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FOR PATIENTS AND PROFITS: ETHICAL ASTUTENESS AND THE BUSINESS OF DIALYSIS

JOSHUA E. PERRY*

I. INTRODUCTION

The business of health care is a unique enterprise wherein a combination of goods and services necessary to preserve or improve the health of another person are bought and sold.¹ Whether in the physician's office or in the clinical examination room or at the hospital bedside, the transfer of care from one person to another creates a unique relational dynamic at the center of this business transaction. Often this engagement between physician and patient is infused with deep trust, intimacy, and vulnerability, as the encounter is frequently marked by fear, discomfort, and uncertainty regarding the potential life and death consequences of decisions made and actions taken.²

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1. See generally Richard Smith et al., *A Shared Statement of Ethical Principles for Those Who Shape and Give Health Care: A Working Draft from the Tavistock Group*, 130 ANN. INTERN. MED. 143, 145 (1999) ("Caring for sick people is a social obligation that extends beyond the commercial realm. Although ownership of health care delivery institutions or other organizations that deliver medical care may be appropriate, care itself cannot be owned and must be viewed as a service that is rendered and remunerated under the stewardship of those in the health care system rather than merely sold to individuals or communities.").

2. For example, worried and bewildered parents often find themselves face-to-face with emergency room physicians and pediatricians. Beyond the dramas of parenthood, thousands of adult children every day must confront a different set of gut-wrenching dynamics as elderly parents waver between life and death. As one's mom or dad, beloved friend, or life partner is in the process of dying, those who sit vigil at the bedside are in no mental or emotional condition to haggle over the price of palliative medications or second-guess the necessity of additional MRIs and CT scans. Or consider the young woman or man, with a history of being sexually abused by authoritarian and trusted figures, sitting naked in an examination room, being asked intimate questions about his or her body, diet, and

These variables differentiate the business of delivering clinical healthcare services from other industries in several fundamental ways.³

lifestyle. It takes an enormous amount of courage and trust for someone to be that vulnerable. Yet, these are the dynamics of the doctor-patient relationship.

Each of these scenarios helps to reveal a little of what makes encounters with the health care system unique in one's daily interaction with other actors and institutions in the marketplace. One's interaction with one's physician is simply categorically different than one's interaction with the gal selling hamburgers or the guy handling overnight package delivery. The dynamics between a physician and her patient involve emotions and vulnerabilities that make it impossible for patients to be the rational and savvy consumers they might otherwise be in every other marketplace transaction. From the time of Ancient Greece until now, purveyors of the healing arts have recognized this gross disparity in "bargaining power" between one who needs care and who has the ability to provide care, and in response a rich and robust ethical tradition has evolved. In *Physician-Owned Specialty Hospitals and the Patient Protection and Affordable Care Act: Health Care Reform at the Intersection of Law and Ethics*, I argued that these ethical dynamics must be considered in the context of healthcare business. 49 AM. BUS. L.J. 369 (2012).

3. See Marc J. Roberts & Michael R. Reich, *Ethical Analysis in Public Health*, 359 THE LANCET 1055, 1057 (2002) ("[H]ealth is generally viewed as special or different from most other things produced by the economy."). See generally Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2 (2001); Norman Daniels, JUST HEALTH CARE (1985) (arguing that healthcare is "special" because of its impact on individual access to opportunity in a free society). In his 2001 essay in *American Journal of Bioethics*, Daniels, continuing to build upon Rawls's theory of justice as fair equality of opportunity, succinctly states that "by keeping people close to normal functioning, healthcare preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life." Daniels, *supra*. But see Andrew C. Wicks & Adrian A.C. Keevil, *When Worlds Collide: Medicine, Business, the Affordable Care Act and the Future of Health Care in the US*, 42 J.L. MED. & ETHICS 420 (2014). Wicks and Keevil offer a nuanced argument that notes the unique aspects of health care, while concluding that "if we take a larger view of business and health care, and see a broader array of stakeholder interests as legitimate and important, then it becomes possible to see the objectives of 'medicine' and those tied to 'business' as less inherently in conflict—and requiring one system to dominate the other—and to see how they may well be complementary." *Id.* at 423. They continue:

This is not an invitation to suggestions that if we just turn medicine into a marketplace then all of our problems are solved. Medicine is a special context and health care is not a "commodity," particularly in the sense we use to talk about many of the discretionary goods that are bought and sold in traditional markets. Many would argue that access to health care is not a discretionary good (e.g., like ketchup or toothpaste). Rather, health care is a basic right that all persons have, particularly because of its fundamental importance to having other basic rights (citations omitted). At the same time there are powerful informational and power asymmetries that make choices about health care far more challenging than in other contexts. Both because of the complexity of the "product" and their lack of technical knowledge, patients frequently have difficulty fully grasping the background information relevant to understanding their condition and the options available to them for treatment. Their dependence on care providers to offer both diagnosis and treatment compounds the difficulty and underscores the need to create a system where patients are not misled or taken advantage of. Noting these challenges is not intended to suggest that the market for health care is *completely* different from other markets for goods and services, or that patients are fundamentally

First, physicians and nurses are professionals that have historically enjoyed a measure of public respect and deference concomitant with an expectation that their medical judgments would be guided first and foremost by what was in a particular patient's best interest.⁴ This dynamic immediately complicates the common understanding of a business venture's first and foremost priority, namely, to produce profits on behalf of shareholders or investors.⁵

In the healthcare business, however, a patient, regardless of her socioeconomic status or level of education, ultimately must trust her healthcare professionals with her wellbeing.⁶ Even as sophisticated healthcare consumers seek multiple opinions and consult virtual libraries of data on the Internet, the motivation to self-educate and question is not driven by a "buyer beware" precaution regarding what alternative motivations – either to shareholder investors or to one's personal ownership interests – might be lurking in the shadows and influencing their doctor's medical judgment. Rather, patients seek second opinions or second-guess their physicians because the practice of medicine is understood to be as much art as it is science.⁷ Sophisticated healthcare consumers appreciate the role that judgment plays in the decisions regarding appropriate medical

unable to advocate for themselves and make good choices. It is simply to note some of the distinctive conditions of health care and the need to design a system in which patients are put in positions where they can make informed and sound choices.

Id. at 426.

4. See Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 48 (1993) ("Indeed, traditional medical ethics insisted that physicians do everything possible for the individual patient, independent of political or economic constraints."). See generally Joshua E. Perry, *The Ethical Costs of Commercializing the Professions: First-Person Narratives From the Legal and Medical Trenches*, 13 U. PA. J.L. & SOC. CHANGE 169 (2010) (discussing the service component and relational aspects at the heart of historic notions of professionalism).

5. Perhaps the most enduring statement regarding the appropriate mission of a business is Milton Friedman's classic, *The Social Responsibility of Business to Increase Its Profits*, N.Y. TIMES MAG., Sept. 13, 1970, at 211 ("In either case, the key point is that, in his capacity as a corporate executive, the manager is the agent of the individuals who own the corporation or establish the eleemosynary institution, and his primary responsibility is to them."). *Contra* LYNN STOUT, THE SHAREHOLDER VALUE MYTH: HOW PUTTING SHAREHOLDERS FIRST HARMS INVESTORS, CORPORATIONS, AND THE PUBLIC 25 (2012) ("The notion that corporate law requires directors, executives, and employees to maximize shareholder wealth simply isn't true."); Gilmartin and Freeman *infra* note 9.

6. See Andrew C. Wicks, *Albert Schweitzer or Ivan Boesky? Why We Should Reject the Dichotomy Between Medicine and Business*, 14 J. BUS. ETHICS 339, 341–42 (1995) ("Due to the nature of the physician-patient relationship under a fee-for-service arrangement, it is in the self-interest of the physician not only to apply beneficial therapies, but to be overzealous. Providing aggressive and even excessive care to patients actually benefits the physician financially.").

7. Ann MacLean Massie, *In Defense of the Professional Standard of Care: A Response to Carter Williams on "Evidence-Based Medicine"*, 61 WASH. & LEE L. REV. 535, 550 (2004) (citing Edward B. Hirshfeld, *Should Practice Parameters Be the Standard of Care in Malpractice Litigation?*, 266 JAMA 2886, 2888 (1991)).

interventions.⁸ To be clear, however, unlike customers shopping on a used car lot or in a fashion boutique where the sales clerk works on commission, healthcare consumers are not expected to take into account what Albert Carr infamously referred to as the acceptable rules of puffery, deception, and self-interest that many understand to be operative in the game of business.⁹

Moreover, consider the “products” of the healthcare delivery business. These too are unique in the marketplace of goods and services. Maintaining good health, preventing the spread of disease, healing sickness, treating chronic and non-curable afflictions, surgical interventions, and improving life’s quality for those dying—these constitute the most popular and top-selling widgets in the doctoring business.¹⁰ All of these outcomes *can* be addressed by costly interventions, but not all require large expenditures or technological wizardry.¹¹ Many healthcare objectives can be achieved at minimal financial cost.¹² Yet, in some circumstances a physician’s motivations can become unnecessarily conflicted by financial incentives that complicate the relational dynamics and delicate balance between the pecuniary interests of the physician, the health interests of the patient, and the best interests of the broader society.¹³ One such circumstance, discussed in this article, is the business of dialysis.

The healthcare delivery business is marked by at least these three distinctive qualities: the centrality of a relationship predicated upon trust between a professional healthcare provider and a patient; the unique potential for vulnerability and compromised judgment on the part of a

8. See Stephen A. Eraker & Peter Politser, *How Decisions are Reached: Physician and Patient*, in PROFESSIONAL JUDGMENT: A READER IN CLINICAL DECISION MAKING 380, 380–81 (1988).

9. Albert Z. Carr, *Is Business Bluffing Ethical?*, 46 HARV. BUS. REV. 143, 145 (1968) (“That most businessmen are not indifferent to ethics in their private lives, everyone will agree. My point is that in their office lives they cease to be private citizens, they become game players who must be guided by a somewhat different set of ethical standards.”). Of course, there are competing views of how the business “game” should be played. See Per Saxegaard, *Being and Acting Business Worthy*, in TIMOTHY L. FORT, THE VISION OF THE FIRM 282, 286 (2014) (“If you try to conduct business without a set of rules and values, it’s not business, it becomes “eat or be eaten. . . . We need to embrace ethical awareness and responsible conduct.”); Mattia J. Gilmartin & R. Edward Freeman, *Business Ethics and Health Care: A Stakeholder Perspective* 27 HEALTH CARE MGMT. REV. 52 (2002) (arguing that much of the criticism of the business of health care flows from a “cowboy capitalism” conceptualization that frames business as a “competitive jungle resting on self-interest and an urge for competition in order to survive” which stakeholder theory challenges).

10. See Laurie Mortara, *A Reminder of Medicine’s Main Purpose*, KEVINMD (Oct. 5, 2012), <http://www.kevinmd.com/blog/2012/10/reminder-medicines-main-purpose.html>.

11. See ALAN HAYCOX, WHAT IS HEALTH ECONOMICS? 1 (2d ed. 2009), available at http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/what_is_health_econ.pdf.

12. See *id.* at 2.

13. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL’Y 23, 24 (1986) (noting that “[w]hen the first physician requested a fee for his services, economics and conflict of interest entered medicine.”).

patient who views her physician first and foremost as an advocate for and guardian of her best interests; and the myriad, integrated issues of cost, quality, and access related to a finite supply of medical services and providers—all against the backdrop of a fundamental good, i.e., public health, necessary for the community to flourish.¹⁴ This trio of concerns makes the business of medicine unique—or at least heightens concerns raised by business ethicists—and triggers a particularly necessary and important reflection upon these ethical considerations.

“Ethics in its broadest sense,” Larry Churchill observes, “concerns how we live and the choices we make.”¹⁵ In the context of practical policy deliberations, such ethical reflection facilitates review of the array of values in play and the commitments of the various participants.¹⁶ Contemplation of ethical concerns, ultimately, makes it possible to understand more fully the operative principles underlying stakeholders’ positions, as well as their implications and likely consequences if adopted.¹⁷ To the extent health policy decisions involve the prioritization of competing goods and the distribution of benefits and burdens, ethical deliberation is, therefore, essential.¹⁸ Moreover, as noted above, the delivery of healthcare is, “at its roots, a helping enterprise,”—a business permeated with the concept of care—that has been historically characterized by individual and corporate commitments to serving the best interests of others, not a reductionist pursuit of profit maximization driven by advertising campaigns, efforts to increase sales, and strategies for capturing market share.¹⁹ This article will argue that as a business that operates with some fundamentally unique variables, those in the healthcare business (particularly those engaged in the delivery of dialysis care to patients) should take seriously the concept of ethical astuteness (a concept that will be further described in Part V)—both as a professional safeguard against the creep of competing economic interests (driven by the demands of third party investors) that might

14. See Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323 (1995) (identifying six core facets of the doctor-patient relationship: choice, competence, communication, compassion, continuity, and the absence of conflicts of interest).

15. Larry R. Churchill, *What Ethics Can Contribute to Health Policy*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 53 (Marion Danis, Carolyn Clancy & Larry R. Churchill eds., 2002).

16. See Brennan, *supra* note 4, at 53 (“The three principles that guide an ethics of health policy [include] . . . patient commitment, institutional commitment, and provider community orientation.”).

17. See Perry, *supra* note 2.

18. Brennan, *supra* note 4, at 72.

19. Brennan, *supra* note 4, at 38. See generally Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. MED. & ETHICS 236, 238 (1995) (discussing what ethical standards will govern competitively managed healthcare organizations). But see Joshua E. Perry, *An Obituary for Physician-Owned Specialty Hospitals*, 23 HEALTH LAWYER 24, 24–34 (2010) (describing the tensions between commercialism and professionalism throughout the history of medical practice in the United States).

compromise the health care profession's primary commitment to patient care and as a pragmatic strategy in the inevitable need to defend the healthcare provider against tort claims of medical malpractice.

II. FINANCIAL CONFLICTS OF INTEREST IN THE HEALTH CARE INDUSTRY²⁰

A. The Rise of For-Profit Medicine

Writing for the Institute of Medicine in 1983, Bradford Gray outlined the controversy surrounding the widespread emergence of for-profit medicine during the 1970s.²¹ Proponents of the investor-owned trend in health care heralded the efficiencies, innovations, and fiscal discipline associated with business management practices designed to grow market share and maximize profits consistent with free market principles.²² Critics, however, argued that conflicts of interest are constitutive of for-profit business models that are premised upon financial incentives designed to encourage the ever-expanding consumption of finite and expensive goods.²³ Such conflicts of interest have, for example, resulted in well-documented cases of unnecessary medical services and treatments, often bloating systemic health care costs at taxpayers' expense.²⁴

20. Much of what follows in this section was adapted from Joshua E. Perry & Robert C. Stone, *In the Business of Dying: Questioning the Commercialization of Hospice*, 39 J.L. MED. & ETHICS 224–234 (2010).

21. BRADFORD H. GRAY ET AL., *An Introduction to the New Health Care for Profit*, in THE NEW HEALTH CARE FOR PROFIT 2 (1983). In fact, observers of the practice of medicine in America have been sounding alarms about the creeping commercialization of U.S. health care for at least the last thirty years. See Arnold S. Relman, *A Second Opinion* 36 (2007). It was 1980 when Arnold Relman, then editor of the *New England Journal of Medicine*, described what he alarmingly viewed as the “new medical-industrial complex” of for-profit corporations in the business of providing health care services to patients. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980) [hereinafter Relman, *The New Medical Industrial Complex*]. Dr. Relman was particularly concerned about the emergence of proprietary hospitals and nursing homes, as well as home care, diagnostic laboratory, and hemodialysis services. *Id.*

22. M. M. Hasan, *Let's End the Nonprofit Charade*, 334 NEW ENG. J. MED. 1053, 1055 (1996).

23. Eleanor D. Kinney, *For Profit Enterprise in Health Care: Can It Contribute to Health Reform?*, 36 AM. J. L. & MED. 405, 428 (2010).

24. James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 209 (1996). Professor Blumstein cites numerous studies confirming the overutilization that results from perverse economic incentives. See OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., NO. OAI-12-88-01410, FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES 18 (1989), available at <https://oig.hhs.gov/oei/reports/oi-12-88-01410.pdf>. (“Patients of referring physicians known to be owners or investors in clinical laboratories received, on the average, 45 percent more clinical laboratory services than all Medicare patients, in general, regardless of place.”); GENERAL ACCOUNTING OFFICE, NO. GAO/HEHS-95-2, REFERRALS TO PHYSICIAN-OWNED IMAGING FACILITIES; Blumstein, *supra*

In extreme cases, pressures to meet profit goals and satisfy investor expectations have resulted in fraud prosecutions of for-profit health care providers, most infamously realized in the cases of Tenet Healthcare and Healthcare Corporation of America (“HCA”), although the nonprofit sector has not been immune from government prosecution arising out of illicit reimbursement practices.²⁵ It is precisely because of congressional cost concerns related to fraudulent billing and other improper over-utilization of Medicare-reimbursable services that anti-kickback legislation, the Stark laws, enforcement of the False Claims Act, and other regulatory efforts have proliferated from the mid-1970s through the most recent health care reforms of 2010.²⁶

Additionally, the emergence over the last thirty years of for-profit health providers has prompted concerns about whether ownership status has any correlation to the quality of care provided.²⁷ On this point, the case of nursing homes is illustrative. Relatively consistent data indicate that differences in care do exist between for-profit and nonprofit nursing home providers “as measured by staffing ratios, quality-of-care and quality of life

(“Studies of the use of diagnostic imaging equipment done in 1990 and 1994 showed that patients of physicians who had an ownership interest in such equipment utilized some equipment 400% more than the patients of nonowning physicians.”) J. M. Mitchell and E. Scott, *Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics*, 268 JAMA 2055, 2057 (1992) (finding physicians having ownership interests in physical therapy clinics or radiation therapy centers similarly recommended patient visits to such facilities fifty percent more than did other physicians.”).

Additionally, Marc Rodwin’s book, *Medicine, Money, and Morals: Physicians’ Conflicts of Interest* (1993) includes copious evidence of ways in which physician self-interest results in Medicare abuse. For example, Rodwin cites a December 17, 1987, personal letter from Jim Codo, a medical laboratory salesperson who claimed that “where a high percent of Medicare recipients reside, there is a correspondingly high percent of physicians invested in laboratory ownership arrangements. The government in allowing such [practices] . . . might as well issue the physician owners their own money press. The physician controls the demand for services, owns the supply of the services, and is guaranteed payment for services by the government.” *Id.* at 97. Moreover, in his article *Physicians’ Conflicts of Interest: The Limitations of Disclosure*, Rodwin points to eighteen published studies by academic researchers and government regulators between 1970 and 1992 as evidence “that physicians who make referrals to medical facilities that they either own or have a financial interest in recommend more (or more expensive) medical tests and procedures than do physicians without a financial interest.” 321 NEW ENG. J. MED. 1405, 1406 (1989).

25. Kurt Eichenwald, *HCA is Said to Reach Deal on Settlement of Fraud Case*, N.Y. TIMES (Dec. 18, 2002), <http://www.nytimes.com/2002/12/18/business/hca-is-said-to-reach-deal-on-settlement-of-fraud-case.html> (reporting on an agreement with the Justice Department to pay more than \$880 million to settle a long-running inquiry into accusations of health care fraud). See also E. T. Wood, *Feds Win \$19.4M in Lawsuit over Renal Care Group Medicare Practices*, NASHVILLE POST (Mar. 23, 2010), https://www.nashvillepost.com/news/2010/3/23/feds_win_194m_in_lawsuit_over_renal_care_group_medicare_practices.

26. Perry, *supra* note 19.

27. COMM. FOR IMPLICATIONS OF FOR-PROFIT ENTER. IN HEALTH CARE, FOR PROFIT ENTERPRISE IN HEALTH CARE 3 (Bradford H. Gray, ed. 1986).

deficiencies, advance care planning discussions, complaints per home, and, in some cases, adverse health outcomes.”²⁸ The conflicting interests inherent in the incentive structures of for-profit health care endeavors demand careful scrutiny.

B. The Medical-Industrial Complex and Dialysis

Dialysis, in fact, presents a “particularly interesting example of stimulation of private enterprise by public financing of health care.”²⁹ When former *New England Journal of Medicine* editor Arnold Relman wrote about the emerging “medical-industrial complex,” he was referring in part to the rapid expansion of the patient population receiving long-term hemodialysis following Congress’s decision in 1972 to cover treatment of end-stage renal disease under Medicare.³⁰ Fueled by the flow of federal funds, the for-profit dialysis industry mushroomed from nearly non-existent in the early 1970s to a 40% market share by 1980.³¹

By 2002, 75% of dialysis services were provided by private, for-profit facilities, and early fears about compromises in patient care were being realized in the form of longer hospital stays (17% more days in hospital) and increased risk for premature patient death among for-profit providers.³² One of the most recent studies, published January 9, 2014, reported that overall hospitalization rates were significantly higher (15%) for patients receiving dialysis in for-profit compared with nonprofit dialysis

28. Melissa D. A. Carlson, William T. Gallo & Elizabeth H. Bradley, *Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey*, 42 MED. CARE 432 (2004) (citing W. E. Aaronson et al., *Do For-Profit and Not-For-Profit Nursing Homes Behave Differently?* 34 GERONTOLOGIST 775 (1994); C. Harrington et al., *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?*, 91 AM. J. PUB. HEALTH 1452 (2001); E. H. Bradley and C. W. Walker, *Education and Advance Care Planning in Nursing Homes: The Impact of Ownership Type*, 27 NONPROFIT & VOLUNTARY SECTOR Q. 339 (1998); B. A. Weisbrod and M. Schlesinger, *Public, Private, Nonprofit Ownership and the Response to Asymmetric Information: The Case of the Nursing Homes*, in THE ECONOMICS OF NONPROFIT INSTITUTIONS (S. Rose-Ackerman ed., 1986); S. Y. Chou, *Asymmetric Information, Ownership and Quality of Care: An Empirical Analysis of Nursing Homes*, 21 J. HEALTH ECON. 293 (2002)). See generally Vikram R. Comondore et al., *Quality of Care in For-Profit and Not-For-Profit Nursing Homes: Systematic Review and Meta-Analysis*, 339 BRIT. MED. J. 381 (2009).

29. Relman, *The New Medical Industrial Complex*, *supra* note 21, at 965.

30. *Id.*

31. *Id.*

32. P. J. Devereaux et al., *Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centers: A Systematic Review and Meta-Analysis*, 288 JAMA 2449, 2450 (2002); L.A. Szczech et al., *Associations Between CMS’s Clinical Performance Measures Project Benchmarks, Profit Structure, and Mortality in Dialysis Units*, 69 KIDNEY INT’L 2094, 2097 (2006) (“[I]rrespective of its minor contribution, profit status was associated with mortality.”); Donald K.K. Lee, et al., *Reexploring Differences Among For-Profit and Nonprofit Dialysis Providers*, 45 HEALTH SERVICES RES. 633, 640 (2010); Y. Zhang et al., *The Effect of Dialysis Chains on Mortality Among Patients Receiving Hemodialysis*, 46 HEALTH SERVICES RES. 747, 759 (2011).

facilities.³³ Furthermore, for-profit dialysis facilities had higher admission rates for heart failure and volume overload (37% higher), as well as vascular access complications (15% higher) compared with nonprofit facilities.³⁴ These findings echo data published fifteen years ago in the *New England Journal of Medicine* that also documented an association between for-profit ownership and a lower quality of care.³⁵

Similarly, additional studies have shown greater utilization of erythropoiesis-stimulating agents (i.e., Epogen, Epoetin, or EPO – the primary drug used to treat anemia resulting from kidney disease) in for-profit versus nonprofit facilities.³⁶ In fact, Medicare reimbursements for Epogen—the second-largest source of dialysis facility income—were discovered to be incentivizing large, for-profit chain facilities to administer dosages of the drug in excess of the clinical guidelines, which resulted in a January 1, 2011, change in Medicare payment structures.³⁷

Finally, it should be noted that researchers have also found decreased rates of listing for transplantation in for-profit facilities, as well as decreased transplant education time with nephrologists at for-profit compared with nonprofit dialysis facilities.³⁸ Attempting to explain their findings, these researchers pointed to a greater emphasis on income generation and concomitant lack of incentives for unprofitable interventions at for-profit dialysis facilities.³⁹

33. Lorien S. Dalrymple et al., *Comparison of Hospitalization Rates Among For-Profit and Nonprofit Dialysis Facilities*, 9 *CLINICAL J. AM. SOC'Y NEPHROLOGY* 73, 73 (2014).

34. Barry M. Straube, *Do Health Outcomes Vary by Profit Status of Hemodialysis Units?*, 9 *CLINICAL J. AM. SOC'Y NEPHROLOGY* 1, 1 (2014).

35. Pushkal P. Garg et al., *Effect of the Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation*, 341 *NEW ENG. J. MED.* 1653 (1999). J.M. Brooks et al., *Effect of Dialysis Center Profit-Status on Patient Survival: A Comparison of Risk-Adjustment and Instrumental Variable Approaches*, 41 *HEALTH SERVICES RES.* 2267, 2286 (2006) (finding that “the competitive market for dialysis services forced all dialysis providers to maintain sufficient quality levels regardless of the overriding goals of each organization.”).

36. In July 2012, DaVita agreed to pay \$55 million to the federal government to settle allegations related to its use of Epogen in dialysis patients. See Michael Booth and Christopher N. Osher, *Denver-Based DaVita Settles Case on Overuse of Kidney Care Drug*, *THE DENVER POST* (July 4, 2012), http://www.denverpost.com/ci_21002816/denver-based-davita-settles-case-overuse-kidney-care (“The Texas whistleblower lawsuit accused DaVita of using more Epogen than was medically necessary, and for double-billing the government for Epogen left over in vials and reused.”). See generally M. Thamer et al., *Dialysis Facility Ownership and Epoetin Dosing in Patients Receiving Hemodialysis*, 297 *JAMA* 1667 (2007).

37. Thomas A. Golper et al., *Home Dialysis in the New USA Bundled Payment Plan: Implications and Impact*, 31 *PERITONEAL DIALYSIS INT'L* 12 (2011).

38. Garg, *supra* note 35; K.S. Balhara, et al., *Disparities in Provision of Transplant Education by Profit Status of the Dialysis Center*, 12 *AM. J. TRANSPLANTATION* 3104 (2012).

39. See Garg, *supra* note 35, at 1660; Balhara, *supra* note 38, at 3110.

III. THE DAVITA CASE STUDY⁴⁰

With revenue in excess of \$8 billion⁴¹ and more than 50,000 employees,⁴² DaVita HealthCare Partners, Inc. is one of the United States' leading providers of kidney care, i.e., dialysis services, and related lab services.⁴³ According to filings with the Securities and Exchange Commission, DaVita provides dialysis and administrative services in the United States through a network of 2,074 outpatient dialysis centers in forty-five states and the District of Columbia, serving a total of approximately 163,000 patients.⁴⁴ DaVita also provides acute inpatient dialysis services in approximately 1,000 hospitals and related laboratory services throughout the United States.⁴⁵

A. Case of William Pepper

On the morning of January 8, 2009, William Pepper began outpatient dialysis treatment at Yakima Dialysis Center (hereinafter, "DaVita"), a medical facility owned and operated by [DaVita, Inc. and Renal Treatment Centers West, Inc]. At the time of his treatment, Mr. Pepper

40. A review of research of litigation involving DaVita revealed the following cases: *Miles v. DaVita RX, LLC*, 962 F.Supp.2d 825 (D. Md. 2013) (involving a Title VII hostile work environment claim); *IHS Dialysis, Inc. v. DaVita, Inc.*, No. 12 Civ. 2468(ER), 2013 WL 1309737 (S.D.N.Y. Mar. 31, 2013) (involving an antitrust action); *United States v. DaVita, Inc. and Gambro Healthcare, Inc.*, No. 1:07-CV-2509-CAP, 2013 WL 1342431 (N.D. Ga. Feb. 13, 2013) (involving a contract dispute and False Claims Act claim); *Chapman v. DaVita, Inc.*, 380 S.W.3d 710 (Tenn. 2012) (involving a worker's compensation claim); *Hunt v. DaVita, Inc.*, No. 10-602-GPM, 2011 WL 2532845 (S.D. Ill. June 24, 2011) (involving a retaliatory discharge claim); *Moran v. DaVita, Inc.*, No. 06-5620(JAP), 2009 WL 792074 (D. N.J. Mar. 23, 2009) (involving an employment dispute); *Total Renal Care, Inc. v. W. Nephrology and Metabolic Bone Disease, P.C.*, No. 08-cv-00513-CMA-KMT, 2009 WL 2596493 (D. Colo. Aug. 21, 2009) (involving an antitrust action); *Mason v. DaVita, Inc.*, 542 F. Supp.2d 21 (D.D.C. 2008) (involving an employment dispute); *Hardiman v. DaVita, Inc.*, No. 2:05-CV-262-JM, 2007 WL 1395568 (N.D. Ind. May 10, 2007) (involving a negligence action); *Gambini v. Total Renal Care, Inc.*, 480 F.3d 950 (9th Cir., 2007) (involving a FMLA employment dispute); *DaVita, Inc. v. Washington State Dep't of Health*, 151 P.3d 1095 (Wash. Ct. App. 2007) (involving a dispute regarding Certificate of Need decision); *Martinez v. DaVita, Inc.*, 598 S.E.2d 334 (Ga. Ct. App. 2004) (involving a covenant not to compete dispute).

41. *Senior Analyst—Revenue Operations, Team Revelation: Position Description*, DAVITA, <http://careers.davita.com/search/208802/37027/senior-analyst-revenue-operations-team-revelation> (last visited Apr. 3, 2015).

42. *Our Careers*, DAVITA, <http://careers.davita.com/careers> (last visited Mar. 24, 2015).

43. DAVITA HEALTHCARE PARTNERS, INC., ANNUAL REPORT (FORM 10-K) 2 (2014), available at <http://yahoo.brand.edgar-online.com/displayfilinginfo.aspx?FilingID=9802387-1121-936138&type=sect&TabIndex=2&dcn=0001193125-14-062565&nav=1&src=Yahoo>.

44. *Id.*

45. *Id.*

exhibited signs of poor health: he was receiving controlled delivery of oxygen, and required significant assistance to move himself into the dialysis chair to receive treatment. Some DaVita staff members expressed concern that Mr. Pepper was receiving outpatient—as opposed to inpatient—dialysis treatment, given his poor condition. Customarily, dialysis patients who are more fragile or ill require a higher level of supervision than healthier patients, and thus receive inpatient treatment.⁴⁶

At approximately 1:55 p.m. that afternoon—several hours into Mr. Pepper’s dialysis treatment—DaVita’s medical staff discovered that Mr. Pepper was unconscious and not breathing. A large amount of Mr. Pepper’s blood had pooled on the floor beneath his dialysis chair, and blood also covered the chair itself and Mr. Pepper’s clothes. Upon discovering his condition, DaVita staff began treating Mr. Pepper. Although Mr. Pepper briefly regained consciousness, he was subsequently transported to Memorial Hospital, where he died at 9:20 p.m. that evening.⁴⁷

At the time Mr. Pepper exsanguinated, [i.e., experienced his extreme blood loss], many DaVita staff members were participating in a “mock audit” in preparation for an actual upcoming audit by the Washington State Department of Health (“DOH”). During this mock audit, only two patient care technicians (“PCTs”) were assigned to the treatment “pod” in which Mr. Pepper and six other dialysis patients were receiving treatment. One of the PCTs, Mauro Hernandez, was on break and not in the treatment area at the time Mr. Pepper exsanguinated. The other PCT, Bonnie Hursh, was connecting another patient to a dialysis machine at the time of the incident. . . . Plaintiff’s [proffered] expert, Tricia West, R.N. [testified during her deposition] that Mr. Pepper’s substantial blood loss was, by itself, evidence of a problem with the visibility of Mr. Pepper’s dialysis access. [Nurse West further testified,] “I believe that [had Mr. Pepper’s] access been visible and

46. Sutton v. Renal Treatment Centers W., Inc., No. CV-10-3067-EFS, 2013 WL 550241 (E.D. Wash. Feb 12, 2013).

47. *Id.*

[had DaVita's staff] observed the dislodged needle, they would have intervened and stopped the blood loss."⁴⁸

....

In response to Mr. Pepper's death, DOH began investigating DaVita's patient safety practices. Several weeks following Mr. Pepper's death, DOH investigators visited the DaVita facility and found that the dialysis accesses of four separate patients were not visible to facility staff at all times during treatment [as required by federal regulations]. DOH also interviewed the facility's administrator, Shomei Meister, and determined that she did not know the proper definition of "visible at all times" with regard to a patient's access. DOH concluded that DaVita's policies and procedures did not properly define—and that facility staff did not have a clear understanding of what constituted—a "visible dialysis access."⁴⁹

B. Case of Deborah Scott

[Deborah Scott], a social worker, was an "at will" employee at DaVita's North Oakland Dialysis Facility ("DaVita Facility") in Pontiac, Michigan, from 1996 to February 5, 2004. . . . In or around November 2003, [Ms. Scott called] a toll-free phone number that was posted at the DaVita Facility [to complain] about "staffing irregularities," such as inadequate and inaccurate reporting of staffing and high staff turnover that she felt adversely impacted patient safety. [Additionally, Scott] complained about "charting irregularities" such as long-term care plans were not done as often as required. [Later, during audits from state regulators, Ms. Scott] made similar complaints about "short staffing, charting issues, turnover in staff," the hiring of inexperienced replacements for technicians, "scheduling irregularities," and patients' fear about their safety.⁵⁰

48. *Id.* at *1. "Defendants argued that Nurse West's opinion about these two potential causes for Mr. Pepper's exsanguination constituted impermissible speculation," but the court disagreed and denied Defendants' motion for summary judgment. *Id.* at *3.

49. *Id.* at *2.

50. *Scott v. Total Renal Care, Inc.*, No. 04-71700, 2005 WL 1680677, *1 (E.D. Mich. July 19, 2005).

Either as a result of Ms. Scott's complaints or patients' complaints, state regulators made an unannounced visit to the DaVita Facility on January 16-18, 2004 and issued citations for lack of documentation regarding long-term care and insufficient staffing.⁵¹ Ms. Scott was terminated on February 5, 2004 and later filed a claim for retaliatory termination on May 5, 2004.⁵² Finding that Ms. Scott was unable to show that she was discharged because of her protected activity, her claims were dismissed by the court.⁵³

C. Case of Demitria Howard

Beginning in late 2007, DaVita employed Demitria Howard as a dialysis technician.⁵⁴ Although Howard regularly worked in excess of 40 hours per week, she sued DaVita alleging violations of the Fair Labor Standards Act on the basis that DaVita did not credit her any time beyond 40 hours, nor did DaVita fully compensate her.⁵⁵

In March 2010, Howard sent an email to the DaVita's regional operations director, Matthew Forsythe, to inform him that she had not been fully compensated for the hours she worked. In May 2010, Forsythe met with Howard to discuss the back pay owed to her. Forsythe offered back pay, but Howard alleges that DaVita owed her significantly more than Forsythe offered. Also, Howard allege[d] that DaVita did not compensate other dialysis technicians for overtime at one and one-half times the regular rate. Last, Howard allege[d] that it was DaVita's policy and practice to falsely deduct hours from its employees['] time cards to bring their total hours below 40 per week to avoid paying overtime.⁵⁶

The trial court denied DaVita's motion to dismiss pursuant to F.R.C.P. 12(b)(6), finding Howard's claims plausible on their face because she had alleged enough facts to raise a reasonable expectation that subsequent discovery would reveal evidence supporting her allegations.⁵⁷

51. *Id.* at *3.

52. *Id.* at *4.

53. *Id.* at *11.

54. Howard v. Renal Life Link, Inc., No. 10 C 3225, 2010 WL 4483323, at *1 (N.D. Ill. Nov. 1, 2010).

55. *Id.*

56. *Id.* at *2.

57. *Id.* at *3.

D. Accusations of Medicare Fraud and Stark Kickback Violations

In July 2012, DaVita agreed to pay \$55 million to the federal government to settle allegations raised by whistleblowers in Texas related to its use of Epogen (a drug used to treat anemia) in dialysis patients.⁵⁸ Overuse of Epogen can lead to heart problems, blood clots, and even premature deaths.⁵⁹ As of 2007, prior to new Medicare reimbursement policies that now limit use of Epogen, 25% of DaVita's revenue and up to 40% of its earnings were connected to the drug, according to the Stanford Group Company research firm.⁶⁰

Filed in 2007 (but only unsealed in 2010), whistle-blower litigation is currently pending in Georgia federal court alleging \$800 million in Medicare fraud from 2003 through 2010 related to administration and wastage of the drugs Zemplar and Venofer.⁶¹ The lawsuit alleges that DaVita required nurses to use one ten-microgram vial of Zemplar, a vitamin D drug, instead of a six-microgram dose in three two-microgram vials.⁶² DaVita then billed Medicare for all ten micrograms even though four were not used.⁶³ Instead of giving an entire 100-milligram vial of Venofer, an iron drug, once or twice a month, the clinics gave twenty-five-milligram doses more frequently, according to the lawsuit.⁶⁴ But since the drug came only in a 100-milligram vial, Medicare was billed for 100 milligrams for each dose, even though seventy-five milligrams were wasted, the lawsuit says.⁶⁵

While DaVita denies all wrongdoing in these Medicare fraud *qui tam* actions – even in the case of its \$55 million settlement regarding Epogen abuse – 2008 figures from a government-funded program that tracks dialysis in the United States reveal that DaVita spent more per patient on iron drugs, Vitamin D drugs, and Epogen than any other chain dialysis provider.⁶⁶

In February 2014, DaVita announced it would pay \$389 million to settle criminal and civil anti-kickback charges stemming from a multi-year

58. Booth & Osher, *supra* note 36.

59. Andrew Pollack, *The Dialysis Business: Fair Treatment*, N.Y. TIMES, Sept. 16, 2007, at B1.

60. *Id.*

61. United States *ex rel.* Vainer v. DaVita, Inc. and Gambro Healthcare, Inc., No. 1:07-CV-2509-CAP, 2013 WL 1342431, at *1 (N.D. Ga. Feb. 13, 2013) (denying defendants' motion for partial summary judgment). *See also* Bill Rankin, *Whistle-Blowers Say Dialysis Firm Bilked Medicare*, ATL. J. CONST. (Dec. 7, 2012), <http://www.ajc.com/news/news/local/differing-views-in-massive-whistle-blower-case/nTPwY/>; Andrew Pollack, *Lawsuit Says Drugs Were Wasted to Buoy Profit*, N.Y. TIMES, July 25, 2011, at B1.

62. United States *ex rel.* Vainer, 2013 WL 1342431, at *8.

63. *Id.* at *2.

64. *See* Pollack *supra* note 59.

65. *Id.*

66. *Id.*

investigation by the U. S. Attorney's Office in Denver, the civil division of the U.S. Department of Justice and the U.S. Department of Health and Human Services' Office of Inspector General into whether DaVita's joint ventures with kidney doctors complied with the Stark laws governing financial relationships that might influence where patients seek medical treatment.⁶⁷

E. Kent Thiry, DaVita CEO: Success and "Cult of Personality"⁶⁸

When Kent Thiry was recruited to run Total Renal Care in 1999, its revenue was \$1.4 billion and its stock traded around \$2.⁶⁹ Thiry changed the company's name to DaVita and overhauled the corporate culture.⁷⁰ Often referred to as the "Mayor" of the "DaVita Village," Thiry is known to wear a musketeer outfit and enthusiastically (and dramatically) cheerlead at corporate training events with an "All for One, and One for All" chant and over-the-top presentation antics.⁷¹ By 2006, Thiry had taken the company to \$4.9 billion in revenues and a \$62 stock price.⁷² As of 2012, revenues had soared to \$8.1 billion and stock was selling near \$100.⁷³ Headquartered in Denver, DaVita owns approximately 2,100 outpatient dialysis centers (second in market share behind German-owned Fresenius) in forty-five states and the District of Columbia, serves 163,000 patients and employees over 53,000 people.⁷⁴

DaVita has been lauded as the subject of a Stanford Business School case study,⁷⁵ recognized by CNN Money as #2 on its rankings of the "World's Most Admired Companies" in healthcare, and – for four consecutive years – ranked number one in innovation on *Fortune Magazine's* "World's Most Admired Companies" ranking of health care facilities.⁷⁶ Moreover, DaVita's compliance and ethics training program, which recently received the "Health Ethics Trust's Best Practices" Award,

67. See Christopher N. Osher, *DaVita to Pay \$389 Million to Settle Anti-Kickback Investigation*, THE DENV. POST (Oct. 22, 2014), http://www.denverpost.com/news/ci_26780485/davita-pay-389-million-settle-anti-kickback-investigations.

68. Luc Hatlestad, *The Strangest Show on Earth*, 5280 MAGAZINE, Sept. 2012, available at <http://www.5280.com/magazine/2012/09/strangest-show-earth>.

69. Pollack, *supra* note 59.

70. Hatlestad, *supra* note 68.

71. *Id.*

72. Pollack, *supra* note 59.

73. Hatlestad, *supra* note 68.

74. *Id.*

75. Jeffrey Pfeffer, KENT THIRY AND DAVITA: LEADERSHIP CHALLENGES IN BUILDING AND GROWING A GREAT COMPANY, Case OB-54, STAN. GRAD. SCHOOL OF BUS., (2006).

76. DAVITA HEALTH CARE PARTNERS, AWARDS AND RECOGNITION, DAVITA, http://www.davita.com/UploadedFiles/About_v4/Media_Room/Awards_and_Recognition.pdf (last visited Feb. 3, 2015).

has been in place since at least 2005.⁷⁷ It is composed of fifty full-time employees and is led by Jeanine Jiganti, chief compliance officer.⁷⁸ DaVita's approach to compliance and ethics training combines in-person training sessions, automated online training, and ongoing real-time guidance and support from the company's compliance team.⁷⁹ According to a report in the journal *Ethikos*, DaVita employees are administered compliance training upon hire, and required to complete at least one compliance training course per year (more, depending on the position and role within the company), with the majority of these trainings occurring via an online educational experience.⁸⁰ Sarah Richardson, a senior director in the compliance department notes that the focus of trainings for "office-based teammates" is on "the False Claims Act, kickback policies, and how to interpret federal regulations," while patient care is the top concern among those DaVita employees located in clinical settings.⁸¹

The compliance and ethics training program notwithstanding, as documented above, a review of legal filings and media reports raises a variety of cases that, in the aggregate, reveal a healthcare firm with financial interests potentially in conflict with the ultimate professional mandate of any health care provider, namely, delivering quality health care in a manner and means that protects the best interest of the patient. Furthermore, as a matter of business strategy, a more robust recognition of the competing interests introduced by a for-profit business model might mitigate exposure to legal liabilities arising out of malpractice claims.

IV. LEGAL ASTUTENESS AS A TEMPLATE FOR ETHICAL ASTUTENESS

In 2008, Professor Constance Bagley published a ground-breaking paper in the prestigious *Academy of Management Review* wherein she argued that "failure to integrate law into the development of strategy and of action plans can place a firm at a competitive disadvantage."⁸² Bagley labeled her concept "legal astuteness" and described it further as "the ability of a [top management team] to communicate effectively with counsel and to work together to solve complex problems" by developing "(1) a set of value-laden attitudes," (2) a proactive approach, (3) the ability to exercise informed judgment, and (4) context-specific knowledge of the relevant law and appropriate application of legal tools."⁸³ The value of

77. Alexandra Theodore, *When It Comes to Compliance Training, DaVita Seeks to Add 'Adventure,'* 27 *ETHIKOS* 1, 1-2 (Nov-Dec. 2013).

78. *Id.* at 2.

79. *Id.*

80. *Id.* at 3.

81. *Id.*

82. Constance E. Bagley, *Winning Legally: The Value of Legal Astuteness*, 33 *ACAD. MGMT. REV.* 378, 378-79 (2008).

83. *Id.* at 379.

“legal astuteness” to an organization might be realized as better internal management or competitive advantage in the market through increased value along one or more of these strategically important domains.⁸⁴ After elaborating briefly on Bagley’s work, Part V argues that in the context of healthcare businesses, such as the business of dialysis, a failure to integrate ethical astuteness into the firm’s culture can similarly create market disadvantages and potential legal exposure.

A. The Attitudinal Component of Legal Astuteness

For business managers, the law, as well as related regulations, sets forth the boundaries of what is and what is not permissible.⁸⁵ In a normative sense, the law also functions as a reflection of society’s values and attitudes regarding right conduct, and savvy is the organizational manager who respects not only the letter, but also the spirit of laws relevant to her industry.⁸⁶ As Bagley notes, “legally astute management teams understand the importance of anticipating tomorrow’s laws and of trying to predict how existing laws may be interpreted, enforced, and changed in the future.”⁸⁷ How a firm responds to the grey areas surrounding bright line legal rules can impact the firm’s public reputation for good or ill.⁸⁸

B. The Proactive Component of Legal Astuteness

As Mary Daly observes, business managers desire legal counsel that addresses business opportunities and threats in ways that are effective, efficient, and strategic.⁸⁹ Contrary to how some business professionals view the law, those bringing “legal astuteness” to business decision-making need not be merely restrictive and concerned with policing business conduct.⁹⁰ Rather, forward-thinking, creative and legally astute management teams can add significant value in the execution of business strategy, as well as the development of legal safeguards.

84. Constance E. Bagley, *What’s Law Got to Do With It?: Integrating Law and Strategy*, 47 AM. BUS. L.J. 587, 588 (2010). See also Robert C. Bird, *Pathways of Legal Strategy*, 14 STAN. J.L. BUS. & FIN. 1, 12–38 (2008) (identifying five behaviors that managers can use to gain competitive advantage).

85. See Bagley, *supra* note 84, at 588–89.

86. See *id.*

87. Bagley, *supra* note 82, at 380.

88. See Bagley, *supra* note 84, at 589.

89. Mary C. Daly, *The Cultural, Ethical and Legal Challenges in Lawyering for a Global Organization: The Role of General Counsel*, 46 EMORY L.J. 1057, 1061 (1997).

90. Robert L. Nelson & Laura Beth Nielson, *Cops, Counsel, and Entrepreneurs: Constructing the Role of Inside Counsel in Large Corporations*, 34 LAW & SOC’Y REV. 457, 463 (2000).

C. The Judgment Component of Legal Astuteness

Bagley's discussion of judgment recognizes that much ambiguity and uncertainty often infuse both legal analysis and business strategy and thus, it is crucial that managers cultivate deliberative wisdom.⁹¹ An appreciation for the law can help in this regard, as precedent can guide analogical reasoning and professional norms, such as prudence can promote caution. Moreover, legal astuteness, at least on Bagley's account, also includes a recognition of the cognitive biases and pressures that can compromise good decision making.⁹²

D. The Knowledge Component of Legal Astuteness

The fourth component of "legal astuteness" refers to the specific and substantive advantage that legal literacy and functional familiarity with "the role that law plays in setting the rules of the game."⁹³ Bagley argues that business managers with the ability to "harness the creative power of legal language are more adept at seeing and shaping the legal structure of the world."⁹⁴ Specifically, she identifies "legal astuteness" as: 1) an ability to use legal tools, such as contracts in ways that strengthen relationships and create options while reducing transaction costs; and 2) an ability to convert regulatory constraints into opportunities and creative advantages.⁹⁵

V. ETHICAL ASTUTENESS

Drawing upon the concept of legal astuteness as developed by Bagley, I define ethical astuteness as a substantive and strategic focus by a firm's management team on its ethical responsibilities to patients and public health.

The view of ethical astuteness that I am introducing and outlining in this paper aims to add value for a firm in the healthcare business – with a particular application to a for-profit organization providing dialysis services – by addressing two chief concerns: A.) The competing priorities between the patient's interest in the healthcare encounter and the investor's interest in generating a return on profits; and B.) The vulnerabilities of a financially-conflicted, for-profit healthcare provider to an allegation of medical malpractice.

91. ANTHONY T. KRONMAN, *THE LOST LAWYER: FAILING IDEALS OF THE LEGAL PROFESSION* 132 (1995).

92. Bagley, *supra* note 82, at 382.

93. *Id.*

94. *Id.* at 383.

95. *Id.* at 386–87.

A. Professional Priorities and Safeguards

As Leonard Weber has observed, healthcare management ethics is business ethics, “but business ethics with a difference.”⁹⁶ Weber frames his discussion of healthcare business ethics in terms of the healthcare organization’s responsibility to community service.⁹⁷ He writes that community-based ethics “requires of for-profits that they be managed with a strong sense of social responsibility, such that they are fully and realistically committed to serving the community at the same time that they are committed to being profitable.”⁹⁸ This sense of social responsibility extends to a commitment to high-quality services and a commitment to respecting patient rights. As discussed earlier, this respect for patient rights flows from a respect for the person and the patient’s right to autonomy.

A robust culture of ethical astuteness can help remind and guide management personnel charged with the daily operation of a dialysis clinic that their business decisions must reflect these complex competing interests of patients and communities. In the business of healthcare, justification of a decision solely on the basis of profit or return on investment – without recognition of additional stakeholders and reconciliation with the priorities of medical ethics and professional standards among healthcare providers – is unsustainable as a matter of business practice. As argued previously, the business of healthcare is unique and must be practiced differently than other business enterprises.

Moreover, another manifestation of ethical astuteness among healthcare managers and business of medicine practitioners can result in greater awareness of the “heuristics and biases” literature.⁹⁹ Indeed findings from this literature and the field of behavioral ethics suggest that errors in framing, for example, contribute to erroneous ethical decision-making.¹⁰⁰ For instance, ethical astuteness would mandate that a manager of a dialysis clinic frame his business priorities each and every day in terms of patient care, vis-à-vis staffing decisions, training, and maintenance of equipment, just as much – if not more than – the attention paid to matters of

96. LEONARD J. WEBER, *BUSINESS ETHICS IN HEALTHCARE: BEYOND COMPLIANCE* 5 (2001).

97. *Id.* at 6.

98. *Id.* at 6–7.

99. See Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 *SCIENCE* 1124, 1124 (1974). As Professor Robert Prentice notes, this article is “one of the most-cited in the history of the social sciences and its ideas have been usefully applied in, among other fields, ‘medical diagnosis, legal judgment, intelligence analysis, philosophy, finance, statistics, and military strategy.’” Robert A. Prentice, *Behavioral Ethics: Can It Help Lawyers (and Others) Be Their Best Selves?*, 29 *NOTRE DAME J.L. ETHICS & PUB. POL’Y* 4, 6 (forthcoming 2015) (citing DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 8 (2011)).

100. RONALD A. HOWARD & CLINTON D. KORVER, *ETHICS FOR THE REAL WORLD: CREATING A PERSONAL CODE TO DECISIONS IN WORK AND LIFE* 95 (2008) (“[O]ur biggest mistakes in ethical decision making are mistakes in framing.”).

budget, payroll, advertising, and market share. As Professor Prentice argues:

Moral awareness is a precondition to moral action.¹⁰¹ It should be the moral responsibility of every individual, to keep ethical considerations in his or her own frame of reference whenever making decisions. And it is the responsibility of firms that wish their employees to act legally and ethically to continually prompt them to do so. The behavioral ethics literature indicates that this can have a meaningful impact.¹⁰²

B. Pragmatic and Authentic Strategy

As a matter of practical, prophylactic business strategy, a healthcare delivery firm, such as a dialysis clinic, could be well-served to create a culture of ethical astuteness that intentionally “promote[s] an organizational culture that encourages ethical conduct and a commitment to compliance with the law,” and thereby formalize protections from liability that might flow from negligent patient care or disgruntled employees.¹⁰³ Professor David Hess has documented the role that codes of conduct and compliance programs, particularly when mandated by legislation like the Sarbanes-Oxley Act of 2002 and the Organizational Sentencing Guidelines, can play in “proactively managing the ethical environment of their firms.”¹⁰⁴ Hess argues that management seeking to heighten ethical awareness must be careful not either to focus exclusively on employee monitoring and control or to adopt regulatory, ethical compliance programs simply as a form of “insurance” in the case of litigation.¹⁰⁵ In the context of dialysis and other health care settings, management must personally demonstrate a commitment to patient-first ethics and incorporate this commitment to patient care into strategic business decisions and cultivation of the organization’s culture.

101. Celia Moore & Francisco Gino, *Ethically Adrift: How Others Pull Our Moral Compass from True North, and How We Can Fix It*, 33 RES. IN ORG. BEHAV. 53, 61 (2013) (“Individuals are better equipped to make moral decisions if they are aware of the relevant moral values and implications of the decisions they are facing.”).

102. Prentice, *supra* note 99, at 16.

103. David Hess, *A Business Ethics Perspective on Sarbanes-Oxley and the Organizational Sentencing Guidelines*, 105 MICH. L. REV. 1781, 1783 (2007) (citing to the U.S. Sentencing Guidelines Manual § 8B2.1(a)(2)). According to the Guidelines, organizations that proactively manage legal compliance face significantly less harsh penalties if they are caught engaging in some form of punishable conduct. *Id.*

104. Hess, *supra* note 103.

105. *Id.* at 1805 (“With limited time and resources to devote to their compliance programs, it is reasonable to expect such managers to focus more of their efforts on internal controls and less on developing an integrity-based program.”).

Hess advocates for an approach to organizational ethical awareness that builds integrity through an emphasis on organizational values and employee self-governance, similar to what Professor Lynn Sharp Paine and others began describing twenty years ago.¹⁰⁶ With an authentic, integrity-based ethics program, the focus is on creating an organizational culture where employees are encouraged to discuss ethical issues and rewarded for making responsible choices. Equipping and empowering employees to make decisions – in the context of dialysis – that are in the best interest of the patient should be among management’s top priorities. Ultimately, it will be a sense of ownership among the employees that will characterize the ethical awareness that flows from an organization’s strategic and authentic integrity-based approach to ethics.

An illustration that demonstrates the distinctive behavior of employee “ownership” can be found in the context of a vacation rental car. When one rents a car on vacation, changing the oil never crosses the renter’s mind. A car renter is merely using the car for a short time, without any sense of personal investment in the long-term condition of the car. Contrast this behavior with one who purchases a car. The reality of ownership is that one must invest in the long-term care of the car, including regular oil changes, so as to preserve the condition and long-term benefits of the car. Similarly, fostering a sense of employee ownership is a critical component to creating a climate of ethical astuteness that not only might mitigate liability in a litigation context, but also should help promote a more genuine commitment to patient care by all members of the health care organization’s staff. In other words, emphasizing ethical astuteness should cause an organization to shift from a focus on mere compliance to a focus on authentic employee buy-in vis-à-vis prioritizing patient care. The potential defense shield in the event of litigation, however, is a strategic and potentially valuable corollary benefit.

VI. CONCLUSION

As noted above, mistakes are made in the delivery of healthcare services, and medical malpractice actions frequently follow. Imagine a hypothetical situation involving a dialysis clinic patient whose needle becomes dislodged, resulting in the patient’s death, and subsequent tort action for malpractice and wrongful death. If the plaintiff’s counsel can establish that the death occurred as a result of the clinic’s failures to

106. Lynn Sharp Paine, *Managing for Organizational Integrity*, HARV. BUS. REV. 106, 110–11 (1994). See also Gary R. Weaver & Linda Klebe Trevino, *Compliance and Values Oriented Ethics Programs: Influences on Employees’ Attitudes and Behavior*, 9 BUS. ETHICS Q. 315 (1999); Gary R. Weaver, Linda Klebe Trevino & Philip L. Cochran, *Corporate Ethics Programs as Control Systems: Influences of Executive Commitment and Environmental Factors*, 42 ACAD. OF MGMT. 41 (1999); Linda Klebe Trevino & Gary R. Weaver, *Organizational Justice and Ethics Program “Follow-Through”: Influences on Employees’ Harmful and Helpful Behavior*, 11 BUS. ETHICS Q. 651 (2001).

adequately secure the needle and/or failures to adequately monitor the patient to ensure that the access site remained visible throughout the duration of dialysis treatment, the plaintiff's lawyer will surely further connect the dots by arguing that either or both were more likely to occur because financial pressures to deliver profits were in conflict with the dialysis clinic's primary duty to do what is in the best interest of the patient.

As the literature and lawsuits noted throughout this Article demonstrate, in addition to the behavioral ethics literature documenting why good people/organizations often fail to make good choices/policies,¹⁰⁷ the tensions between financial best interests and patients' best interests are not always resolved by for-profit health care facilities and for-profit providers in ways that promote or safeguard patient well-being.

In the absence of evidence documenting a culture of ethical astuteness, it will be difficult for the dialysis clinic to rebut the presumption that divided loyalties introduced by for-profit firm structures is particularly dangerous for dialysis patients who are in a vulnerable position – physically, emotionally and psychosocially. In front of a jury, dialysis patients who rely on the nurses and techs and other employees at the dialysis facility to put the patients' best interest first and foremost, will be sympathetic plaintiffs indeed. One need not be an avid viewer of courtroom television dramas to imagine the plaintiff counsel's closing argument:

And so, ladies and gentlemen of the jury, it is for you to decide—in the absence of any culture of ethical awareness or astuteness—whether it is more likely than not that if the nurses and techs and other dialysis clinic employees had put the patient's well-being first on that fateful morning, his needle would not have become dislodged and remain dislodged resulting in the catastrophic exsanguination that resulted in his death. Surely, you must reach the conclusion that the dialysis clinic's failure to keep the patient's best medical interest and personal wellbeing as the business's primary interest can be best explained as an unintended consequence of a culture that – regardless of whatever corporate slogans and values are espoused by the corporation's charismatic leader – was ultimately compromised by the subtle, yet powerful, incentives and influences created by this publicly traded health care corporation's conflicting financial interests.

107. *See e.g.* MAX H. BAZERMAN & ANN E. TENBRUNSEL, *BLIND SPOTS: WHY WE FAIL TO DO WHAT'S RIGHT AND WHAT TO DO ABOUT IT* (2011); PATRICIA H. WERHANE ET AL., *OBSTACLES TO ETHICAL DECISION-MAKING* (2013); *BEHAVIORAL BUSINESS ETHICS: SHAPING AN EMERGING FIELD* (David DeCremer & Ann E Tenbrunsel eds., 2012).