STEWARDSHIP AND ORGANIZATIONAL ETHICS

How Can Hospitals and Physicians Balance Scarce Resources with Their Duty to Serve the Poor?

BY MARK REPENSHEK

Clinical concerns have tended to overshadow the landscape of ethics discourse in health care for nearly 30 years. Beginning in the 1990s, however, the complexity inherent in partnerships among health care organizations, systems, and networks began to require a new kind of guidance involving principles of bioethics. However, many of these principles were not immediately applicable to the organizational issues requiring analysis.[1]

In the absence of a broader ethical framework that could provide an organization with guidance, Catholic health ministries often relied on mission statements to help frame the discourse. However, the principles invoked in many of these mission statements are part of a moral tradition that understands the principles in specific contexts—contexts that, moreover, may historically be only indirectly related to health care.[2] One such principle, which has a rich history in the Catholic moral tradition, is that of *stewardship*. In this article, I will examine a particular understanding of the principle of stewardship—in the context of a Catholic health ministry's commitment to its mission and its subsequent organizational responsibilities. In particular, I will consider the principle of stewardship as understood in the context of the "preferential option for the poor." This particular understanding of the principle of stewardship, I believe, provides the basis for a reimbursement scheme that serves to compensate a health ministry's physicians while meeting its obligations to be a good corporate steward (see **Box,** p. 32). Stewardship, understood in the context of a preferential option for the poor, contributes to a broader ethical framework relevant to organizational ethics.[3]

Mr. Repenshek, a doctoral candidate, is health care ethicist, Columbia St. Mary's, Milwaukee.

The Principle of Stewardship

Stewardship is principally understood in relation to ecological themes in Catholic social teaching.[4] In this context, human beings are understood to have limited dominion over the rest of God's creation.[5] Yet many health ministries have incorporated the principle into their statements of mission, vision, or values. This inclusion reflects Catholic health ministries' recognition that, possessing only limited dominion over their resources, they have a responsibility to allocate these limited resources in the communities they serve in a manner consistent with their commitment to human dignity and the common good.[6]

Catholic social teaching views health as integrally related to human dignity and human flourishing. Access to health care is therefore considered a basic human good to which there is a basic human right, insofar as health care can improve one's ability to flourish on a personal and social level.[7] For this reason, the principle of stewardship as applied to Catholic health care should not be limited simply to how we allocate resources and manage the "bottom line." It should also concern the way we do both of these things while, at the same time, promoting equity, fairness, basic human rights, and the common good. In this conception of stewardship, an inherent tension exists between our limited resources and the social and individual goods we promote. For example, Catholic health ministries have a responsibility, on one hand, to increase access to health care and, on the other, to reimburse the

physicians they employ in a fair, just, and competitive manner.

Human Dignity, the Common Good, and the Preferential Option

As noted, a commitment to the principle of stewardship entails a corresponding obligation to the common good and human dignity.[8] The National Conference of Catholic Bishops, in its 1981 pastoral letter on *Health and Health Care*, noted that health is "integrally related to human flourishing on a personal and social level." This statement reflects an essential connection between the good of health for the individual and the common good; namely, health allows one to contribute more fully to the common good. This understanding of the common good presupposes that an appropriate understanding of the principle of human dignity necessarily implies certain social obligations. In other words, a consideration of human dignity and the common good are better understood in conjunction with one another than in isolation.[9] When these two principles are considered in tandem, they provide the basis for the particular conception of stewardship found in the Catholic moral tradition.

This particular conception posits human need as the material criterion of stewardship. In this understanding, stewardship is about responding to the human dignity of all people by meeting the fundamental needs required to live a genuinely human life and to achieve at least a basic level of human well-being. Because the poor are those with the greatest need, Catholic social teaching recognizes that the poor have a "preferential" claim on the resources of society and, therefore, ought to be given priority among the variety of claims on the common good.

Although a rigorous analysis of the preferential option for the poor is beyond the scope of this article, we must consider two of its implications regarding health care. First, a commitment to a preferential option for the poor has implications for the way the principle of stewardship should be understood and applied in light of a Catholic health care ministry's commitment to its mission. Second, to integrate a preferential option for the poor into the principle of stewardship does not mean that the poor are the *only* concern of Catholic health care organizations. Rather, the implication is that allocation decisions should be evaluated, first, according to the way they affect access to health care for those who are poor, and, then, by the way they affect access for people in general.

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Stewardship Viewed in Light of the Preferential Option

Modern health care is driven by an ever-increasing consumption of resources.[10] This consumption is carried out by a complex system that attempts to negotiate a number of competing factors: a growing reliance on technology; an emphasis on freedom of choice for both providers and consumers; escalating expectations concerning quality and quantity of care; extensive market and profit pressures; a growing population of the elderly and a growing need for long-term care for them; and a growing number of uninsured people and a need to provide them with access to basic care.[11]

To this increasingly powerful compendium of appetites, the principle of stewardship brings a message of restraint and limits.[12] These limits exist on both a macro and micro level. At the macro level, resource allocation serves to demarcate the portion of community resources dedicated to health care relative to the portion dedicated to other elements of the common good—education, for example, or public safety. In other words, there are many basic goods competing for their share of a community's finite collective resources. When resources are dedicated to one area of the common good, those available to other, competing areas are to some extent necessarily limited.[13] Once the proportion of societal or community resources is identified with a particular area of the common good, allocation or distribution of those resources within that area is delegated to a micro-allocation process.

In the area of health care, the micro-allocation process is concerned with the allocation or distribution of finite resources in a balanced manner across the quasi-infinite health needs of the community. Here, too, there are a number of forces competing for health care dollars. For example, a health care organization must allocate a certain amount of funds to the acquisition of technological advances, maintaining its physical plant, compensating employees, and reimbursing physicians. The latter concern presents a special challenge insofar as third-party payers reimburse at different levels according to the services rendered and the

An Alternative Reimbursement Scheme

The alternative reimbursement scheme referred to in this article distributes payment to physicians for services at fair market value despite the disparity in the actual reimbursement rates from third-party payers. Practically, this means that the health care organization arrives at an agreed-upon reimbursement rate with its physicians for services provided, based on fair market value, independent of the reimbursement rate of third-party payers.

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population served. An unfortunate implication of this situation is that physicians may be discouraged from accepting new patients who are members of those populations for whom reimbursement is at the lowest rate or even nonexistent.

It is precisely these patients for whom the preferential option for the poor grounds a special claim to the good of health care. Through the lens of the preferential option for the poor, one sees that this reimbursement scheme actually marginalizes those whom the health care system should be helping the most. Moreover, according to the preferential option for the poor, the situation of those who are marginalized by such societal structures, institutions, or practices ought to be at the forefront of discourse on how to allocate resource dollars. It does not follow, however, that a preference for those who are marginalized or vulnerable ought to be the *only* consideration of the discourse. For example, this preferential claim to the good of health care on behalf of those who are marginalized or vulnerable must be evaluated in light of its impact on physician practice as well as its impact on a health care ministry's ability to sustain its own mission. In other words, stewardship requires health care ministries to balance, on one hand, their responsibility to alleviate (in proportion to their ability to do so) the marginalization of the poor and vulnerable with regard to health care and, on the other hand, their organizational commitment to their associates, community, and the common good. The challenge is to distinguish the unmet needs calling for reform—those arising from a commitment to a preferential option for the poor grounded in the principle of human dignity—from the unmet needs calling for acceptance—those arising from the explicit condition of limitations.[14]

One possible means of responding to this challenge is to devise and implement a physician reimbursement scheme that allocates dollars based on services rendered rather than on population served. Insofar as such a reimbursement scheme supports a framework that encourages physicians to serve the health needs of patients who are financially vulnerable, rather than discouraging them from doing so, the previous analysis of stewardship and the preferential option for the poor would, if correct, almost seem to require it.[15] Moreover, the limitations built into this reimbursement scheme are consistent with an implicit professional commitment by physicians to care for the poor and vulnerable. However, this reimbursement scheme necessarily limits the extent to which health care dollars can be allocated to other avenues of care, including, but not limited to, other dimensions of care that serve vulnerable and marginalized populations. Therefore, in order to distribute the limited resources in a manner proportionate to the good served while maintaining a preferential option for the poor, health care ministries cannot advocate or provide unlimited reimbursement. To do so would deny the organization's responsibility to allocate limited health care dollars in a manner that recognizes a reasonable proportionate good of other services that substantively support the common good.

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Commitments to Care for the Marginalized

The principle of a preferential option for the poor is evident in medicine's long-standing and well-recognized tradition of care for the marginalized. When health care institutions speak of a responsibility to serve "vulnerable populations," the notion truly represents a collaborative effort on the part of both the organization and the individual physician. Having said this, one should probably elaborate on that long-standing tradition.

The American Medical Association (AMA) has long recognized the principle of service to the vulnerable. From it the association derived an ethical obligation of physicians to assume individual responsibility for making health care available to the needy.[16] The association's first code of ethics provided that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."[17] Most recently the AMA adopted the position that "all physicians should work to ensure that the needs of the poor in their communities are met. . . . Caring for the poor should be a regular part of the physician's practice schedule."[18] These statements evidence the history physicians have for providing care for those who are vulnerable.[19]

As private practice shifted to institutionalized care, the degree to which institutions were able to provide consistently for those in need of health care became increasingly difficult as the health care system grew in complexity and expense.[20] What remains a constant, however, is the individual physician's obligation to care for the poor. This tenet of medical practice is rooted firmly in the duty of beneficence and charity. Indeed, "[a] cardinal principle of the helping professions has been the availability of services; no one who needs basic help should lack it."[21]

Although different models exist, care for the sick is a consistent moral ideal in varying attempts to define objectives of the medical profession. According to the AMA's Council on Ethical and Judicial Affairs, "that single imperative is the essence of the physician: to treat the ill, without concern for who they may be, what their diseases are, or whether they can afford to pay."[22] Although this imperative must be practically bal-

anced with a means of compensation for the service rendered, reimbursement for treatment is not the primary end of the professional. Medicine's integrity demands that physicians move past influential and powerful business models of strict cost/benefit analysis to the moral objectives that grounded the profession. Indeed, as has been said, "one of the characteristics of a true profession remains in its special relationship with the poor."[23]

The Council on Ethical and Judicial Affairs contends that an obligation to the poor, requiring physicians to place others' concerns above their own, has grounding in at least three ethical principles unique to the patient-physician relationship.

Concerning the Nature of Illness E. D. Pellegrino, MD, and D. C. Thomasma, PhD, in writing about this specific topic, note that

> the sick person is in a uniquely dependent, anxious, vulnerable, and exploitable state. Patients must bare their weakness, compromise their dignity, and reveal intimacies of body and mind. The predicament forces them to trust the physician in a relationship of relative powerlessness. Moreover, physicians invite that trust when offering to put knowledge at the service of the sick. A medical need in itself constitutes a moral claim on those equipped to help.[24]

Concerning the Social Status of the Healing Profession The second principle involves the social nature of the healing profession itself. This is recognized both in the privileged status afforded the physician as well as the social investment in the education of those who are willing to take care of people in need. The privileged status echoes Pellegrino and Thomasma's point regarding the unique access physicians have to the intimate details of people's lives. Hence, a degree of respect is presupposed by the very nature of the profession.[25] This presumed respect is also derivative of the investment society places in medical education and biomedical research. It is only through the contribution of society to the education of its physicians that any are able to learn and practice medicine. Acknowledging this substantial debt implies recognition of the medical profession's obligation to serve all those in need by virtue of their illness, not their ability to compensate the professional.[26]

Concerning the Professional Oath In taking a professional oath, the physician is making a public acknowledgement that one of his or her sworn responsibilities is to care for the ill.[27] From the beginning of their careers, physicians thus dedicate themselves to their patients' welfare.

It would be disastrous for the medical profession to lose its traditional focus on mercy.

However, a variety of forces conflict with the physician's ethical obligation to care for those in need. I do not wish to minimize those conflicts. On the other hand, acknowledgment of such conflicts only underlines the physician's need to continue to recognize his or her obligation to help care for vulnerable persons. For as A. R. Jonsen notes, "without charity, something essential goes out of medicine, something vital disappears from the life of its practitioners. Recall the words of the medieval hospitaler, 'I cannot sell mercy for gold.' The disappearance of charity care . . . means the disappearance of mercy as a quality of medical care and as a characteristic of the life of practitioners. This is an inestimable loss."[28]

It would be disastrous for the profession of medicine to lose this focus. The implications of such a loss extend far beyond the relationship between the physician and the person in need, and extend, in fact, to the patient-physician relationship as a whole. Care for those in need calls inevitably on a physician's capacity for mercy, compassion, and empathy. Caring for the most vulnerable, then, "reaffirms the primacy of medicine as a helping profession."[29]

Reimbursement and Stewardship

The tenets of Catholic health care are fundamentally aligned with the tenets of professional physician practice. As such, Catholic health care institutions and physicians share a commitment to being good stewards of resources in light of a preferential option for those who are vulnerable and marginalized. As a corollary, neither party ought to bear a disproportionate burden in order to achieve the shared goal of serving those who are vulnerable. Yet, as I have noted in this article, there are two equally crucial aspects to this commitment—an organizational aspect and an individual aspect.

At the heart of the organizational aspect lies the organization's commitment to its mission and to the fundamental principles found therein, both of which frame its organizational ethic. A health care institution that is committed to a preferential option for the poor serves those in need in response to their fundamental human dignity. Health care organizations that make a priority of serving the poor and vulnerable are more than aware that certain advocacy measures are necessary to correct inequities that result in disproportionate burdens placed on marginalized populations.[30] The recurring question is: How can resources be best used in serving this noble end? One possible response is the limited reimbursement scheme described above, which supports physicians in their effort to care for the vulnerable

and marginalized. Consistent with an understanding of the principle of stewardship that includes a preferential option for the poor, compensation formulas can correct the present inequity in the reimbursement rate for physician services. Of course, this is not an all-or-nothing affair. The principle of stewardship as guided by a preferential option for the poor requires balance with regard to the compendium of services that demand allocation of finite resources.

In terms of the individual commitment, each physician engages the notion of stewardship of resources on a very pragmatic level—delivering expert care to those in need. Here, too, the individual physician realizes that a commitment to a preferential option for the poor cannot be an unqualified distribution of limited resources. As such, the particular understanding of the principle of stewardship that underlies the limited reimbursement scheme supports the professional obligation of physicians to care for the vulnerable. In this way, the limited reimbursement scheme supports individual physicians by correcting inequities that disproportionately burden physicians who strive to extend care to the poor and vulnerable, people marginalized by the current reimbursement schemes. □

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How can resources be best used in serving the poor and vulnerable?

NOTES

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