might call the "super-system"—the market itself.

To describe the shortcomings of a modern society defined by greater differentiation of social roles and increased bureaucratization in the operation of institutions, Weber used the famous image of the "iron cage."[5] In such a deterministic system, professional callings become job descriptions; ethical obligations give way to functional imperatives; individual responsibility is replaced by institutional excuses.

This situation is particularly problematic when the claims of professional integrity and institutional survival conflict. Victory inevitably goes to the stronger. Institutions are more powerful than individuals, and market considerations, in this culture, carry more weight than professional standards. The inevitable result of such conflicts is the progressive devaluation of the moral claims of professionalism in the interest of ensuring economic fortunes and the stability of institutions.

No one denies that the tendency to centralize the delivery of health care in large institutions presents great opportunities for medical research and practice. In fact, we all benefit from them. However, those technical advantages are purchased at the price of social and ethical disadvantages. To quote Toulwin again:

> To the extent that, in the operation of a modern hospital, budgetary claims tend to outweigh those of a moral calling, the institution acts like Weber's "iron cage." Medical professionals collectively cease to be a profession. The work of the individual health care professional, circumscribed by institutional imperatives, is removed from the sphere of moral commitment and put instead into the realm of social necessity. As a result, the work of such professionals is inevitably de-*moral*-ized.[6]

Consequences Exemplified

I do not intend to promote a particular sociological theory here. The fact that we may or may not agree with Weber's analysis is beside the point.

CASE STUDY: *Personal and Professional Integrity*

BY ELLA PRITCHARD CURRY, RN

Robbie was a 40-year-old man who had been HIV-positive for nine years and in our care within the Division of Infectious Diseases for seven years. He had advanced AIDS with a T-cell count less than 50 (normal is 800-1200) and an HIV viral load more than 250,000 (less than 400 is desirable).

Robbie was admitted to the hospital with a diagnosis of severe azole-resistant esophageal candidiasis, an overgrowth of fungus that had nearly obstructed his esophagus. Because the fungus had not responded to any oral medications, the indicated treatment was intravenous amphotericin B. Because this drug is particularly toxic to the kidneys and may cause a loss of vital electrolytes and minerals, we admitted Robbie to the hospital for initiation and stabilization of dosing. The anticipated course of treatment was 14 to 21 days.

When patients are admitted to our service, my role as clinical nurse case manager for Infectious Diseases includes anticipation of discharge needs and assessment of insurance benefits to establish services such as home infusion therapy. Robbie is fully disabled by AIDS; and the inpatient record listed Medicare as his insurance. Medicare covers only four intravenous medications for administration in the home, one of which is amphotericin B. I documented that fact in his chart and outlined the plan for discharge home once clinical tolerance of the drug was established.

Within 24 hours of the first dose of amphotericin B, Robbie's serum creatinine level doubled from 0.8 to 1.6, a sign of kidney toxicity. Concurrently, both his potassium and magnesium levels dropped to the point of requiring aggressive intravenous repletion. This was the beginning of a rocky hospital course. On day two of therapy, Robbie's creatinine level continued to climb despite aggressive hydration and a dose reduction in amphotericin. As a result, we were forced to change to a liposomal form of amphotericin. For me, as a case manager, that meant two very important changes in terms of discharge planning: (1) the use of liposomal amphotericin would likely preclude home care (because the Medicare guidelines do not specifically address this much more expensive form of amphotericin, and home infusion companies are reluctant to chance reimbursement for such an expensive agent) and (2) successful placement in subacute care would not be possible because in the era of prospective payment, few facilities will even consider admitting a patient with such an expensive pharmaceutical in the treatment plan. I shared these implications with Robbie as I began to reshape his expectations of leaving the hospital within four or five days of admission.

On day three of Robbie's admission, I received a telephone call from Nancy, who identified herself as a nurse case manager representing Robbie's insurance provider. She informed me that the company had preauthorized a three-day stay at the time of Robbie's admission; she was interested in hearing either the discharge plan or the clinical justification for continued hospitalization. I was surprised to learn that Robbie had this coverage because it was not identified on the

What I *do* want to provide is a heuristic device that might help readers develop their own conclusions. However, Weber's thesis does help explain some of the problems that have become daily experience for hospital administrators, health care professionals, and patients.

Weber's picture of modern society—moving inexorably toward greater differentiation of roles and greater bureaucracy—helps to clarify the dilemma that contemporary health care administrators face. Their predicament is normally described as "economic": They must develop strategies to defend their organizations' budgetary soundness, on one hand, and its public reputation, on the other. Following one such strategy, an administrator might encourage his facility to establish (and enforce) high productivity standards, promote vigorous utilization review—and avoid patients who lack insurance coverage. Although unfortunate, and perhaps ethically wrong, these actions are entirely consistent with the administrator's ability to act, given current reimbursement levels and competition. One could even say that this is precisely what the administrator's job requires him or her to do.

Such administrative practices have a notoriously large impact in health care institutions. Physicians, for example, tend to see them as limiting their professional discretion. What is worse, caregivers may begin relating to their patients in a cynical rather than generous manner. When faced with the decision of whether to play by the rules or fight them, many caregivers may choose to protect their privileges rather than serve patient needs.

What about the patients of such an institution? One cannot blame them for the growing suspiciousness they bring to their (increasingly brief) encounters with health care professionals. The medical profession still likes to project a romantic image of the doctor-patient relationship on such encounters. But, given the obvious constraints, patients are rapidly coming to see that the image is unrealistic.

The Impact on the Notion of Integrity

When one takes seriously the current social trends in health care institutions and refrains from facile

demographic sheet of his chart. She repeated that her company was indeed the primary insurer and she would be my contact person throughout the hospital stay.

Robbie confirmed this and told me that his former employer had offered to keep him on the group insurance plan as long as he could afford the monthly premium. He had opted to do so. He confided that he still dreamed of returning to work one day, and this seemed a good way to retain some options. Under most circumstances I would have been heartened to learn of the existence of an insurance policy with potential subacute care options. In this case, however, I was not because I knew from previous experience that Robbie's benefits through this insurance provider would be very limited.

I proceeded to establish a rapport with the insurance case manager and outlined for her the events of the first three days and the change in therapy to liposomal amphotericin. I also requested that she investigate Robbie's subacute and home infusion benefits so that I might pursue and document available options. She agreed to do so and extended the admission authorization by two days.

Robbie continued to have difficulty tolerating even the new therapy. Steadily rising serum creatinine levels forced another dose reduction and aggressive hydration along with daily repletion of electrolytes and minerals. I called Nancy with the 48-hour update and justification for ongoing acute admission. She extended his stay for two more days and then reviewed the home care benefits: the drug and related supplies would be covered at 70 percent if we used a mail-order service to procure them; otherwise the drug would be covered at only 50 percent. When I protested that we could not possibly use a mail-order service to obtain an intravenous medication such as liposomal amphotericin, she acknowledged the unfeasibility of that approach. In reality, the benefit was 50 percent coverage if I used the contractually preferred home infusion provider. No subacute care benefit was available.

I called to discuss Robbie's case with the identified infusion company. Because I have worked in this position for more than 10 years, I know many of the regional home care agency personnel. I asked the reimbursement team to calculate the daily cost of medication at Robbie's current dose and to please include the related intravenous supply costs so that I could establish Robbie's 50 percent obligation for completion of this therapy at home. The figures were not surprising: $600 per day for the drug and $175 for supplies and equipment; the charge for nursing would add another $125 per visit. At roughly $900 per day, Robbie's 50 percent obligation translated into approximately $3150 per week.

Robbie's facial expression was priceless when I shared this information with him. "Are you saying $500 a day? Ella, I only receive $488 per month from disability, and my rent, food, and insurance premium use almost all that. I couldn't pay that; do you have patients who could?" I assured Robbie that I knew few people for whom those payments would be possible.

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moralizing about them, one is forced to admit that the question of professional integrity needs to be radically rethought. The problem with the complementary model of integrity and compliance—that it does not address the larger context in which health care organizations function—is now obvious. As long as we refuse to address that larger context—the hyper-market culture in which commercial values dominate—we should not be surprised if health care professionals capitulate to a complementary model of integrity in which their behavior is governed by economic interests, their own interests and those of the organizations they serve. The system's "iron cage," not their own lack of moral strength, will have already imposed this particular model of integrity on them.

Of course, one could simply tell health care professionals to ignore the "iron cage" and follow their consciences. But this individualistic approach misses the point for two reasons.

Individualism and Commercial Culture The individualistic approach ignores the larger cultural framework in which the individual professional operates. When confronted with the shortcomings of an increasingly bureaucratic and impersonal milieu, a professional (whether physician, nurse, social worker, or chaplain) cannot help but feel powerless and frustrated. His or her institution has already decided, through its resource allocation and other strategic decisions, the degree of moral sensitivity with which professionals will be allowed to do their jobs.

Nor can we blame the health care institution itself. After all, it is only a part of the larger commercial culture—which has in turn already decided the degree of moral sensitivity with which the institution will be allowed to do *its* job. We should not be surprised if health care values mimic those that drive societal relations in general.

What Edmund D. Pellegrino, MD, calls the "internal morality of medicine" and others refer to as the "non-negotiables" of moral health care—justice, patient-first orientation, and a notion of health that encompasses more than physiological functioning—cannot exist in a vacuum as the isolated moral insights of enlightened health care professionals.[7]

CASE STUDY: *Personal and Professional Integrity (Cont'd.)*

He became very serious and added that he could not with clear conscience agree to take on that kind of debt because he would be, in his words, "a fraud" to lead anyone to believe he could ever pay it off. His next question was no less surprising: "Ella, will they make me go home and say I have to try to pay that kind of money?" I assured him that his body's response to the side effects of the drug still required aggressive intervention that precluded management outside the hospital. As long as we had sound medical justification for treating him in the hospital, we were in no danger of being forced to send him elsewhere. What I did not say aloud was that pressures to discharge him did exist, both from within and outside the hospital, and that these might come to bear if his condition stabilized enough that his treatment could be managed in subacute or home care.

With the next clinical update, Nancy extended the stay by another three days. As I reported my findings regarding home infusion costs, I took the opportunity to explain who Robbie was: a disabled man on a fixed income; a responsible man who takes his financial obligations seriously; an amazing man who, just 10 months before, laid in the intensive care unit comatose for 15 days; a proud man who worked hard for months to rehabilitate to the point of living independently in his own apartment again.

Nancy listened and acknowledged that the home care benefit in this instance was, in actuality, no benefit at all to Robbie. As we reflected on the challenge this represented to both of us regarding our mutual responsibilities, a subtle but perceivable shift in understanding occurred: I realized that Nancy and I were now both acting as advocates for Robbie. For Nancy, he was no longer merely a name on an insurance policy with a set of less-than-adequate benefits; because of my descriptions, Robbie had come alive in fuller context.

Nancy informed me of an appeal process that was possible within her oversight of Robbie's case. She was willing to take the case to the company's medical reviewer if Robbie stabilized to the point of manageability at home. The outcome of such a review, she emphasized, was totally unpredictable. She concluded our conversation by saying, "Let's hope his creatinine level stays up and his potassium level stays down. Maybe then we will get through all 14 days in the hospital and not have to appeal anything."

Throughout Robbie's stay, I documented all my conversations with the insurance case manager. I also fielded daily inquiries from zealous house staff who were eager to discharge Robbie and less than eager to hear the minutiae of details regarding systems and factors that impede discharge plans. I wrote each note with serious deliberation, ever mindful that although Nancy and I believed a 50 percent copayment of home care services was not an option for Robbie, some within our mutual institutions may assess the fact differently and some of them, like our house staff, are uninterested in specific details.

Robbie did continue to have daily manifestations of toxicity and required aggressive hydration therapy around the clock.

No "internal" morality of medicine can exist entirely separate from the "external" morality that drives the whole of society. We cannot seriously expect it to be found in a generation of young people brought up to see competition and ambition as essential ingredients of success. The current generation of health care professionals is being taught, at least implicitly, that human relations are not values in themselves, but rather a means toward egotistic return and profit. Even the best possible school, having such students for no more than the few years of their professional education, would fail to instill in them a substantially moral notion of integrity.

Individualism's Weak Impact The second problem with a purely individualistic strategy is the fact that it would represent, at best, an act of goodwill and would fail to have a real impact on society. Commendable as it might be, such a strategy could be neither sufficiently effective nor prophetic.

Today's health care professionals should be playing an openly prophetic, politically militant role in society. In fact, however, many professionals criticize health care's increasingly for-profit mentality while, at the same time, feeling perfectly comfortable with the for-profit thinking that shapes their overall social outlook. No wonder such professionals are rarely found on the front lines, reminding the rest of us that health care, a social good of a special nature, is not a commodity like all the others.

Because larger cultural values inevitably influence health care values, health care professionals must learn to act collectively, rather than individually. As members of a profession (as well as individual professionals), they must finally declare that, unless a profound social change occurs, they cannot practice medicine any more. It is impossible to predict how such a prophetic, civic movement might take shape.* I am convinced, however, that it must occur soon.

*Physician groups seeking health care reforms exist at present. However, the movement I describe here will require a more thoroughgoing and unified critique of the entire system.

Reconstructing Integrity

To address the real challenge, we must return to the Weberian metaphor of the "iron cage."[8] The

We made it through extensions of authorization, in clusters of two and three days, up to day 14. Nancy's wish had been realized; Robbie had the desired clinical response. There was no need for appeal and no dispute regarding reimbursed patient days. On the surface, it was the proverbial happy ending/good outcome.

As a nurse case manager, I have many relationships: with patients, our interdisciplinary infectious diseases team, the medical center, representatives of insurance companies, and nurses and physicians in training and in practice. I share Robbie's case because it captures the tensions characteristic of my work in the midst of competing interests. My institution and team have an interest in the performance of my duties, which are to participate in the admission and timely discharge of patients, to document and communicate accurately rationales for decisions and treatment plans, to perform each function to ensure reimbursement for services provided, and to avoid disallowed inpatient days. My patients have an interest in reliable clinical information and understandable explanations regarding insurance benefits, available options, and responsible stewardship of their resources. They also have an interest in the development of discharge plans that are realistic and tailored to their particular needs. Insurance representatives have an interest in the accurate portrayal of clinical status and decision-making and in the financial soundness of services provided. Likewise, I have my own interest in access to accurate information and patient records and the education of medical and nursing students to whom I hope to entrust the skills of seeing patients as individuals living with strengths and challenges unique to each of them.

Constituent to these competing interests are lingering worries. From 13 years of HIV/AIDS care, I know that some people would say Robbie was deserving of his infection and undeserving of our time, resources, and attention. I also know that those who hold authority over decisions regarding patient benefits have the power to affect not only health care, but also a patient's sense of worth and well-being. And, sadly, I acknowledge that at times those of us who collaborate in discharge planning find ourselves hoping aloud for things such as ongoing drug-induced toxicity to spare a patient the confrontation of inadequate benefits and an uncertain medical review process.

In Robbie's case, I was blessed to have Nancy as the insurance case manager. Unlike countless other times when I have spent far too many conversations listening to sweeping judgments about who deserves what in this world, with Nancy I was in collaboration with another nurse who, despite representing a very different set of interests, came to meet me at the most important point of mutual interest: our patient.

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