions. For example, most social theorists identify a structured group organization as an integral element in being considered a profession, yet the formal organization of the engineering profession is much more loosely structured than medicine or law, while the academic profession is marked by voluntary organizations that are very loosely structured. Even within a traditional profession like clergy, different structures exist along a continuum line from extremely organized (e.g., Catholicism) to moderately organized (e.g., Methodism) to very loosely organized ("store-front" churches).²²

What counts is not the formal institution of profession, but that society recognizes that particular occupational groups possess exclusive expertise needed to address fundamental human needs or social concerns and grants them (relative) autonomy in practice. It is important again to emphasize that identification of a profession should not be confined to the historical and culturally limited perspectives of the social theorists considered in Chapter I. Society grants professional status to different occupational groups structured in different ways at different times. While healthcare administration presently lacks many of the visible features associated with the professions by the social theorists, this does not mean that society has not come to view this occupational group

as being a distinct profession.23

Professional Obligations

A fourth essential feature of profession, and what is of most concern to this dissertation, is the moral dimension of profession. It will be proposed that this moral dimension includes seven different categories of moral obligation that, taken together as a group, are unique to professional groups and their members. Analyzing the moral norms of professions may be conducted in a different fashion, but this particular set of seven categories seems to best facilitate this investigation and lead us to the important elements of professional ethics.24

Before addressing these categories of professional obligation, it is important to note that it is normally assumed professionals possess good moral character, that is, that they are individuals of integrity and of general moral uprightness. While this assumption may seem somewhat quaint and even archaic today, it should be pointed out that possessing a good moral character still remains a formal requirement in the licensure of physicians and lawyers in many states.


24These seven categories of the moral obligation of professions and their members will be drawn from David Ozar and David Sokol, Dental Ethics at Chairside (St. Louis: Mosby, 1994), 31-35.
today. Literature on ethics in health care administration is likewise filled with such exhortations as, "We must make integrity a way of life and act with unimpeachable character," and, "We are guardians of ethics and social justice in the health care marketplace." This presupposition of good moral character has recently received increased attention in the ethics programs developing in many of the schools training candidates for the professions. However, providing skills in ethical reasoning and theory cannot of itself motivate professionals to act in a morally upright fashion.


D. Kirk Oglesby, "Ethics and Hospital Administration," *Hospital and Health Services Administration* 30 (September-October 1985): 43.


Identification of the Chief Client

The first category of the moral obligation of professions and their members involves identification of the profession's chief client. This includes identification of the chief client when there are a set of persons or groups whose well-being the profession and its members are committed to serving.

The chief client of a physician is obviously her patient. It must also be stated that a physician has multiple chief clients in this same category inasmuch as she has many patients to whose well-being she is committed. At any given moment, however, it is normally only one patient at a time who serves as that chief client. When there are multiple patients the physician must decide who becomes the chief client among the different patients given the severity of particular patient needs and her ability to address those needs. Nonetheless, her chief client almost always remains the individual patient.

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organization or investor-owned corporation. The sociological theories which have almost exclusively studied the "traditional" professions of medicine, law and clergy, groups that have been viewed as having more clearly defined individual clients or patients, offer little help in identifying the chief client of professions such as healthcare administrators whose clients are largely made up of groups rather than individuals. As will be developed in Part Two, the identity of the chief client for health care administrators will vary depending upon which model of profession, i.e., the Commercial, Guild, Agent or Interactive models, is adopted.

Ideal Relationship with Chief Client

The second category of the moral obligation of professions and their members is the defining of this relationship between the professional and the client or patient. The purpose of the relationship is to address the client's or patient's need in ways that the client or patient is incapable of doing himself. Satisfactorily addressing this fundamental human need will require both the professional and the client or patient to make a number of judgments and choices about the professional's interventions. For healthcare administrators, these judgments and choices have been treated in the different revisions over the years of the American College of Health

See James Summers, "Doing Good and Doing Well: Ethics, Professionalism, and Success," Hospital and Health Services Administration 29 (March-April 1984): 84-100.
Care Executives' Code of Ethics. These revisions reflect the emerging values and changing views of healthcare administrators and society regarding the relationship of healthcare administrators with the patients and different client-groups to whose welfare they are committed to serving.31 Once again, the nature of the professional obligations to clients or patients will vary greatly depending if the institution of profession is examined within the Commercial, Guild, Agent, or Interactive models.

**Commitment to the Good of the Chief Client**

The moral dimension of profession is to a great extent understood to mean that professional groups and their members are committed to some good larger than their own self-interest. Normally this is taken to mean that professionals are expected to possess a commitment to the welfare of their individual clients or patients and to society itself, and that their use of professional knowledge and skills will be significantly oriented towards the benefit of these other parties and not (only) toward the professional's own benefit. For example, it is understood that physicians have an obligation to act for the health good of individual patients, and that healthcare administrators have an obligation to act for

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the health good of patients collectively.\textsuperscript{32}

This professional commitment to act in more than a self-interested manner in promoting the good of clients or patient may be termed an "atypical moral commitment".\textsuperscript{33} Professions and their members are involved in addressing a particular fundamental human need or social concern. Professionals work with clients or patients who are in a state of vulnerability or dependency, requiring for example a restoration to health to relieve physical suffering, or justice to restore lost freedom, goods or rights, or reconciliation with God to restore a meaningful existence. Clients or patients ordinarily lack the knowledge and skills to help themselves during a crisis or to address some highly valued human need.

Furthermore, the relationship that clients or patients enter into with a professional is dependent upon trust in the professional's claim to exclusive expertise and to the professional's pledge to use that expertise in the best interest of the client or patient. Those in significant need must trust that their vulnerability will not be exploited. In order to be helped, clients and patients often must "open up" confidential aspects of their lives, whether it be baring their bodies to physicians, their weaknesses to lawyers, or

\textsuperscript{32}See Barry Greene, "Alexander's Dilemma: Conflict Between Professionalism and Entrepreneurialism in Health Services Administration," \textit{The Journal of Health Administration Education} 4, no. 4 (Fall 1986): 581-589.

\textsuperscript{33}This term is borrowed from Camenisch, \textit{Grounding Professional Ethics in a Pluralistic Society}, p. 33.
their sins to clergy. They entrust themselves and basic components of their well-being to professionals. Those who approach professionals simply in need of their expertise, e.g., an architect to construct a new house, must still trust that their dependency upon the professional's expertise will obtain for them the desired benefit without imposing any significant harm. In sum, therefore, the foundation for the professional's "atypical moral commitment" is the societal expectation of the profession and its members to be committed to the welfare of their clients and patients and to society.\(^{34}\)

Members of society take offense when they sense that professionals have utilized their exclusive expertise to promote their own interests to the detriment of their clients or patients. As a result, they hold professionals obligated to uphold their atypical moral commitment to promote the good of their clients or patients. Yet this obligation should not be viewed as imposed upon professions by society, but rather is part of the very identity of what makes an occupational group a profession. To become a professional knowing what society's expectations of such persons are is to place oneself under certain criteria which can be invoked to assess one's moral performance. The societal expectation of this atypical moral obligation is part of the societally defined role of

\(^{34}\)This is argued in Edmund Pellegrino, "What is a Profession?" Journal of Allied Health 12, no. 3 (August 1983): 168-176.
profession.\textsuperscript{35}

The careful articulation of the extent of this commitment, for example, how much sacrifice it entails of the professional's own self interest and in regard to other social commitments external of the profession, and under what circumstances, is one of the most important ethical issues that a professional must wrestle with in daily practice.

There are a number of ways to try to qualify this obligation of professions and their members to the welfare of clients or patients and to society. A "maximalist" interpretation of this professional obligation would claim that professionals have an obligation to place the well-being of their clients or patients ahead of every other consideration, including their own interests and their obligations to others. While some professions may articulate this view and some of their members may be considered model professionals to the degree they emulate this interpretation, such behavior in our society would seem to be commonly considered heroic and supererogatory and not the required norm. In contrast, a "minimalist" interpretation would argue that professionals have only an obligation to consider the well-being of their clients and patients to be among their most important concerns, but not given any specific priority over other concerns. Again, given the societal expectation of profes-

\textsuperscript{35}This is argued in Camenisch, \textit{Grounding Professional Ethics in a Pluralistic Society}, 34.
sional commitment to vulnerable and dependent clients or patients that contributes to our understanding of what it means to be a professional, something stronger than this interpretation seems warranted.

A "parity" interpretation would propose that the professional is obligated to consider the client or patient's well-being to be at least equal in importance to the professional's own well-being. While this approach has appeal, it allows for the possibility that the professional may use his position to advance his own well-being, e.g., conducting non-harmful but non-beneficial expensive procedures on the client or patient.

The approach that best articulates what is commonly meant by professional obligation to the welfare of others is the "greater than self" interpretation. This view holds that the professional's commitment to the client or patient's well-being is of greater ethical significance than commitment to their own well-being, providing that this obligation is limited to the fundamental purpose for the existence of the profession as applied to the client or patient's well-being and providing that there is no excessive risk or burden to the professional. The profession of medicine exists for the sake of benefiting the health of patients; a physician is considered obligated, therefore, to place greater ethical significance on the health needs of her patient than on her own well-being when treating a patient, for example, with an infectious disease, providing she is not exposed to excessive risk or
burden. There are limits to this greater than self" obligation, but the criteria which constitutes risk or burden to be "excessive" is always relative to changing historical and cultural norms.36

Central Values of the Profession

If the nature of the atypical moral commitment and obligation of professionals is to be identified, then it is essential that the central values of particular professions are identified and prioritized. This constitutes the fourth category of moral obligation of professions and their members.

Professionals are not considered obligated to bring about all aspects of their clients' or patients' well-being, but only those aspects of their well-being that are among the central values of their profession. As there is often more than one central value to a profession, those central values must be prioritized so that when a conflict emerges prohibiting the honoring of all the central values there will still be a means to determine which values predominate. In given situations if there are no conflicts between the central values, then professionals would be obligated to all those aspects of a client or patient's well-being that are associated with the central values of their profession providing this does not constitute excessive risk or burden to the professional.

36This discussion of limits has been based on Ozar and Sokol, Dental Ethics at Chairside, 80-84.
Identifying the central values of the healthcare administration profession can be attempted only somewhat tenuously, since this is not an endeavor that is normally explored within this profession. The issue of central values is perhaps best approached by asking healthcare administrators what they value in their work, or, what they are trying to accomplish in the work they consider essential to their professional role. Members of society, who hold up healthcare administration as a profession, should also be asked what they value in the work of healthcare administrators. The following central values of the profession of healthcare administration, therefore, emerge as a combination of both values and valued tasks. These tasks are considered important (or "valuable") because of the values those tasks hope to bring about. The desired values which these tasks are meant to achieve will vary, however, in the Commercial, Guild, Agent and Interactive models of profession. For example, maintaining good relations with a medical staff is highly valued by healthcare administrators in all four models of profession, but (as will be shown in Part II) in the Commercial model of profession this is valued for the financial benefit returned to the institution, while in the Interactive model this is valued for the health benefits resulting to patients and the local community.

It will be proposed here that there are five central values or valued tasks for the profession of health care
administration. Among these are promoting the health of individual patients, promoting the health of the local community, assuring the financial viability of the healthcare organization, working to develop and maintain capable and effective management of employees and good relations with the medical staff, and maintaining institutional integrity, i.e., administering according to the mission and values of the healthcare institution. As will be developed in Part II, the prioritization of these central values for healthcare administrators will vary depending upon how the various clients of healthcare administrators are prioritized, i.e.,

37 These central values, or a combination of values and valued tasks, are collected from surveying the literature of healthcare administration and informally interviewing a number of healthcare administrators. This list of five central values or valued tasks is not intended to be exhaustive or exclusive, but is an initial attempt to summarize and structure the values guiding the behavior of healthcare administrators.

determining the hierarchical order of the "chief clients," and depending upon how the nature of the professional-client relationship is viewed, i.e., whether the Commercial, Guild, Agent or Interactive model of profession is adopted.

Commitment to Professional Competence

The fifth moral category of professions and their members is the obligation to professional competence. Development and maintenance of exclusive expertise is fundamental to the very identity of a profession and professional. This category, therefore, is the commitment of the professional to be trained and remain updated in the publicly recognized standards of competence for her professional field. Minor failings in this obligation leave the professional open to criticism from her peers and possibly from her clients or patients. Significant failings in this obligation exposes the professional to possible discharge from the professional group with resultant loss of her professional status.

Healthcare administration as an occupational group has grown into recognized professional status with corresponding responsibilities and obligations largely due to the advancement in the size, complexity and technological advancement of healthcare institutions; more so than in the past, society now needs professional competence to successfully administer institutions which have been created to serve fundamental
The obligation to competence is perhaps the easiest to describe in the abstract. A professional is obligated to remain competent in his field, to apply his competence to the client or patient's fundamental need, and to undertake only those tasks that are within his competence. But defining competence in actual professions is very complex. Determining what is sufficient or minimally adequate competence for an individual to be considered a member of a profession is normally - and almost by necessity - left to the profession itself since those outside the area of expertise are largely incapable of judging the satisfactory acquisition of that expertise. But determining what is sufficient or minimally adequate competence for an occupational group to be considered a profession is dependent both on the general availability of the competence or expertise to laypeople, i.e., society must recognize a particular occupational group as experts who determine the content of their expertise, and on the trade-off in benefits which society receives in designating professional status upon the group. This means that the profession must always be justifying to society what it considers to be

sufficient or adequate competence for the admission of its individual members into its profession in order for society to continually grant professional status to those individuals.

**Relationship with Fellow-Professionals**

The sixth category of the moral obligation of professions and their members concerns the relationship between the members of the profession. This relationship is normally viewed as a blend of cooperation, competition, and (some relative amount of) accountability. Cooperation is entailed in that as an occupational group the granting of professional status both implies and requires that the group establish standards for education, entry into, and continuance with the group. Cooperation is also exercised in the group's commitment to continuing development in its field for the sake of better addressing the good of its clients or patients in its own field of expertise. Yet the relationship between members of a profession is also marked by competition; physicians in the same specialty compete for patients and for referrals, lawyers compete for clients, and clergy do not normally refuse members from other churches joining their own parishes.

Some sense of accountability is also implied in the relationship between members of a profession, yet this accountability is rarely actualized or is enforced only through subtle and implicit measures. Few physicians, for example, are ever held publicly accountable by their peers for not keeping up-to-date with the research literature or with

As with other professions, the relationship between healthcare administrators seems to have changed over time depending upon the cultural environment shaping the provision of health care services. During the past few decades competition between healthcare institutions for healthcare dollars has shaped an acute sense of competition which is a significant mark of the relationships between healthcare administrators. Current times, however, have dictated that institutional survival is dependent upon a greater sense of collaboration
between institutions, and this in turn has likewise effected a more collaborative attitude between healthcare administra-
tors.

**Relationship with Society at Large**

The seventh and last category of the moral obligation of professions and their members is their relationship as a group and as individual members with society at large, i.e., with persons who are neither co-professionals nor clients or patients, but who recognize the occupational group as a profession and who rely upon that profession to address a specific fundamental human need or social concern. This is one of the least studied aspects of professional obligation, largely because the traditional focus of professional obligation has been on the individual professional-client/patient relationship and because obligations to the larger society have normally been viewed as the responsibility of the professional group as a whole rather than the responsibility of individual members.

Such limitations to the understanding of professional obligation toward society no longer suffice today. Until recently, for example, physicians were not to allow concerns about scarce or expensive medical resources on the macro-level to influence their treatment decisions for individual patients on the micro-level. Increasingly now, however, that approach is viewed as irresponsible and many different kinds of approaches to more thoughtful utilization of resources by
individual physicians have been proposed. A similar shift in thinking has been occurring in healthcare administration. In the past, society was largely viewed by healthcare administrators as simply an entity that benefitted from and thus should fund healthcare in whatever way healthcare organizations deemed best. Increasingly today, however, there exists the awareness that healthcare administrators have a social responsibility to provide not only high-quality but also cost-effective and community-directed healthcare; that is, that healthcare administrators are obligated to act in such a way so as to best serve their local community rather than (just) their own institution. Since the clients of healthcare administrators include not only individual patients but other groups both within and outside their institution, analyzing this last category of the moral obligation of professions and their members will be critical to the understanding of the professional ethic of healthcare administrators.

41 See, for example, Terese Hudson, "Are Futile-Care Policies the Answer?" Hospitals and Health Networks 68, no. 4 (20 February 1994): 26-32.

42 See, for example, Howard Zuckerman, "Redefining the Role of the CEO: Challenges and Conflicts," Hospital and Health Services Administration 34, no. 1 (1989): 25-38.

43 This is suggested in Samuel Levey and James Hill, "In Search of Basic Values," Health Progress 67, no. 5 (June 1986): 51-53; D. Kirk Oglesby, "Health Care Leaders - It's Time to Step Forward," Frontiers of Health Services Management 8, no. 3 (Spring 1992): 34-36.
Conclusion

Adopting a "central instances" approach to describing the institution of profession has allowed for the development of a clear and manageable description of profession that encompasses the ordinary usage of the term. It has been proposed that this description reveals the essential features of profession to be exclusive expertise, relative autonomy in practice, societal or institutional recognition, and the existence of seven categories of professional obligation. The following chapter will propose that what has been called a "social contract" serves as a justification for, and as a conceptual clarification of, these professional obligations for professions in general and for healthcare administrators in particular.
CHAPTER IV

SOCIAL CONTRACT: A FOUNDATION FOR PROFESSIONAL STATUS AND PROFESSIONAL OBLIGATIONS

In the previous two chapters the position has been proposed that a profession comes into existence in our society when an occupational group develops an exclusive expertise which society deems extremely valuable in the addressing of fundamental human needs or social concerns, and this occupational group is granted relative autonomy in practice in exchange for the benefit their service provides to society, coupled with the understanding that specific moral obligations will be expected of their profession and their members.

Before the professional obligations of healthcare administrators may be examined, however, a justification for the existence of professional obligations and a conceptual clarification of the nature of professional obligations must first be given. This chapter will propose that this justification can be found in what has come to be known as the "social contract."

This chapter will first give a brief overview of social contract thinking. This overview will be limited; the purpose of this dissertation is not to thoroughly analyze social contract thinking, but to develop an understanding of
the nature of professional obligation in general and of the professional obligations of healthcare administrators in particular based upon a social contract account of these obligations. It will be argued that the social contract referred to here is not an actual signed contract between members of society, but neither is it a hypothetical or imaginary contract. It is a means of conceptually explaining the development of certain regulatory behaviors for all members in society as well as for professions and their members. Four criticisms which attempt to undermine the notion of social contract will later be addressed.

The second part of this chapter will argue that the social contract idea is implicit in our understanding of particular occupational groups as professions. Relative autonomy in practice is granted to professions by society, either explicitly through the development of social institutions or implicitly through the societal tolerance for particular practice behaviors, in exchange for the benefit this provides to the society, i.e., the service the profession through its relative autonomy in practice provides to the common good and to individual members of society in addressing fundamental human needs or social concerns. In light of the social contract account, it will be argued that the primary purpose of professions is determined not by the professions alone, but by the ongoing dialogue between society and the professions. The professions receive benefits from society in
the form of social and financial rewards, but these benefits -
as well as relative autonomy in practice - can be taken away
if society judges it no longer benefits from the services of
a particular profession.¹

The third part of this chapter will attempt to show that
a social contract is implicit in the existence of professional
obligations. It is not that these moral obligations exist
because the professions and their individual members hope to
receive relative autonomy in practice in exchange for this
professed moral commitment, but rather that these profession-
specific moral obligations are voluntarily taken on in the
sense that individuals join a profession knowing society has
particular expectations of the values and role-behavior of
that group. For the degree of the perceived obligation to
practice those values and moral behaviors may be said to
correlate to some degree to the risk of harm to clients or
patients or to society in general should those professional
values and moral behaviors not be practiced. The relative
autonomy in practice granted to professional groups and their

¹Medical schools, for example, establish their own
professional standards and are federally subsidized and tax-
exempt. Their autonomy in the practice of setting their own
standards recently has been threatened, however, by charges
that they fail to adequately train their medical students in
such basic skills as cardiopulmonary resuscitation and other
forms of emergency medicine, and the provision of their
federal benefits has been questioned due to charges that their
emphasis on training subspecialties rather than general
medicine fails to address the growing sense in our society
that physicians should be instrumentally involved in providing
all Americans with some basic forms of healthcare.
members by society is relativized, regulated, and potentially taken back by society to the degree that society perceives professional groups as abusing or misusing that autonomy. Professional ethics, therefore, can never be determined by the professional groups themselves but only through the interaction with society which establishes the values and expected role-behavior of the professional groups.

The Idea of the Social Contract

Overview of Social Contract Theory

Justifying the existence and nature of professions and professional obligations on a social contract foundation utilizes a concept originally developed by political philosophers to explain citizens' obligation to obey the law, and the limits of that obligation. This "social contract" was first used to describe a theoretical political contract which justified the moral weight of laws and actions of the state or government.

Historically, the concept of the social contract was first advanced by Hobbes, Locke and then Rousseau, among others. Each described a society without a civil state or government, and then highlighted the benefits society received from its members agreeing through a "social contract" to have a civil state or government.

Hobbes holds that without government human beings would

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live in a condition, the "state of nature," a condition in which everyone is pitted against the other for their own self-preservation or advancement with no power or authority to make peace among them. A social contract or common agreement is needed between the people and a sovereign who could (by monopolizing the power to enforce laws) maintain peace among the people to better advance their self-preservation and self-interests.

Locke views a group or people without government not as existing in a terrible condition, but as living in a tolerable though mildly unruly situation. People possess such natural moral rights as the right to property and freedom in this condition, but lack an efficient means to arbitrate their disputes and to protect their rights. To remedy this, people first establish "civil society" and then negotiate an agreement (social contract) among themselves to establish a government to protect their rights. This social contract or common agreement establishes duties and grants power to the government while protecting the rights of the people.

Rousseau differs from Locke in viewing the creation of a social contract as the very coming together of individuals into society whereby they surrender their individual rights to

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the society to promote the common good of all. The welfare of the society as a whole constitutes the "general will" which is considered to be as important and as valuable as the desires and well-being of the individuals constituting the society.

Perhaps the best known contemporary social contractarian is John Rawls. He proposes that the elements of a just society are best determined by the theoretical agreement imagined in a social contract between people in an "original position" behind a "veil of ignorance." By this he means that we can best understand the standards to be used in judging appropriate conduct in our social lives together by imagining theoretical agreements between individuals who are free, rational, and self-interested but who lack knowledge of any specific content of their interests. This social contract is a conceptual means for determining standards of justice which theoretically are not bent to serve particular self-interests but rather can be agreed upon by all.

No attempt will be made here to develop this notion of social contract in detail. It suffices to point out that social contract language has been used by many political theorists to describe the relationship between the members of society and their government. Three observations can be made

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about this way of understanding this relationship. 6 First, social contract theory developed during a time of social change and reform. It has been used as a moral ideal higher than the law of the state against which the actions and even the existence of the state can be evaluated. Second, while a first reading of social contract thinking in political philosophy views people to be originally in a "state of nature" agreeing to create an organized society and government, a second and more prevalent reading utilizes the social contract to define the terms of the relationship between society and the existing government. Third, while different variations exist in how the social contract is envisioned, all emphasize the consent of all the parties involved. Thus, all individuals in the Roussean "state of nature" must agree to form a society, and both the people of the society and the government that is established must agree according to Locke to the terms of their relationship, i.e., allowed and disallowed behaviors, certain rights and duties, and so on. This consent assumes that all participants in the social contract enter the agreement willingly for their own personal benefit and gain.

Social contract theory has typically been applied in social-political philosophy, but it has not been limited to

discussions of large-scale societal justice. Increasingly social contract theory has been applied to business and in organizational theory. In the same way, social contract theory can be applied to the study of professions. Professions can be understood to be social constructs arising from agreement both within the society, and between the society and the occupational groups accorded professional status by the society, for the express purpose of addressing specific fundamental human needs or social concerns such as health, justice, and religious salvation.

Responses to Four Criticisms Raised Against the Idea of the Social Contract

A number of criticisms have been raised against social contract theory. Four major criticisms will be discussed here. First, social contract theory is accused of lacking clarity or agreement over who actually constitutes "society," i.e., who enters into and makes up the terms of the social contract. It can be charged that the term "society," for that matter, has been used freely in the first two chapters of this dissertation without adequate definition or clarification.

A second charge is that there is lack of clarity or agreement over what might actually constitute a mutual benefit or advantage such that "society," or the members of society, might reach some sort of agreement on and then develop

7See, for example, Donaldson, Corporations and Morality; and Michael Keeley, A Social-Contract Theory of Organizations (Notre Dame, IN: University of Notre Dame Press, 1988).
corresponding rights and responsibilities to protect the existence and continuation of that benefit. This second criticism rests on the premise that our society is marked by a pluralism of values such that it is impossible to reach a value-consensus regarding a particular benefit (outside of the freedom to choose whichever benefits are subjectively valued) which could be agreed to in a social contract.

The two remaining criticisms of social contract theory attack the supposed lack of reality or actual occurrence of the social contract. The third criticism argues that no social contract that is rationally and freely agreed to and signed by all involved participants exists or has ever

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8This is meant to suggest that our society, with a primary emphasis on the value of freedom of choice, i.e., the value of choice itself, lacks agreement on any other values which might constitute a "good" for all members of our society. The claim is that there could never be agreement, therefore, on a benefit to be protected by the social contract outside of the protected freedom of individuals to value whichever benefits they individually choose.


actually existed. But, the objection continues, an imaginary agreement is not an actual agreement, and imagination cannot be used to justify actual rights and responsibilities. Furthermore, even if the social contract is meant to refer to tacit (as opposed to imaginary) understandings between participants in a given relationship, as for example in a doctor-patient relationship, if the terms of that tacit understanding are never completely or adequately spelled out, there will always be disagreement concerning the terms of that contract and its implications for, for example, actual doctor-patient relationships.

The fourth criticism argues that even if the idea of a social contract is not of an actual written contract, but it is a conceptual means of explaining patterns of social behavior about which all participants in the agreement have common knowledge, it is still hard to explain how everyone in our society, with a pluralism of cultures, interests and values, could be fully aware of all the details and obligations imposed by such an abstract contract. For example, even if social contract language is employed to explain why pornography should be banned or its availability be made limited in our society, this still does not mean that everyone agrees on the criteria for establishing a common definition of pornography. Such a social contract, therefore, cannot be said to exist in a given society, e.g., our own, if the details of that contract cannot be agreed upon or known by
all.

Each of these four criticisms needs to be addressed. While the following responses to the criticisms perhaps do not completely blunt the full force of each criticism, together these responses nonetheless seem to carry enough weight to justify adequately the continued use of social contract theory as a way of explaining the existence and nature of professional obligation in our society today.

Response to the First Criticism

The first criticism - that social contract theory too easily assumes a common understanding of the meaning of "society," i.e., that the term is used without thorough clarification - is a serious charge and one that cannot be completely countered because the term has many uses. The term "society" can refer to an aggregate of individuals who make up that society, or it could refer to an entity that is more than the sum of those individuals and thus include families, religions, civic and cultural groups, etc., or possibly it could refer even to an entity composed of general or communal interests that are not directly parallel to or products of its individual members' interests, thus including interests such as nationalism or civic spirit.

To respond to this criticism, it is helpful to point out that social contract theory is rooted in Western rational philosophical tradition with a corresponding emphasis upon individualism and the use of human reason. For purposes here,
then, the term "society" will be used to mean an aggregate of individuals who possess the capability of reason and discourse to deliberate and potentially to agree on particular services and the means of delivering those services which will best meet their individual and collective needs.

It is acknowledged that much literature exists which criticizes this conception of society, and that such an emphasis upon human reason and discourse does not mean that individuals do not possess different values as well as different ways of perceiving occupational groups such as professions. It will still be proposed here, however, that the term "society" can be used meaningfully to refer to the aggregate of individuals making up a human community. It will be assumed here that the capability of reason and discourse allows for the members of a community to work towards a consensual agreement on the best means to address fundamental human needs or social concerns such as health, justice, and religious salvation.

Response to the Second Criticism

The second criticism of social contract theory argues that the presence of moral pluralism and the lack of value-

consensus among members of our American society results in a lack of agreement over what might constitute a benefit such that all the members of our society could reasonably discourse about that benefit and address it through a social contract. In hospital ethics committees, for example, moral dilemmas arise over just such disagreement about what constitutes a benefit to individual patients; e.g., the debate over providing or withholding a feeding tube to a permanently comatose patient is based to a great extent on the ongoing lack of consensus over the value of physical life void of cognitive or affective faculties.

To respond to this second criticism of social contract theory, however, it can also be pointed out that a great deal of value consensus is present in our American society. For example, in the case above involving the hospital ethics committee, if the patient had advance directives stating she did not want resuscitative measures employed once she became permanently comatose, then in all likelihood no one would object to a "Do Not Resuscitate" order being given because of the value of her autonomy. Such an example of seemingly unanimous respect for patient autonomy in normal circumstances within a hospital setting is indicative of the fact that there exists in our society other examples of consensual agreement over other moral values and norms. This means that there actually does exist in our society a sufficiently widely accepted and substantive moral core to give significant
agreement on numerous values and benefits in the context of what could be called a social contract. For example, there is broad agreement even in our pluralistic society that a good life does not include being a victim of fraud or brutality, of being subjected to involuntary, unproductive pain, of being deprived against one's will of one's property, of being slandered, and so forth. Furthermore, there seems without exception to be a common belief that some goods exist such as health and justice which are fundamental or intrinsic human goods, i.e., goods that are essential to the "good life." The provision of these goods addresses fundamental human needs and thus are basic concerns of society, i.e., they are the concern of all members of a given community. It may therefore be concluded that there are a number of "goods" in which members of our society can agree to protect and promote in terms of what could be referred to as a social contract.12

Response to the Third Criticism

The third criticism challenges the reality or actual occurrence of the social contract. It argues that no such contract literally exists, especially in written form, and that surmising a hypothetical contract from the perceived tacit understandings or value-consensus among the participants in an agreement fails since the details of such tacit

12This argument is developed at length in Paul Camenisch, *Grounding Professional Ethics in a Pluralistic Society* (New York: Haven Publications, 1983), Chapter 4.
understandings making up the supposed social contract are never adequately defined or spelled out.

A successful response to this charge is to agree with the criticism but to insist that its presumed conclusion does not necessarily follow. A social contract by its very nature cannot - and indeed, should not - be thought of as an actual written contract among all participants in the agreement. Once negotiated and put into writing, this contract could then no longer lay claim to having status as a basic analysis of the moral foundation underlying the relationship between the participants, for then it would be only one more existing social arrangement among others which, in turn, would itself be subject to further moral evaluation. Existing social arrangements are not self-validating and thus cannot serve as their own moral justification. No written contract is fair or just simply because all parties agree to the contract; it must always be justified by something beyond itself, thus always allowing for its potential revision as values and perspectives change over time. Even the American Constitution is not self-validating, but rather draws on the moral foundation of a social acceptance of its norms, i.e., a social contract in the sense employed here. The notion of social contract as utilized here can never take written form without losing its meaning and purpose; its lack of written form, then, affirms rather than denies its existential reality.

The language of social contract is heuristic in the sense
that it does not describe a standard sort of contract but rather conceptualizes existing states of affairs, i.e., the common recognition by professionals and members of society that there are certain standards binding upon professionals. This is the nature of that which serves as a moral foundation or justification. Rights and obligations, liberties and duties, the common good, the general will, and other such fundamentally prescriptive concepts are all used heuristically to describe existing states of affairs in our society.

The heuristic language of social contract can serve as a moral foundation given the premise that it is possible, and in fact is normally what happens, that people will appeal to some form of social contract when they are forced to justify the moral foundation of their position about some social matter. The social contract is dependent upon the image of reasonable people coming together in discourse in order to contract to or at least agree on a moral framework. In this coming together to discourse on a moral foundation, some participants would hope to identify a natural law or a divine law from God, others would hope to discover what an "ideal observer" would approve of, still others would seek to discern through rational processes an existing moral order, and so forth. Though participants are limited by their own historical-cultural circumstances and most likely biased by their own self-interests and deeply-held values, the nature of discourse assumes that reasonable people eventually will seek to achieve
as close to an impartial point of view as possible through ongoing discussion and through a full consideration of everyone's interests. The social contract, then, is not a hypothetical construct drawn from tacit understandings or supposed value-consensus among participants, but is a heuristic device trying to explain how any existing social arrangement may be evaluated morally according to the criteria of whether all involved participants, through ongoing discussion and full consideration of everyone's interests, would grant approval to such an arrangement.  

Response to the Fourth Criticism

The fourth criticism against social contract theory argues that even if it is acknowledged that the social contract is only a conceptual means of explaining patterns of social behavior, given the great membership size of our society with its corresponding pluralism of cultures, interests and values, it would seem highly unlikely that the details and obligations articulated in an abstract social contract would be readily available to or known by every member of our society. Different people will often have different interpretations of the details and obligations.

supposedly agreed to, thus undermining attempts to universalize the supposed agreement into a social contract. For example, even if it is commonly agreed that professions and their members are expected to possess and exercise an atypical moral commitment to their clients or patients, many differences of opinion will continue to exist as to the exact nature of the specific obligations of that atypical moral commitment.

The response to this last criticism will parallel in some respects the response offered to the second criticism, namely, that a close look at normal social discourse and exchange reveals a great deal of consensus on the details of proper behavior in general and on the specific obligations expected of specific professional groups and their members in particular. The relevant details of the social contract, therefore, conceivably can be known by most if not all (adult) members of a society. One way to reach this point is to articulate details in what has been called a "social rule."  

A social rule describes patterns or standards of behavior for which there is a perceived obligation to conduct one's behavior according to that expected pattern or standard simply because that is what is expected in one's society. A social rule is not a social habit as when people act similarly, but

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conformity to the pattern has no special merits; violation of such social habits involve social disapproval because following such rules is expected. Social rules exist, however, when there are insistent and imposing obligations demanding conformity to the rules and when the social pressure brought to bear upon those who deviate or who threaten to deviate from the rules is great. The rules supported by this serious pressure are thought important because they are believed to be necessary to the maintenance of social life or to some highly prized feature of it.

Examples of such social rules include: the restriction of violence, the requirement of honesty or truth and of keeping promises, and parental protection for small children. These social rules are assumed to be so important and essential to society that they are commonly accepted and employed without further justification; these social rules are popularly considered to be self-justifying because it is understood or commonly agreed that the actions governed by these rules are essential for the society, or, to put it broadly, the actions governed by the social rules are justified because, "That's how we do things here." Social rules are therefore an essential part of the morality of a social group in that they define standards of behavior to which all members of the group are expected to conform.

Social rules are present both internally and externally to professions. Internal social rules include some sense of
fraternalism or comradery, the normal refusal to publicly approbate a colleague's professional work, the maintenance of emotional distance from one's clients or patients, the portrayal of disinterest in personal gain, and so forth. Internal social rules may be reflected in the group's Code of Ethics, although most of them are not explicitly set down anywhere.

Of greater interest here are the external social rules of profession. These social rules are determined by the society in which the professions exist. Violation of these rules by the profession or its members at best leads to charges of acting "unprofessionally," while at worst violation of these rules calls into question the very professional status of the occupational group. For example, if a given professional's behavior is perceived to be exclusively financially motivated with no evidence of an atypical moral commitment to the client or patient, then she may be accused of acting unprofessionally. If the whole professional group is perceived as acting in this manner, then society may raise the legitimate question asking if this occupational group should still be considered a profession and granted relative autonomy in practice. External social rules for professions arise from a particular cultural setting in which there is a clearly established view of a fundamental human need or social concern and for which a particular occupational group has been granted the exclusive practice to address this need or concern; when the desired
human or social good is not actualized in the way society envisioned, then the occupational group may be accused of acting unprofessionally or of no longer constituting a profession.¹⁵

The existence of social rules assures that many of the details and obligations that may arise from utilizing social contract theory as a moral foundation for given social arrangements can be, and in fact are commonly known, by most if not all (adult) members of a society. The existence of social rules within the social contract means that the members of society possess some common agreements over the appropriateness of certain behaviors and over the importance of particular values. These behaviors and values are not necessarily absolute, but may vary between different societies and within the same society over time. An ongoing discussion among the participants of the society, and for our purposes here, between society and its professions, is always necessitated so that the standards of expected behavior at a given time in that society are understood and articulated.

The four criticisms against social contract theory have thus been shown unable to undermine the validity of drawing upon the social contract idea as an articulation of the moral

foundation of professional status and the moral obligations of professions in general and of health care administrators in particular. The second part of this chapter will now argue that the social contract idea is implicit in our understanding of particular occupational groups as professions.

The Existence of Professions and the Idea of the Social Contract

It has been proposed that professions should be understood as occupational groups which possess exclusive expertise for addressing specific fundamental human needs or societal concerns. But the function and product of the professions and their members cannot exist simply because as occupational groups they insist that they alone possess the expertise to provide society with a needed service, and therefore that the society owes them a dominance in the market with the exclusion of all competitors for the service they provide. Instead, professions are granted relative autonomy in practice and dominance in the market by a society because that society views this structure as the best available means to benefit its members through addressing fundamental human needs and social concerns, and because that society has mechanisms in place to assure that its members will not be harmed by professionals abusing their autonomy or market dominance.

Professions ultimately are accountable to society, then, though this accountability can be partially mediated through the government as established by the society. While it is
true that society lacks professional competence and the ability to adequately judge professional skills, society can judge the benefits brought to, or the harms wrought on, its members through the practice of professional skills and behaviors. This provides society with authority over the function and product of professions. To begin with, society maintains control over the professions and their members by judging the results of professional skills as either satisfactorily or inadequately addressing the specific fundamental human needs or social concerns that gave rise to the professions. Society does not assign areas of public action, welfare, or responsibility to any occupational group irrevocably; ultimately society (or its government) must say whether the public is being properly served, and those occupational groups given the exclusive right to serve the public in a particular way are held accountable to society. As an example of this, the literature for healthcare administrators is beginning to articulate a growing awareness that their institutions' provision of health care is a function granted by the community it serves, and increasingly by the society at large and its government which finances that healthcare. This means in turn that healthcare administrators are obligated first and foremost to meet the health needs and expectations of the communities they serve.16

16See, for example, Gary Filerman, "The President's Report: The Future of Medicine and Management Education," The Journal of Health Administration Education 9, no. 4 (Fall 1991):549-
Once the institution of profession and each particular profession is understood as created by and accountable to society, an occupational group's claim to professional status must always be evaluated by a very straightforward question: Is this arrangement a good bargain for society? Does this particular social division of labor achieve an appropriate level of benefit to society at an acceptable cost? The degree to which this can be answered in the affirmative is the degree to which occupational groups are rightly granted professional status.17

What is often overlooked or taken for granted by the professions and their members is that society invests heavily in the development of professions. Massive amounts of money, both public and private, are regularly spent to fund professional education, to fund the research on which professional practice rests, to fund the institutions in which and the

structures through which much professional activity occurs, and now more than ever before to fund specific individual client or patient demands for professional services. These unearned or only partially earned benefits are given by society to professions and their members so that individuals can become professionals and carry on their professional activity. Healthcare institutions are the beneficiaries of financial gifts, benefits and tax-exemptions which are bestowed upon them by society, and healthcare administrators are thereby charged with exercising responsible stewardship of these gifts and benefits for the sake of society.18 Thus, in accepting such gifts and benefits, professions and their members should understand that they also accept the corresponding obligation to use those gifts and benefits in a manner consistent with society's intentions in giving them.

Should professions object that the intention of such financial benefits is for the sake of clients and patients and not for the sake of the professions themselves, this only furthers the argument; the fundamental intention of society in such fundings to professions is ultimately to benefit those citizens in the society needing professional services. Professions are accountable to society to assure that their services which are funded to a great extent by society do in fact benefit society. If society does not benefit from such

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funding of professional services, then it has every moral right to control or regulate the professions until the desired benefits are acquired, or else remove their funding and thus diminish the professional role and status of that occupational group.¹⁹

Much of the criticism of professions found in contemporary literature charges not only that professionals have fallen short in fulfilling their expected atypical moral commitment to clients and patients, but that the current make-up and function of particular professions no longer provides the desired benefit to society warranting the granting of relative autonomy to these occupational groups. There seems to be a tendency among many professions and their members to believe that professions are entities unto themselves, i.e., that the primary function and duty of a profession is to practice its exclusive expertise regardless of its effect on or cost to society. It is as if some professionals take their market-monopoly so much for granted they forget their relative autonomy in practice is a privilege given in exchange for a public benefit.

It is always important to distinguish between a profession and its function, i.e., the services it provides. The function may always be needed in human society, for the

provision of such services as healthcare, justice, or religious salvation will most likely always be needed by human beings. However, the cluster of practices and relationships arising from the function or the provision of needed services at a given time and place which constitutes a particular occupational group as a profession can be diminished or destroyed if society no longer perceives that occupational group to be providing the desired benefit adequately or at an appropriate "cost" to the society, or if a better means of providing those services can be achieved.

Physicians now face just such a challenge in emerging societal regulations of their practice, e.g. the development of diagnostic regulations and clinical pathways, the formation of the National Practitioner Data Bank by Congress to track physicians with possible problems of competency, and limiting physician ownership of healthcare facilities, to name just a few. Healthcare administrators face this same challenge in emerging societal responses and regulations to skyrocketing health care costs, e.g., managed care, fixed reimbursements per diagnosis, and third-party payer alliances which are facilitating the merging of healthcare institutions into large alliances, also to name just a few. All of these changes are contributing to a loss of certain aspects of autonomy in the practice of medicine and healthcare administration. Societal oversight of professions may diminish their autonomy in practice - which, from the perspective of many professionals,
also diminishes their professional status when society judges that it no longer benefits from the granting of certain aspects of autonomy in practice with corresponding institutional structures to particular occupational groups. 20

Professions are thus accountable to society for their very existence. By maintaining some authority over the function and product of professions, society may establish, maintain, diminish or take away the professional status of particular occupational groups. The existence of professions is thus determined by what can be called a social contract between society and the occupational groups to which it accords professional status.

The Existence of Professional Obligations and the Idea of the Social Contract

The third section of this chapter will now argue that the contents of the ethics of professions are also established through an ongoing dialogue between society and the professions. By helping to determine the professional norms and role-specific duties of the professions and their members, society possesses a second means to establish, maintain, diminish or take away the professional status of occupational

groups. The existence and content of the professional norms is thus determined by what could be called the social contract between society and the occupational groups to which it accords professional status.

Society preserves the rightful authority to help determine the role-specific duties and to maintain some control over the behaviors of professions and their members in three ways. First, the atypical moral commitment of the professional to the client or patient is expected and required of professions and their members in order for these occupational groups and their members to be granted (and to be allowed to maintain) the status of profession; if this atypical moral commitment is perceived to be lacking, the very status of the occupational group and their members as constituting a profession is called into question.

Secondly, professions are granted certain kinds of relative autonomy in practice in exchange for the benefit this provides to society, e.g., physicians are granted professional status with accompanying autonomy in practice in exchange for the health benefits this brings to society. Professions and their members are therefore obligated to promote the benefit their occupational group provides to society in ways that will serve the interests of society and not (merely) their own interests.

Thirdly, the norms of professional behavior which shape professionals' conduct with individual clients or patients are
partly limited and determined by the common moral norms of the society, i.e., the professional norms must be consistent with the moral principles and values present in the society which first created or promoted the professions and to which the professions are ultimately accountable. In addition, via the ongoing dialogue between the society and the professional group, the remaining details of the norms are adjusted to the society's changing needs and conditions, e.g., the formerly acceptable norm of paternalistic behavior in medicine has in recent decades been replaced by the norm of patient informed consent. The remainder of this chapter will develop these three ways in which the content of the ethics of professions and their members are determined by society.

The existence of particular moral obligations is essential to our understanding of profession

In Chapter II it was argued that the atypical moral commitment of professions and their members (as described, even if in idealistic terms, in the Functionalist approach to profession) constituted an essential feature of our understanding of profession. The justification for identifying this atypical moral commitment to clients or patients as an essential feature of profession is sometimes historically based upon the religious origin of the meaning of the term, "to profess."

The term "to profess" is cited as initially referring to nuns and monks prior to the Middle Ages who professed to live
the Christian virtues in a manner higher than the common norm. These professed religious in their monasteries and convents became known for providing essential services to their society such as education, healthcare, and alms for the poor while living a virtuous lifestyle of self-denial and penance. In time the professed male religious founded the first universities and educated their fellow professed religious (and eventually laypeople as well) in medicine, law, and divinity, which came to constitute the first (and for many, the "traditional") professions. The contemporary expectation of professions and their members that they possess an atypical moral commitment to their clients or patients is traced by some authors as originating in the exemplary lifestyle of Christian virtue portrayed by these early professed religious.  

Citing the religious origin of professions cannot of itself, however, constitute a justifying claim explaining the atypical moral commitment expected of professions and their members. It would be fallacious to assume that the religious origin of professions is determinative of their present structure and significance to our American society. Different layers of meaning have been added to our concept of profession, and the nature of profession must now be studied as it is commonly understood in normal language usage. What is

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still noteworthy is that it would seem that an atypical moral commitment like that expected of the professed religious centuries ago is still expected today of our professions and their members, albeit in a different form.

A better approach to justifying the atypical moral commitment of professions and their members as constituting an essential feature of our understanding of profession is to argue that the service provided by the exclusive expertise of the professions which addresses specific fundamental human needs or social concerns is so important to society, and that the consequences of abuse of that exclusive expertise are so serious, that society must demand accountability from the professions and their members on how their relative autonomy in the practice of their exclusive expertise is exercised. It may be argued that society is willing to grant the professions relative autonomy in their practice because society entrusts to the expected atypical moral commitment of the professions and their members the well-being of its members, and trusts that the professions and their members will not abuse their relative autonomy in practice solely for their own self-aggrandizement or to the harm of society.

Much of the recent literature on professional ethics adopts a critical approach towards professions and represents a growing mistrust of the supposed fiduciary relationship between professionals and clients or patients. Increasingly professionals are accused of misusing their autonomy in
practice when they act paternalistically, or when they exclusively promote the primary value of their profession even if that may not be the primary value in their client or patient's life. They are also accused of abusing their autonomy and failing to exemplify an atypical moral commitment to their clients or patients when their professional practice is perceived as primarily existing to promote their own financial and social welfare. Much of the literature on the ethics of healthcare administrators is keenly sensitive to these criticisms, and examines how healthcare administrators may preserve their atypical moral commitment, for example, to patients, while still seeking the financial good of their own institution (with presumably corresponding personal rewards for themselves).22

The exact nature of the professional's atypical moral commitment, i.e., the professional's role-specific duties, may well vary and change over time as society develops new conceptions or understandings of what ought to be the proper moral behaviors of professionals. These differences will be reflected as the four different models describing the professional-client/patient relationship, i.e., Guild, Agent, Commercial and Interactive models, are explored. Explaining how professional obligations in general are grounded in a

22For example, see Marc Hiller, "Ethics and Health Care Administration: Issues in Education and Practice," The Journal of Health Administration Education 2, no. 2 (1984): 147-192.
social contract is a lot easier than determining the exact content of those obligations. This will require careful reflection on the ongoing dialogue and ever evolving agreement among the members of society and between society and the professions over the exact nature of the professional atypical moral commitment of each profession.

Relative Autonomy in Professional Practice is Granted in Exchange for Benefits to Society

The second way in which society exerts control over the behavior and role-specific duties of professions and their members is requiring that the professions promote the benefit which they are designed to address in ways that will best serve the interests of society rather than their own interests. It is this dimension of the social contract which seems least emphasized in the literature on professional ethics, and yet which has involved great abuses and which has resulted in increasing reaction from society seeking measures to control and regulate the professions.

The profession of medicine may serve as a good example here. This profession evolved to address society's health needs. In America the medical profession has been revered for its conquests of diseases and illnesses, and healthcare now accounts for almost one-sixth of our country's national expenditures; yet there is strong political movement afoot to drastically overhaul our healthcare system to better serve the needs of our society. A growing consensus is emerging in our
society that our present healthcare system is too expensive and serves too few, and that the social priority of medicine should not be focused on prolonging life but on helping all the members of society achieve a higher standard of health. Yet the medical profession as a whole has not been at the forefront calling for change in our healthcare system or offering credible potential solutions that will better benefit the provision of healthcare to all members of our society. As a result, many people now see the medical profession as part of the healthcare problem rather than as part of the solution, and consequently urge measures which would bring about greater control and regulation over the medical profession.

Professions are granted relative autonomy in practice because the services they provide are deemed by society to serve the common good, i.e., professional services are viewed as offering the best benefit to society over all other potential structures or possible means of providing that same benefit. In speaking of the "common good" of society, however, two problems arise. First, the sense of the common good that animates judgments within the professions, i.e., the common good as envisioned by professionals, tends to be specific to the benefit provided by each profession rather than some sort of global notion of net aggregate utility across society. In other words, professions and their members tend to promote the specific service their profession provides over all other values, especially because that is the area of
their expertise. Conflicts can therefore arise between professions and society regarding the nature of the common good and the place of the profession's service within the society's values and its conception of its common good. For example, the medical profession and healthcare administrators in our country have traditionally focused on (with a corresponding application of society's resources) crisis intervention and acute care in meeting the perceived health care needs of society instead of advocating and focusing on preventive health care or caring modalities for chronic illnesses, which are two health values increasingly espoused in our society today. Current movements in healthcare reform toward these newer directions are thus encountering a less than enthusiastic response from physicians and hospitals.

A second problem in defining the "common good" of society arises in that the professional commitment to the common good has traditionally been interpreted as the commitment of the professional to the individual client or patient and not to the good of society at large. For example, a physician may prolong the life of an irreversibly insensate patient at immense public cost, or a lawyer may ardently defend and win acquittal for a child-molester who then returns possibly to threaten more children in society.

The popularly-accepted justification for the expected professional's willingness and even commitment to act in the defense or promotion of individual interests, despite an
apparent cost to the common good, is that the social practice which creates those professional commitments to individuals and not to society at large is, on balance, deemed more preferable to a social arrangement within which the professional abandons that commitment to the individual client or patient whenever the common good seems imperiled by strict fidelity to the individual's good. In other words, it is generally agreed that concerns on the "macro" level should not dictate professional's decisions on the "micro" level, since the danger of subjective application of those "macro" concerns is too great. For example, medical care might be withheld much earlier from non-paying insensate patients under the guise of preserving expensive medical treatments, or an innocent man might be denied a fair trial because no lawyer believes in his innocence.

On the other hand, it is generally acknowledged that there are limits to each professional's commitment to the individual client or patient; it is rare, however, for that point to be clearly defined where the common good should take priority over individual interests and this sort of standard then guide professional action. The professional obligation to promote the common good is part of the exchange with society, however, for society grants relative autonomy in practice to the professions and their members in exchange for the overall benefit this provides society. It would thus be incumbent upon professionals to temper their traditional
near-absolute commitment to the individual client or patient with a greater sense of their commitment to the common good.  

Perhaps the best way for professionals to exercise their obligation to promote the common good of society is to proactively engage in public discourse over the nature of the services or benefits promoted by their professions. Our society has grown culturally dependent upon the professions as custodians and interpreters of many of the more most basic values which address our fundamental needs and societal concerns, values such as health, procedural justice, civil liberties, academic knowledge, economic prosperity, and even equity in the distribution of social benefits and burdens. These values tend to be largely addressed in our society through government and corporate policies, which in turn require moral reflection and perspective about the ends and values that our societal institutions should serve and the justifiable means to achieve those ends.

Professionals, then, are in a unique leadership position to help the society reflect on and articulate the best means to achieve the well-being or common good of its people.

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Rather than pursing their own advantage or position as special interests groups seeking to promote their services for their own benefit, and rather than pursuing merely the value of their own profession over all other values in society, professionals are called upon, by nature of their commitment to the common good, to help society develop and maintain the means and structures to guarantee its safety, the integrity of its basic institutions and practices, and the preservation of its core values. In our own liberal society those core values would seem to include governance by law, freedom, protection from injury, equality of opportunity, privacy, and social welfare. Other core values may be identified or may emerge in time.

Professionals would thus be considered obligated not merely to promote the primary value of their own profession and the best interests of their individual clients or patients, but to take a leadership role in engaging in public discourse over the best means and structures to promote the common good as relating to their own field of expertise. Medicine, therefore, should help raise the fundamental questions about what it means for human beings to have good health and how health relates to human welfare. The legal profession ought to call attention to where the law needs reform and where justice could be better implemented. Healthcare administrators should conscientiously help communities decide which healthcare needs in each community should be
addressed and in what priority, as well as discerning the best means and resources to address those needs.\textsuperscript{24}

Professional Conduct is Shaped by Societal Norms

The third way in which society partly limits and determines the behavior of professionals is to evaluate the moral norms of professionals in light of the moral principles and values commonly held in the society. It is this aspect of professional morality which seems to receive the most attention in the literature on professional ethics.\textsuperscript{25}


\textsuperscript{25}Much of the literature on professional ethics describes this issue as a conflict between "professional role morality" and "ordinary morality." The latter term is a misnomer, however, for three reasons; ordinary morality is often interpreted in an unduly simplistic and absolute way, as in suggesting it is always wrong to lie or to harm another. Secondly, there are a variety of moral theories that conceivably could contest for the term, "ordinary morality," and thirdly, much of what passes for ordinary morality actually constitutes various other forms of role moralities, e.g., a professional may also be a spouse, a parent, a citizen, etc., with each role containing its own specific obligations. The term "ordinary morality" will here be used to convey a sense of commonly accepted moral principles and values - most particularly the principle of client or patient autonomy, i.e., the right to be fully informed and to choose or refuse
The popular argument against this position states that professionals, by virtue of their exclusive expertise and institutionally-protected role, have rights and duties that are unique to their professional positions and which may differ from or even be contrary to the rights and duties commonly found in societal morality. Infringing on the moral rights of clients or patients is sometimes argued to be justified on the grounds that this infringement actually contributes to or results in the ends desirable to the professions and to society. For example, role-differentiated behavior for physicians might justify lying to the patient if the physician believed the truth would have a significant detrimental effect on the health of his patient. The physician's primary professional obligation to the patient's health might be held to outweigh his normal moral obligation to truth-telling and respecting patient autonomy. A lawyer might be justified in withholding client-information professional help in accordance with one's wishes and values, since it is this principle which seems to always be the major source of conflict in the literature with professional role-differentiated morality.

from the court, even if this meant the obstruction of justice or the harm to another person, since the lawyer's obligation to promote the client's interests take precedence over all other moral values.

The attempts to justify a strongly role-differentiated morality (in which role-obligations can easily "trump" ordinary morality) are to a great extent not compatible, however, with the terms of the social contract which has been discussed. In this social contract, professions are established as constituting the best means to address particular fundamental human needs or social concerns. Thus the role-specific duties regarding interactions between professionals and lay people normally are limited and guided by the commonly accepted moral values and norms present in that society which helped give rise to the professions, because society cannot easily create professions with contrary moral values and norms that are not held by the society. 27

It must be acknowledged, however, that the terms of the social contract may allow in some instances digressions from "ordinary morality" if those digressions are viewed as less significant than the value promoted by the professional

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service. For example, a physician may elect to offer a placebo to a suffering patient, or to withhold "bad news" from a patient until she judges the patient to be capable of receiving the information; in both cases she defends her apparent violations of ordinary morality, i.e., respect for patient autonomy, on the grounds that in these cases she judges her professional obligation to beneficence, i.e., to act in the best interests of the patient, to outweigh her ordinary obligation to respect patient autonomy. Similarly, a lawyer may harangue a rape victim and disclose her past sexual history for the benefit of aiding the case of his client; in this case, the conflict between valuing procedural justice and valuing substantive justice makes it unclear if he has unjustifiably violated the mores of "ordinary morality."

For purposes here, however, two points will be acknowledged. First, since society has established, through the social contract, the existence of professions and therefore reserves the authority to define the nature of the moral values and norms of the professions, then normally professionals should not be excused for violating the moral values and norms of society.

Secondly, when circumstances occur such that the role-specific duties of professionals obligates them, in their judgment, to act in ways that outside of their professional role they would judge to be wrong, then a serious problem arises negatively impacting the moral character of the
professional. This issue cannot be fully addressed here; for now it suffices to say that there are times when the professional experiences moral conflict and suffers resultant "moral costs" as a result of perceived conflicts between "ordinary morality" and the role-specific duties established by society for his or her profession. When apparent violations occur, the authority remains with society - and not with the professions alone - to determine if the digressions from "ordinary morality" are less significant than the value promoted by the professional service. This determination will most likely never be exact, unanimous, or absolute, and the degree of tolerance for divergence from ordinary morality will vary depending upon the degree of the perceived violation, the amount of resultant harm occurring due to the violation, and the importance granted at any one particular time to the moral value or norm that has been violated.28

For purposes here, when the professional's atypical moral commitment to clients or patients seems to require some sort of role-differentiated behavior, this will be understood in a limited fashion to mean only that the professional is expected to undertake an intensification of specific values commonly found in society. The professional emphasis upon particular

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values found in "ordinary morality" is sometimes deemed necessary for the fulfillment of the professional tasks. For example, the value of confidentiality is intensified in almost all professional practice. This allows the patient to bare his body to the physician to be healed, his personal life to the lawyer to obtain justice, and his soul to the priest in seeking salvation. Because of the value of the service offered by the professions, breaches in confidentiality in professional practice are taken much more seriously than when they occur in normal human relations.

Similarly, much of the literature on professional ethics argues that the moral principle of beneficence marks perhaps the most distinguishing characteristic of professions and professional obligations. Writers within the Critical approach to professions, however, view an intensification of beneficence as merely a supererogatory duty of professionals, and cite the moral obligations of professionals to be no more than "ordinary" moral constraints with the provision that professionals utilize all means available to them for the benefit of their client or patient. An analysis of the role

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of beneficence in professional practice will be undertaken in Chapter VII.

To conclude this section of the chapter, then, there are three ways in which society determines the content and normative function of professional ethics within the social contract. It is important to add, however, that the role-specific duties of professionals as constructed by society in the social contract should not be viewed as standards or obligations imposed upon professionals. Rather, the role-specific duties of professionals are part of the societally-defined understanding of what it means to be a professional. Being a professional involves a specific set of commitments and duties by the very nature of being a professional. To become a professional knowing what society's expectations of such persons are, is to place oneself under certain criteria which can be invoked to assess one's moral performance of that role. Publicly committing oneself as a professional and receiving societal recognition of professional status commits oneself to the role-specific duties required by society of that professional position. By joining a profession, therefore, an individual commits oneself to - and can justifiably be evaluated by - the moral norms established by society for that professional position.\[31\]

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Conclusion

The existence of professions and the determination of the content and normative function of professional ethics is thus the result of a social contract. Again, this contract is not a written or formal document, but is a conceptual means of explaining the social arrangement establishing professions and their ethics. In Part II, four different models of the professional-client/patient relationship currently espoused in the literature on professional ethics and in the literature on the ethics of hospital administrators will be explored and evaluated within the framework of the social contract. It will be argued that the first three models, i.e., Guild, Agent and Commercial models, all fail to satisfy the criteria established by this social contract; only the Interactive model of profession and professional ethics will be found to be acceptable within the terms of the social contract.

CHAPTER V
THE ETHICS OF HEALTHCARE ADMINISTRATORS
IN THE GUILD MODEL OF PROFESSION

This chapter will attempt to identify the moral obligations of healthcare administrators as conceived in the guild model of professions. The term, "guild model," is used as a theoretical construct to understand - or to give one interpretation of - historically developed characteristics of profession. The guild model will be the first of four models or perspectives through which the professional ethics of healthcare administrators will be examined.

Presuppositions of the guild model will be first identified. Characteristics of the medieval guilds and of the later professional associations which left a historical imprint on the development of professions in our own country will be briefly described in order to clarify the model.

In the second part of this chapter the guild-like characteristics that are still found in professions today and that contribute to our understanding of "professionalism" and to the notion of "acting professionally" will be examined. It will be proposed that there are five guild-like characteristics which may be discerned in our popular conception of profession today: 1) A preparatory liberal education followed
by a professional education which consists of theoretical knowledge coupled with hands-on practical application of that knowledge; 2) An ongoing commitment to excellence in one's professional field, with a common understanding that the final intellectual authority on professional expertise resides within the professional group; 3) A commitment to apply the exclusive expertise of the profession in a parental or paternal manner for the good of the client or patient; 4) An allegiance and accountability primarily to one's professional peers resulting in a defensive posture toward outside nonprofessional interference in professional matters, because only the professional group is competent to select, train, credential and discipline members of the profession; 5) An aristocratic or "gentlemanly" behavior in the general conducting of one's professional life.

The major part of this chapter will then attempt to identify the moral obligations of healthcare administrators as these would be understood within the guild model of profession. This will be done by examining the seven categories of professional obligation: 1) identification of the chief client, 2) ideal relationship with the chief client, 3) commitment to the good of the chief client, 4) central values of the profession, 5) commitment to competence, 6) ideal relationship with fellow professionals, and 7) ideal relationship with society at large.

The final section of this chapter will critique the
concept of profession and professional obligation as understood within the guild model. It will be argued that the guild model, despite contributing important characteristics to our popular understanding of profession, would not be an acceptable model of professional obligation for healthcare administrators within the social contract between society and this profession. First, the type of near-absolute autonomy in professional practice with accompanying paternalistic relations with clients or patients that is requisite within the guild model of profession runs counter to our contemporary practice of social democracy in general and to the increasing emphasis given to the autonomy of clients or patients in their relationship with professionals in recent years. Second, and contributing to the trend just mentioned, professions which have attempted to exercise the type of guild-like autonomy in professional practice historically have often been characterized as misusing or abusing that autonomy to promote their own interests to the detriment of society. Third, in the guild model of profession problems inherent in the practice of self-regulation greatly limit professions promoting the best interests of clients or patients or of society in general. In sum, since clients and patients do not benefit proportionately to the degree of autonomy in professional practice presupposed under the guild model of profession, it is therefore unreasonable for society to "contract" with professions according to the presuppositions of the guild model of profession.
Presuppositions of the Guild Model of Profession

The term "guild" as used here takes its meaning from the medieval guilds and from the professional associations which emulated critical characteristics of the medieval guilds. Historically, the first guilds were groups of craftsmen or artisans who banded together in European towns between the eleventh and thirteenth century. These groups developed required steps in training and credentialing for becoming a member of the guild; these served both to mark the development from apprenticeship to the mastering of the craft and also to restrict competition in each group's marketing of their craft.

With the rise of the European universities in the thirteenth century, what came to be known as "professional associations" of teachers and students, or "guilds of learning," most of whose members were persons of high prestige and honor due to their aristocratic birth and inherited title and wealth, began to cluster around specific fields of study such as medicine and law. These laypeople joined the clergy who were already involved in those disciplines as well as in the fields of theology and philosophy. Provision of a "liberal education," that is to say, an education fit for a gentleman that was based more on classical culture than on practical skills, distinguished these professional associations or
"learned guilds" from the "common man's" craft-guilds.¹

In the following centuries, the evolving occupational groups of medicine, law and clergy retained many of the characteristics of these early guilds and associations. Though the crafts and learned guilds were accused of market abuse and were subsequently abolished in Europe in the late eighteenth century, their characteristics of brotherhood, cooperation, solidarity, examining, licensing, monitoring specific areas of knowledge, and an attitude of expertise survived in many of the workers' cooperatives or associations. Philosophical justification for the value of these associations was offered by Hegel, who viewed the family and these workers' guild-like associations as constituting the two basic moral roots for state and society. Hegel observed that in large modern states the individual rarely has an opportunity for direct involvement in public matters and state affairs; but through membership in an association the individual was able to become involved in public ethics and public policy.²

The value of worker cooperatives and, among the more learned of what came to be called professional associations, was that such groups or "collective persons," were more powerful, 


longer lasting, and more stable than individuals, that they bound together individuals with common interests, and that they combined common values, goals and expertise which enable individuals to produce more goods and achieve more goals than if they acted alone.\textsuperscript{3}

These sorts of professional associations also developed in America in the 19th century. By this time science in this country had come to epitomize the very essence of intellectual authority. The validity of expertise was determined by what could be called "peer review." This was understood to mean that a scientific practitioner must expose his work to review by peers for judgment, and that none but his peers were entitled to judge him. This established a "community of the competent" which was to serve as the final arbiter of authority in establishing scientific truths within the professional associations through a consensus of capable investigators. This development in turn reinforced the difference between the expertise of the professional and the laypersons served by the professional, namely, that since the professional has knowledge and practical experience that their patients or clients lack, then the judgment of the professional should dominate in

all decisions relating to that expertise.⁴

Characteristics of the Guild Model of Profession

Much of the contemporary literature in sociology which studies the professions tends to identify existing professions by their guild-like characteristics.⁵ The second part of this chapter will propose that there are five principal guild-like characteristics that contribute to the popular understanding of what it means to be a member of a profession or to "act professionally".

The first guild-like characteristic refers to the type of education expected of a professional. Since professionals "practice" their trade and make their living by providing needed services to their clients or patients, a practical education involving "hands-on" learning and apprenticeship or internship modeled after the original guilds of artisans is required. Yet, possibly due both to the influence of the early "guilds of learning" from which the "traditional" professions of medicine, law and clergy emerged and to the

⁴This point is examined in Thomas Haskell, "Professionalization as Cultural Reform," Humanities in Society 1 (1978): 103-114.

belief in our country that science is the basis for intellectual authority, professionals today are generally expected to also possess the theoretical background and justification for their practical knowledge. Professionals are expected to know both how to accomplish something and why it works. As argued in Chapter II, the popular image of one who is trained only in practical knowledge is that of technician, while the one who possesses only the theoretical knowledge is a scholar. It is the combination of the two that is generally required in our popular understanding of professions and professionals.

The early guilds of learning historically were also made up almost exclusively by the nobility or gentry. Trained in the classics and with an extended education in liberal arts, these members of the early professional associations were known for their ability to think broadly and to speak eloquently on a wide variety of issues. Even today, part of what could be termed the "professional image" includes a sense of being "cultured" and generally knowledgeable on a wide range of issues. But a broad liberal education has a practical application as well; though most professional knowledge has a scientific basis, the practice or application of that knowledge has long been considered an art and a good liberal arts education has often been viewed, therefore, as beneficial to successful professional practice. Even though much professional training is highly specialized today, this popular association of professional with broad understanding
and liberal training persists. Healthcare administrators, for example, require broad education in business and management principles, finances, and healthcare delivery, yet success in their job is dependent upon their ability to apply their theoretical knowledge in day-to-day practice.\(^6\)

A second guild-like characteristic which seems to influence our popular understanding of profession is the obligation of the professional to excellence in his or her field, that is, to ongoing competence in professional skill. With continued advancements or developments in scientific knowledge, in law, in theology, or in other matters directly pertaining to professional practice, standards of competence increase with the professions. A professional who hasn't bothered to keep up with developments in his professional field is viewed as irresponsible, since he may not provide an available benefit to a client or patient and may in fact even cause harm through his insufficient knowledge or skill. If this happens on a wide-spread basis, i.e., many members of a given profession do not keep up with developments within their field of expertise, their very professional status then becomes threatened as clients or patients seek out other means to address their needs. A professional is expected to remain competent as a matter of good faith to his or her commitment as a professional.

\[\text{This perspective is also suggested in Larson, The Rise of Professionalism, 3-8, 80-103.}\]
The service provided by the professions traditionally has been understood to be the only available means (or the primary means) to assist people when they require assistance in addressing fundamental values such as health, justice or religious salvation. Professionals are therefore required to maintain and continually grow in their area of exclusive competence in order to maintain market control of their needed services. For healthcare administrators facing a highly competitive and rapidly changing healthcare delivery system, ongoing growth in their area of expertise is required not only for their own job and institutional survival, but for the very maintenance of their professional role and market control over their services.

Furthermore, it is understood in the guild model of professions that the criteria for determining professional competency can be established only by the profession itself. Even if professionals are employed by nonprofessionals, the professions are left relatively free to develop their own special areas of knowledge and to determine what are professionally acceptable practices. Though professionals today increasingly find the quality of their services measured by third-party payers, those measurements still tend to be determined by fellow professionals employed by the third-parties. Professional associations or societies establish the criteria for professional competency as well as the standards for accreditation for the professional schools training the
candidates of their own profession. Professional knowledge and the criteria determining quality professional service, therefore, ultimately is controlled by the professional group, and not by the individual practitioners and not by society at large (except as it recognizes, supports or tolerates the expertise of the professional group). 7

The third characteristic that can be associated with the guild model of profession is the professional's commitment to apply the exclusive expertise of one's profession in a parental or paternal fashion for the good of the client or patient. The professional commitment to excellence in one's field of expertise is conjoined with the commitment to use professional services in a personally disinterested manner for the benefit of the client or patient.

There is an elegant anonymity in this commitment of professional trustworthiness. If a person, for example, were to become sick away from home and go to a hospital emergency room, he can trust the doctors and nurses since they are certified members of professions who can, prima facie, be taken as willing to abide by the norms of their professions. This would not be the same case if one's car broke down away from home; there one is dependent on the personal integrity of the automobile mechanic rather than being able to rely on

any group-norms of his occupation. But in the hospital a patient can trust in the competency and personal disinterest of his caregivers simply because they are professionals.⁸

This special trust exists because of the unique nature of the relationship between professions and society. The individual client or patient has significant needs which she cannot address. Professions arise if, as occupational groups, they come to possess the exclusive expertise to address those needs. Healthcare institutions were developed to address the health needs of communities, and healthcare administrators have grown into professional status due to their unique ability to capably manage these highly complex healthcare institutions which benefit the health needs of our society.

The commitment of the professional to the good of the client or patient is not entailed by the moral status of the individual client or patient or even from the collective moral status of society. Rather, it derives from one's membership in the profession and from the promises made when accepted into the profession, which in turn exists for the principle purpose of addressing specific fundamental human needs or social concerns. The professional commitment to the good of the client or patient is logically required and practically expected solely and precisely because the professional is a

member of that profession.

In the guild model professions promise to direct their exclusive expertise to address fundamental needs of laypeople who are uninformed and unskilled in the means to help themselves. Laypeople know only if they are physically hurting, if they have run afoul of the law, or if they are estranged from God. It oftentimes takes professionals, however, to determine what exactly is the cause or root source of their need and how best to address those needs. Consequently the clients or patients are oftentimes dependent upon the professional's expertise and become the passive and grateful recipients of the essential services provided by the professional as a representative of his or her profession.

Essential to the guild model's understanding of the relationship between the professional and the client or patient is the inevitability of professional paternalism. While paternalism may carry negative overtones in today's society, it is unavoidable in the guild model professional-client/patient relationship because of the professional's exclusive expertise and the corresponding ignorance, helplessness or need of the client or patient. The guild model attempts to justify paternalism in the professional-client/patient relationship.

First, because of her exclusive expertise, a professional possesses relevant knowledge which her client or patient lacks. She is thus better able to perceive the advantages and
disadvantages of alternative treatments or causes of actions and consequently has a certain amount of authority and responsibility for such decisions. For example, the patient may know he has stomach pains in the emergency department, but it is the physician who has the knowledge to determine the cause of the pain and to decide on an appropriate means to restore the patient to health. The patient seeks emergency healthcare, but it is the physician who is best equipped to decide what is appropriate care. A community may recognize the need for providing obstetrics services to the poor, but it is the healthcare administrator who best knows how those services may be delivered.

Second, clients or patients who, for example, approach the traditional professions of medicine, law or clergy for help may do so partially because they experience their autonomy as threatened or diminished by their illness, by legal threats, or by spiritual despair. These deficits, combined with a potentially strong sense of accompanying anxiety and dependency, prohibit the full exercise of their autonomy. They may need the professional to direct their care, their legal help, or their spiritual lives to restore their sense of lost autonomy. There are times, therefore, when clients or patients have to trust in the expertise and judgment of professionals, which, when exercised in a parental or paternal manner, serves to restore their lost or diminished sense of autonomy.
Third, because the services provided by professionals address human needs that are oftentimes fundamental to people, professionals are sometimes allowed to exercise judgment regarding what is in the best interests of the clients or patients. For example, requiring an unwilling patient to undergo painful physical therapy following a knee replacement is beneficial to that patient. Implementing clinical pathways for individual patients in an age of reduced reimbursements may help assure the long-term presence of a needed healthcare institution in a given community, even if this forces the initially unwilling community to develop structures for caring for the sick outside of the healthcare institution. The guild model presumes that human beings, as individuals and as members of a community, normally desire that threats or limitations to their fundamental well-being be addressed in the best way possible, which, according to the guild model of profession, normally occurs through the means offered by the professional. Consequently, for these three reasons, in the guild model of profession paternalism is a natural feature of the professional-client/patient relationship.9

A fourth set of characteristics of profession associated with the guild model is primary allegiance and accountability

to one's professional peers, with an accompanying defensive posture toward outside interference, since only the professional group has the competency to select, train, credential and discipline members of its own profession. While some economic competition exists between members of the same profession in a sheltered market, a sense of fraternity and collegiality reminiscent of the medieval guilds tends to exist among the professions in the guild model. This is reflected in practice in a number of ways.

Members of the same profession tend to offer comparable pricing for their services (and, until recently, in the forbidding of advertising for their individual services) which supposedly reduces competition and the incentives of material interest. Protecting their income not only from internal competition and also disallowing outside competition from non-professionals is presumed to enable professionals to focus on "working well" and on gaining the approval and respect of their colleagues through the capable practice of their professional expertise. Thus, their evaluation of their own and each other's work is based on contemporary conceptions of genuine quality and not on cost or even outcome; these latter criteria are typical of non-professional modes of measurement.

Professionals in the guild model believe that their expertise is so exclusive that members of society are too ignorant to offer input of any value to the knowledge or proper functioning of their professional practice. Physicians
tend to react negatively to third party payer interference in their treatment decisions, and many healthcare administrators view their boards and trustees as failing to fully appreciate how a capably-run healthcare institution should function. Professionals in general tend to exhibit resentful defensive-ness with corresponding group posturing for mutual self-protection in the face of attempts by nonprofessionals in society to interfere with their internal practices. Criticism by professionals of their own peers is rare since there is a presumption among professionals that their colleagues are persons of integrity and competence and that they are governed by the internal controls inculcated during their professional training.¹⁰

The fifth characteristic of profession found in the guild model is what could be called aristocratic or "gentlemanly" behavior in the conducting of one's professional practice. While this is somewhat of a minor feature compared to the

previous four categories of guild-like characteristics, this last feature does play a part in what could be called the professional image or mentality. The early professional associations were composed of aristocrats of high birth and title, educated in liberal arts and in the classics, who were therefore expected to conduct themselves in a manner above the behavior of the common class. Combined with a serious study of the sciences, a commitment to excellence in their profession and a pledge to personal disinterest in promoting the good of their client or patient, professional behavior in the guild model can be characterized by what could be called a "gentlemanly" behavior, i.e., qualities such as integrity, confidentiality, and a commitment to quality in the provision of their professional services, as well as traditional behavioral traits associated with the English gentry class such as seriousness, aloofness, and remaining unruffled in the face of pressures or demands. These "gentlemanly" qualities, combined with the professional attitude of paternalism toward the good of the client or patient, has contributed to the development of the popular meaning of "acting professionally," or "professional etiquette.""

These five characteristics or categories of characteristics that derive from the medieval guilds and early

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professional associations, and that survived in the European workers' associations in the following centuries and in the early development of the American professions, are still significant in our popular understanding of the meaning of profession today. In the third part of this chapter, the implications of these guild-like characteristics for professional conduct will be developed into an account of the moral obligations of healthcare administrators as understood according to the guild model of profession.

Professional Ethics of Healthcare Administrators in the Guild Model of Profession

Identification of Chief Client

The ethics of healthcare administrators will be analyzed throughout this study by means of the seven categories of professional obligation described in Chapter III. The first category is identification of the chief client of healthcare administrators as understood according to the guild model of profession. This is a more difficult task than when engaged in studying the "traditional" professions where the identity of the chief client is self-evident, e.g., the physician and his patient, the lawyer and her client, the priest and his parishioner or congregation. Unlike all other healthcare professionals whose chief client consists of individual patients, in the guild model of profession the chief client of the healthcare administrator - by nature of the exclusive expertise which has brought professional status to healthcare
administration, namely, the ability to utilize a unique blend of multiple skills and talents to administrate a highly complex institution designed to serve a community's health needs - is not the collection of individual patients, but rather is the healthcare institution itself.

The professional role of healthcare administration has evolved because of the societal response in creating and promoting healthcare institutions to address the healthcare needs of individual patients. But healthcare administrators have very little contact or involvement with actual patients, and never directly take part in the actual provision of healthcare which is the very function of their institution. Their relationship with individual patients is very distant and exercised only through layers of management and employees. In the guild model of profession, patients become the passive recipients of the highly technical healthcare offered by a variety of professionally-skilled personnel under the management and structures developed or administered over by the healthcare administrator. The only input healthcare administrators require from patients comes from patient satisfaction surveys, from which they can learn what are the popular features of their institution which they can market to the community and what are the problem areas in their institution which require their expertise to address. Patient suggestions or recommendations are dismissed since they cannot "grasp the big picture" and cannot understand what is involved in
administrating a complex healthcare institution.

Patients who are sick or hurting come to healthcare institutions when they lack the means to address their health problems. The healthcare institution, with the healthcare administrator at its head and as its public representative, is generally expected in our American society to act in the role of service to the community in addressing the healthcare needs of individual patients. The healthcare administrator is commonly held responsible for assuring that the healthcare institution is designated for and publicly committed to the healthcare needs of patients, and that it concentrates and makes available those resources that a person from that community needs when sick or hurting with the promise that the institution will assist the sick person to regain his lost health and autonomy to the maximum degree possible. The healthcare institution, with the healthcare administrator understood to possess a considerable amount of decision-making authority, may also be expected to make its services available

In referring to the "healthcare institution acting", what is meant here is the moral agency of the group of healthcare workers whose collective decisions and actions represent the healthcare institution and are expected to be undertaken in the interests of the individual patients. There has been considerable philosophical debate about the idea that institutions act as unitary agents and can therefore have at least some of the features of individual human agents attributed to them. In defense of this view, see Larry May and Stacey Hoffman, eds., Collective Responsibility: Five Decades of Debate in Theoretical and Applied Ethics (Savage, MD: Rowman & Littlefield, 1991); Thomas Donaldson, Corporations and Morality (Englewood Cliffs, NJ: Prentice-Hall, 1982); Peter French, Collective and Corporate Responsibility (New York: Columbia University Press, 1984).
to all in the community and to not compromise patient care - at least urgent patient care - over concern for cost-containment measures, and also to not profit unjustly in offering treatment for patients' needs.\textsuperscript{13}

Capably organizing and managing a complex healthcare institution requires an exclusive expertise which has given rise to the profession of healthcare administration. In regards to individual patients and to the local community, the healthcare administrator represents the profession's response to facilitate the healthcare institution's reasonable provision for the highest quality healthcare possible to meet their health needs.

In regards to physicians, management and employees, the healthcare administrator alone possesses the necessary business and management skills to optimally facilitate the delivery of their healthcare services within the healthcare institution to individual patients and the local community. In regards to the sponsor of the healthcare institution, the healthcare administrator is best qualified to assure that the sponsor's interests and values are respected in the function of the healthcare institution.

In the guild model of profession, therefore, the chief client of healthcare administrators - whose welfare they are

\textsuperscript{13}These points are drawn from Edmund Pellegrino and David Thomasma, \textit{A Philosophical Basis of Medical Practice} (New York: Oxford University Press, 1981), 244-265; Frank Marsh and Mark Yarborough, \textit{Medicine and Money} (New York: Greenwood Press, 1990), 30-32.
committed to promoting - is the healthcare institution itself. Only healthcare administrators possess the exclusive expertise, i.e., the necessary knowledge, training, and experience, to capably and efficiently direct and operate the highly complex healthcare institution. It is not uncommon to hear healthcare administrators, viewing their role from the perspective of the guild model of profession, to claim that their primary responsibility and professional obligation is to promote the good of their healthcare institution.

For all other healthcare professionals, therefore, the healthcare institution is only a means (a facility with needed technology) for providing their professional services to their chief client, namely, the individual patients. Healthcare administrators alone, by virtue of the nature of their exclusive expertise, have as their chief client the healthcare institution itself.

Ideal Relationship with Chief Client

The ideal relationship of the healthcare administrator with its chief client, the healthcare institution, is a rather peculiar relationship for two reasons. First, administrating a complex and highly technical healthcare institution requires a great number of highly specialized skills which the healthcare administrator could not hope to personally possess. Secondly, many of the employees of healthcare institutions either consider themselves to be or are commonly considered by society to be professionals as well.
In dealing with the first issue, then, it is critical that the healthcare administrator surround herself with both highly competent and loyal individuals who make up the administrative team or council. It is imperative that the healthcare administrator be able to rely upon these individuals for their expertise and for their commitment to the healthcare institution. With their input the healthcare administrator, who remains the final authority and decision-maker in the guild model, will best be able to make capable decisions on highly complex matters of management and business to best promote the welfare of the healthcare institution.

In regards to the second issue, managing professionals who are directly involved in patient care requires a delicate balancing of allowing those professionals control over the content of their work while the healthcare administrator yet maintains control over the terms of their work. In other words, professionals such as nurses, respiratory therapists, anesthetists, and so forth, and even physicians, possess an exclusive expertise in their own field which should be honored, e.g., nurses know best how nursing care should be provided. These professionals, however, are focused almost exclusively on the benefit their services provide to their own individual patient. The healthcare administrator, by virtue of his responsibility to promote the good of the institution as a whole, must provide mechanisms for oversight and regulation so that it is the institution and the fulfillment of the
institution's responsibility to all its patients which ultimately benefits through the services of the professionals it employs. There may well always be tensions existing, then, between the healthcare administrator and the professionals employed by the institution over issues such as staffing and capital expenses because these different professionals have different chief clients, but those decisions must always be made by the healthcare administrator because she alone has the exclusive expertise and responsibility to judge what is best for the healthcare institution.

Commitment to the Good of the Chief Client

The third moral category is commitment to the good of the chief client. The healthcare institution exists to address the fundamental healthcare needs of the members of a local community. The profession of healthcare administrators exists to address the societal need for healthcare institutions to be operated as capably and as efficiently as possible. In the guild model of profession healthcare administrators, by virtue of being members of this profession, undertake the responsibility to promote the good of their chief client, the healthcare institution.

Healthcare administrators may be said to understand the "good" of the healthcare institution in four different ways. First, a good institution is one that is achieving its purpose. A healthcare administrator, then, is obligated to utilize her administrative skills to promote high quality care
for patients throughout the institution. Second, a good institution is one that has effective and productive employees. A healthcare administrator, then, is obligated to promote, develop, maintain, and improve the institutional structures to facilitate the provision of quality care, and to develop the skills and attitude of the healthcare workers so that they are able to function at the fullest extent of their capability. Third, a good institution is one that is known for its integrity and fidelity. A healthcare administrator, then, is obligated to always act in a morally upright manner and to assure that ethical decisions are made on both the clinical and institutional levels. Fourth, a good institution is one that is financially solvent. A healthcare administrator, then, is obligated to exercise astute business skills and to make appropriate decisions to best assure the healthcare institution will survive and thrive.\(^\text{14}\)

The professional obligation of the healthcare administrator to promote the good of her chief client, the healthcare institution, takes priority over other moral obligations which exist with the other clients of healthcare administrators, including their own employers.\(^\text{15}\) That is, many healthcare administrators may then appeal to the hierarchy of central values of healthcare administration which will be examined next in the fourth category of professional obligation.

\(^{14}\)Should conflicts arise in attempting to fulfill all four of these professional obligations, the healthcare administrator may then appeal to the hierarchy of central values of healthcare administration which will be examined next in the fourth category of professional obligation.

\(^{15}\)See pages 62-63 for a listing of the client-groups of healthcare administrators.
administrators feel a tension in their atypical moral commit-
ment to their institution due to particular pressures which
may be laid upon them by their institution's sponsor, owner,
or shareholders, e.g., to consistently show a positive bottom
line regardless of impact on patient care, or to always
possess favorable relations with the medical staff regardless
of any repercussions this may have with employees. Should the
healthcare administrator succumb to pressures from her
employer and oblige such requests, then she has violated the
professional obligation to promote the good of her chief
client, which in the guild model of profession is understood
to be the healthcare institution.

For healthcare administrators within the guild model of
profession, to maintain their claim to professional status
they must have developed the understanding with their institu-
tion's sponsor, owner, or shareholders that while they will
work to represent whatever mission or interests those groups
may have, the primary obligation that healthcare administra-
tors possess by nature of being members of their profession is
to promote the good of their chief client, that is, their
healthcare institution. To do otherwise is to destroy their
professional status and to consign them into being no more
than business managers operating under the direction or whim
of their boss who signs their paycheck.

Central Values of the Profession

The fourth category of professional obligation is the
identification and prioritization of the central values of the profession. Most of the decisions of healthcare administrators are inherently value-laden and involve choices between conflicting values. A careful analysis of the role of healthcare administrators reveals five fundamental or central values of this profession. Four of these values are directed towards promoting the good or well-being of the healthcare institution, as previously identified in the third category of professional obligation. The fifth value, which is the health of the community, is a value related to and yet distinct from the well-being of the healthcare institution. It is important not only to identify these central values but to rank them in a hierarchic scheme to assist healthcare administrators in determining which values can and should have a determinative role in ethical decision-making. It is proposed that these five value considerations dominate the ethical reflection of healthcare administrators, and that the proposed hierarchic scheme of values can and should direct healthcare administrators' deliberation when faced with value-conflicts.¹⁶

¹⁶As the role of healthcare administration continues to develop with changes rapidly occurring in the provision of health care, i.e., a decline in the number of patient days in an acute care setting, and a rise in the number of patients utilizing rehabilitation and outpatient treatment centers or requiring home assistance or institutional care for chronic or debilitating illnesses, the central values of the healthcare administrator may likewise continue to evolve. But the emphasis upon particular values in the hierarchy of central values will most likely remain constant as defined within each of the four models of profession examined here in Part Two, despite developments and shifts within healthcare institutions.
The hierarchical ranking of these central values of healthcare administrators will differ for each of the four models of profession used to study the profession of healthcare administration in Part Two. This is because each model develops a different understanding of profession, each with a different emphasis upon particular values. In the guild model of profession, it is proposed that the central values of healthcare administrators can be identified and prioritized in a hierarchic scheme (with "1" as the highest central value and the rest in descending order of priority) as follows:

1. Effective and capable management of employees, and good relations with the medical staff
2. Institutional integrity
3. Financial viability of the organization
4. Health of individual patients
5. Health of the community

The first value on the hierarchic scheme for healthcare administrators in the guild model of profession is the existence of effective and capable management of employees, and good relations with the medical staff. The primary skills of healthcare administrators are management and business skills, which constitute the nature of the exclusive expertise which society expects in its healthcare institutions, and for which healthcare administrators as the profession designed to meet this expectation has developed.\(^7\) As a result, healthcare administrators in the guild model of profession apply

\(^7\)For a sample listing of these skills, see Terry Cooper, The Responsible Administrator: An Approach to Ethics for the Administrative Role (San Francisco: Jossey-Bass, 1990), 222-235.
their exclusive expertise so that the healthcare institution may function to its fullest capability. This means that the activities of healthcare administrators are primarily geared towards promoting the essential or highly valued qualities of a good healthcare institution, namely, effective and capable management of employees, and good relations with the medical staff. Without these qualities, the healthcare institution could not provide the healthcare expected by society.

These valued qualities together constitute the most important central value for healthcare administrators in the guild model of profession since they can be brought about only by healthcare administrators. These qualities of a good healthcare institution, therefore, are not merely valued instrumentally for the sake of promoting the health of patients. While it is presumed that the application of the exclusive expertise of healthcare administrators will promote the health of individual patients in the healthcare institutions, developing and facilitating effective and capable management of employees and good relations with the medical staff are the qualities or tasks most highly valued by healthcare administrators in the guild model of profession since only their exclusive expertise can bring them about, regardless of the overall impact on the health of individual patients. It is the healthcare institution which is the chief client of healthcare administrators in this model, and whose well-being they are committed to promoting. These qualities
which are necessary for a healthcare institution to function, then, have intrinsic and not just instrumental value for healthcare administrators in the guild model of profession.

Two further points need to be mentioned. First, working with effective and capable management and employees not only contributes to the healthcare administrator being able to exercise good management and business skills, but is also to a great extent dependent upon the good management skills of the healthcare administrator.

Second, good relations with the medical staff can be expressed in various ways. Earlier in this century the success of the healthcare administrator was often directly correlated to his positive or negative relations with the medical staff. In recent times, however, the "balance of power" has shifted and healthcare administrators now exert considerable control over the practice and behavior of physicians in their institutions. Currently, however, as physician-hospital alliances are being formed in response to the evolution of managed care and capitation reimbursement, healthcare administrators and physicians now find that they must work closely together as equal partners for mutual benefit in the alliance.

The second central value in the hierarchic scheme is

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institutional integrity. This means that the healthcare administrator must be committed to the mission of the healthcare institution, that is, to the reason or the purpose for the existence of the healthcare institution. When anyone assumes leadership of an organization or corporation it is understood that that person is not representing his or her own interests nor other individuals' interests, but rather using prudent judgment to further the best interests of the organization or corporation. For healthcare administrators this means that a fundamental central value, with a corresponding professional obligation, is to pursue the good or well-being of their institution. Healthcare institutions are expected by society to benefit the patients they serve. In the guild model, the healthcare administrators' role in providing this benefit is determined not so much by the quality of the healthcare provided to patients but by the successful and capable operation of the institution.\footnote{This point is exhibited in Chuck Meyer, "Sin Boldly: Ethical Issues of DRGs," Hospital and Health Services Administration 31, no. 3 (1986): 83-90; Jim Summers, "Managers Face Conflicting Values," Journal of Healthcare Material Management 7, no. 5 (1989): 89-90; M. Dean Jellison, "As I See It," Trustee 36, no. 11 (1983): 46.}

Promoting institutional integrity, however, ranks as only the second central value in this hierarchic scheme. This is because in the guild model of the profession, the professional knows what is best for his chief client. Normally the healthcare administrator exercises a relatively autonomous
role in acting to promote the value of effective and produc-
tive management of employees and good relations with the
medical staff for the purpose of promoting the mission of the
institution. But there are times when the healthcare adminis-
trator judges that what is best for the healthcare institution
may require a re-direction of its mission or purpose. For
example, the healthcare administrator may judge that an acute
care hospital should evolve into a long-term care facility due
to its inability to compete in its former market, or that a
community hospital should change into a for-profit healthcare
institution to greater assure its ability to survive or
prosper. In other words, the mission or purpose of the
institution may have to change for the benefit of the institu-
tion, and this re-direction is to a great extent brought about
by the healthcare administrator who, in the guild model of
profession, is best equipped to judge what is best for the
institution.

The third central value in the hierarchic scheme is the
financial viability of the healthcare institution. This is an
important value to healthcare administrators because without
institutional financial viability, individual healthcare
administrators would lose their jobs and be afforded no
occasion or resource to practice their exclusive expertise.
While it should be acknowledged that there is pressure on
healthcare administrators to make this value the predominant
one in their hierarchic scheme of values due to increased
competition between healthcare institutions with greater financial risks than ever before,\(^2\) in the guild model of profession this value still ranks lower than the two values listed above. The exclusive expertise of the healthcare administrator which has been developed in response to the societal concern for the provision of institutional healthcare is the capable and efficient administrating of healthcare institutions. Just as physicians, lawyers and clergy in the guild model of profession are traditionally expected to put the healthcare, justice or religious needs of their individual patients or clients above any financial considerations, so too are healthcare administrators expected to value their work with management, employees, and physicians and the purpose or mission of their institution above financial considerations.

This does not mean that acting to maintain the financial viability of the institution is not important. It does mean, however, that if the healthcare institution can financially survive or prosper only by compromising on its purpose or mission to the detriment of its ability to allow its staff and physicians to exercise their professional roles, then it becomes no more than a profit-maximizing business and the role of the healthcare administrator loses its professional status and instead requires only a good businessman.

\(^2\)And it could be presumed that this pressure is even greater on the administrators of for-profit healthcare institutions, whose primary purpose as an institution is to offer a favorable financial return to investor and stakeholders.
The fourth central value is the health of the individual patients in the healthcare institution. This lower ranking reflects the facts that patients do not constitute the central client of the healthcare administrator and that administrators have little actual contact with patients in their day-to-day functioning. In the guild model of profession patients are the passive recipients of highly technical healthcare delivered by highly skilled personnel in an extremely complex healthcare institution. While these institutions exist to address the healthcare needs of patients, the healthcare administrator is most concerned with and primarily responsible for the capable and effective operation of the institution. It is assumed that this indirectly results in benefits for the health of individual patients, and all management and business practices should be conducted with this in mind. Nevertheless, concern for their needs cannot directly take priority for the healthcare administrator over the needs of the healthcare institution for whose benefit and welfare he or she is ultimately responsible.

The value of the health of individual patients is even placed below the value of good relations with the medical staff for the reason that the quality of individual patients' medical care may be allowed to be compromised - on occasion, and with the provision that the compromise is not significantly harmful to individual patients - for the sake of maintaining overall good relations with physicians, for this is judged
to be in the best interests of the healthcare institution.

The health of individual patients ranks lower than institutional integrity, for the healthcare administrator may elicit change in the purpose or mission of the institution for the benefit of the institution, even if this brings about an overall net negative effect on the health of individual patients. The health of individual patients also ranks lower than the financial viability of the institution. While the long-term care of particular critical or chronically ill patients may impose a financial burden on the institution, such occurrences cannot happen frequently or at great unreimbursed expense to the institution without severely compromising its ability to exist and to provide healthcare to the community at large. Unprofitable services, then, may justifiably be discontinued to protect the welfare of the healthcare institution regardless of the benefit those services had provided to individual patients.

The fifth and last central value in the hierarchic scheme is the health of the community. This is valued by the healthcare administrator since it has been the impetus for society to develop healthcare institutions, and because the health of the community directly interacts with the nature of the health of individual patients who utilize the services of the healthcare institution. For example, poverty, adolescent pregnancies, or the presence of infectious diseases within a local community may significantly impact and determine the
type of healthcare offered by a healthcare institution. Nonetheless, the value of the health of the community ranks lowest in the hierarchic scheme since it exists outside the actual operation of the healthcare institution. While the health needs of the community may indirectly affect the purpose or mission of the institution and have a significant effect on its financial viability, the health welfare of the community is distinguishable from the normal functioning of the healthcare institution itself whose welfare the healthcare administrator is primarily committed to promote. The healthcare administrator practices his exclusive expertise to address the health needs of the community, but never in any way that will be of detriment to the healthcare institution itself. All services that promote the health of the community are offered because their provision is judged to also benefit the healthcare institution.

Commitment to Competence

Moving beyond the central values, the fifth category of professional obligation is the commitment to competence. For healthcare administrators, the practice of capably and effectively operating the complex healthcare institution begins with education in healthcare administration, but is to a great extent learned only through experience. An aspiring healthcare executive candidate must then be willing to exercise a number of different leadership roles within an organization in order to gain that needed experience. Like the competence for
physicians and lawyers which is maintained through learning of new medical treatments or developing case law, ongoing competence for healthcare administrators is maintained by continual study of and exercise in developing management and business techniques and by regular evaluation and feedback from private healthcare management consultants and by institutional evaluators such as the Joint Commission for the Accreditation of American Health Organizations.

Relationship with Fellow-Professionals

The sixth category of professional obligation is the ideal relationship with fellow healthcare administrators. The general relationship among members of professions has been described earlier in the fourth characteristic of profession within the guild model. In a number of ways healthcare administrators resemble this description. Healthcare administrators train and credential their own members. While utilizing advisory boards at their healthcare institutions, they generally are reluctant to allow "outside" input into their decision-making. They rarely criticize their peers (in public) and almost never hold one another accountable to their Code of Ethics. Yet in one significant way healthcare administrators do not reflect the guild model of profession in

their relationship with one another. The collegial relationship expected of professionals in the guild model is to a great extent absent among healthcare administrators. While overt expressions of mutual respect and role-familiarity may exist at gatherings of healthcare administrators, their relationship is largely characterized by a sense of competition. This seems due to the fact that their healthcare institutions, whose welfare they are committed to promote, vie with one another for market share and for access to increasingly limited reimbursement. Healthcare administrators, then, are not above aggressively competing with one another, and even attempting to drive one another's institution out of business and thereby potentially eliminating the job of a fellow-professional.  

Relationship with Society

The seventh category of professional obligation is the ideal relationship of healthcare administrators with society at large. This obligation within the guild model of profession is fairly minimal. The profession of healthcare administrators in the guild model does not believe it has contracted with society for its own existence, but rather views its role as an occupational group and its status of profession as having arisen in response to the societal need for the

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administration of its complex healthcare institutions. The relation of the profession to society is a one-way relationship in the guild model. The profession of healthcare administration owns the exclusive expertise and graciously offers it to facilitate the societal need for institutional healthcare delivery. Laypeople in society are largely untrained in the knowledge and skills of healthcare administration, and therefore are unable to determine the proper tasks and norms of ethical behavior of healthcare administrators. Attempts by society to restrict or regulate the professional practice of healthcare administration are intrusions into the proper functioning of this professional group.

**Critique of the Guild Model of Profession for Healthcare Administrators**

The guild model of profession remains a popular image among many members of the traditional professions of medicine, law and clergy. Its description of profession, which to a great extent draws from the Functionalist understanding of profession, would seem to reflect a favorable image of profession as often found in our society today. For three reasons, however, it is not likely that this guild model of profession has ever been seriously embraced by healthcare administrators.

In the first place, the guild model of professions to a great extent seems to presuppose an image of professionals as
solo-practitioners tending to individual clients or patients and bonded together as a group for the determination of the criteria and norms of their professional practice. The role of healthcare administrators, however, is integrally linked to institutions and to the responsibility of managing or administering groups of people rather than individual clients or patients. Furthermore, the development of their role and of their professional association for establishing criteria and norms for professional practice has occurred only in recent times, and this has been marked by increased competition between healthcare institutions and healthcare administrators rather than by the development of any guild-like characteristics for this profession.

In the second place, the rise of healthcare administration as a profession has also occurred to a great extent at the same time that the Functionalist view of profession with its guild-like characteristics has been falling into disfavor due to the growing popularity of the Critical views of profession within the sociological literature. Thirdly, the development of healthcare administration as a profession has been occurring roughly at the same time that belief in client or patient autonomy, i.e., the right of clients or patients to choose or refuse particular aspects of professional services in accordance with their own wishes and values, has been taking root, thereby discrediting and discouraging efforts of any profession to adopt guild-like modes of service provision
which could be interpreted as paternalistic.

Current efforts in the literature to articulate the ethics of healthcare administrators, however, still consistently propose adherence to some sort of professional ethics which invoke images of a guild notion or model of profession. In the fourth section of this chapter, however, three criticisms of the guild model of profession will be raised arguing that this model should be rejected as the foundation for determining the professional status and the nature of professional obligations for healthcare administrators on the grounds that this model would not be acceptable to the members of our society, i.e., society would not agree to contract with healthcare administrators according to the characteristics and norms understood to exist within the guild model of profession.

First Criticism

The guild model of profession tends to adopt or justify a paternalistic relationship between the professional and client or patient. Three arguments were raised earlier attempting to justify paternalism in the guild model. In addressing these arguments, it is important to distinguish between strong and weak forms of paternalism. Strong paternalism consists in the overriding of the competent wishes and choices of another. Weak paternalism occurs when an action is taken in the best interests of another who cannot for some
reason give a fully informed directive.\textsuperscript{23} The value of patient or client autonomy is currently so strong in our society that the exercise of strong paternalism over competent adults is generally considered to be seriously objectionable. Weak paternalism generally is justified in our society, however, providing that the "best interest" of a client or patient is judged on a "reasonable person" standard, that is, the benefit brought about by weak paternalism reflects what a reasonable person would most likely desire. Only the third argument that was raised earlier to justify paternalism, i.e. the example of requiring the unwilling and not fully competent patient to undergo physical therapy after a knee replacement, is acceptable according to weak paternalism.

The other two arguments attempting to justify professional paternalism fail, however, for they are versions of strong paternalism. First, the argument that clients or patients often lack the knowledge or skills to capably choose what is best for them which obliges them to a passive role in their relationship with professionals and to oftentimes rely on professionals to make their decisions for them, is not necessarily an accurate portrayal of clients and patients. To use medicine as an example, patients possess subjective values besides their value for health which they incorporate into their decisions regarding proposed medical treatments. These

\textsuperscript{23}This distinction is articulated in Edmund Pellegrino and David Thomasma, \textit{For the Patient's Good} (New York: Oxford University Press, 1988), 7.
subjective values are important components in a patient's decision, and knowledge of these values and of the weight patients give to these values are not included in the expertise of the physician. Similarly, for healthcare administrators, the management, employees and physicians at a healthcare institution cannot be viewed as the passive recipients of the healthcare administrator's exclusive expertise. Instead, they possess knowledge, skills and experience which can contribute to the effective operation of a healthcare institution. An open and ongoing give-and-take of ideas and opinions and a consensual "buy-in" of administrative decisions by management, employees and physicians would seem to best serve the healthcare institution. The exclusive expertise of the healthcare administrator must then include the ability to facilitate this process and to incorporate the results of this process in administrative decision-making.  

Second, the argument that clients or patients who seek professional help may oftentimes be highly anxious and dependent and require professionals to paternalistically make some decisions for them in order to have their autonomy restored, is a practice that must be severely limited to avoid ready tendencies to abuse client or patient rightful exercise

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of their own autonomy. It is true that some clients and patients acquiesce to professionals and to the mystique of professionalism, and if this is done so willingly, then the professional response in deciding for such clients or patients would seem to embody an acceptable form of weak paternalism. But a strong case can also be made that the highly anxious and somewhat dependent client or patient does not require paternalism at all from the professional, but rather the practice of beneficence in order to restore her lost or limited ability to exercise her autonomy.  

While many patients who come to healthcare institutions are somewhat anxious and potentially dependent upon the expertise and good-will of the professionals addressing their healthcare needs, this fact in and of itself does not justify a paternalistic relationship towards them on the part of healthcare professionals, or, for purposes here, on the part of healthcare administrators. Individual patients still have valuable contributions to offer regarding the capable and effective operation of healthcare institutions. While they may not be privy to the intricate workings of these complex institutions, they are keenly aware of how the workings of the institution positively or negatively affect them on a personal basis. Furthermore, society funds the existence of healthcare institutions through payments for services, charitable

25 This will be developed in the Interactive model of profession in Chapter VIII.
contributions and restriction of taxes. Society, then, naturally evaluates the structure and function of healthcare institutions in light of their meeting the health needs of the members of society. The claim of healthcare administrators within the guild model that they possess the exclusive expertise to best provide institutional healthcare to society is wrong; it is more proper to state that their expertise is in knowing how best to devise the means to provide the kind and amount of healthcare society decides it wants.

Second Criticism

A second major difficulty with the guild model of profession is that experience does not bear out professionals' claim to a supposed ongoing commitment to excellence, nor is it necessarily true that the final intellectual authority for professions should rest solely with themselves. From a social contract perspective, there are two problems with the professions' claim or promise to excellence.

First, while it is undoubtedly true that many professionals are dedicated to the welfare of their clients or patients and are committed to ongoing professional development so that they may offer the best possible professional care or service, sociological studies within the Critical view of professions also cite either the perception of, or examples of, professional behavior that is driven by proprietary values and self-
interest. Healthcare institutions, with healthcare administrators at their helm, have come under much criticism in the last two decades for allowing the market to shape healthcare delivery in such a way that the healthcare institutions profit regardless of the overall effect on the health of the community.

Within the conditions of the social contract, if society perceives that the professions are not fulfilling their promise to an ongoing commitment to excellence in the provision of their services but instead are abusing their authority and autonomy in practice for their own self-aggrandizement, then society reasonably views its arrangement with the professions in a negative light as not benefitting the members of society. Recent interest in removing the tax-exempt status


from healthcare institutions has largely arisen from the perception in some circles that healthcare institutions increasingly are run by their administrators as a business seeking financial return to benefit the institution, rather than as charitable organizations existing to serve the health needs of the community. If society judges its members are not benefiting from the existence of particular professions like healthcare administrators, then society will more strictly regulate those professions and professional authority and autonomy in practice will be diminished or removed. This is, in fact, what seems to be happening to many of the professions today. So the guild model's one-sided view of expertise and its consequent rejection of "outsiders'" judgment of professional performance is not a viable way to conceive of the profession of healthcare administration under any reasonable interpretation of the social contract regarding its ethical standards.

There is a second problem from a social contract perspective with the professions' claim to excellence in their field of exclusive expertise. Even if professionals honor this claim with integrity and fidelity, the result is not that they pursue the societal notion of the good that first brought

about the professions, but rather that they tend to focus on and promote the profession's own notion of that good. For example, throughout this century the evolution of the medical profession and of hospitals has centered around the dramatic cure of diseases within an acute care setting; to a great extent this was supported and financed by our society. In recent times, however, our society is beginning to value preventive care and the treatment of debilitating or chronic illnesses, yet our medical profession and our healthcare institutions remain woefully unprepared to address these needs. Medical schools continue to train specialists and healthcare institutions continue to provide costly high-technological care, even though this may well not address the healthcare needs nor reflect the healthcare values perceived to exist in our society today.

The problem with the commitment to excellence in the professions, then, as understood within the guild model of profession, cannot be corrected merely by recruiting better applicants, improving their training or calling upon greater efforts at self-regulation; the problem cannot be eradicated by the professions themselves. Professionals naturally commit themselves, with the best of intentions, to a career based on a specific conception of the nature of their work, and this conception cannot be overcome merely by appeal to ethical dedication to the good of society since professionals sincerely believe their conception of the nature of their work is the
only proper way to serve the good of society. The conception of professional excellence, then, cannot be determined by the profession alone, but must be tempered by administrative or bureaucratic mechanisms that stress accountability to the societal conception of that group's professional excellence. The guild notion of commitment to excellence in the healthcare administration profession is therefore, from a social contract perspective, inherently flawed. 29

It is also not necessarily true that the final intellectual authority for determining excellence in the professions should rest with the professions themselves. Many occupational groups have arisen with such titles as "paraprofessionals" or "semi-professions" who possess much of the same exclusive expertise as the traditional professions and, in fact, have achieved high levels of sophistication in specialized areas of the traditional professions. Just as physicians increasingly must rely upon the expertise of such healthcare professionals as pharmacists, respiratory therapists and dieticians, so too must healthcare administrators depend upon the expertise of their financial advisors, clinical directors and quality assurance personnel.

Increasingly the general public is also recognized as being more educated and sophisticated and often able to

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perceive professional incompetence. Members of society may not always know how they were cured or received relief from their suffering, but they are often quick to lay blame on the physician or the healthcare institution when their healthcare needs are not satisfactorily addressed. A broader notion of professional intellectual superiority which includes the input and evaluation of those not directly considered to be members of a specific profession is needed to more accurately reflect the current state of affairs in professions and the evolving relationship between professionals and clients or patients.³⁰

Third Criticism

A third problem for the guild model of profession from the social contract perspective is the guild model's emphasis upon primary professional allegiance and accountability only to one's fellow professionals. There are two principle reasons why attempts at self-regulation and professional accountability fail. First, peer evaluation of professional practice tends to evaluate the process of that practice, e.g., what procedures or steps the physician took in surgery, or the healthcare administrator took in deciding to close an unprofitable service. Members of society, however, tend to evaluate not the process but the outcome of the professional practice.

e.g., if the patient benefitted from the surgery or if the healthcare administrator's decision improved or worsened the overall healthcare delivery for patients or the community. Professionals argue that focusing strictly on outcome performance ignores the complexities and unique features of individual cases. But this means that a professional who is successful in the evaluation of his or her peers relies solely on criteria established by the profession itself, regardless of the interests or values of society which is the beneficiary—or the victim—of the professional services.

Secondly, professional self-regulation under the guild model is hindered by a sense of in-group solidarity. Despite their competition with one another, healthcare administrators are like members of other professions in that they exchange some favors and information with one another and so develop collegial ties, making it difficult to objectively evaluate or to bring charges against one another. Negative public reaction to professional malpractice can be severe and can be generalized to the whole group, and so healthcare administrators, like other professionals, tend to protect endangered colleagues unless doing so will bring harm to the whole group. Informal internal regulation does occur through subtle means, e.g., by raising general questions in professional meetings or, as physicians may not refer patients to colleagues with questionable practice, so too will healthcare administrators offer negative references or not hire fellow-professionals who
exercise questionable leadership or management behavior. In general, "professional etiquette" seems to discourage publicly criticizing one's peers. Furthermore, like other professional groups, healthcare administrators tend to have neither an effective regulatory body nor effective sanctions to correct professional malpractice.  

As a result of these two inherent problems with professional self-regulation, it is unrealistic to suppose that society would find it beneficial to itself to refrain from becoming involved in the evaluation of professional practice. The professional allegiance and accountability to peers as espoused in the guild model of the healthcare administration profession would not satisfy the terms of the social contract.

Conclusion

Because of these three major criticisms of the guild model of the healthcare administration profession, it is evident our understanding of professional obligation of healthcare administrators cannot be drawn from this model of profession. While there are some positive features in the guild model of profession that society would find beneficial to maintain and promote in the healthcare administration profession.

profession, particularly the possession of exclusive expertise and the public commitment to address the social need for the delivery of high-quality healthcare, nonetheless another model of profession must be discovered or developed which can satisfy the reasonable terms of the social contract more completely.
CHAPTER VI

THE ETHICS OF HEALTHCARE ADMINISTRATORS
IN THE AGENT MODEL OF PROFESSION

In response to the criticisms of the guild model of profession explored in the last chapter, an increasing amount of literature on the professions and on professional ethics has argued for what will be called an agent model of profession. This model is consistent with the Critical view of professions found in the sociological literature, and yet it allows for occupational groups to maintain their professional status. In this chapter the moral obligations and role-specific duties of healthcare administrators will be examined from the context of this agent model.

The first part of this chapter will briefly examine the principle presupposition of the agent model of profession. This model views the exercise of client or patient autonomy as the most fundamental value in our current social democracy. A pluralism of values in our society means that professions exist solely to restore or promote particular ends subjectively valued by individual clients or patients.

The second part of this chapter will examine the concept of profession as understood within the agent model. This model has grown in popularity in the past three decades as the guild model of profession increasingly has been criticized and
rejected, and as our developing cultural value of the near-absolute individual right to self-determination has been transferred to clients and patients in their relationship with professionals. Professional practice is seen as justified in its existence and in its specific practice to the degree it promotes the autonomy of clients and patients. The agent model attempts to redefine the function and moral obligations of professions by reversing the authority in the roles of the professional and client or patient from what was described in the guild model. Healthcare administrators, like all other professionals, are only technical experts without important decision-making authority who contract for their services with members of society. The professional's role in this model is to place his or her expertise at the service of the client or patient to whom primary decision-making authority is now assigned.

The third part of this chapter will explore the moral obligations and role-specific duties of healthcare administrators as understood to exist within the agent model of profession. As in the previous chapter, the seven categories of professional obligation will serve as the format for this exercise.

The fourth part of this chapter will argue that the concept of profession and of professional obligation in the agent model of profession fails to satisfy the terms of the social contract. This approach must therefore be rejected as
a means for determining the moral obligations of healthcare administrators. Two arguments are given for this.

First, the agent model is structured on the liberal premiss of client or patient autonomy existing as the fundamental value. But this requires professionals to be no more than technicians protecting or honoring individuals' autonomous choices while assisting them in pursuing their own subjective ends. Yet in reality the service provided by professionals is often desired by clients or patients to address some fundamental human need or social concern, and thus it is incorrect to claim that professional services are value-free. Furthermore, the provision of professional services is often desired by clients or patients to restore some of their lost or diminished autonomy, thus resulting a relationship that gives professionals a certain amount of authority over clients and patients; special obligations of the professional arise due to this position of relative authority.

Secondly, the agent model of profession presupposes that professionals judge only the means and not the interests or ends of their clients or patients, and that they remain unbiased towards those interests or ends despite their own interests and values. Professionals, however, do in fact judge tend to judge the ends or interests of their clients or patients in light of societal and profession-specific values, and oftentimes will tend to promote the ends of their clients
or patients to a great extent through the perspective of those values.

As a result, the agent model of profession inadequately describes the value of the professional services sought by clients or patients, and fails to accurately portray the professional-client/patient relationship as it actually exists. Subsequently, the agent model of profession cannot satisfy the reasonable terms of the social contract in determining the moral obligations of healthcare administrators.

Presupposition of the Agent Model of Profession

The key presupposition underlying the agent model of profession is the near-uncompromisable value of client or patient autonomy or self-determination. This represents a rejection of paternalism as understood to exist in the guild model of profession. The value of autonomy is firmly grounded in the dignity of human persons and the claim that human beings have on each other to privacy, self-direction, the possession of their own values and goals in life, and the freedom to act in accordance with those values and goals.

The historical origin of the current emphasis on autonomy traces largely back to the period of the French and English Enlightenment and the emergence of the doctrines of personal and political rights to freedom that undergird modern democracy. Autonomy has been increasingly emphasized in our own society for three reasons. First, political democracy has
expanded to almost every sphere in civic life, leading to a common desire within our society for people to participate in decisions that affect their lives as individuals. This has also been accompanied, especially recently, by a general distrust of authority and expertise traditionally wielded by professionals in the guild model of profession that dominated professional practice for many decades into the second half of the 20th century.

Second, there has been a general improvement in the education of the public and in the dissemination of information by the media regarding areas of knowledge formerly belonging only to the exclusive realm of professionals. This lends credibility to input clients and patients desire to have in the professional decisions affecting their lives.

Third, the increasing presence of moral pluralism in our society has resulted in a general recognition that personal values should be protected and important decisions not be usurped by others. Moral conflicts are generally viewed as irreconcilable since the only absolute value in our society is the freedom to choose according to one's own wishes and values, providing such choices do not seriously harm the freedom of others to choose according to their own wishes and values.¹

¹This key presupposition of the agent model of profession is explored in Edmund Pellegrino and David Thomasma, For the Patient's Good (New York: Oxford University Press, 1988), 11-22.
Autonomy or self-determination presupposes that individuals possess the resources to act, i.e., freedom from physical and social restraints, bodily health and strength, etc., that they possess preferences or values, that they are able both to weigh those preferences or values and to act in such a way as to bring about particular states of affairs consistent with those preferences or values. Autonomy or self-determination for a client or patient, then, should be understood as the right to choose or refuse particular professional services or service options in accord with the client or patient's wishes and values. There has been a growing consensus in our society that autonomy or self-determination is something to be valued both in itself and as something that has great instrumental value in contributing to the individual's well-being. Strong paternalism, on this view the deliberate overriding of a competent person's decision, wishes or values (for the sake of that person's well-being), is considered always to be morally culpable as a serious violation of patient or client autonomy or self-determination.


Disagreement exists whether weak paternalism, i.e., acting in the presumed best interests of a patient or client who cannot give a fully informed consent for some reason, or who is not afforded the full possibility of full choice, also violates the patient or client's autonomy or self-determination, but this issue will not be of concern here.
Characteristics of the Agent Model of Profession

The second part of this chapter will explore the concept of profession as understood within the agent model. This view of profession presupposes not only that clients or patients are competent individuals with both the ability and the right to exercise their autonomy or self-determination, but also that the services which can be provided by professionals represent only one good among many goods which the client or patient will choose from depending upon his wishes and values.

A client or patient approaches a professional for assistance in addressing some fundamental human need or social concern which the client or patient is incapable of addressing unaided. The professional cannot presume, however, that she knows what is best for him. The client or patient may more highly value some other good more than the good which the professional can provide. Furthermore, professionals should be careful not even to assume that they can offer what is in the client or patient's best professional interests, i.e., their best medical, legal, or spiritual interests; there are many times when clients or patients value more highly some other interests or ends besides their medical, legal or spiritual interests or ends. Professionals should then acknowledge, when making treatment or service recommendations, that these will only address the patient's or client's need specific to the professional's realm of expertise. Professionals cannot claim, or pretend to know, that their treatment
or service recommendation is in the overall best interests of
the client or patient; only clients or patients can know that
for themselves, and decide accordingly.

Many of the current institutional structures providing
professional services in health care, for example, both
reflect and contribute to the need to promote client or
patient autonomy. The emergence of tertiary care facilities
and the proliferation of specialties and subspecialties have
made it very difficult for physicians and caregivers to gain
knowledge about the personal lives and values of their
patients. This has helped contribute to a continually
increasing emphasis upon the importance of patients autono-
mously directing their own treatments in light of their own
personal values. The Joint Commission for the Accreditation
of American Health Organizations understands ethical behavior
in healthcare institutions almost exclusively in terms of
healthcare providers respecting patients' informed choices, as
well as their confidentiality and privacy.4

The role of the professional in the agent model of
profession is far different, then, from the role envisioned in
the guild model of profession. In the agent model the client

4 For a broader discussion on the role of client or patient
autonomy in the agent model of profession, see John Kultgen,
Ethics and Professionalism (Philadelphia: University of
Pennsylvania Press, 1988), 274-306; Allen Buchanan, "The
Physician's Knowledge and the Patient's Best Interest," in
Ethics, Trust and the Professions, ed., Edmund Pellegrino,
Robert Veatch and John Langan (Washington D.C.: Georgetown
University Press, 1991), 93-107; Mark Osiel, "The Politics of
or patient is not a helpless and passive beneficiary of the professional's expertise who may paternalistically determine both the cause of the need and the best means to address that need. Instead, the client or patient is an autonomous individual who decides about the kind of service she wishes to receive from the professional. The role of the professional, therefore, is to apply his skills in such a way as to help the client or patient achieve her desired ends.

In the relationship between the professional and the client or patient, the professional possesses expert knowledge and skills which can address some fundamental human need or social concern, and brings this expertise to the relationship; the client or patient possesses knowledge of her own needs and of her own particular values, and brings the ability to exercise self-determination to satisfy her own needs and to promote her own values to the relationship. The professional and the client or patient, then, enter into a type of contract which specifies the terms under which the professional will provide his expertise in technical matters in whatever way the client or patient judges those services to best meet her own needs and values. The professional offers options of technical services that are appropriate to the client or patient's need; the professional services that are administered, however, are chosen by the client or patient according to her
wishes and values.\textsuperscript{5}

In the guild model of profession all authority resided with the professional. In the agent model of profession, the reverse is true; all authority resides with the client or patient.\textsuperscript{6}

One popular variation of this relationship found in the literature on the professions, which seeks to incorporate the more personal aspect of the professional-client/patient relationship resulting from the greater vulnerability felt in self-disclosure to physicians, lawyers and priests, has been termed the "friendship model." In this slanted contractual view the professional acts in a type of one-way limited friendship to help the client or patient address some fundamental need. Like a friend, the professional takes her client or patient's interests and values seriously and gives them more weight than she does the interests and values of other persons. The professional continues to offer her services only in a manner which will respect and promote the client or patient's wishes and values, however, so as to respect his autonomy and self-determination within the bounds permitted by

\textsuperscript{5}The only exceptions to this occur if the client or patient requests the professional to act in a manner declared illegal by the state, or in a manner that the professional personally believes to be morally wrong.

society. 7

In the agent model of profession the technical skills which the professional possesses are valued for the benefit they bring to their clients and patients, but those technical skills in and of themselves basically are considered to be amoral or value-free, i.e., neutral with respect to the ends they might be made to serve. Given a client or patient's specified end - curing an illness, obtaining a divorce, seeking a baptism - the professional offers an effective means to that end. The professional contracts with the client or patient to provide the needed technical services so that the wishes and values of the client or patient may be realized. The professional, then, is a "hired gun" employed to do the client's or patient's bidding regardless of the moral worth or value of the client's or patient's desired ends.

It would be an improper intrusion by the professional to


There are problems with this analogy, however. Friendship implies a relationship of equals which is not the case in professional-client/patient relationships. Furthermore, a friendship is mutual but a professional has a concern for the client's or patient's interests which is not returned in kind to them, the affective commitment of friendship is usually lacking in the relationship with the professional, most encounters with professionals are with strangers rather than with friends, and the friendship model cannot be applied to professionals like healthcare administrators whose clients are groups and not individuals. For further discussion of problems with this analogy, see Bayles, Professional Ethics, 2d ed., 73-74.
offer input or judgment concerning clients' or patients' motives or objectives. Professions have been established and granted relative autonomy in practice for the purpose of helping members of society meet specific fundamental needs; the value or moral status of those needs in our society cannot be determined by experts, but are set aside to the arena of the client or patient's personal freedom. Professionals are limited to their value-free knowledge and skills and, in the agent model of profession, should not influence the autonomous choices of their clients or patients.

The contract relationship between the professional and the client or patient as conceived within the agent model of profession has become popular image in recent times for many professionals as well as for many clients and patients. This has not come about from any newly discovered moral aversion on the part of professionals to the old attitude of paternalism so often associated in the past with the guild model of profession. Rather, many professionals now want to view their role more as technicians who offer their expertise in a value-free manner to assist their clients or patients in meeting their own goals. These professionals do not want to decide

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what is best for their clients or patients as in the guild model of profession, and in fact purposely render no judgment on the desired ends of their clients or patients but only on the best means to pursue those ends. This perspective allows professionals to distance themselves from what they view to be the inflated moral claims of their forerunners and from the unrealistic and undesirable moral expectations of society.

For example, some physicians now offer treatment options with no recommendations and obligingly follow whatever directive they receive from the patient or family, or even from the third-party payer. They do not feel responsible to promote certain treatments, to encourage healthy behavior, or to lobby the third-party payer when particular treatments are financially denied. Many lawyers will offer their expertise both in understanding, interpreting, and applying the law and in manipulating trial court proceedings to advance the cause of their client regardless of whether or not this contributes to a just verdict. The moral responsibilities of professions in the agent model of profession would seem to be minimized by the constraints placed upon the professionals to promote only the valued ends desired by their clients or patients and not any values intrinsic to individual professions themselves.

The origin and development of healthcare administration in our country would seem to be representative of the agent model of profession. As hospitals historically developed in the early part of this century, trustees assumed the role of
fundraising and all clinical matters were left to the domain of physicians. This left hospital administrators to organize and manage the non-medical workforce, coordinate the day-to-day operation of the institution, and to oversee the "hotel management" of patients. If administrators then could even be called a profession, their role could be understood as promoting the health interests of the local community (embodied by the trustees or by the hospital board) and the interests of the medical staff for the capable and efficient management of the hospital. Many physicians today, in fact, believe that healthcare administrators should return to this purely managerial role with few if any professional values, responsibilities or obligations.9

As levels of reimbursement for hospital services grew after World War II through the development of health insurances such as Blue Cross and later through the federal programs of Medicare and Medicaid, and as the source of funding for building and development shifted from community contributions to federal allocations through the Hill-Burton Act, promoting merely the interests of the local community or board and the physicians has diminished. Instead, many healthcare administrators now view their professional

9See, for example, Peter Morgan and Lynne Cohen, "Can Physicians Afford Not to Get Involved in Hospital Administration?", Canadian Medical Association Journal 146, no. 5 (1 March 1992), 751-754; Gordon Ferguson, "Where's the Credibility in Hospital Administrators?", Canadian Medical Association Journal 132, no. 3 (1 February 1985): 286-287.
responsibility as effectively and capably directing their healthcare institutions in such a way as to promote the interests and values of their healthcare institution's sponsor, community board, or owners or shareholders. As the role and responsibilities of the healthcare administrator expanded, the claim and image to professional status has more clearly emerged. Yet the understanding of the healthcare administrator's role as promoting others' interests and values, first with the community and later with the institution's sponsor, is perhaps best described through the agent model of profession.\(^\text{10}\)

In the current climate of rapid change in the delivery of healthcare and with healthcare reform on the near horizon, a good deal of the literature on the professional ethics of healthcare administrators is calling for a return to or a revitalization of professional responsibilities as perhaps best understood within the agent model of profession, i.e., the obligation of healthcare administrators to promote the interests and values of the local community or of the institution's sponsor. In the third part of this chapter, then, the ethics of healthcare administrators will be explored from within the context of the agent model of profession, utilizing once again the seven categories of professional obligation.

\(^\text{10}\)What I have claimed to be a historical shift in the chief client of healthcare administrators is described in Rosemary Stevens, *In Sickness and in Wealth* (New York: Basic Books, 1989), 72-79, 241-283.
The chief client of a professional is understood to be the individual or group whose welfare the professional is most committed to promoting. In the agent model of profession, the professional is obligated to practice her exclusive expertise in the way most desired by the chief client. She possesses the technical skills while the chief client determines how those skills will be utilized to advance his own ends. In the agent model of profession the chief client of the healthcare administrator would be that group whose interests and values the healthcare administrator will utilize her skills to promote. It appears, therefore, that the chief client is not the individual patient, as stated in the Code of Ethics of the American College of Healthcare Executives, but rather is the employer of the healthcare administrator, i.e., the sponsor of the not-for-profit healthcare institution, the board of the community hospital, or the owner or shareholders of the for-profit healthcare institution. The healthcare administrator, then, applies her technical skills to promote the welfare of her institution's sponsor.

11American College of Healthcare Executives, Code of Ethics, Expectation I.

12The term "sponsor" will be used hereafter to refer to all three groups who employ healthcare administrators.
Ideal Relationship with Chief Client

The ideal relationship between the healthcare administrator and her chief client, her institution's sponsor, is readily found in the literature on the ethics of healthcare administration. Increasingly the professional role of the healthcare administrator is described in terms of "leadership" within the healthcare organization. Increasingly, the professional obligation of the healthcare administrator corresponding to this leadership role is described in terms of "management by values" or "management-based values." These values by which healthcare administrators are extolled to lead by are not uniquely correlated to the role of healthcare administration nor are they necessarily commonly associated with the provision of healthcare. Rather, "management by values" refers to leading or administrating according to the values of the institution as defined by the sponsor of that institution.

Numerous resources under the title of "administrative ethics" are now available encouraging and instructing healthcare administrators to, "Put the values of your organization ahead of yourself and your own interests," to "Continually reinforce with your entire staff what your institution stands for," and to "Assure that all members of the organization know, understand, and accept these values of your institution as the ultimate criteria for judging decisions and individual behavior." Coupled with this emphasis upon managing according
to the values of the institution as defined by the sponsor of the institution are the reminders or admonitions that, "It should not be our goal to implant our values on the organization," and "It is your role either to adopt the values of your institution or to make sure that those values are compatible with your own." In the agent model, there are no unique role-specific values to healthcare administration, but rather their exclusive expertise is assumed to be value-free and designed primarily to promote the values of the institution's sponsor. Values may be adopted or discarded depending upon the sponsor's preference and upon the effect those values have upon the successful administration of the healthcare institution. 13

Commitment to the Good of the Chief Client

As a professional, the healthcare administrator must be committed to the good of his institution's sponsor, however that good is conceived. That commitment is based on the professional promise to exercise one's exclusive expertise toward the desired end of the client with whom one has contracted without passing judgment or determining the moral value of that client's end. The exclusive expertise of the healthcare administrator is the effective and capable operation of that healthcare institution, but it is the institution's sponsor which determines the definition of "effectiveness" and "capability" in the healthcare administrator's operation of that institution. These definitions in the agent model are not dependent upon some objective or universally accepted notions of effectiveness and capability, but rather they refer to matters of degree of effectiveness or capability in light of promoting the sponsor's own notion of the good.

The nature of and specific duties established in the relationship between the institution's sponsor and the healthcare administrator should normally, then, be very clear and well-known to both parties. The healthcare administrator can be said to effectively and capably operate the healthcare institution if the practice of her exclusive expertise results in the sponsor's goal being achieved, e.g., continuing or fulfilling the mission of the sponsor, or providing an acceptable quality, amount and type of healthcare to the local
community, or profit-maximization for the sponsor, or some combination of these or other goods. The skills of the healthcare administrator are value-neutral, but are utilized by the sponsor to promote the goals and values of the sponsor.

The relationship of healthcare administrators to the good of individual patients is only indirect and instrumental in nature; the good of patients is generally met through the healthcare administrators' facilitating the work of other professionals and not through any direct contact with the healthcare administrator, and it is the collective good of patients as understood through the interests and values of the sponsor which the healthcare administrator structures the institution to address. Through the skills of good management, business, and public relations, the healthcare administrator addresses the health needs of patients by attracting and keeping capable physicians and healthcare professionals as well as by providing high-technological equipment and a productive work environment to facilitate the provision of their healthcare. Through the skills of good management and communication, the healthcare administrator facilitates patients exercising their autonomy or self-determination through the development of institutional structures which respects their dignity and privacy and which promotes increased dialogue between physicians and other healthcare professionals with patients, to better assure that patients are able to select treatments in accordance with their own
wishes and values.

Central Values of the Profession

The fourth category of professional obligation is the identification and prioritization of the central values of healthcare administrators. Central values are drawn upon or assumed when decisions must be made that are value-laden.

In Chapter III it was proposed that there are five central values to the profession of healthcare administration: health of individual patients, health of the community, financial viability of the organization, effective and capable management of employees and good relations with the medical staff, and institutional integrity. In the agent model of profession, however, these cannot be considered values central to the profession of healthcare administration, but rather as values that most commonly are assigned to or expected of healthcare administrators by their institution's sponsor. That is, these are values generally held by the sponsors of healthcare institutions and thus, in the agent model of profession, these are the values which healthcare administrators are committed to upholding or promoting solely because (or if) they are the values of their institution's sponsor.

But sponsors are not limited to these five values, and subsequently, in the agent model of profession, neither are healthcare administrators. Different sponsors will possess and promote different values. For example, one not-for-profit institution may value a mission that is strongly oriented to
care for the poor, while another may be deeply competitive and highly financially motivated. One for-profit institution may have a sponsor which establishes strict criteria restricting the admission of unprofitable patients and limiting the kinds of treatments it will offer in order to yield the greatest return on investment, while another for-profit institution may include criteria for charity care and have a reputation for responding to the health needs of its community.

Different sponsors will also prioritize their values in different ways, and subsequently, in the agent model of profession, so too will healthcare administrators. This is because, as stated before, in the agent model the healthcare administrator commits the use of her skills to advancing the interests and values of her institution's sponsor. Her skills are considered to be value-free, and thus there are no role-specific values she brings to the exercise of her professional role. Furthermore, she herself cannot impose or implant her own personal values onto the organization without violating the autonomy or right to self-determination of that institution's sponsor to have that institution function according to the sponsor's own directives and values.

The sponsors of institutions contract with (and substantially pay\(^4\)) healthcare administrators to promote their interests and values. Through specialized education and

training, healthcare administrators maintain control over the content of their expertise, but sponsors determine the form in which that expertise will be exercised, i.e., the healthcare administrator knows best how to manage and make particular business decisions pertaining to her institution, but the sponsor provides the mission and the values the administrator's expertise must promote as well as the criteria for determining the success or failure of the management and business skills of the healthcare administrator.

In the guild model, the healthcare administrators prized effective and productive management of employees and good relations with the medical staff as the primary and most fundamental value in their hierarchic scheme of values. In the guild model, healthcare administrators believed that they owned and applied their exclusive expertise to the healthcare institution in whatever manner they judged to be best for the healthcare institution. In the agent model of profession, however, the skills of healthcare administrators are valued only because they can be applied in whatever manner the sponsor decides will best meet the interests and values of the sponsor. In the agent model of profession, the skills of healthcare administrators mean little to the sponsor if they are exercised for purposes other than promoting the mission and values of the sponsor.

It is important that the healthcare administrator fully understand the mission and values of the institution whose
leadership has been entrusted to him, so that he does not experience serious conflict between this and his own personal value system,\textsuperscript{15} and so that he may promote the mission and values of his institution's sponsor in the way he applies his special expertise of the practice of healthcare management and business skills.

Promoting the mission and values of the institution's sponsor void of any central values of their own profession provides multiple opportunities for the professional careers of healthcare administrators. As it is quite feasible for healthcare administrators to contract for the utilization of their exclusive expertise with various institutions possessing different missions and values, a scenario is created that can be beneficial to both parties. In an era of tremendous change in healthcare delivery, institutions may benefit from an influx of different leadership ideas and management styles through contracting with different healthcare administrators at different times, who in turn can bring a wealth of experience to each new position that can directly advantage the sponsored institutions. This perhaps partially explains the 25\% turnover rate of hospital CEO's every year throughout the last decade.

\textsuperscript{15}The requirements here are minimal; the healthcare administrator need not be in agreement or fully support the mission and values of his sponsored institution, but rather that mission may simply be tolerated and the institution's values need only not be in serious conflict with his own personal value system.
Commitment to Competence

The fifth category of professional obligation is the commitment to competence. Every professional is obligated both to acquire and to maintain the expertise needed to undertake his professional tasks. Every professional is also obligated to undertake only those tasks that are within his competence and to assist clients whose needs are beyond his expertise in locating a fellow-practitioner who can assist them. In the agent model of profession, these two obligations pose special problems for the healthcare administrator.

Healthcare administrators gain their professional expertise not just by acquiring a degree from a school certified in healthcare administration, but by also obtaining the needed experience by advancing through different levels and positions in administration in one or more institutions. Theoretically the best talent rises to the top, but it is well known in healthcare administration that job-placement is highly connected to personal contacts, i.e., who you know is as important as what you know. It is therefore not necessarily the most competent of the candidates who may call themselves healthcare administrators, but rather those who are able to best adapt themselves to, and thereby promote, the interests and values of their institution's sponsor. Competency, therefore, is not determined by the profession itself, but by the differing measures of criteria established by the varying sponsors of healthcare institutions.
Secondly, many healthcare administrators find it personally very threatening to acknowledge that some areas of needed competency desired by their institution's sponsor are beyond their own professional expertise. This most likely is due to the possibility that admitting professional incompetency may cost them their job. A physician is expected to refer a patient to another more qualified physician to address some specific problem beyond his realm of expertise without fear of losing patients of his own; for a healthcare administrator, however, to acknowledge an area of incompetency may result in him being viewed by the institutions' sponsor, i.e., his employer, as an indication that he is inadequate for the job. There is a natural tendency, therefore, for healthcare administrators to deny or coverup their own particular areas of professional incompetency or inadequacy rather than defer the tasks associated with those specific areas to a fellow professional or to a subordinate on her administrative team. A sense of loyalty or a greater assurance of job stability offered by the institution's sponsor may help alleviate this self-preserving tendency on the part of healthcare administrators, but this attitude is not often found in today's highly competitive healthcare environment.

Relationship with Fellow-Professionals

The sixth category of professional obligation is the ideal relationship with fellow-professionals. The description of this relationship is in marked contrast with that in the
guild model of profession. Here the relationship is understood in a much weaker form, since the common skills and central values of healthcare administrators are dependent upon the recognition of their institutions' sponsors and are not determined by the profession itself.

First, since sponsors hire and terminate employment of healthcare administrators, the ultimate authority for determining professional expertise within healthcare administration rests more with the sponsors than with the profession. Unlike in the guild model, in which the professions themselves established their own standards for training and determining competency, in the agent mode of profession it is the sponsors who determine levels of competency and who dictate which skills healthcare administrators must possess.

Secondly, in the agent model of profession, the skills of healthcare administrators are understood to be value-free and offered to promote the directives and values of their institution's sponsor. The values of their sponsor which they promote may be in marked contrast to the values promoted by other healthcare administrators exercising their professional role in the name of their sponsors. Again, the high turnover rate of hospital CEO's suggests that sponsor's values may be put on or taken off like a garment as many administrators embrace various sponsors' values throughout the course of their professional career. This lack of consensus and consistency regarding the values of sponsors has the effect of
weakening any relationship between healthcare administrators. Unlike the guild model where the profession determines the values by which its skills are practiced, in the agent model of profession it is the sponsors of healthcare institutions which dictate the professional values which guide the practice of healthcare administration skills. In the agent model of profession therefore, the ideal relationship between healthcare administrators is relatively weak due to lack of clear ownership in determining the standards of professional skills and to a lack of professional consensus over role-specific values.

Relationship with Society

The seventh category of professional obligation is the ideal relationship of healthcare administrators with society at large. In the agent model of profession, this relationship is determined and guided by the interests and values of the sponsor of the healthcare administrator's institution.

A healthcare administrator is committed to the welfare of his client, namely, his institution's sponsor, rather than to the welfare of the community utilizing the services of his institution. The healthcare administrator's involvement with his community is primarily conducted through marketing and public relations so as to promote his institution. There are no role-specific duties or obligations for the healthcare administrator guiding his marketing or public relations except whatever will benefit the interests of the sponsor. The more
important issue to explore, in another context than this, is the ideal relationship of the sponsor to society for which the healthcare administrator serves only as the sponsor's representative. But again, in the agent model of profession, the healthcare administrator would have no input into the nature or content of this relationship.

A further point can also be made. Entering public discussion regarding societal issues such as healthcare reform or defining the elements of community health which should be addressed or advanced does not presuppose any special expertise on the part of healthcare administrators; their expertise is in the effective operation of a healthcare institution according to the criteria established by the sponsor and not in any public forum regarding the value of particular forms of healthcare provision. A leadership role in a healthcare institution does not imply for healthcare administrators any role-specific duties or obligations toward society in general.16

Critique of the Agent Model of Profession for Healthcare Administrators

The ethics of healthcare administrators in the agent model of profession are determined according to the foundational obligation of not exercising value judgments regarding the ends of their healthcare institution's sponsor. For professions in general, this foundational obligation of judging only the means and not the ends of their chief clients is in marked contrast to, and in some degree is in reaction against, what is often perceived to be the failure of professions in general to honor the moral obligations understood to exist in the guild model of profession. Determining the ethics of professionals according to this foundational obligation may well be considered beneficial since it serves to make professional ethics more easily identifiable, more capable of being lived up to for some professionals, and in general easier for society to hold members of professions accountable. Yet, as this fourth section of the chapter will present, there are two important reasons to argue that the obligations of professionals as understood to exist within the agent model of profession would not be acceptable within a social contract setting.

First Criticism

A first criticism of the agent model of profession is that this model presupposes patient or client autonomy as an absolute or fundamental value. This is in contrast to the guild model of profession, and emphasis upon this value has to a great extent successfully challenged professionals to avoid
paternalism and to utilize their knowledge, judgment and skills to expand and not replace the autonomy of clients or patients. This has been argued for on both deontological terms, i.e., professional respect for client or patient autonomy based upon their inherent dignity and inalienable right to self-determination, and on utilitarian terms, i.e., professionals best promote societal ends by helping clients or patients achieve benefits such as health, justice, or reconciliation with God. Yet focusing on autonomy as the most fundamental value fails to do justice to the human condition which gives rise to the unique relationship between the professional and the client or patient and which cannot adequately be described within the context of the agent model of profession.

Professional practice, although empowered by exclusive expertise, is ultimately based on relationships with clients or patients that arise naturally as the result of the human condition. People become sick and need assistance in healing, or are victimized and seek redress in justice, or despair from tragedies in life and require counseling or spiritual support. It is natural to seek relief from physical suffering, to desire respect for one's rights or to be recompensed when one has been wronged, or to be relieved of emotional or spiritual distress.

These arguments can be found in Kultgen, Ethics and Professionalism, 351-353.
Seeking professional help in these situations does not elicit a mere contractual relationship, as what occurs when a customer desires to purchase an automobile from a salesman; there the salesman "pitches his wares" but ultimately honors the will or desire of the customer and so respects her autonomy. But when one seeks professional help to address a fundamental human need, the professional is not merely helping the client or patient to satisfy her desires but he is helping her live more authentically according to what she truly is as a human being. It is the nature of the fundamental needs which professions address that makes the recipient a client or patient instead of a customer, and that contributes to making the helper a professional instead of a salesperson. To the client or patient, therefore, the exclusive expertise of the professional is not value-free but is intrinsically valuable in its ability to restore a lost or diminished fundamental human mode of functioning.

Similarly, healthcare administrators are instrumentally involved in the provision of a needed service, i.e., healthcare, and not just another commodity, to a local community. There are times when members of society require healthcare that can be provided only through a healthcare institution. Because healthcare is commonly considered to be a fundamental good to society, the sponsors of healthcare institutions cannot arbitrarily pursue their own chosen ends regardless of the impact those ends have on the delivery of the fundamental
good of healthcare to that community. Expectations are placed upon healthcare institutions that they will, to some extent and to some acceptable fashion, deliver needed available healthcare to the community. These expectations are largely placed on healthcare administrators through community or local governing boards, but also by the community in general which perceives sponsors to be largely absent from the day-to-day operation of local healthcare institutions. Healthcare administrators are therefore held accountable to some degree by their local communities to assure that their healthcare institution delivers the available healthcare in an acceptably beneficial way to the community. This intrinsic value of professional services, however, cannot be accounted for in the agent model of profession.

Furthermore, this gives healthcare administrators some limited type of authority in their relationship with their institution's sponsor. The delivery of healthcare is not value-free, but is intrinsically valuable in its ability to restore lost or diminished health function to members of society. Regardless of the particular interests or ends of sponsors of healthcare institutions, healthcare administrators exert a certain type of limited authority over their sponsors in the sense that they must administrate their healthcare institution in such a way that the health needs of the community are addressed in a manner generally acceptable to the community. If this does not occur, then eventually, in
some form or other, the community will call the sponsor to accountability or act in such a way that the sponsor will not be able to pursue its own interests or ends. Healthcare administrators, therefore, because of their formal knowledge and training which constitute their exclusive expertise and because they direct institutions which provide services that are considered essential or fundamental to human functioning, possess some authority in their relationship with their institution's sponsors which cannot be accounted for in the agent model of profession. 18

Second Criticism

A second criticism of the agent model of profession is that this model presupposes professionals to be psychologically capable of judging only the means and not the interests or ends of their chief client, and that they remain unbiased towards those interests or ends despite their own interests and values. This presupposition, however, can be challenged in two different ways.

First, respecting a client's or patient's pursuit or choice of their own interests or ends requires an absolute

respect for their autonomy and a willingness (as well as an ability) to subjugate one's own autonomy, i.e., not to exercise one's own autonomous, value-laden choices, in that professional-client/patient relationship. It is not uncommon, however, to find among professionals, as members of society at large, a belief that possession of certain virtues or character traits or particular ends is essential to "the good life." For example, even some who might claim to advocate the agent model of profession hold that one integral and necessary component of a good life consists in being a self-determined or autonomous person; this in turn would seem to require specific physical, mental and social functioning in order for this fundamental value to be exercised. To the degree, therefore, that clients or patients request specific treatments or services that do not promote, and in fact, may lessen the ability to exercise their autonomy, then some professionals may in turn advocate different treatments or services in the belief that clients or patients are mistaken. In other words, they will exercise weak paternalism in order to benefit or restore client or patient autonomy.

Other goods or values generally agreed upon in society as constituting fundamental elements of the good life may also be proposed or advocated over the client or patient's wishes. Healthcare administrators, while committed to promoting the interests of their institution's sponsor, may exercise a certain amount of discretion in interpreting what they may
believe are somewhat misguided or uninformed directives from their sponsor in order to promote their sponsor's interests in a way that they judge is best. Presuming that the client or patient should hold or pursue values or interests that are commonly held in society, or that the professional believes should be held or pursued, is not consistent with the agent model of profession, however, which insists that client or patient preferences or ends must be respected regardless of societal or personal conceptions of supposed "objective" ends or "universal" values.

Furthermore, there is a natural tendency among professionals to promote the value of their exclusive expertise over other values which clients or patients may hold. Professionals provide a service addressing a fundamental human need or societal concern which they often tend to view, in light of their commitment to education and training in providing that service, as more important than most other values. Physicians will then often promote medical treatments to benefit physical health regardless how this is valued by the patient, and healthcare administrators will promote particular functions of the healthcare institution valued due to the perspective of their education, training and leadership style regardless of how this is valued by their institution's sponsors. As argued in Chapter III, possessing profession-specific values seems to be intrinsic to professionals in a way that the agent model of profession cannot address.
Secondly, it is too simple to state that the agent model of profession conceives the professional's role as using her training, knowledge and experience to provide the facts to the client or patient about her specific problem and the alternatives available to address that problem, and the client or patient's role as providing the values and conception of the good with which to evaluate these alternatives and selecting the one that is best for himself. Underlying this view of division of labor are presuppositions about the nature and relation of facts and values that are the legacy of a logical positivism which has long since been rejected by most philosophers. Positivism distinguished between descriptive statements that were considered true or false according to whether they in fact correctly described and explained the world. By remaining properly descriptive or empirical, such factual statements theoretically were value-free. Expressions of value, on the other hand, were only expressions of emotions or attitudes and were neither true nor false, correct nor mistaken. 19

It is generally agreed that such a distinction between fact and value is no longer meaningful, but that in many ways the identify and nature of so-called facts in intimately bound up in value judgments. For purposes here, then, it can be stated that clients or patients are never provided with

value-free facts from professionals. There are a number of ways this can be illustrated.

First, the language used by professionals to describe treatment or service alternatives is itself part evaluative, e.g., by telling a family that providing a particular treatment will only prolong the patient's suffering, the suffering is presented as bad for the patient. Secondly, when often it is not possible to provide all possible relevant facts about the treatment or service options, a value judgment is always made about which facts are the most important. Thirdly, professionals often use body language, tone of voice, or emphasis in presenting information that reveals their own positive or negative evaluation of various alternatives. Fourthly, many professionals couple the process of informing the client or patient about treatment or service options with a recommendation that a particular alternative be pursued. Fifth, many professionals commonly see a part of their role as securing client or patient agreement with the service or treatment they have decided upon, and so they become strong advocates for that service or treatment. In sum, professionals are almost always naturally hindered in their attempt to promote only the interests and values of their healthcare institution's sponsor by their own natural biases and lack of objectivity. 20

20 This is explored in Dan Brock, "Facts and Values in the Physician-Patient Relationship," in Ethics, Trust, and the Professions, 113-132; Robert Veatch, "Is Trust of Profes-
Conclusion

The agent model of profession, therefore, inadequately describes the value of the professional services sought by clients or patients, and fails to adequately describe the type of relationship that actually exists between professionals and their clients or patients. Professionals, therefore, do in fact often judge the ends or interests of their clients or patients in light of societal and profession-specific values, and may well promote the ends of their clients or patients to a great extent through the perspective of those values. Yet this leaves the problem which the agent model of profession tried to correct, namely, the unwanted paternalism naturally built into the guild model of profession coupled with the unchecked dangers of professionals either abusing their relative autonomy in practice or exploiting clients or patients for selfish gain.

Two possible solutions emerge. One reflects the desire found in our society to maintain client or patient self-determination along with the desire found among many professionals to be freed from unwanted role-specific professional obligations. This solution proposes that a different view of professionalism is needed and is in fact evolving in our society today. This view sees professions as constituting no more than occupational groups with some specific expertise...
that they market for financial gain, and professionals as individuals who embark on careers in the professions for their own personal gain. The professions maintain relative autonomy in practice only in the content of their work, and allow their customers to decide which professional services they wish to purchase. No role-specific moral obligations should be expected of professionals except for those ordinary norms that generally apply to other business transactions in our society.

The second possible solution is to preserve the expectation of role-specific moral obligations as both essential to our understanding of the meaning of profession and as a practice which society deems to be beneficial and worthy of keeping. The problems commonly associated with the guild model of professionalism may be addressed not by throwing out the expected atypical moral commitment and behavior of professionals, but by improving the institutional structures of professions and by widening their accountability to society.

The first proposed solution will be examined in Chapter VII as the commercial model of profession. The latter solution will be discussed in Chapter VIII as the interactive model of profession.
CHAPTER VII
THE ETHICS OF HEALTHCARE ADMINISTRATORS
IN THE COMMERCIAL MODEL OF PROFESSION

This chapter will explore the moral obligations of healthcare administrators as understood to exist within a commercial model of professions. The commercial model is a relatively recent and increasingly popular attempt to define the nature of profession and professional obligation in such a way that the problems arising from the traditional guild model of professions may be satisfactorily addressed.

Presuppositions of the commercial model will be first identified. Defining professions and their moral obligations within the commercial model is dependent upon a Libertarian theory of economics and justice. The only moral obligations and role-specific duties within this model are the obligations and duties normally associated with everyday business transactions.

In the second part of this chapter the commercial aspects of professions in general and of healthcare administrators in particular will be explored. Drawing on the Critical view of professions found in the sociological literature, the commercial model views professions simply as occupational groups which have successfully arisen to control the market by
gaining relative autonomy in practice in their area of expertise. It will be proposed that the commercial model of professions aptly describes many features of healthcare administrators' practice in the last three decades (1960's through 1980's).

The third part of this chapter will then attempt to identify the moral obligations of healthcare administrators as understood to exist within the commercial model of professions. As in the previous two chapters, this will be done by examining the seven categories of professional obligation: identification of the chief client, ideal relationship with the client, commitment to the good of the chief client, central values of the profession, commitment to competence, ideal relationship with fellow professionals, and ideal relationship with society at large.

The final section of this chapter will critique the concept of profession and professional obligation for healthcare administrators as understood within the commercial model. It will be argued that this understanding of professions and their obligations would not be acceptable in the social contract. It is not just that legitimate criticisms can be mounted against the minimal moral responsibilities argued for in the Libertarian model of economics and justice. More importantly, the fundamental human needs and societal concerns which give rise to the professions cannot be satisfactorily met in a commercial model of professions; the needy client or
patient is not on a "level playing field" with the professional, the relationship between the professional and the client or patient is not a business transaction, and there are no grounds to trust the professional or to believe in his supposed commitment to service and to a fiduciary relationship when profit-maximization is the overriding moral norm.

Presuppositions of the Commercial Model of Profession

The commercial model of profession is based upon the presupposition of the possibility and integral value of a free enterprise economic system. Free enterprise systems allocate and distribute goods and services by means of market exchanges, market prices and consumer choices. This in turn requires institutions to protect private property and to enforce contracts, a recognized medium of exchange, and a competitive market structure. Competition in the free market is held to reward extraordinary skills and efforts, and also offers opportunities for enterprise, invention, and adaptation so as to most efficiently maximize the production and exchange of goods in society. Consumer preferences, ordinarily without government interference (some free enterprise theorists permit government regulation in the specific case of unavoidable technical monopolies), are the sole determinant of price and profit incentives in this model. In this model goods and services are offered on the presupposition that consumers and producers are primarily motivated by the desire to maximize
their own self-interest, which in turn is held to yield (through what is often referred to as Adam Smith's "invisible hand" guiding the free market) the best possible social consequences in the distribution of goods and services.¹

In the commercial model the free market system is also held to be the best means of assuring a just distribution of goods because, in this account, a distribution is just, no matter how unequal, if it has arisen from an originally just position of free transfers between individuals voluntarily buying or selling goods or services. Justice simply involves the preserving of what has been called each person's entitlement - rights to property originally created or received in voluntary exchanges, regardless of the advantages or disadvantages received by an individual in the "natural lottery," i.e., the genetic, social, economic and political endowments that are independent of people's voluntary exchanges.² This system is held to provide the maximum satisfaction of aggregate demand or wants. Government should therefore avoid regulating business activities except insofar as intervention is necessary to prevent the use of force or fraud (or, as mentioned, in the face of technical monopolies according to


some versions of the theory). Immoral behavior is understood to occur in the commercial model only in situations when force or fraud prohibit voluntary market exchanges. There are no special moral obligations outside of the responsibility of persons in the marketplace to conduct transactions in a noncoercive manner. Coercion and acts of bribery, falsification of records, theft, corporate espionage, and so forth violate the very conditions necessary for making contracts and market exchanges voluntarily, and therefore are immoral and may, if law can effectively control them, be regulated by law. "In the end business has only two responsibilities - to obey the elementary canons of everyday face-to-face civility (honesty, good faith, and so on) and to seek material gain." Immoral behavior is understood to be only that which prohibits free and open competition, and this is normally understood to mean only the practice of coercion and deception. No other moral behaviors are prohibited. Claims of supposed existing obligations on the part of those


engaged in business transactions to promote the common welfare through specific practices of social responsibility are denied by arguing that businesses are not designed for nor capable of practicing social welfare, and that restrictions placed upon business negatively affect the benefits naturally provided to society by businesses since, in the long run, what is good for business is ultimately good for society.  

Characteristics of the Commercial Model of Profession

In the second part of this chapter the commercial aspects of actual professions will briefly be explored. It is the claim of social theorists within the Critical perspective that professions in American society should be understood as business enterprises arising from and developing a uniquely advantageous position within the structures and values of the marketplace.

Some of the Critical social theorists do not view this perspective on profession as something new. They hold that the earliest craft guilds in the Middle Ages, which are considered by many to be the forerunners of modern professions, were constituted by artisans and tradesmen whose primary orientation was a commercial marketing of services.

Modern professions, much like the earliest professions, they argue, are primarily a means for individuals who become professionals to earn an income on the basis of transacted services. The occupational groups which constitute the modern professions simply emerged preeminent over competing groups offering similar services solely through the organizational efforts of their leaders and their own voluntary associations. These organized occupational groups first created a distinctive commodity, then created and controlled the market for their services, induced new recruits to accept their standards and programs for training and licensure, sought to convince their potential clientele of their goodwill and trustworthiness to be granted relative monopoly and autonomy in practice, and finally solidified their professional status through legal and other institutional structures and societal recognition of their exclusive expertise. 7

Regardless how the origin and rise of professions in America actually occurred, all Critical social theorists reflect the perspective and sentiment (which is also found both outside and sometimes within the professions) that professions should be viewed as commercial entities with no distinctive role-specific moral obligations that would set

them aside from other players in the market. Their only obligations are those normally associated with everyday business transactions. This perspective on professions is maintained for three reasons.

First, this commercial view of professions views professional claims to a disinterested, self-sacrificing fiduciary relationship with clients or patients with skepticism because it considers human motivation to be primarily self-interested. Individuals may join a profession for a variety of reasons, but ultimately their motivation is to advance their own self-interests, whether this be through financial gain, social prestige, or the emotional rewards of a public life of service. If these interests or benefits were taken away, proponents of the commercial model would argue, few if any members would remain with their profession.⁸

Secondly, since individuals utilize their professions to make a living, they cannot but help being influenced by the commercial or free enterprise system in our American society. Professionals generally are rewarded for their marketable skills with high prestige and income. One of the most attractive features of becoming a professional is the anticipated higher level of income commonly perceived to be associated with professional status. Thus, even if the previous

point about motivation was not true, these theorists argue, the system within which professionals practice requires them to act according to the commercial model anyway.

Thirdly, the vast majority of professionals are now employed by corporations or are part of group-practices whose primary purpose is profit-maximization. The presence and purpose of these organizations tends to diminish or remove the traditional one-on-one relationship with the client or patient and fosters in professionals a greater loyalty to the institution and to its profit-maximization than to the client or patient. Even professionals working in so-called not-for-profit institutions must practice in such a way that the institution's survival is secure. In every respect, then, professional practice is constrained to follow the pattern of the marketplace. ⁹

Within the commercial view, professions maintain a monopoly in the market to the degree that their services are not offered or emulated by other occupational groups that might take away the buyers of their services. Normal societal problems with market monopoly such as price controls and regulation of quality of the product or service are addressed by professional attempts at self-regulation (which is not a response to any generally agreed upon terms of a social contract, nor is there any moral obligation to self-regulate

in this model; instead, this is simply a strategy to keep monopoly-busters at bay) and by proclaiming (as part of their advertising) an atypical moral commitment to the client or patient and by claiming extraordinarily high standards for entry into and life-long accountability within the profession, so the higher-priced professionals are — or are perceived to be — more capable in rendering the higher-quality service to more people than under any proposed competitive alternative. Any qualified person attracted by the anticipated rewards is free to incur the training sacrifice and debt assumption to enter any profession. Should the anticipated rewards fail to materialize, exit from a profession is virtually costless save for the possibility of a few psychological scars.¹⁰

In the commercial model the service provided by the professional is viewed as a commodity transaction. This transaction occurs between two equal partners who freely contract for the desired service. Healthcare or its delivery, legal advice or representation, religious counseling or preaching, are all ultimately commodities to be bought and sold in the marketplace. The professional "owns" the expertise which can be offered in practice to the client or patient who is the purchaser of the services; together they bargain over the price of the commodity. The client or patient exchanges funds for the services, prior to that agreement

¹⁰This point is argued in Ira Horowitz, "The Economic Foundations of Self-Regulation in the Professions," in Regulating the Professions, 3-28.
possessing only the rights usually accorded a consumer in a free-market economy, i.e., the right not to be deceived or coerced.\footnote{This view of professional service as a commodity transaction is also examined (and criticized) in Edmund Pellegrino and David Thomasma, \textit{For the Patient's Good} (New York: Oxford University Press, 1988), 101-102; Michael Bayles, \textit{Professional Ethics} (Belmont, California: Wadsworth Publishing Company, 1980), 72; George Agich, "Professionalism and Ethics in Health Care," \textit{The Journal of Medicine and Philosophy} 5, no. 3 (1980): 186-199.}

The role of healthcare administrators in the past three decades increasingly has been understood in terms of the commercial model of profession. This is largely due to the fact that their role has become more and more like that of the administrators of other large non-healthcare institutions competing in the marketplace. Hospital expansion in size and technological services began after World War II, continued in earnest through the 1950's with the predominant emergence of third party payers, and exploded with the introduction of Medicare and Medicaid reimbursements in the 1960's. Until the 1980's, the more expenditures healthcare institutions incurred, the more income they received. Providing more healthcare to more people was handsomely reimbursed. The profitability of healthcare institutions led to a number of consequences; competition increased, for-profit institutions developed, healthcare systems emerged with multiple institutions, and not-for-profit institutions and systems began to emulate the services, product-lines, and business practices of
the for-profit chains. The introduction of DRGs (Diagnostic Regulated Groupings which pay a set fee per case) in 1983 to cut healthcare costs was also intended to foster competition between institutions to treat patients faster, more intensively, and with greater success than their less efficient competitors.

Much of the literature on the ethics of healthcare administrators has reflected this increasing emphasis upon a market mentality. There is recognition that healthcare administrators formerly viewed themselves as directors of charitable institutions established for patient care, community service, scientific research, and training and education programs. Now, however, healthcare administrators tend to view themselves as presidents of large businesses competing with numerous other healthcare facilities for customers and market share in an increasingly crowded and varied healthcare field.¹²

The reasons proposed for this change towards a market perspective on their professional practice include increased competition with other healthcare providers, reaction to government and third-party payer pressures on cost-contain-

ment, introduction and emulation of big for-profit chains, emphasis on business skills in healthcare administration education, and a shifting emphasis toward the value of personal self-advancement among those now entering the profession. The result of this change in perspective is that the professional skills necessary for successful healthcare administration are now commonly identified in the literature to be marketing, finance, strategic planning and management, the primary professional qualities desired in healthcare administrators are proposed to be ambitiousness and


competitiveness, and the primary moral obligation of healthcare administrators is described as personal self-interest expressed through activities seeking to assure institutional survivability and profit-maximization. The Code of Ethics for the American College of Healthcare Executives obligates healthcare administrators, except for its focus on patients' health, only to a series of general moral norms that are consistent with the minimal ethics guiding business transactions in the free enterprise system, i.e., to refrain from coercion and fraud and to fulfill their contractual commitments.

Professional Ethics of Healthcare Administrators in the Commercial Model of Profession

To more carefully delineate the moral obligations of healthcare administrators as understood within the commercial model of professions, this third section of the chapter will

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now address each of the seven categories of professional obligation from within the context of the commercial model of profession.

Identification of Chief Client

Despite claims to the contrary in the Code of Ethics of the American College of Health Executives, in the commercial model of profession individual patients do not constitute the chief client of healthcare administrators. The professional relationship of healthcare administrators with individual patients is shaped by the fact that the healthcare administrator is directing and managing the production of healthcare that is sold like any other commodity in the marketplace to patients who are consumers desiring or needing the services which only a healthcare institution can provide. The healthcare institution, directed by the healthcare administrator, contracts with the patient for particular services at specific prices as occurs in any other marketplace transaction. The patient is not resigned to being a passive recipient of whatever kind of care and treatment the healthcare administrator has elected to offer. The patient first

17 The patient's insurance company, HMO, or Medicare supplemental coverage is normally the party which contracts for the services with the healthcare institution in place of the patient, but this should be understood to constitute part of the meaning whenever only "the patient" is referred to here as doing the contracting.

18 The type and quality of care and treatment offered is integrally related to the corresponding physician practice; this should be understood to constitute part of the meaning
judges the value of the service offered in terms of benefits and costs and then chooses whether or not to purchase those services.

The relationship between the healthcare administrator and the individual patient is thus an impersonal one, and is marked exclusively by the communications about the offered commodity and its price, and then the actual exchange of that commodity for the price that is agreed upon. In this model the healthcare administrator and patient are primarily competitors. Each is trying to obtain from the other the greatest amount of what he or she wants (money, restoration to health or well-being, etc.) while giving up in the exchange as little as possible. Thus the criterion by which the healthcare administrator determines the kind of care and treatments to offer the patient is determined by what the patient is willing to pay for and by what will yield the greatest return to the healthcare institution in terms of least cost in time, effort, and materials.\(^{19}\)

As a result, the patient should not believe that he is receiving the best possible quality care and treatment from whenever only "the healthcare administrator" is referred to here.

the healthcare institution. The patient also should not be surprised if she becomes the beneficiary of unnecessary tests or treatments. The primary goal of the healthcare administrator is maximization of profit; as a purchaser of healthcare, the patient is but a consumer well advised to be self-protecting, i.e., "Caveat emptor;" and the patient is free to purchase whatever kind and amount of healthcare she really needs, wants or can afford. The patient should expect no more of the healthcare administrator and the healthcare institution than she would expect from any other seller in the marketplace.²⁰

It should be apparent, therefore, that in the commercial model individual patients are not the chief client of the healthcare administrator. The patient ranks far down the list of clients whose well-being the healthcare administrator is committed to addressing.

In the commercial model of profession, the chief client whose well-being the healthcare administrator seeks to

promote, would seem to be the physicians. Healthcare institutions cannot earn a profit without patients. For a patient to be admitted into a healthcare institution or to utilize their outpatient services, however, a physician's medical order normally is required. Patients don't "use" the services of a healthcare institution, rather they are sent there by their physicians. Physicians are the ones who use most of the services a healthcare institution provides. Healthcare institutions, therefore, are dependent upon physicians for their patients and for the utilization of their services. Physicians thus constitute the chief client of healthcare administrators in the commercial model of profession.

Ideal Relationship with Chief Client

In our society hospitals and physicians have long existed in varying degrees of tension with one another. Hospitals need physicians but (until recently) did not employ them; physicians need hospitals as an extension of their own private practice but can exert only limited influence and control over the internal power structure of hospitals. Some physicians ally themselves closely with a particular hospital, but many physicians prefer to have privileges at more than one hospital and either utilize the services at different hospitals that best meet their particular specialty or tastes, or "play" one

21With a tradition of acting as solo-practitioners, physicians historically have not often exercised their potential to work in unison to exert control over hospital administration.
hospital off against the other to exert control over decision-making and capital expenditures.

Healthcare administrators in return seek ways either to placate their medical staffs through decisions which entice physicians to utilize their hospital, or to control physicians through contracts, employment, or financing physician offices in proximity to their hospital. As physicians build their own labs, radiology centers, etc., in response to the increasing healthcare reimbursement for outpatient treatments and services, however, hospital administrators now find themselves competing against physicians for the same business as well as trying to appease and control them. New models of hospital-physician relationships are continually being proposed in the literature, and the final direction of health-care reform will undoubtedly dictate which model is chosen. In the meantime, healthcare administrators maintain a difficult and delicate relationship with physicians as their chief clients whose well-being they seek to promote in order to gain financial reimbursement.²

Another client group which is rising in importance almost to the level of physicians are the third-party payers. Patients are not only not the ones who "use" the services at healthcare institutions, and they are also predominantly not

the ones who pay for those services. Almost all healthcare is
now funded by Medicare, Medicaid, HMO's or PPO's, and private
insurance. Patients may be billed for deductibles or for co-
payments, but their portion of their bill is significantly
less than that assigned to third party payers. While Medicare
DRGs increase the institutions's reliance upon physicians as
their chief clients to successfully treat patients in a timely
manner, other third-party payers who have already contracted
with specific physicians now negotiate and contract for
services from healthcare institutions at prices significantly
lower than charges. These third-party payers are already
contracted with particular physicians and the payers authorize
hospital admissions payment for particular services. Increas-
ingly healthcare administrators must rely on contracts with
these third-party payers rather than simply on physicians for
their business. It is incumbent upon administrators, there-
fore, to "sell" these third-party payers the product that
their institution can provide the highest quality care for the
lowest price. 23

Commitment to the Good of the Chief Client

The "good" of physicians should be understood to mean, in
this context, as their ability and willingness to practice
their skills at the healthcare administrator's institution.

23This trend is explored in Robinette, "Adapting to the Age of
A healthcare administrator seeks to promote this understanding of the good or well-being of physicians by providing them with the best affordable technology and by designing the operation of the healthcare institution to best facilitate the practice of their medical skills.

The commitment of the healthcare administrator to the good of physicians, however, is dependent upon the benefit that type of commitment yields to the healthcare administrator. The healthcare administrator is concerned about the physician's well-being only as a means of improving the financial well-being of his own institution, and, in turn, securing his own position and financial well-being.

The physician's need for particular services and technology in a healthcare institution in order to provide medical tests and treatments for individual patients imposes no special ethical obligation upon the healthcare administrator. The physician's need may function as a motivator for them to seek and contract for medical staff privileges from a particular institution, but this need can be used effectively by the healthcare administrator to market the services and technology of his healthcare institution to entice physicians to join the medical staff and thereby, through the utilization of the institution's services and technology, financially benefit the institution and, in turn, the healthcare administrator.

The only moral obligations that exist for the healthcare administrator are those that exist for all other bargainers in
the market place as well, namely, not to coerce, cheat or defraud, and to keep the contractual commitments one makes with others. If the practice patterns of individual physicians results in a healthcare institution losing rather than making money with negative repercussions for the healthcare administrator, then the healthcare administrator may choose not to renew the medical staff privileges of those physicians and thus terminate their contract, regardless of the benefit those practice patterns provided to individual patients.

Central Values of the Profession

The fourth category of moral obligation is the central values of healthcare administrators. These values were first identified in Chapter IV. In the commercial model of profession the central values are, in prioritized order:

1. Financial viability of the organization
2. Effective and capable management of employees and good relations with medical staff
3. Health of individual patients
4. Institutional integrity
5. Health of community

The growth in professional status of the healthcare administrator in the last three decades has been integrally tied to the financial success of healthcare institutions. A consistent positive bottom line and growth in the physical plant and technological services offered by the healthcare institution have been the key criteria by which administrators have been judged by their sponsoring organizations, boards, and peers. CEO salaries and turnovers have been directly
associated with the success or failure to achieve this primary central value. Because of the emphasis upon profit-maximization in the commercial model of profession, the value of maintaining the financial viability of the organization normally supersedes all other values for the healthcare administrator.

The second central value in the hierarchic scheme is effective and capable management of employees and maintaining good relations with the medical staff. The high ranking of this value reflects the dramatic impact physician practice has on the financial viability of the healthcare institution which results in physicians becoming the chief client of healthcare administrators. Effective and capable management of employees is highly valued by the healthcare administrator since it assists her exclusive expertise and promotes the financial viability of the institution.

In the commercial model these two central values are more important to the healthcare administrator than the health of individual patients. This ranks as only the third central value in the hierarchy of values. While delivering a good product to individual patients is important in order to maintain credibility in the healthcare business, patients are viewed as only the beneficiaries of healthcare services; to maximize profit, it is far more important to address the concerns of those who use and pay for the services, namely, the physicians and third-party payers. By promoting the
interests of those clients, it is generally assumed that the value of addressing the health needs of individual patients will also be realized.

Occasionally in isolated incidents, when the potential harm to a patient may be so great, the value of the health of the individual patient may rise in priority to take precedent over the value of good relations with the medical staff and maintaining effective and productive management of employees. In those cases the healthcare administrator may intervene, even if this causes problems with physicians or staff, to avoid potential liability and negative public relations over the revealed harm to the individual patient, which could cause significant harm to the healthcare institution and potentially to the healthcare administrator. Such cases normally should be rare, however, according to the belief that promoting good relations with the medical staff and maintaining effective and capable management and employees serve as the best means to prevent harm occurring to individual patients.

The fourth central value is maintaining institutional integrity by promoting the mission and values of the healthcare institution. This value has recently been given greater attention in business management books, but only for the purpose of helping to achieve the more important values ranked above it in the commercial model of profession. Institutional mission and values are important only if promoting them in turn promotes the bottom line, facilitates relations with the
medical staff and with third-party payers, is popularly viewed as mechanisms of good management, and help employees deliver a better product to patients at a lower cost. It is highly unlikely in the commercial model that an institution's sponsor will prize the promotion of institutional integrity if the healthcare administrator financially mismanages the organization, lacks good management and business skill, antagonizes the medical staff, or allows the health of individual patients to suffer in any public way under his administration.

The least important of the central values for healthcare administrators is the health of the community. Since individual patients, who pay for the services provided by healthcare institutions, return to their community, healthcare institutions do take interest in - and thus value - the health status of the general community. In the commercial model, however, valuing the health of the community is to a great extent exercised as a marketing tool for advertising or to provide good public relations. A general improvement in the overall health of the community would actually negatively affect the financial return to healthcare institutions, which prosper only when there are health problems in a community resulting in the admission of patients. Healthcare institutions benefit, therefore, from health problems in the community. Unless managed care with capitation reimbursement develops to provide different financial incentives, then, it is hard to comprehend how the health of the community could rise any
higher in the hierarchic scheme of central values for the healthcare administrator in the commercial model of profession.

Furthermore, no professional obligations exist in the commercial model unless an explicit contract has been established defining those obligations. Healthcare institutions exist, like any other business, ultimately for the purpose of profit-maximization; charges of supposed social responsibility to society at large, as in providing healthcare for the poor and uninsured, unfairly ask healthcare institutions to take on others' responsibilities and unjustly detract from their ability to pursue means of profit-maximization.²⁴

Commitment to Professional Competence

Moving beyond the central values of healthcare administration in the commercial model of profession, the fifth category of professional obligation is the obligation to possess and maintain competence. Education and training of healthcare administrators now focuses on management, strategic

planning, finance and marketing. Since in today's highly competitive healthcare market the survivability of the healthcare institution and the preservation of the healthcare administrator's job are dependent upon his or her remaining competent in these areas, the motivation for healthcare administrators to remain competent in their field of exclusive expertise is "built in" for individuals wishing to remain in this profession. Competency in the commercial model is directly correlated with the ability to compete in the marketplace.

Relationship with Fellow-Professionals

The sixth category of professional obligation is the relationship with fellow healthcare administrators. This relationship has rarely been analyzed in the literature on healthcare ethics. The highly competitive healthcare market in the past three decades has led to two dichotomous yet coexisting behavioral patterns in the relations between healthcare administrators. Internally their relations are often marked by ruthless competition as they seek institutional advantage over one another in the marketplace; yet publicly they often maintain cordial and even friendly

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25 See, for example, the textbook: Lawrence Wolper and Jesus Pena, eds., Health Care Administration: Principles and Practices (Rockville, MA: Aspen Publishers, Inc. 1987).

26 This has begun to change in the last few years as market conditions have begun forcing healthcare administrators to consider collaboration with other institutions in order to insure their own institutional survivability.
relations as if out of respect for the dated guild or gentry mentality of profession. Professional incompetence is rarely publicly criticized and the offender is almost never held accountable by the profession; it is understood that both incompetence in skill and moral incompetence within the commercial perspective, i.e., coercing or failing to keep contracts, will punish itself in the marketplace.

Relationship with Society

The seventh category of professional obligation is the relationship of healthcare administrators with the wider community. In actuality this category does not exist in the commercial model of profession.

In the commercial model, obligations occur only when services are contracted for; the provision of healthcare is contracted with individual patients and not with the community at large, and therefore healthcare administrators do not believe that they or their institutions are obligated to the larger community, either to provide healthcare to the poor and indigent or in any other way. Charity care traditionally has

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27 Perhaps, too, with the high turnover rate in healthcare administration positions in the past decade, i.e., the average length of hospital CEO tenure is only four years (see Brian McCormick and Linda Brooks, "Shared MD/Hospital Values," Trustee 43, no. 6 (1990): 17. These publicly harmonious relations are maintained out of necessity to maintain possibilities for potential future job placements.

been offered to those without the means to pay, but only on a limited basis and in exchange for institutional tax-exempt status, philanthropic gifts, and the right to shift those costs to paying customers.

Many healthcare administrators, however, find it beneficial to business to be perceived as providing some sort of community service or to promoting the general health of the community at large. Most healthcare administrators do not have strong ties to the local community primarily because they transferred into their job from another geographical location and because, as has been mentioned, in today's highly volatile market the length of CEO tenure is short and the rate of turnover is high. In the commercial model, however, healthcare administrators are encouraged to become involved in their community so as to advance their career or to promote good public relations for their institution.29

Critique of the Commercial Model of Profession for Healthcare Administrators

In the final part of this chapter, three sets of criticisms will be raised arguing that the professional obligations of healthcare administrators as defined within the commercial model of profession fail to satisfy the requirements of any reasonable social contract regarding the healthcare administration profession. Because of this, the account of professional obligations as outlined above must be rejected in favor of a model of profession that would satisfy the terms of the social contract.

First Criticism

The first criticism is that the free market in and of itself is suspect and possesses two inherent problems. First, a general assumption is made in the free enterprise system that business, left to itself without outside interference, is the means best suited to serve the needs of society. It is not true, however, that behaviors promoting profit-maximization will guarantee maximal aggregate utility to society. Profits can be secured by supplying people with what they want, but this does not necessarily involve helping them or providing them with what they need. In addition, social costs or harm to the public does not always figure into producers' costs. The free market's demand for freedom from interference or regulation should not be acceptable to society without qualification, if at all, therefore, and thus the commercial model of profession cannot satisfy the requirements of the social contract. As society questions itself about the kinds
of institutions it wishes to have, it may need to require that elements of social responsibility, i.e., particular social structures or behaviors that promote the welfare of the members of society in place of, or along with, the welfare of the institutions, be considered normal obligations for at least some forms of business, e.g., those dealing in meeting peoples' basic human needs.  

A second problem with the free market is that it seems to presuppose that people involved in business act without any personal set of values, and that institutions involved in business transactions are void of values except for the sole purpose of profit-maximization. Yet it is not true that business people as a rule act without personal values or that institutions are created and operated in a value-free manner. Successful business practice, i.e., the maintenance of long-term survivability and profitability, requires of business people the personal values of integrity, honesty, and loyalty to the client and to the institution, and it requires that institutions possess or be perceived as possessing the social values of consistency, reliability, and good stewardship. Profit-maximization cannot be pursued value-free without undermining the very moral foundation necessary for

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Second Criticism

It is quite possible, however, to successfully argue that these two general criticisms of the free market can be satisfactorily addressed while still keeping many of the same components and values of the commercial model; these two criticisms above, after all, serve as part of the foundation for teaching ethics to those involved in business. It will not do to merely describe a commercial model in its worst possible light and then "knock down the straw man." Further criticism of the commercial model of professions in general and of its application to healthcare administration in particular is needed.

A second set of criticisms, therefore, needs to be raised arguing that the producer-consumer transaction as described in the commercial model is not what should take place in the professional-client/patient relationship, particularly in regards to healthcare administrators. Healthcare administrators facilitate the provision of healthcare by their institutions to individuals and to the community at large. Yet the nature of healthcare and the nature of its provision have become so complex that individuals and the community at large

cannot fully play the rational consumer's role in selecting and choosing among options in healthcare or between healthcare institutions themselves. Laypeople are at a marked disadvantage due to their lack of knowledge regarding the kinds of medical treatments and the means of providing healthcare, which makes them easy prey for overtreatment or for expensive treatments since they generally lack the capability of seeking out and weighing all possible options. No reasonable society would establish institutions that presume that ordinary patients could overcome this problem on their own.

Second, people seek out healthcare only when they are sick. Illness often is experienced as a threat to or as a lessening of an individual's autonomy. This is not just because illness involves symptomatic deficits of function, but also because the experience of being sick is an experience of no longer being in control of one's body - which includes a sense of no longer being fully in control of one's life or one's goals. People seek out healthcare in part to recover their autonomy, to have their control over their own bodies and lives restored. This means, however, that many times they may lack the full capacity to be co-equal bargainers with physicians and healthcare institutions in the marketplace. The commercial model, therefore, misrepresents the position of people seeking healthcare by failing to recognize the potential limitations in their autonomy, and is not a model that a reasonable society would choose for administering healthcare.
Third, many people do not seek out healthcare, especially its provision through the facilities of healthcare institutions, unless it is an emergency or until they believe they no longer adequately function without the provision of healthcare. Again, it seems clear that a patient cannot function as a rational consumer, comparing all alternatives in terms of cost and benefit, if he no longer has the option not to buy at all.

Fourth, with the reimbursement for the provision of healthcare coming primarily from third-party payers, many people now find their options for selecting physicians and healthcare institutions to be extremely limited. Short-term contracts in managed care result in financial pressure being applied to patients to change physicians and to receive the provision of their healthcare from one select institution. Once again, this means that patients cannot play the part of the rational consumer able to refuse offered products if none are judged satisfactory on a cost-benefit analysis. 32

A number of reasons exist, therefore, to argue that the nature of the professional-patient relationship in the provision of healthcare is much different from the

producer-consumer relationship assumed in the commercial model. Because of this, no reasonable society would establish the institution of profession according to the commercial model if the members of society are unable to exercise the role expected of them in the commercial model.

Third Criticism

A third set of criticisms can also be raised arguing that since the provision of healthcare addresses a fundamental human need and societal concern, specific obligations are expected by society on the providers of healthcare that are not expected on the providers of other goods and services within the free market system. The literature on the ethics of healthcare administrators seems to frequently emphasize this point.

It is often claimed that medicine and healthcare - because they address basic human needs - ought to be, and are commonly understood in our society to be public goods, and not a private commodity to be bought and sold in an ordinary market arrangement. The purpose of healthcare is to cure illness, improve function, and to provide comfort for the suffering; healthcare is also essential to preserving and sometimes restoring the autonomy of patients, and is thus a prerequisite for individuals to be able to participate in market transactions in order to enjoy the goods and services offered in a free market economy. Therefore, because medicine and healthcare constitute a more basic kind of human and
societal good, different expectations, i.e., different professional obligations, are expected of those entrusted with the provision of those goods. Some type of fiduciary relationship or atypical moral commitment to the good of patients seems to be commonly expected of both physicians and healthcare institutions and those who administrate them. This seems to represent a general understanding by patients and by society at large, that healthcare institutions exist to promote the welfare of the sick and those whom they serve and not merely to "sell" healthcare as a product in pursuit of their own financial gain. A pure commercial model of healthcare provision is incapable of describing or justifying the kinds of relationships reasonably to be expected of healthcare providers, including healthcare administrators.  

Even if a broader sense of moral values and a sense of

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social responsibility are allowed to operate along with the commercial model, its emphasis upon profit-maximization is generally viewed as not compatible with the intrinsic value individuals and society place upon healthcare. This is not to imply that profit-making cannot be part of the picture of providing healthcare in our country. It is to say, however, that profit-making cannot be the primary motivation or the driving force in the institutional structures a society establishes for its healthcare providers. In addition, this means that great caution, societal input, and careful regulation must all be involved in the provision of healthcare in order to avoid or correct the natural tendency in commercial dealings involving healthcare delivery to limit access to care, to limit the provision of care, to provide only care which can be reimbursed, and to defend cost containment at the expense of the health needs of the poor and those unable to pay.34Because of the great value placed upon healthcare by

individuals and by society at large, the commercial model of profession must be set aside and another model sought instead.

This chapter will attempt to identify the moral obligations of healthcare administrators as conceived through the interactive model of profession. It will be argued that this is the only model of profession and professional obligations which is acceptable according to the terms of the social contract that a reasonable society would accept for the profession of healthcare administration.

Two key presuppositions of the interactive model first will be defined. One is that social discourse has an integral value in society for the determination of the structures desired to best facilitate the meeting of fundamental human needs and societal concerns. Professions can then be understood to be occupational groups who, through social discourse, are structured to address those vital needs and concerns. In the interactive model, dialogue occurs within society, between professions and society on a general level, and between professionals and clients or patients on an individual level regarding how best not only to attain those needs and goals, but also what is the appropriate understanding of those needs and goals in light of other needs and goals possessed by
members of society.

A second key presupposition in the interactive model of profession is the integral association of the principle of beneficence with the expected atypical moral commitment on the part of professionals. Relative autonomy in practice is granted to the professions and their members to a great degree in exchange for practicing their profession in two beneficial ways. First, it is understood that professional practice normally should respect client or patient self-determination, it should enable clients and patients to reacquire to the degree possible the fullness of their autonomy, and it should seek the good as perceived by clients or patients while at the same time remaining faithful to the primary purpose and central values of the profession. Secondly, professions are obligated to contribute to the common good by engaging in public dialogue and by becoming involved in the development of public policy in order to best promote the primary purpose or function of their profession as understood to exist through continual dialogue with society in general and with clients or patients in particular.

The second section of this chapter will develop the concept of profession within the interactive model. It will be proposed that the interactive model blends together what has been argued normatively to be the best characteristics of the guild and agent models. Important characteristics of profession gleaned from the guild model include the possession
of exclusive expertise and the public commitment to address fundamental human needs and societal concerns. The important characteristic taken from the agent model is the element of dialogue. Though in that model the dialogue was restricted to the professions and their members offering input only on the most effective means to reach clients' or patients' ends, in the interactive model of profession the role of professions and their members in the dialogue is expanded.

In the interactive model an ongoing dialogue occurs between society and the professions in order to determine the nature of professional services, the proper mode for their delivery, and the norms for the professional groups. It will be proposed that the relationship between professionals and clients or patients is best described as covenantal rather than paternal as in the guild model or contractual as in the agent model or potentially exploitive as in the commercial model.

The major part of this chapter will then attempt to identify the moral obligations of healthcare administrators as understood to exist within the interactive model of professions. This will be done by examining the seven categories of professional obligation as in the previous chapters.

The final section of this chapter will address two principle challenges to the interactive model of profession. While it may be charged that beneficence may not necessarily be considered as important as social discourse in the
interactive model, it will be argued that it is difficult to conceive of the relationship between the professional and the client or patient which arises out of a significant need in the human condition without the expectation of accompanying beneficence on the part of the professional. Secondly, legitimate concerns may be raised to challenge the very notion of social discourse which is essential to the interactive model of profession. An attempt will be made to address these concerns by clarifying the notion of social discourse to illuminate more carefully its role in the determination of professional ethics in general and the ethics of healthcare administrators in particular.

Presuppositions of the Interactive Model of Profession

The first key presupposition of the interactive model concerns the nature and value of discourse in society for the determination of professional ethics. Professional ethics are best identified descriptively and normatively in public social discourse; that is, matters of genuine societal concern which involve professions are best addressed within society at large and not merely in an internal fashion between colleagues within a given profession.

The nature of discourse and its involvement in and impact on ethics has been thoughtfully developed by Habermas.¹

¹See Jurgen Habermas, Moral Consciousness and Communicative Action (Cambridge: MIT Press, 1990); The Theory of Communicative Action: Reason and the Rationalization of
Admittedly, his philosophical presuppositions are not above challenge. For example, a purely rational discourse about interests or needs seems impossible without at least some "thin" presupposition about the good. In addition, consensus alone is not an absolute grounds for establishing truth; nor can moral norms be justified apart from the rational traditions from which they emerged. Nevertheless, Habermas' discourse ethics remains a strong influence in moral psychology, sociology and political science today. His communicative ethic calls for a "genuine communication," which is understood as recognition of the autonomy and responsibility of the participants, their cooperation in pursuing shared goals of understanding, and their search for distorted communication and varying social realities.

For purposes here, social discourse will be presumed to be the means by which the ethics of professions in general and of healthcare administrators in particular may be evaluated.

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Brian O'Toole, "A Critical Look at Discourse Ethics" (Term paper for Loyola University Chicago, Philosophy 490: Issues in Moral Philosophy and Psychology, 1992). Despite these criticisms, I argue that a "watered-down" version of Habermas' model may be implemented if the participants in the dialogue possess a preliminary acceptance of a common or generalized notion of the good, e.g., health, justice, religious salvation, and so forth, and if there are "experts" present whose very self-identity is bound up in their commitment to this particular notion of the good to lead and guide the discussion; in other words, if the participants in the discussion are representative members of professions and society.
according to the image of the social contract developed earlier. Such discourse can occur between a profession and society, and between individual professionals and individual clients or patients. Discourse presumes that each participant takes a role as full and equal partner in the dialogue, and that the dialogue seeks common grounds in understanding the wishes and values of the participants and in identifying attitudinal biases or personal agendas.

Such social discourse about a profession and its ethics has multiple purposes; one function is to search for the values, interests, and assumptions among the participants, particularly those views submerged or lost in conventional thinking, political expediency and distorted communicative process. Another function is to look for varying meanings or perspectives in regard to the fundamental human values or societal goals that have elicited the professional practice in the first place. A third function is to try to achieve common ground in the determination of the nature of specific professional practices and specific professional norms.³

The determination of professional ethics, therefore, can be said to be a kind of ongoing conversation and renegotiation of the social contract between the professions and society. If the moral obligations of professionals are determined

solely by the professions themselves, as the guild model holds, then members of society - who have been left out of the discourse establishing professional ethics - experience themselves as disenfranchised in the resulting social relationship. Similarly, if lay persons are given complete authority for specifying the framework of their relationship with the professions, as the agent model holds, then professionals are omitted from the discourse and lose all sense of being autonomous agents able to make moral and other value choices. The determination of professional ethics, then, should be seen as the product resulting from social discourse yielding a continually developing social contract through ongoing negotiation between the parties. This process identifies the relevant belief system, the moral values, and the way those values are to be applied to specific problems in the professions' practice.⁴

The social discourse concerning professional ethics which ideally takes place between the professions and society and, against the background of that larger conversation, also between individual professionals and clients or patients,

would seem to be ever ongoing because new technical and social situations arise involving professional services, and because different values become more or less important over time in a given society. Such changes are most satisfactorily addressed for all involved parties through social discourse between the professions and society, which sets the parameters for the more personal discourse between individual professionals and clients or patients.

Social discourse concerning professional ethics would also seem to be ever ongoing due to divergent views of morality in our society today. For example, social discourse between proponents of the agent model of profession and the guild model of profession would seem unable to easily reach agreement due to their contrasting values. On one hand, as so powerfully exhibited in the agent model of profession, the value of autonomy or self-determination is held in such esteem as to be considered (almost) nonviolable; this results in the foregoing (or loss, depending upon one's normative perspective) of any commonly accepted notion of the good, which means that professionals are viewed as serving individuals' notions of the good but possessing no essential or fundamental good intrinsic to their service. This agent model of profession determines professional ethics according to the standard of respecting client or patient autonomy, or, to express this in other words, according to the standard of what best promotes a society with the values of freedom, equality, prevention of
harm, welfare, and privacy. On the other hand, as suggested by the guild model of profession, it is possible to argue that there are fundamental human values that are specific to the professions, e.g., physical and emotional wholeness in human beings for physicians, justice in human relations for lawyers, and the service of God or the facilitation of religious salvation for clergy. This position holds that these values are universal human values which normally should guide professional behavior in their relationship with clients or patients.

Now these two contrasting positions should not necessarily imply that one or both are incorrect, or that agreement between the participants representing these two divergent positions, when they appear in the discourse, is impossible. Neither the agent model nor the guild model of profession was found capable of offering a satisfactory foundation for grounding professional ethics. Yet professions remain with us today as societal institutions designed to serve fundamental human needs and societal goals, and each model can offer useful elements of a reasonable and adequate social contract.


This point is strongly developed in Gilbert Meilmanender, "Are There Virtues Inherent in a Profession?" in Edmund Pellegrino, Robert Veatch and John Langan, Ethics, Trust, and the Professions (Washington D.C.: Georgetown University Press, 1991), 139-155.
Yet, to the degree that there is disagreement expressed with the role and ethics of the professions, there is the ongoing need to continue and even broaden the dialogue between society and the professions in an ongoing search for increased consensus on the nature of professional ethics. This chapter of the dissertation is an effort to contribute to that ongoing dialogue.

The second presupposition of the interactive model of profession is that the principle of beneficence is integrally associated with professional practice. This is in marked contrast to the view of the agent model of profession which considered the principle of client or patient autonomy to be the preeminent moral value professionals were obligated to respect. As previously argued, however, absolutizing the value of client or patient self-determination neglects the fact that their decision-making regarding professional services is often an interpersonal transaction with professionals; the client or patient faces a threat to or an inadequacy regarding his human condition while the professional possesses expertise to address that need; this binds the two parties to each other in a way that makes absolute decisional autonomy on the part of the client or patient unrealistic and undesirable goals for both parties.

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"This point is also expressed in Lisa Newton, "Profession-alization: The Intractable Plurality of Values," in Profits and Professions: Essays in Business and Professional Ethics, 23-36."
Furthermore, absolutizing the value of client or patient autonomy does not give sufficient attention to the impact of disease, injustice, or religious despair on the client's or patient's capacities to exercise his autonomy. Lastly, the fundamental values of the professional services, i.e., healing, justice, or restoring a relationship with God, in the central instances of profession, constitute essential goods in normal circumstances to clients or patients\(^8\), and this is not given sufficient weight in the agent model of profession (The central values of the healthcare administration profession according to the interactive model will be examined in the third section).

But the principle of beneficence involved in the interactive model is also in marked contrast to the view of the guild model of profession which justifies a paternalistic relationship with clients or patients. Beneficence, as the term will be used here, is not to be confused with (strong) paternalism which assumes not only that professionals know what is best for all clients or patients, but also that professionals may therefore override the client's or patient's own directives.

\[^8\]The development of this position, which space constraints prohibit here, is to argue that since these are fundamental goods to human existence, in normal circumstances human beings are morally obligated to pursue these goods for their own fundamental well-being. This strikingly illustrates a significant difference between the principles of beneficence and autonomy, for the latter does not recognize any moral obligation to pursue supposed fundamental goods but rather presupposes the absolute value of value-free choosing, or the selection of goods based entirely upon a subjective interpretation of those goods.
and values in pursuit of the profession's central values (e.g., healing, justice, or religious salvation). Such (strong) paternalism is objectionable because it violates the respect for the autonomy of the client or patient. It is generally agreed in our society that it is essential to the nature of human beings that they be respected in their freedom to decide about the conduct of their own lives. The profession's central values, the fundamental goods that professional services can provide, are not in all cases the highest or most important goods to the client's or patient's way of thinking. Circumstances may well present themselves when the value of the professional services is outweighed by other more important values to the client or patient. It is a tenant of contemporary understandings of professionals' roles that it is ordinarily wrong for a professional to paternalistically override this.

Beneficence, then, can be understood as a commitment to the best interests of the client or patient. This includes a deep respect for autonomy, i.e., the client or patient may choose among personally valued goods, while acknowledging that some goods are normally considered in our society to be more fundamental and therefore normally are expected to be weighed more heavily in the benefits-to-burdens calculus by the client or patient.

In the interactive model of profession, beneficence in this sense is expected to be an important component of
professional ethics in the professional's relationship with individual clients or patients and in the professions' involvement in society at large. The role of beneficence in professional ethics is exhibited in a number of ways in the relationship of professionals with individual clients or patients; by the presence of the atypical moral commitment on the part of professionals to the problems and needs of the clients or patients, by the promise to do no harm, by the presumption in favor of both the professional good and the autonomy of the client or patient so that no decisions are made without first seeking to achieve consensus between the professional and the client or patient, and by the resolution of conflicts or of difficult moral quandaries by means which preserve as many values of both the client or patient and professional as possible.

The autonomy and the welfare of clients or patients may at times conflict. The role of beneficence in the professional ethics guiding the relationship of individual professionals with clients or patients attempts to bridge that conflict, even though it is not able to magically resolve it in every case. Beneficence obligates the professional to respect the self-determination of clients or patients, and yet it also obligates the professional to bring about the central values of the profession if the client or patient so chooses, and it also obligates the professional to restore that autonomy to the client or patient when it is diminished or questionably
The principle of beneficence is also integral in determining the moral obligations of professions toward society at large. In Chapter III it was argued that professions are obligated to contribute to the common good by engaging in public dialogue and in public policy formation to promote the central purpose or function of their profession as understood and valued by society at large. Professions are powerful shaping forces in our society's culture. Professions affect not only how individuals live and how institutions work, but also the way we think about how we should live and about the ends our social institutions should serve. They nurture particular values that are integral to our cultural heritage and our way of life. It is essential, then, that professions actively contribute to the discourse within society about how we want to understand the nature of our fundamental human needs and how we want to design the institutions that provide professional services to meet those needs.

The social discourse about professions is intended also to allow society to influence the professions' view of their own services. The nature of the value of the professional services, i.e., the general understanding of what is meant by

"This above discussion of beneficence has been adapted from Edmund Pellegrino and David Thomasma, For the Patient's Good (New York: Oxford University Press, 1988), 11-36; Frank Marsh and Mark Yarborough, Medicine and Money (New York: Greenwood Press, 1990), 65-95."
health, justice, religious salvation, etc., must be determined by compromise and consensus between all the participants in the discourse, i.e., professions and society together.

There is always a concern, of course, that professions may be tempted to present themselves in the discourse as no more than special interest groups promoting their own view of their professional value for the benefit of the members of their group. Should this occur, or should this be perceived as occurring, then society may view professions as evolving into an undesired guild or commercial model of profession and subsequently exercise its prerogative within the terms of the social contract to restrict the professions' relative autonomy in practice. Discourse within the social contract allows for a "check and balance" system which helps encourage or "prod" the professions into fulfilling their obligation to promote the fundamental value of their professional services in a manner that is acceptable and beneficial to society.\textsuperscript{10}

**Characteristics of the Interactive Model of Profession**

In the second section of this chapter, the concept of profession within the interactive model will now be more fully developed with the above presuppositions about social discourse and beneficence incorporated as important features of

\textsuperscript{10}These points are drawn from Bruce Jennings, Daniel Callahan and Susan Wolf, "The Professions: Public Interest and Common Good," Hastings Center Report 17, no. 3 (February 1987): 3-11.
professions in general and of healthcare administration in particular. The interactive model, like the agent model of profession, deeply values the client's or patient's autonomy or self-determination. Like the guild model, the interactive model views the professional as possessing an exclusive expertise and an atypical moral commitment to the good of the client or patient.

In the interactive model the value of autonomy or self-determination is applied to both parties in the professional-client/patient relationship. This autonomy must be mutually respected since each cannot presume to know or be able to fully learn the other party's values. Furthermore, each enters the relationship viewing the professional services through the perspective of values which can only be mutually understood through communication and cooperation. In short, the professional possesses the expertise to address the client's or patient's need and a commitment to certain (central) professional values, but the client or patient has the understanding of her own values, goals and priorities, without which the decision to accept the professional's interventions cannot be made."

Professionals and clients or patients are then morally obligated to dialogue with one another to mutually arrive at

"This point is drawn from David Ozar and David Sokol, Dental Ethics at Chairside (St. Louis: Mosby, 1994), 44; Ozar, "Three Models of Professionalism and Professional Obligation in Dentistry," Journal of the American Dental Association 110, no. 2 (1985): 176.
a good decision about professional intervention. A good decision is not just one that provides the most proper technical service in terms of professional expertise, but also one that best fits this particular client or patient given her aspirations, expectations, values, and situation in life. The interactive model of profession, then, necessarily obligates the professional to the practice of discourse.12

As has often been stated, however, frequently the client or patient experiences a diminishment or loss of autonomy due to his need that requires the services of a professional. The client or patient, therefore, is often unable to be a coequal bargainer with the professional as required in the commercial model of profession, and lacks the requisite ability to autonomously choose personal ends as assumed in the agent model of profession. Yet a major reason why clients or patients sometimes seek out professionals is to have their diminished or lost autonomy restored to the greatest extent possible through the provision of needed professional services. Thus the paternalistic spirit of the guild model must also be set aside.

The interactive model, like the guild model, also proposes that a critical aspect of the nature of profession is the atypical moral commitment of professionals to the good of their clients or patients. Now this commitment does not

12This point is explored in Edmund Pellegrino, "Toward a Reconstruction of Medical Morality," Journal of Medical Humanities and Bioethics 8, no. 1 (1987): 7-18.
derive only from the professional's membership in the profession, as was held in the guild model. Rather, the source of this commitment is found in the value given to the professional service by society at large, and the individual practitioner's participation in the profession's commitment to the larger society to provide that service for the benefit of the members of society. The paternalistic spirit of the guild model is thus replaced in the interactive model by the principle of beneficence, i.e., acting to benefit society by promoting the good of the client or patient as understood to mean a restoration from lost or diminished autonomy normally through the provision of professional services.

Society places great value on the services provided by professionals. The client or patient seeks the services of a professional because she is incapable of satisfactorily addressing some fundamental human need such as health, justice, or a relationship with the divine, and in many cases because this threat to her fundamental human condition has threatened or diminished her autonomy. Individual patients and local communities appeal to healthcare institutions, with healthcare administrators at their head, to facilitate the provision and delivery of needed healthcare.

Since the client or patient is disadvantaged in the relationship with the professional for reasons frequently cited, it is essential that the needed professional services be offered with the understanding that the client or patient
will not be exploited and that the professional's authority will not be abused. Clients or patients open the most private domains of their bodies, minds, social and family relationships to professionals, and to be able to do this they must be able to trust that their vulnerability will not be exploited for power, profit, prestige or pleasure. Our society currently conducts social programs to financially reimburse healthcare institutions for providing healthcare to the elderly and poor, grants tax-exempt status in exchange for healthcare institutions providing charity care, and heavily subsidizes medical research to aid the development of technology in healthcare institutions. This can only be done or maintained if society believes healthcare institutions are functioning for the greater benefit of society's members, and not primarily for their own financial benefit.

Because the services which the professional provides may be so vital to human functioning and to the good order of society, it is essential to our understanding of the nature of profession that these services are recognized as offered for the good of the client or patient, and thus for society at large. A reasonable society therefore creates professional roles which includes in its understanding the principle of beneficence as articulated above, shaping the expression of the societal-expectation atypical moral commitment of the professional to the good of the client or patient. According to the principle of beneficence, the professional is obligated
to seek to bring about the client or patient's understanding of the good relative to his professional expertise for three reasons\(^3\); first, because respect for her autonomy calls forth respect for that which she values, namely, the addressing of her fundamental need, secondly because she has approached a member of a profession who, by the very meaning of the nature of his being a professional, possesses the exclusive expertise to address the fundamental human need of the client or patient, and lastly because the application of professional services may be the exclusive means by which to facilitate the restoration of her autonomy.\(^4\) The principle of beneficence, therefore, means that the professional is obligated to draw upon her expertise to address the health, justice or religious needs of her clients or patients or the healthcare delivery needs of her institution's local community, in such a way that their interpretation of the good life will be protected or promoted, and not so that the profession's understanding of the nature and value of its services

\(^3\)Another possible reason obligating the professional to respond to the good of the client or patient is that her plight or suffering resulting from her fundamental human need calls forth, in an ideal communicative setting, a natural sentiment of sympathy on the part of the professional who possesses the exclusive expertise to address that need. This reason breaks rank with Habermas' concept of communicative ethics, however, though it does represent my own view as indicated in footnote number 2, and which at a future time I hope to develop further.

\(^4\)This is drawn from Ozar and Sokol, Dental Ethics at Chairside, 44-45; Michael Davis, "The Special Role of Professionals," Business and Professional Ethics Journal 7 (1988): 51-62.
can be maintained or promoted.

In Chapter VI it was argued that the professional possess a certain type of limited authority over the client or patient in the area of exclusive expertise. In the interactive model, society will accept this limited amount of professional authority only if it is managed in a manner that is responsible to the needs and interests of the society whose values the professional services. This has been described in terms of a fiduciary relationship. In this relationship both parties are considered to be autonomous and responsible agents and their own particular judgments are given consideration. Because the professional has a greater opportunity for effective autonomy since he is not in a needy position and is expertly informed, he has special obligations to protect the interests and values of his client or patient who must trust the professional. The patient or client consents to particular professional services, but cannot determine their nature without assistance from the professional. It is the professional's role to propose certain appropriate courses of action, and the patient or client consents to a particular recommendation or decides against all proposed causes of action based on her own wishes and values.

The nature and value of the professional services thus requires that the client or patient extend some limited part of herself, i.e., some aspect of her prudence or judgment, to the professional. The client or patient trusts in the
existence and utility of the professional expertise, and in its possession by the one who is being consulted. This trust is inspired less by the actual person than by the common recognition of the defined social role that the person holds. The professional, by nature of a societal-recognition of his role, is deemed to be — and because of his acceptance of and representation of that societal-recognized role, is obligated to be — worthy of that trust, or trustworthy.

The professional promises to be the finest he is capable of being in the sense of knowledge and technical competence. He further promises to be responsive to each client or patient within their unique circumstances and condition, and to be responsible for all that is said and done on behalf of that client or patient. The professional promises to accurately analyze the client or patient's problem, canvass the feasible alternatives, know as well as one can their likely consequences, fully convey this information, oftentimes make a recommendation, and work honestly and loyally for the client or patient to effectuate the chosen alternative. This is expected not only of the physician with his patient, but also of the healthcare administrator, who oversees the function of the healthcare institution, with the local community which depends upon that institution for its healthcare delivery. In short, the trust placed in the professional is dependent upon the belief that the professional will use his knowledge and ability in the interests of the client or patient, or, in the
example of the healthcare administrator, for the benefit of the local community. In doing this, the professional is fulfilling his moral obligation and his responsibility to both his profession and to society which has established his profession.15

While this professional commitment to promote the good of the client or patient by virtue of being a member of a profession may be reminiscent of the guild model of profession, two features of this commitment distinguish it within the interactive model of profession. First, in the guild model, the inequality of the relationship results in professionals exercising paternalism in determining the appropriate mode of intervention for the relatively passive client or patient. In the interactive model, however, professionals participate in social discourse and are held to the principle of beneficence, which require them to actively engage with the client or patient so as to offer not only professionally appropriate services but also treatment or help that will be most consistent with or best promote the client or patient's wishes and values.

Secondly, in the guild model, it was the responsibility

of the profession itself to determine its own moral standards, to decide on the nature and degree of its moral obligation to clients or patients, and to regulate or discipline its own members to uphold its established moral standards. In the interactive model, however, since it is society which confers professional status upon particular occupational groups, society thereby is authorized to offer a substantial voice in the establishment of professional moral standards, in the understanding of the nature and degree of the professional obligation to clients or patients, and in the manner of regulation and disciplining of professionals in their professional practice and behavior.

This societal involvement is required because of the very nature of professional work. On the one hand, a profession is a calling realized in a community and centered around the intrinsic goods of certain practices such as healing or the delivery of healthcare, restoring justice, counseling or preaching, and so forth. On the other hand, a profession is also a career in which individuals earn their livelihood, and in which professional practice occurs in social institutions which may sometimes function with aims quite different from the aims of the professional practice itself.

The intrinsic goods of professional practices, i.e., healing or the delivery of healthcare, justice, assisting in religious salvation, and so forth, may be sharply distinguished from another class of goods, external to the practice
itself, that engaging in the practice may also bring about, i.e., financial reimbursement and social rewards. Professions are continually reminding their members of the priority of the goods internal to professional practice over the external goods of wealth and prestige. Yet, as the sociological literature in the Critical view of professions demonstrates, relying on the professions alone to maintain their atypical moral commitment to clients or patients is open to abuse and fraught with examples of failure. What is required is that the institutional conditions of professional education and of professional practice itself must be reformed in the direction of promoting and emphasizing a public service orientation. This will and can not occur, however, without societal input and involvement in the determination of professional standards of practice and of the nature of professional norms and obligations.16

The relationship between the professional and the client or patient in the interactive model of profession may be called a covenant here rather than a contract. The biblical roots of covenant originally speak of a relationship between unequal partners in which the more powerful party promises to

take care of or look after the needs of the less powerful party. In applying the covenant relationship to the professional-client/patient relationship, three important characteristics of the covenant relationship may be emphasized, namely, openness, flexibility, and growth.

Unlike contracts which establish clearly defined and usually quite restrictive obligations or rights and duties between the parties, in a covenant the professional and the client or patient enter into a relationship without clear foreknowledge or strong restrictions on what might be required of them in the future. This involves trust that each will be able and willing to meet the expectations of the other and that the demands on the other will not be inappropriate. Secondly, a covenant also establishes a distinctive sort of relationship for the professional which becomes a part of her very moral identity. Lastly, a covenant relationship challenges both the professional and the client or patient to growth and flexibility in their ways of relating to one another, and allows for the possibility of enlargement of their relation and of themselves through the relation. Covenant language has been invoked in the professional-client/patient relationship to describe the flexibility, indeterminacy, and trusting nature of the relationship that naturally evolves in light of the complexity of the goals pursued, the unpredictability of what might be required in order to attain those goals, and what steps might be required
if those goals are unattainable.\textsuperscript{17}

**Professional Ethics of Healthcare Administrators**

**in the Interactive Model of Profession**

There are strains within the literature of healthcare administration which are beginning to call attention to the role of society in determining the professional role and norms of healthcare administrators as understood and as embodied in the decisions and directives undertaken by their healthcare institutions. It is generally acknowledged that currently the commercial model of profession seems to be the predominant view among most healthcare administrators. The literature on healthcare administration, which is largely geared towards "gaining the competitive edge," is then occasionally interrupted by prophetic calls or conscientious reminders that the goal of health services is to improve the health of individuals and communities, and not just to gain additional revenues, institutional or community pride, or market domination.\textsuperscript{18} The


healthcare administration literature is also beginning to include suggestions on how healthcare institutions may collaborate with one another and with physician groups rather than compete so as to better benefit the community served by those institutions and groups. Yet it seems to be largely the changing market for healthcare services which is forcing healthcare administrators to look more closely at community and patient needs and to seriously consider various methods of collaboration with former competitors, for there is a growing sense that this will serve as the future foundation and means for their own institutional survivability.

The third section of this chapter, then, will attempt to

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further this discussion by explicating the professional ethics of healthcare administrators from the perspective of the interactive model of profession.

Identification of Chief Client

Identification of the chief client of a profession is the first category of moral obligation of profession. Many healthcare administrators would argue that the collective group of individual patients constitute their chief client. Indeed, the Code of Ethics for the American College of Health Care Executives states in its first standard, "Individuals shall hold paramount the welfare of persons for whom care is provided." It may well be true that healthcare administrators are first and foremost obligated to promote the welfare of their institution's individual clients. It is proposed here, however, that the chief client of healthcare administrators, principally those members belonging to the American College of Healthcare Executives, is the actual community served by the healthcare institution which the healthcare administrator directs and represents. The welfare of the community, however, to which the healthcare administrator is expected to possess an atypical moral commitment, is limited

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21The American College of Health Care Administrators, Code of Ethics, Expectation I.

22This restriction is meant to distinguish only those who serve in top administrative roles of healthcare institutions and who subsequently have a great deal of involvement with the community, its leaders and with the community's governmental representatives.
to - or, to phrase it better, is focused on - the health of the community at large.\textsuperscript{23}

Proposing that the community of the healthcare institution is the chief client of the healthcare administrator is based on the view that the changing face of healthcare currently occurring in our society is producing a changing purpose and function for healthcare administrators. This evolving role brings with it a new chief client, a new prioritization of the central values of the profession, and correspondingly new moral obligations.\textsuperscript{24}

Ideal Relationship with Chief Client

The ideal relationship of healthcare administrators with the community as its chief client takes three forms. First, there must be continual dialogue between them so that the healthcare administrator can be aware of the health needs of the community and develop or adapt her institution's services accordingly. The community must also be made aware of the type and cost of particular services so that technology is

\textsuperscript{23}This discussion will also incorporate the seventh category of professional obligation, i.e., ideal relationship with the larger community.

\textsuperscript{24}The changing face of healthcare is occurring principally for market reasons, i.e., government and third-party payers are increasingly placing restrictions on payments for high technological treatments for which hospitals have heavily invested, and instead are compensating programs that provide preventive, rehabilitative, or non-curative care, and they are moving towards managed care and capitation reimbursement. These changes in healthcare delivery will continue to occur regardless of the success or failure of the passage of any type of national healthcare reform plan.
chosen and utilized in a manner that is both most effective and most consistent with the community's wishes and values. 25

Secondly, institutional structures which enable the community to have a voice in the healthcare institution must be developed or strengthened. Typically the trustees, governing board or citizens board is intended to fulfill this function. It is not unusual, however to find that their loyalty is to the institution more than to the community, and that they are utilized more in an advisory capacity or as a lobbying group for the healthcare institution than in terms of practical feedback on how to allocate funds, judge the acceptability of services, plan for future services to address community needs, or provide accountability for the overall practice of the institution. Their role must be better developed and other structures formed to facilitate the two-way communication between the healthcare administrator and the community and to increase the sense of institutional accountability to the community. 26

Thirdly, healthcare administrators increasingly should

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utilize their exclusive expertise in the institutional response to healthcare needs by adopting key advocacy roles in health policy issues on the federal and state levels. While there is a natural tendency and danger to lobby chiefly, even exclusively for the needs of the healthcare institution, healthcare administrators are obligated by their professional status to publicly speak out on the health needs of their legislators' constituents. Furthermore, in the absence of a national consensus, healthcare administrators increasingly are presented with the opportunity to take a leadership role, based upon their understanding of the needs and values of their community, in helping our society define what the appropriate goals of medicine and healthcare should be, and what portion of our social assets should go toward those trying to achieve those goals.27

Commitment to the Good of the Chief Client

In the interactive model of profession the commitment to the health good of the community seems to arise, as it did in the guild model of profession, from the healthcare administrators' role as leaders of the institutions developed by society to address the healthcare needs of patients. In the

interactive model the source of the moral obligation is
different, however. In the guild model of profession the
healthcare administrator's obligation to serve the health good
of patients utilizing her healthcare institution arises from
her membership in the profession which pledges this commitment
to patients. In the interactive model of profession the
obligation arises from the relationship between the individual
healthcare administrator and the community at large; it is
the community, rather than the profession, which confers upon
the healthcare administrator the status of a professional with
the corresponding moral obligations to serve the health good
of the community.

The current view which society has of healthcare institu-
tions, especially of hospitals, is hampered by assumptions and
expectations of their institutional function that are now
becoming out of date. Hospitals may be said to be stuck in a
conceptual groove, still focusing on inpatient care, acute
care, and high technological care, concentrating on getting
patients in and out of the hospital rather than on the
patient's total period of illness, and rarely using the social
authority vested in the healthcare institutions as a force for
health in the community as a whole. Communities today, either
reflecting or following the lead of those entities which
finance healthcare, are looking to hospitals and to other
healthcare institutions to include all medical technology that
can usefully be applied to both health and illness. The newly
evolving conception of the purpose of healthcare is therefore conceptualizing a good healthcare institution as one that maintains the health of the community through education and preventive care, through the provision of high-quality but low-cost acute care for times of accidents and temporary illnesses, and through technologies which address disabilities and chronic illnesses. Hospitals, then, might eventually become places where people go at the beginning rather than at the end of their sickness.28

Healthcare institutions increasingly are being called upon to address the healthcare needs of their community in new ways. The leadership role then naturally falls to the healthcare administrator to respond to this call from the community. If hospitals are understood to be social institutions developed for the sake of, and supported by, local communities, then within the social contract the professional status of healthcare administrators is to a certain extent dependent upon the realization of their atypical moral commitment to the welfare, i.e., health needs, of the local communities.

Central Values of the Profession

The identification of the community as the chief client

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of healthcare administrators is reflected in the prioritization of central values of healthcare administrators as understood to exist within the interactive model of profession. This constitutes the fourth category of professional obligation.

It is proposed that the central values of healthcare administrators in the interactive model of profession are prioritized as follows:

1. Health of the community
2. Health of individual patients
3. Institutional integrity
4. Financial viability of the organization
5. Effective and capable management of employees and good relations with medical staff

The health of the community ranks as the premier value for healthcare administrators by virtue of the community establishing or supporting healthcare institutions to protect and promote the community's health, and by virtue of the community recognizing the professional status of healthcare administrators with the accompanying expectation that their exclusive expertise as the leaders and representatives of those healthcare institutions will be exercised for the benefit of the community's health. This value ranking is reflected in the "Guidelines on Ethical Conduct and Relationships for Health Care Institutions," adopted in 1981 by the American Hospital Association and the American College of Hospital Administrators. This statement defines hospitals

29 This group is now known as the American College of Health Care Executives.
as service organizations that should provide not only patient care but also a wide range of health-related services for their communities. Hospitals are understood to carry public responsibilities for the health of their communities. Guideline number 1 prescribes that hospitals are to be interested in the overall health status of people and not simply in providing direct patient care services. While it may be apparent that this moral stance has not been universally observed, community health interests and the concerns of government and third-party payers appear to be serving as a motivating force for healthcare administrators to rediscover the value of - and their obligation to - the health of the community served by their institution.\footnote{This perspective is raised in Robert Sigmund, "A Community Perspective on Hospital Ownership," Frontiers of Health Services Management 1, no. 1 (1984): 33-40; Stuart Wesbury, Jr. "Ethics and the Health Care Executive: Current Perspectives," Michigan Hospitals 22, no. 12 (1986): 17-20; Ruth Rostein, "The Marketplace Should Not Decide Who Survives," Hospitals 63, no. 21 (5 November 1989): 60-61; Judith Shaw, "How the Public Eyes Hospitals," Kentucky Hospitals 7, no. 4 (1990): 16.}

The second central value in the hierarchic scheme is the health of individual patients. This takes high priority in the interactive model since society, which bestows professional status on healthcare administrators, traditionally has helped create and support healthcare institutions for the purpose of benefitting their members who, as individual patients, require medical tests and treatments. In the interactive model of profession however, that benefit is
understood both in terms of the treatments and modes of care which will best promote the health of the patients as well as in terms of the expected openness in communication to best assure that patients are capable of giving informed consent to treatment modalities which are most in keeping with their personal wishes and values.

In the guild model, the healthcare institution pledges to make resources available to patients who are sick or hurting with the promise to help them regain their lost or diminished health to the greatest extent possible. The nature and type of care, however, is largely decided by the physicians within the healthcare institution managed almost exclusively under the expertise of the healthcare administrator. In the interactive model, however, the healthcare institution serves the health needs of patients in a manner that patients deem most consistent with their own wishes and values. Patient autonomy must be respected and promoted by both physicians and healthcare administrators through the structures of their institutions.

The commitment to the good of individual patients, then, on the part of healthcare administrators is not just a commitment to address their health needs, but it is a commitment as well to respect and promote the restoration of patients' autonomy or self-direction. Essential to the nature of the healthcare administrator's commitment to the good of the patient, then, is the principle of beneficence, i.e., a
commitment both to his welfare and to his person which involves a collaborative enterprise between individual patients and the healthcare institution which the administrator directs and represents.

This means that healthcare administrators, as leaders of their healthcare institutions, must assure that individual patients are adequately informed of their diagnosis, treatment options, consequences and potential side effects of those various options, the goal and the chance of reaching that goal for each of the options, and their overall prognosis in light of each option. Structures must be in place and personnel fully trained to openly and honestly communicate with patients in order to remove or reduce any misunderstandings or disagreements about treatments or procedures. Furthermore, any elements of self-interest which may cloud or influence the judgments of physicians or other caregivers must be disclosed, and structures must be provided to facilitate the seeking of second opinions, other physicians or caregivers, or another healthcare institution. Procedures must be in place to allow for feedback from individual patients on the quality of their treatment and care so that continual efforts are made to improve the services of the healthcare institution for the benefit of the patients. Fulfillment of this moral obligation on the part of healthcare administrators to promote the good of their patients undoubtedly is costly in terms of time spent for unreimbursed services, but all of this is mandated by the
professional role of the healthcare administrator as established through the social discourse between the profession and society. 31

Though healthcare administrators have little contact or involvement in the actual day-to-day care of patients, they are ultimately responsible in the eyes of the community for the fiduciary relationship expected from the healthcare institution as a whole toward the patients it serves. Unlike the guild model, in which the healthcare administrator had a moral obligation to his profession to serve the health needs of patients, in the interactive model the community, which bestows professional status on the administrator, conceives of the administrator as professionally obligated not to the profession but to the community to promote the welfare of individual patients. Though the personal relationship of healthcare administrators with individual patients is exercised primarily through physicians and through layers of management and employees, the professional role of healthcare

administrators obligates them to the community to capably and effectively administrate and manage their complex healthcare organization for the benefit of their patients.

The value of the health of individual patients cannot supersede the value of the health of the community, however. While healthcare institutions are established to treat the healthcare needs of individual patients, this is only because such a function is considered to be of vital importance to the overall health of the community. Healthcare institutions do not exist for individuals first of all, but for communities.

While normally the healthcare needs of individual patients should not negatively impact the overall health of the community or the healthcare institution's ability to address the healthcare needs of the community at large, with today's expensive high-technological treatments it is conceivable that individual patients may require or demand an inordinate amount of healthcare resources to the detriment of the available healthcare to the community at large. Should this occur, local communities or society in general may elect to allocate limited healthcare resources in such a way that would deprive some individual patients of particular treatments in order not to deprive greater numbers of patients less costly yet also needed treatments. While the criteria for determining which treatments will or will not be funded has been and will continue to be debated, individual patients do not have an absolute claim on an inexhaustible amount of
healthcare to the grave detriment of society from the point of view of the obligations of healthcare administrators. Since individual healthcare institutions possess an obligation to provide healthcare to their communities, then this obligation cannot be allowed to be significantly negatively impacted by the inordinate use of healthcare resources by a few individual patients.

The third value of healthcare administrators in the interactive model of profession is institutional integrity, or administrating according to the mission and values of the institution. The mission or purpose of healthcare institutions cannot take priority over the two previous values. If healthcare institutions are viewed by their communities as acting unfavorably towards vulnerable or dependent patients, e.g., overpricing, overtreating, or discharging too early, or as acting unfavorably towards the community which utilizes and depends upon its services, e.g., closing unprofitable though needed services or failing to provide what the community judges to be adequate amounts of charity care, then healthcare institutions would be perceived as no different than other businesses in society. This might well result in a loss in the charitable and service-orientation image of healthcare institutions, for if they exist for their own sake and not for the benefit of society, then, according to the reasonable terms of the social contract, they must be societally-regulated like any other business. This would in turn, then, also
diminish the professional role and responsibility of healthcare administrators.

Healthcare institutions exist to promote the health of the community and of individual patients, and society would expect that the mission and values of these institutions promote, and are thus subservient to, this primary function of healthcare institutions. The particular charism or characteristic values of individual healthcare institutions would not be valued as highly as the institution's purpose of providing healthcare, especially since most people cannot pick or choose from between different healthcare institutions due to the proximity of institutions or the restrictions imposed by their third-party payers. Furthermore, it would seem that society would cherish the mission and values of particular institutions only if that mission and those values safeguarded or promoted the self-determination of patients as well as other particular values deemed important by society at large.32

The fourth value in the interactive model of profession is maintaining the financial viability of the organization. For a healthcare administrator of a for-profit healthcare institution, this value would rise to number three in the hierarchic scheme providing that it is understood that the for-profit institutions' basic mission or purpose is to make money. Although appearances may be deceiving, this is not the

32This point is raised in Michael Czerny, "Health Care in Search of Ethics - An Age-Old Dilemma," Catholic Health Association of Canada Review 13, no. 2 (1985): 5-11.
same for a not-for-profit healthcare institution; most sponsoring organizations would (or should) find it objectionable to seriously compromise on their particular mission and values, i.e., the provision of healthcare for a community and individual patients within their own traditional charism and values, at the cost of losing their identity or "selling out" on their values for the sake of institutional survival or simply to turn a profit. For example, Catholic healthcare institutions were to a great extent developed to address the healthcare needs of those who exist on the margins of society: the elderly, the dying, the disabled, and the most neglected. To neglect those values for the sake of market success would result in a loss of their mission and their Catholic identity.33

For both for-profit and not-for-profit institutions, society normally would not value the profitability of healthcare institutions over the provision of needed healthcare for the community and for individual patients; if healthcare institutions survive or prosper to the detriment or neglect of the community's health, then their purpose for existence

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begins to wane. Similarly, borrowing from the criticisms raised against the commercial model of profession, it does not appear likely that society would look favorably upon institutional survivability or profitability if this is done at a cost to individual self-determination or the health of individuals in the community, or to other values which society may cherish.

Placing the financial viability of the healthcare organization below the value of institutional integrity in the hierarchic scheme of values assumes that the community will have access to health care from other local healthcare institutions should a particular institution reduce or eliminate the provision of its services rather than compromise on its mission and values. If the health of a community would seriously suffer because of the closure of a healthcare institution, however, it is not inconceivable that maintaining the financial viability of the healthcare institution would be given greater importance. In the interactive model a community may be willing to accept a compromise in the institution's willingness or ability to carry out its mission and values in exchange for the institution still serving the healthcare needs of the community.

The fifth central value in the hierarchic scheme is effective and capable management of employees and good relations with the medical staff. This is valued to some extent by healthcare administrators since it is commonly
associated with the exclusive expertise which has lead to the societal recognition of professional status for healthcare administrators. Communities highly value the services of healthcare institutions and subsequently highly value their capable and effective operation. While there are many books and workshops today promoting a variety of theories of management and business, management styles or business practices which are consistent with the interactive model of profession are those which address the need of healthcare administrators to dialogue with physicians, management and employees to create a sense of shared purpose to integrate individual efforts toward this common purpose, i.e., to beneficently treat and care for the healthcare needs of the community and of individual patients.

Effective and capable management and employees of good relations with physicians ranked first in the hierarchic scheme for healthcare administrators in the guild model of profession, because it was possession of that expertise that allowed the profession to acknowledge its members as professionals. In the interactive model, however, since it is the

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community which bestows professional status for the benefit returned to the community, this exclusive expertise of healthcare professionals is not viewed as intrinsically valuable but only as instrumentally valuable for the sake of safeguarding or promoting the greater value of the general health of the community and the health of the individual patients directly utilizing the services of the healthcare institution. The possession of good management and business skills by healthcare professionals would not be valued by the community or by patients if they themselves did not benefit from this exclusive expertise; subsequently, unlike in the guild model, this value cannot rank any higher in the hierarchic scheme.

The somewhat low ranking of this value in the hierarchy is perhaps reflective of the diminished influence and authority of physicians over healthcare institutions. With mandated utilization review services and clinical pathways coupled with the introduction of economic criteria for credentialing in hospitals, and with the development of third-party payer authorization over patient tests and treatments, physicians no longer have as much control over hospital operations as in the past.

It is important to note, however, that the importance of the value of good relations with physicians may change with the possible evolution of partnerships between healthcare institutions and physicians. The old model of the hospital
being the doctor's workshop is obsolete, and it is becoming increasingly harder for physicians to play one hospital off against another for their own benefit or to obtain desired expensive technology. With the development of managed care, increasingly the fortunes of healthcare institutions and physicians are integrally linked together as third-party payers contract for the services of specific physicians and particular healthcare institutions. Achieving greater efficiency of care, i.e., quality, low-cost care, will work to the betterment of both parties. Should this partnership become the normal model in the provision of healthcare within the next few years, then even more importance will be given to the value of healthcare administrators maintaining good relations with the medical staff.

Commitment to Professional Competence

The fifth category of professional obligation is the commitment to competence. In the interactive model, the competence required of healthcare administrators is three-fold. First, much like the skills and values emphasized in the guild model of profession, healthcare administrators are expected in the interactive model to be highly trained in their management and business skills.\(^\text{35}\) Given the evolution of management theory and the changing face of healthcare,

continual updating in these management and business skills is presumably also required.

Secondly, much like the skills and values emphasized in the agent model of profession, healthcare administrators in the interactive model are expected to be competent in developing and coordinating institutional structures which not only respect but also promote the autonomy or self-determination of the individual patients as well as the ability of other healthcare professionals to work to the fullest extent of their capability.

Third, the interactive model also requires that healthcare administrators be highly trained in communication skills with their communities as well as with the various client-groups whose welfare they seek to address, so that their exclusive expertise is exercised in a way that promotes the wishes and values of their community and client-groups. This communication does not consist simply of listening to the wishes or discerning the values of the community as understood within the agent model, but is rather a give-and-take dialogue in which healthcare administrators also advocates for particular health needs and particular modes of healthcare provisions based upon their own exclusive expertise. Maintaining this dialogue with openness and integrity is the best assurance, i.e., is the best means of maintaining accountability, that healthcare administrators reflect a beneficent rather than a
self- or institutional-serving position.36

Relationship with Fellow-Professionals

The sixth category of professional obligation is the relationship with one's peers. This relationship is stronger in the interactive model than as described in the agent model of profession. This relationship in the interactive model is also protected here from the shortcomings of its description in the guild model of profession due to the continual interaction of healthcare administrators with the community and due to the fact that it is the community (and not the institution's sponsor or the profession itself) which bestows professional status upon healthcare administrators.

The relationship between peers in the agent model is very weak. Healthcare administrators in that model are dependent upon the wishes and values of their institution's sponsor for the recognition and direction of their professional skills. This results in a lack of cohesion, harmony, and common identity within the occupational group. In contrast, in the interactive model healthcare administrators are working towards the common purpose of benefiting the health needs of the community at large and of individual patients within that community. This lends itself to greater group-identity and support. Discourse with the community over how the health care needs of the community are being addressed.

needs of the community might best be addressed also serves, then, to direct when the institutions of healthcare administrators should collaborate with one another and when they should compete with each other. The interactive model provides a forum for a greater sense of peer accountability since the discourse with society is public and the criteria for accountability is the beneficial or detrimental effect the actions and decisions of healthcare administrators have upon the healthcare needs of the community.

The relationship between peers within the guild model was much stronger. While there professional groups profess to regulate themselves due to their atypical moral commitment and expertise which excludes nonprofessionals from being able to judge their behavior, the result often tends to be mutual self-protection and lack of adequate accountability. The relationship between peers within the interactive model, however, is not as strong or as self-protective. The bonding is weaker since it is society rather than the profession which bestows professional status upon healthcare administrators. The self-protection is exposed through the open discourse with the community. This public accountability is therefore conducive to greater internal accountability within the profession as part of the overall discourse.37

Critique of the Interactive Model of Profession for Healthcare Administrators

In the final part of this chapter, criticisms of the interactive model of profession will be raised and responses offered. There are two principle criticisms which must be addressed if the interactive model of profession is to be defended as the only model which satisfies the social contract that a reasonable society would contract for regulating the profession of healthcare administration.

First Criticism and Response

The first criticism is less of a threat to the interactive model itself and thus can be more readily addressed. This criticism questions the obligation of beneficence expected of professionals in the interactive model, both by clients or patients and, in fact, by society at large. This criticism stresses the natural inequality of the professional-client/patient relationship, and raises two concerns. First, it is not clear that reliance upon beneficence will allow for the full respect entitled to the autonomous choices or right to self-determination by clients or patients. Second, it is not self-evident that the principle of beneficence moves beyond the individual professional-client/patient relationship and fully captures what are perceived by many to be the social duties of professionals (and of all members of society) to address the social issues surrounding the provision of professionals services, e.g., issues of medical cost-contain-
ment or the identification of a healthcare package entitled to all members of society.

In response, it must be acknowledged that, given the social discourse within society and between the professions and society, it is theoretically possible that agreements may be reached in which beneficence is not given the priority as a role-specific norm of professionals that has been described here. Given the threats to, or the needs inherent in, the human condition which have given rise to the very need for and subsequent existence of professions, however, it is hard to conceive how beneficence would not be required of professionals at all. But the possibility must be acknowledged that a given society would accord it less importance than is presently the case, as in fact it once did in American society in relation to physicians only a few decades ago. In this respect, social discourse is more essential to the interactive model of profession than beneficence.

It is true that there will always be a risk in emphasizing the principle of beneficence in professional practice that client or patient autonomy may not be fully respected. Presumptions by the professional about the inordinate value of her professional services and about what she perceives to be objective goods to the human condition may threaten the autonomous choices of clients or patients. In reply, this threat must simply be acknowledged as ever-present in our American culture which continually struggles over the
balancing of autonomy vs. other values and needs. The interactive model of profession would attempt to address this potential threat to client or patient autonomy by proposing that ongoing social discourse within society acts as a "watchdog" to such threats, thereby allowing the continual evolvement of norms or role-specific behaviors for professionals by which such threats to the autonomy of clients or patients may be continually monitored and checked as society deems necessary.

The same response may be made to the second question raised about the practice of beneficence. Only through social discourse may a clear understanding and separation of the individual moral obligations of the professional to the client or patient and the social duties of the professional to society as a whole be established. It was proposed earlier that the principle of beneficence obligates professionals to utilize the exclusive expertise of the limited realm of their professional services to take a leadership role in the social discourse and public policy debate over the social provision of their professional services. Providing that public accountability successfully checks the potential for professions to inordinately promote the value or a specific means of provision of their professionals services, it is hard to conceive how social discourse over the provision of vital professional services may take place without the leadership involvement of the professions themselves. Nonetheless, it is
theoretically conceivable that society would decide not to allow for professions to undertake this role within the social discourse over the proper nature and method of the provision of professional services. Again, the principle of beneficence is not as central as social discourse to the core idea of the interactive model of profession.

Second Criticism and Response

A second and more threatening criticism against the interactive model of profession challenges the very notion of social discourse itself, which is a fundamental component of the interactive model of profession, and, in some respects, of the very notion of social contract itself. Social discourse has been criticized as presenting an inadequate view of human rationality and as being a concept that is for all practical purposes unrealizable in actual human practice.

To begin with, rational discourse as understood to theoretically exist in its purest form in the social contract presupposes that universal moral norms may be intersubjectively recognized through ideal speech communications between participants. In other words, in formulating the contents of a society's social contract and in particular its standards of professional conduct for healthcare administrators, it is presupposed that sufficient unity of values, interests and needs exists among the participants in the social discourse that they can come to consensual agreement about the matter. Only those moral norms are part of the social contract that
could be agreed to after a sufficiently open and informed debate and could be chosen as representing a generalized interest or meeting a generalized need, and not simply particular interests or needs. This is a reformulation of the Kantian approach to morality, substituting Kant's monological model of decision-making by reformulating the universalizability principle along lines compatible with the procedural rules of argument geared to attain communicative agreement.

Two critical problems have been raised about this understanding of the nature of social discourse. First, it has been argued that rational discourse alone cannot yield universalizable moral norms because reason does not exist in a pure form but is conceptually dependent upon cultural-historical traditions. Consensus, therefore, can function only as a self-contained criterion of validity, based upon agreement itself rather than expressing universal moral norms.

Second, it has been argued that discourse within the social contract requires an ideal speech situation, namely, the opportunity to discourse without limitation as to duration, number of participants or variation of perspectives or views. It requires participants who are equal in communication skills, who are fully and identically informed about the real world, who are set free from their own particular interests and values in such a way that they can fully

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understand the particular interests and values of all other participants, and who all desire to achieve consensual agreement.

In actual practice, it has been argued, it is difficult to conceive how discourse may be practiced employing the use of reason alone, for argumentative strategies are necessarily affective and even manipulative in their attempts to convince because arguments in search of consensus or of some objective understanding of truth do not employ merely reason but invariably engage passions and prejudices at many levels. It is also conceivable that what might be called "special interest groups" may morally justify their particular interests and be resolute and uncompromising in the discourse situation because they truly believe those interests should be accepted by all of the society.

Furthermore, as often experienced in the encounter between the professional and the client or patient, rational discourse can never entirely remove itself from a recognition of expertise. Individuals who have a command of language and know how to use it well, or who have a strong educational background or a rich portfolio of experience as many professionals do, can also be accorded a kind of authority that somewhat undoes the "balance of reason" among the participants of the discussion. It would seem that discourse would often involve such disparities in actual communicative power.

An illustration of the difficulty of achieving an ideal
situation for social discourse may be seen in dialogue between philosophers, who consider themselves to be roughly equals and to share a common body of knowledge, and who pride themselves on their ability to engage in rational discourse. Nevertheless, they are frequently unable to replicate among themselves the ideal of the discourse model.  

It seems highly unlikely that such an ideal speech situation would be ever possible, and in any case that none has been actually achieved in any real life situation in which professional standards of healthcare administration have been determined.

These are significant criticisms. But for purposes here all that is required to meet them is an adaption of the discourse model and of our understanding of the social contract.

First, it is not necessary to depend upon truly universal rational discourse to establish the moral norms of healthcare administrators. It can be presumed instead that the health of the community and the healthcare needs of individual patients are ideas whose content is commonly agreed to and whose role as fundamental human needs and societal concerns are commonly

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accepted in our society. They thus constitute commonly agreed-upon notions of the good for our social discourse about the healthcare administration profession. The specific understanding of "good health" or "the proper addressing of healthcare needs" will vary between different societies and within the same society at various historical times; therefore, the professional obligations of healthcare administrators cannot be discerned by reason alone independent of people's experience in particular times and places nor can they be considered necessarily universalizable. In addition, the product of discourse may at times require compromise to achieve consensual agreement between a profession and society regarding the moral norms of that profession, as well as an ongoing dialogue in a continuing and never-ending effort to identify the unfolding and potentially changing moral obligations of professions and their members.

Second, even if an ideal speech situation as envisioned in social discourse is most likely impossible to actually achieve, this does not mean that the process of social discourse or the ever-developing results emerging from the ongoing process of social discourse in establishing the moral obligations of healthcare administrators is without significant value. Natural limitations to an ideal speech situation can be acknowledged without significantly diminishing the value of social discourse.

The social discourse model may serve as an ideal norm to
which the members of society may continually seek to actualize or to emulate through actual efforts of ongoing dialogue over the determination of professional ethics. One important value in discourse may be the moral conversation itself and the development of the human capacity for learning how to listen, for reversing moral perspectives and for broadening moral point of view of the participants. The process of the discourse rather than any premature claims to some absolute end may be the best assurance that a professional ethic acceptable within our society may ever come closer to being actualized.

In an important sense, one of the goals of social discourse should be not only the end of dialogue with certain results of the dialogue now established as guides for professional conduct, but also the actual dialogue itself; that is, not only current consensus but also the ongoing conversation and mutual understanding. Or rather, consensus should be understood as a continual generation of reasonable agreement about the moral norms of professions via an open-ended moral conversation, with a continual emphasis upon the human relationships fostered in discourse rather than with the pure rational component of dialogue.

Therefore, despite natural limitations to an ideal situation, an ongoing understanding of the professional obligations of healthcare administrators may yet be an actual product of an actual, if defective according to Habermas' view, dialogue.
The social discourse is surely imperfect, but in social contract thinking it still remains the source of the establishment of professional norms.

Conclusion

In conclusion, strong reasons have been put forth to argue that the ethics of professions and their members in general and of healthcare administrators in particular cannot be developed in a manner acceptable to many if not most members of society by appealing to the other models of profession. Paternalistic self-regulation within the guild model is too open to misuse or abuse of professional autonomy. The value-free approach required in the agent model fails to do justice to the unique expectations placed upon the professional due to the significant need of the client or patient for assistance in achieving well-being, which has given rise to the expected relationship with the professional. A commercial view of profession unacceptably fails to protect society from potential exploitation of clients or patients.

The interactive model of profession, therefore, proposes that professional ethics can be satisfactorily defined only through ongoing discourse within society and between society and the professions. This discourse is always analyzing and critiquing currently espoused or exercised professional norms according to the criteria of the values of society and in light of what is generally understood to be the needs of the society and its members. As these societal
values may evolve and the needs of society change, however, the role-specific moral norms and obligations of the professions will likewise evolve and change. This dissertation, then, should be viewed not only as an attempt to philosophically justify the interactive model of profession, but also as a contribution to the ongoing process of defining the professional ethics of healthcare administrators.
CHAPTER IX

SUMMARY AND CONCLUSIONS

This dissertation has been an attempt to contribute to the discussion concerning the moral obligations of healthcare administrators in our American society. This is an important contribution since the current literature addressing ethics in healthcare administration is limited in quantity, incompletely developed, and either focusing on personal values and institutional standards or on loose applications of ethical theories. Nowhere is there a serious attempt to identify the central values or the role-specific moral obligations of healthcare administrators.

Healthcare administrators in American society commonly consider themselves to be members of a profession and, because of their responsibility in facilitating the institutional delivery of highly valued healthcare in our society, are subsequently treated in our society as professionals. Therefore it has been assumed in this dissertation that the question, "What are the role-specific obligations of the profession of healthcare administrators?" is an important one deserving of careful examination.

Defining the professional obligations of healthcare administrators first requires an understanding of the nature
of profession so as to make sense of the unique character of professional obligations. This task was undertaken in Part One. A great deal of sociological literature exists regarding the professions in our society. However, a careful examination of this literature reveals four different understandings or conceptual models of profession.

What has been called the Functionalist model views a profession as an occupational group characterized by its special expertise and monopoly in competence which, combined with the commitment of its members to altruism in unselfishly addressing particular fundamental human needs or social concerns, results in relative autonomy in practice and freedom from control by society. The other three understandings of profession found in the sociological literature, however, criticize this Functionalist model as idealistic and as a normative rather than a descriptive portrayal of professions.

What has been called the Dominance model views a profession as an occupational group which has successfully organized itself to gain a monopoly over a service and control of the market so as to develop a demand for the service in the form it alone provides. What have been termed the Deprofessionalization and Proletarianization models agree with this critical view of profession, but the former also claims that professional autonomy in practice has eroded due to formalized and hierarchical controls imposed by society, while the latter argues that professional autonomy has diminished due to the
general practice now of employing professionals in most fields.

It is apparent, therefore, that sociology is unable to construct one paradigm model of profession. Three reasons were given for this. First, social theorists presuppose the "traditional" professions of medicine, law, and clergy without explaining what structures or features of those occupational groups make them prime examples of a profession, thus leading to disagreement both between and within the different models over the essential features of a profession. Second, the different models make different normative assumptions about the institutional function or purpose of profession. Third, social theorists evaluate the claims of other occupational groups to professional status in light of their limited historical-cultural perspective of American professions in this century. As a result of these three problems, we cannot turn to sociology for an adequate understanding of profession in order to determine the professional obligations of health-care administrators.

Instead, a philosophical approach to describing a profession was undertaken in this dissertation. It was proposed that occupational groups commonly considered in our society today to be professions be identified, and that the popular image or common conception of profession which those groups embody in ordinary language usage be developed from these "central instances" of profession. In other words, it
was argued that a popular image of profession as conceptually understood in common language usage exists and is dependent upon medicine, law and clergy as the central instances of profession - even if these particular occupational groups have never perfectly embodied the contents of our image of profession in any particular historical time.

Utilizing this approach, it was proposed that there exist four essential features of profession in our popular image of profession as found in common language usage. If any occupational group lacks one or more of these essential features, it can be called a profession only by analogy to the central instances. The four essential features are: 1) Exclusive expertise - the possession of both theoretical knowledge and practical application of a skill, learned only through membership in the profession, which provides a service highly valued by members of society since it addresses some fundamental human need or societal concern like health, justice, or religious salvation; 2) Relative autonomy in practice - the relative control over the determination and evaluation of the technical knowledge and skills used in their work, as well as relative control over the social and economic terms of their work; 3) Societal or institutional recognition - the acknowledgement by society of an occupational group's professional status either through the visible formal structure of a social institution or through the granting of relative autonomy in practice; 4) Professional obligations.
This last feature is of most interest in this dissertation. David Ozar has proposed that there are seven different categories of moral obligation that, taken together as a group, are unique to professional groups and their members. They are 1) identification of the chief client, 2) ideal relationship with the chief client, 3) commitment to the good of the chief client, 4) central values of the profession, 5) commitment to professional competence, 6) ideal relationship with fellow-professionals, and 7) ideal relationship with society at large.

Before examining the professional obligations of healthcare administrators, however, a justification for the existence of professional obligations and a conceptual clarification of the nature of professional obligations was offered using the conceptual structure that has come to be known as the "social contract." Historically social contract language has been used by many political theorists to describe the relationship between the members of society and their government, but increasingly it has been applied to business and organizational theory. For purposes here, it is used to understand professions as social constructs arising from agreement both within society, and between society and the occupational groups accorded professional status by the society, for the purpose of directing specialized expertise to meeting specific fundamental human needs or social concerns such as health, justice, and religious salvation.
In utilizing social contract thinking in this study, it was first proposed that the term, "society," can be understood to mean an aggregate of individuals who possess the capability of reason and discourse to deliberate and potentially to agree on particular services and the means of delivering those services which will best meet their individual and collective needs. Second, despite the presence of moral pluralism and the lack of value-consensus in our society, a good deal of unanimity does exist on a number of values which allows for potential agreement on the provision of such goods as health and justice. Third, though a social contract may not exist in visible reality, e.g., a written contract, this idea is a means of conceptualizing an existing state of affairs and a heuristic device for explaining how any existing social arrangement may be evaluated morally according to the criteria of whether all involved participants would grant approval to such an arrangement. Fourth, the unwritten details of a social contract can be known through "social rules," an expression borrowed from H.L.A. Hart to refer to patterns or standards of behavior for which there is a perceived obligation to conduct behavior according to that expected pattern or standard simply because that is what is expected in society.

In light of such a social contract, each profession exists and are granted relative autonomy in practice and dominance in the market by a society because that society views this structure as the best available means to benefit
its members through addressing fundamental human needs and social concerns, and because that society wants mechanisms in place to assure that its members will not be harmed by professionals abusing their autonomy or market dominance. Every occupational group's claim to professional status must therefore always be evaluated by a very straightforward question: Is this a good bargain for society? Does this particular institution, this profession as presently constituted, achieve an appropriate level of benefit to society at acceptable cost?

In light of such social contracts, professional obligations exist because there is a common expectation in our society that professionals, in exchange for relative autonomy in practice, must exhibit an atypical moral commitment to the good of the client or patient and must also provide their professional service in ways that will serve the interests of society. Furthermore, the norms of professional behavior are to a great extent limited and determined by the common moral norms of the society.

The professional obligations of healthcare administrators are therefore articulated and measured by the reasonable terms of such a social contract. In Part Two of this dissertation, the professional obligations of healthcare administrators were described according to four different theoretical constructs or interpretations of historically developed characteristics of profession. These were called the Guild, Agent,
Commercial, and Interactive models of profession. These four accounts of professional obligations of healthcare administrators were then evaluated in light of the terms of a reasonable social contract for this society.

The guild model of profession identifies characteristics of the medieval guilds and of later professional associations which left a historical imprint on the development of professions in our own country. These characteristics include a professional education in theoretical knowledge coupled with hands-on practical application of that knowledge, ownership of exclusive expertise and a life-long commitment to excellence in one's professional field, atypical moral commitment paternalistically expressed towards clients or patients, primary allegiance and accountability to one's fellow-professionals, and an aristocratic or "gentlemanly" behavior in professional life.

In the guild model, the chief client of the healthcare administrator is the healthcare institution. This is because the healthcare administrator possesses the exclusive expertise to manage the healthcare institution, whose welfare the healthcare administrator is thus committed to serving. The healthcare administrator's relationship with the institution is characterized by skillfully managing the work of other healthcare professionals while maintaining final authority on all matters of management and business. Healthcare administrators promote the good of the healthcare institution in four
ways; by helping the institution achieve its purpose of providing high quality care for patients utilizing its services, by capably managing the work of employees and physicians, by fulfilling its institutional mission and values, and by maintaining the organization's financial viability through sound business decisions.

The premier central value of healthcare administrators in the guild model is effective and productive management of employees and good relations with the medical staff, for this constitutes the nature of the exclusive expertise which society expects of healthcare administrators for the successful operation of healthcare institutions. The second value in the hierarchic scheme is institutional integrity. The healthcare administrator represents and promotes the interests of the institution, but sometimes can redirect its mission or values since the administrator knows what is best for the institution. The third value is financial viability of the organization. This is important for the welfare of the institution, but it cannot supersede its mission or the healthcare administrator's professional role without diminishing the healthcare administrator into a mere businessperson. The health of individual patients comes next. It is presumed that they will benefit from the healthcare administrator's capable and effective operation of the healthcare institution, but they are not his primary concern. The health of the community is valued in light of its impact upon individual
patients.

The guild model of profession, however, would not be acceptable to the members of our society in a social contract. Three reasons can be given for this. First, this model presupposes that professionals know what is best for their clients or patients. This paternalistic relationship is largely unacceptable in a society which today values client or patient autonomy or self-determination. Second, societally-unregulated professional practice has often been shown to not benefit society, because professionals often either inadequately regulate themselves or naturally tend to promote the value of their professional service over all other values in society. Third, professions and society measure the success and benefit of the professional services according to different criteria, but the guild model removes societal input from this matter. Because of these problems, the professional obligations of healthcare administrators cannot be drawn from the guild model of profession.

In contrast to the guild model, the agent model of profession is anchored on the premiss that client or patient autonomy or self-determination is uncompromisable. This means that the professional offers only technical services to help a client or patient achieve a desired end. The professional's services are considered to be value-free, and are given value only in light their ability to assist clients or patients achieve their desired ends. In the guild model of profession
all authority resided with the professional; in the agent model, all authority resides with the client or patient.

In the agent model the chief client of the healthcare administrator is his employer, which will be called the healthcare institution's sponsor. The sponsor owns the healthcare institution, and contracts with the healthcare administrator to manage the institution to enable the sponsor realize desired ends. Regardless if these ends are medical education, care for the poor, or profit-maximization, the healthcare administrator applies his exclusive expertise seeking to achieve those ends. The healthcare administrator manages according to the mission and ethics of the sponsor, and is totally committed to the welfare of the sponsor in the sense of seeking to bring about the sponsor's desired ends.

There are no values central to the profession of healthcare administration in the agent model, but only those values held by the sponsor and therefore adopted by the healthcare administrator. The healthcare administrator is committed to the health of individual patients and to the health of the community only to the degree and manner of the sponsor.

Two problems can be raised with the agent model of profession, however. First, focusing on client or patient autonomy as the most fundamental value fails to do justice to the human condition which gives rise to the unique relationship between the professional and the client or patient. Many people seek professional help to restore lost or diminished
autonomy. Further, the service provided by many professionals, including healthcare administrators, address a fundamental need or social concern like healthcare delivery. Subsequently that service is generally not viewed as value-free in our society but as intrinsically valuable in its ability to restore a lost or diminished human mode of functioning. Second, it seems inadequate to presuppose that professionals do not relate to clients or patients in light of societal or professional conceptions of good ends. In sum, therefore, the agent model of profession fails to adequately describe the type of relationship that actually exists between professionals and clients or patients, and thus is unable to help clarify the professional obligations of healthcare administrators according to the terms of the social contract.

Another popular model of profession is the commercial model. Here professionals are viewed as commercial players whose service is a commodity transaction with a consumer; the professional owns the expertise and the consumer bargains over the price in order to purchase the commodity. In this model there are no distinctive role-specific moral obligations for professionals other than those normally associated with everyday business transactions, i.e., avoiding coercion and deception which violate the very conditions necessary for making contracts and market exchanges voluntary.

Applying this model to the ethics of healthcare administration, the chief client of healthcare administrators here
would seem to be the physicians. It is physicians who use the services of a healthcare institution and on whom the financial welfare of the institution is dependent. While healthcare administrators may "sell" their expertise to the sponsors of healthcare institutions, it is the physicians whose welfare they must seek to promote for the institution (and the healthcare administrator) to financially benefit. Healthcare administrators therefore seek ways either to placate their medical staffs through providing particular services and technology which entice physicians to utilize their institution, or to control physicians through contracts, employment, or networking arrangements.

The primary central value of healthcare administrators in the commercial model of profession is the financial viability of the organization. This is premised on the belief that the healthcare administrator prospers in direct relation to the healthcare institution. The second most important value is effective and productive management of employees and good relations with the medical staff, for this has direct impact on the financial status of the institution. The health of individual patients ranks next, and presumably they benefit by promoting the two higher values. Institutional integrity ranks fourth, for in the commercial model it is highly unlikely that the sponsor will prize this above the other values which are directly related to profit-maximization. The health of the community ranks last, for the healthcare
administrator has not contracted with the community at large for any services. Furthermore, promoting the community's health would actually lessen the need for, and thus the financial return to, the healthcare institution.

Three problems arise from the point of view of society and the social contract when conceptualizing the institution of profession within the commercial model, however. First, it is not self-evident that the free market system, left to itself without outside interference, is the best means to serve the needs of society. Furthermore, profit-maximization cannot be pursued completely value-free without undermining the very moral foundation necessary for continuance of successful practice in business. Second, the producer-consumer transaction as described in the commercial model is not what normally takes place in the relationship between the professional and the client or patient. Lay people are at a marked disadvantage in the relationship with professionals due to their lack of knowledge, their urgent need for professional care, and their oftentimes diminished personal autonomy which has lead to they seeking professional service. Third, the nature of professional services are commonly viewed differently than other commodities bought and sold in our society, in that professional services address basic human needs and sometime restore diminished autonomy. In other words, many professional services are considered a prerequisite for individuals to participate in market transactions rather than
being unconditionally dependent upon them. For these reasons, the commercial model is not an acceptable means according to the social contract for determining the professional obligations of healthcare administrators.

After rejecting the attempts of the three previous models to describe the professional obligations of healthcare administrators, this dissertation argues that only the interactive model of profession and professional obligations, a model which is based on the notion of social discourse and on the principle of beneficence (i.e., commitment to the best interests of the client or patient), would be acceptable to the terms of the social contract that a reasonable society would accept for the profession of healthcare administration. In the interactive model, social discourse between professions and society, and between individual professionals and individual clients or patients, seeks a consensual agreement on the nature of professional obligations for healthcare administrators.

In the interactive model the professional possesses the expertise to address a fundamental human need or social concern, while the client or patient possesses the understanding of his own values, goals and priorities. It is understood that the service provided by the professional addresses a valued human good, but that good must be weighed in light of other goods important to the client or patient. Both parties are then obligated to discourse so that the agreed upon
professional service best serves the particular client's or patient's understanding of the good. The professional practices beneficence when her service respects the autonomous choice of the client or patient, or, when that autonomy is lacking, when she promotes the valued good of the professional service and honors the central values of her profession to restore the client's or patient's autonomy.

Applying this interactive model to the ethics of healthcare administrators, it appears that the community served by the healthcare institution is the healthcare administrator's chief client. This requires that there be continual dialogue so that the healthcare administrator can be aware of the health needs of the community and adapt the institution's services accordingly, while also assuring that the community is responsive to the institution's needs as well. It also requires that healthcare administrators, in light of their exclusive expertise and in response to their community's needs, adopt key advocacy roles in health policy issues and take a leadership role in helping society define the appropriate goals and costs of healthcare. In today's healthcare environment, commitment to the good of the community's health also requires that healthcare administrators reconceptualize and re-engineer healthcare institutions from merely addressing illnesses to becoming centers of wellness and health.

In the interactive model the primary value in the profession of healthcare administration is the health of the
community. This value understands healthcare institutions, which healthcare administrators have the unique expertise to operate, to be established by society as service organizations to provide a wide range of health-related services for their communities. The health of individual patients comes next, often paralleling the first value but trumped only if individual patients are overutilizing resources needed for the whole community. Institutional integrity ranks third in the hierarchy of values, providing that the mission and values of the healthcare institution are designed to promote the two higher values. The financial viability of the organization ranks low, for it is assumed that communities will support needed healthcare institutions and that communities will not value the profitability of those institutions over the provision of needed healthcare for the community and individual patients. Likewise, effective and capable management of employees and good relations with the medical staff is valued only if this promotes the first two values in the hierarchy.

Two concerns can be raised regarding the interactive model of profession, but neither weakens the case that this model is the most satisfactory for a reasonable society to contract for in determining the professional obligations of healthcare administrators. First, while it is theoretically possible that social discourse may reach an agreement in which beneficence is not considered a role-specific norm of professionals, given the human situation that gives rise to the need
for professions it is hard to imagine how beneficence would not be required at all in the professional-client/patient relationship or in public policy debate over the social provision for professional services. Second, though there are natural limitations to the ideal speech situation presupposed in social discourse, consensus in social discourse can be understood as a continual generation of reasonable agreement about the moral norms of professions through an open-ended moral conversation. An ongoing understanding of the professional obligations of healthcare administrators can be an actual product of an actual, even if imperfect, dialogue. It was proposed that this dissertation should be considered not only as an attempt to justify the interactive model of profession, but as a contribution to that ongoing understanding of the professional obligations of healthcare administrators.

Some final thoughts will now be offered as observations which hopefully someday may be followed up on in more depth. First, it is striking to note that the interactive model of profession turns the central values of healthcare administrators "on their head" in comparison to the other three models. The value of the health of the community ranked last in the guild, agent and commercial models, but is the premier value in the interactive model.

On one hand, this reflects what is increasingly perceived to be a changing attitude toward healthcare delivery in our
society. For decades we took pride in, and provided mechanisms to financially support, the technological advances and life-prolonging measures that developed in our healthcare institutions. Now, however, there is now a growing conviction that our healthcare industry does too much for too few, and that far too members of our society are either without basic healthcare coverage or find their healthcare costs escalating out of reach. As a result, society is calling upon healthcare administrators and other healthcare leaders to re-direct healthcare delivery to better serve the needs of all the members of society.

On the other hand, it is seems that the value of the health of the community has risen in importance for healthcare administrators due to market forces. Managed care and the development of capitation reimbursement has changed the old "illness model" of healthcare institutions from being a revenue producer to a financial liability. In the next few years, it is expected that healthcare institutions increasingly will be reimbursed for keeping people healthy rather than for treating their illnesses. This, of course, raises a number of ethical issues which will not be addressed in this paper; of note here is that healthcare administrators may be assisted in honoring the primary central value of their profession by financial considerations, which possibility, of course, raises issues of moral motivation as well as how this central value is viewed if in various ways it is not supported
by financial considerations.

A second observation is that placing the health of the community as the primary central value of healthcare administrators now puts them at odds with physicians, who, according to the traditional medical morality, normally value the importance of the health of their individual patients above the health of the community. In a managed care environment, however, respect for autonomous patient choices regarding expensive treatments now comes into conflict with the increasingly valued principle of fairness or proportionality of benefits and burdens to the whole group of patients. It remains to be seen if healthcare administrators will take a leadership role in redefining moral norms in this newly emerging area of ethical concern.

A third observation is that this dissertation on the ethics of healthcare administrators has been written at a time of extreme and rather sudden upheaval in the profession. With hospitals dramatically downsizing and hastening to merge, form integrated delivery networks with other healthcare facilities, develop healthcare alliances with former competitors, and increasingly focus not only on outpatient care but on extended care facilities and home health care, the size and nature of our healthcare institutions may be quite different in just a few years. Many healthcare administrators will not work just in an individual institution in one given community as in the past, but will exercise authority over a network or alliance
of many different kinds of healthcare institutions. The professional obligations of healthcare administrators as described in the interactive model of profession will remain the same, but examples or illustrations of these obligations may be far different in a few years - and apply to a lot fewer people.

Last, a number of other issues pertaining to the ethics of healthcare administrators were put aside in this dissertation. Among the unaddressed issues, which I remain interested in, is the issue of how to reformulate the mission and values of an institution when it merges or networks with other institutions, the question of how best to provide moral education to the candidates for the profession of healthcare administration, the concern of how to motivate healthcare administrators to observe their professional obligations, and the problem of how to integrate the professional obligations of healthcare administrators with personal concerns, e.g., facilitating a merger or an alliance with another institution that will negatively impact the healthcare administrator's own job. Hopefully these issues may be addressed in another format at another time.


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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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