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- Bowie, N. E. and Freeman, R. E. (1992). *Ethics and Agency Theory: An Introduction*. New York: Oxford University Press.
- Donaldson, L. and Davis, J. (1994). Boards and company performance: Research challenges the conventional wisdom. *Corporate Governance: An International Review*, 2, 151–60.
- Eisenhardt, K. M. (1989). Agency theory: An assessment and review. *Academy of Management Review*, 14, 57–74.
- Jensen, M. C. and Meckling, W. H. (1976). Theory of the firm: Managerial behavior, agency costs and ownership structure. *Journal of Financial Economics*, 3, 305–60.
- Mitnick, B. M. (1973). Fiduciary responsibility and public policy: The theory of agency and some consequences. *Proceedings of the 1973 Annual Meeting of the American Political Science Association, New Orleans, La.*, 69, Ann Arbor, MI: UMI.
- Mitnick, B. M. (1975). The theory of agency: The policing “paradox” and regulatory behavior. *Public Choice*, 24 (winter), 27–42.
- Mitnick, B. M. (1992). The theory of agency and organizational analysis. In N. Bowie and R. E. Freeman (eds.), *Ethics and Agency Theory*. New York: Oxford University Press, 75–96.
- Mitnick, B. M. (1993). *Corporate Political Agency: The Construction of Competition in Public Affairs*. Newbury Park, CA: Sage.
- Moe, T. M. (1984). The new economics of organization. *American Journal of Political Science*, 28, 739–77.
- Noreen, E. (1988). The economics of ethics: A new perspective on agency theory. *Accounting, Organizations and Society*, 13, 359–69.
- Pratt, J. W. and Zeckhauser, R. (eds.) (1985). *Principals and Agents: The Structure of Business*. Boston, MA: Harvard Business School Press.
- Ross, S. A. (1973). The economic theory of agency: The principal’s problem. *American Economic Review*, 62, 134–9.
- Shapiro, S. P. (1987). The social control of impersonal trust. *American Journal of Sociology*, 93, 623–58.

## AIDS

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AIDS is an acronym for Acquired Immunodeficiency Syndrome. AIDS is generally, although not universally, thought to be associated with the presence of HIV, the Human Immunodeficiency Virus. All persons with HIV cannot appropriately be said to have AIDS. The United States Center for Disease Control’s (CDC’s) technical

descriptor of AIDS has to do with either the presence of an opportunistic infection associated with HIV, and/or a diminution of the body’s CD4 (T-lymphocyte or T-cell) count to below 200 per cubic millimeter of blood. Evidence suggests that HIV is spread through transmission of bodily fluids typically associated with intimate sexual contact and/or intravenous drug use, though cases of *in utero* mother-to-child transmission are on the rise. HIV is fragile once outside the body, and is therefore not transmittable through casual contact. AIDS is treatable but not curable. With proper treatment, it is not unusual for individuals to live ten years or even longer from time of initial diagnosis with HIV to eventual death.

The CDC currently estimates that globally more than 16 million people have died of AIDS and more than 16,000 people become newly infected each day. Geographic impacts have been disparate. Developing countries are currently being hardest hit, particularly those in Sub-Saharan Africa where over 23 million adults and children are living with HIV/AIDS and more than 13 million have died, accounting for more than 80 percent of the world’s deaths due to AIDS. In the United States there are now 800,000 to 900,000 people living with HIV, with approximately 40,000 new HIV infections occurring every year. In the US, HIV-related illness and death historically have had a tremendous impact on men who have sex with men (MSM); even though the epidemic has increased during the last decade among injection drug users and heterosexuals, MSM continue to account for the largest number of people reported with AIDS each year. Though they represent only 13 percent of the US population, more than half of new HIV infections occur among blacks (<http://www.cdc.org>).

HIV/AIDS should be a core business issue for every company – particularly those with interests in heavily affected countries – according to the Global Business Coalition on HIV/AIDS (<http://www.businessfightsaids.org/>). Estimates by the World Bank suggest that the macroeconomic impact of HIV/AIDS may reduce the growth of national income by up to a third in countries where the prevalence among adults is 10 percent. Additionally, rates of HIV infection worldwide are highest for the young

and for women, who are major contributors to the workforce (<http://www.bsr.org/BSRResources/IssueBriefDetail.cfm?DocumentID=49032>). In some countries – most notably South Africa – the tendency of a significant proportion of employers has been to discriminate against employees and job applicants living with HIV/AIDS through use of HIV testing to exclude those that are HIV-positive. In the case of *Hoffmann vs. South African Airways*, the Constitutional Court ruled against this practice (Ngwena, n.d.). In response to such expansions of workplace protections to those infected with HIV/AIDS, several global companies have policies in place underpinned by principles of inclusion, non-disclosure, confidentiality, tolerance, and non-discrimination. BP asserts their “global approach prohibits unfair discrimination against people living with HIV/AIDS...it promotes an environment in which people who are HIV-positive are able to be open about their status, without fear of stigma or rejection” ([http://www.bp.com/environ\\_social/bus\\_ethics/hum\\_rights/hiv.asp](http://www.bp.com/environ_social/bus_ethics/hum_rights/hiv.asp)).

HIV/AIDS has become such a critical business issue that academic programs focusing specific attention on this dimension of the pandemic are now emerging. In response to their belief that unevenness, inadequate training, and distrust between managers and workers characterize the management of HIV/AIDS in workplaces and cause negative effects on the quality of life and work, the African Centre for HIV/AIDS Management in the World of Work at Stellenbosch University and the National School of Public Health at Medunsa have partnered in offering a Postgraduate Diploma in the Management of HIV/AIDS in the World of Work (<http://www.aidscentre.sun.ac.za/diploma.html>). Case materials focusing on a variety of ways to manage people with AIDS at work and a broad range of perspectives informing managers’ decisions about this painful and complex issue have been developed ([http://www.caseplace.org/newsletter-url3128/newsletter-url\\_show.htm?doc\\_id=180238](http://www.caseplace.org/newsletter-url3128/newsletter-url_show.htm?doc_id=180238)).

Underlying the pragmatic impacts of HIV/AIDS reside deep ethical concerns. Links between HIV infection and such social “baggage” as homosexuality and drug abuse make this a volatile issue for those formulating corporate

policy. From the view of KANTIAN ETHICS, or deontology, there is a potential clash of rights (*see* RIGHTS) between the HIV+ worker and the HIV– co-workers. The concern on the part of some individuals is that the ease of transmissibility of HIV has been grossly understated. One study of corporate and public service employees found that “thirty percent of the respondents expressed skepticism about the accuracy of public information” related to AIDS, with nearly one in four stating they would be “afraid of getting AIDS from working near PWAs [Persons with AIDS]” (Barr, Waring, and Warshaw, 1992: 226). Such individuals typically advocate for disclosure of co-workers’ HIV status. Conversely, those infected with HIV are concerned with the variety of discriminatory practices, including erosion of the right to PRIVACY, revocation of health benefits or escalation of the cost of such benefits (*see* HEALTHCARE ETHICS AND BUSINESS ETHICS), shunning by co-workers, and even termination of employment, which often accompany making a positive diagnosis with HIV a matter of public record. Additionally, the right of the AIDS sufferer to his or her WORK must be considered against the backdrop of the right of the employer to exercise the doctrine of EMPLOYMENT AT WILL. This particular conflict is compounded by the Americans with Disabilities Act (ADA), which in part treats workers with AIDS as a disabled class subject to the protections contained in this legislation.

The issue of resolving rights conflicts with respect to persons with AIDS in the workplace is necessarily complicated by consideration of RISK tolerance. Few, if any, rights are absolute; therefore, the challenge for the deontologist is to decide which among a competing set of rights is most foundational. This determination is in some sense dependent upon the probability, or risk, of alternative realizable policies. Neither the view that the rights of the AIDS sufferer must be protected at all cost, nor the view that the rights of co-workers are inviolate, seems correct. However, the suggestion that determination of a “rights hierarchy” – and thereby of one policy versus another – is dependent upon risk assessment necessarily moves the argument toward consideration of the utilitarian consequences of alternative policies.

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UTILITARIANISM requires that we consider the consequences of including or excluding AIDS sufferers from the workplace, with an eye toward bringing about the “greatest good for the greatest number.” Those familiar with the debate over whether HIV+ medical providers should be compelled to disclose their HIV status to patients have seen this particular issue evolve from one in which rights were of central importance, to concern over the impact of mandatory disclosure policies on the healthcare profession in general and ultimately the welfare of society at large. The presupposition of utilitarian argumentation is that relevant benefits and costs can be both identified and quantified. While utilitarians are well versed in dealing with such complexities, when it comes to workplace AIDS transmissibility, the issue is so emotive as to make consensual policy formulation a virtual impossibility. What is known is that the well-being of the AIDS sufferer is to a great extent a function of AIDS policy. Research into the longevity of HIV+ individuals indicates that a supportive community (*see* COMMUNITARIANISM) leads to life extension. One of the drawbacks of traditional utilitarianism, however, is its compatibility with injustices: in seeking to promote the greatest good for the greatest number, the interests of the non-majority are rather easily overridden. For the HIV+ minority, the consequences of restrictive workplace AIDS policy might well be the foreshortening of their very lives.

At least one writer suggests Kantian and utilitarian ethics can be meaningfully combined. Brady suggests we should make “exceptions to rules when so doing recognizes or promotes the affiliation and connectedness of persons” (1990: 144–5). With this understanding, should HIV+ individuals be offered organizational membership in spite of a general rule affording all employees a safe working environment? Consistent with designation of HIV infection as a disability under the ADA, Brady’s principle implies that the objective of affiliation should override more general workplace safeguards. In effect this principle injects classical utilitarianism with JUSTICE considerations. The objective is to have the manager approach the crafting of workplace AIDS policy with specific reference

to the idiosyncrasies of each specific work environment.

Consideration of the personal – and relational – implications of AIDS policy formulation and implementation suggests we consider the ethics of care. The topic of AIDS in the workplace needs to be a matter of conversations about how we as human beings live, and more particularly how we live in caring relationship with one another. Such caring conversation is hindered by language which creates unnecessary – or even inflammatory – distinctions. As Sedgwick (1990: 1) has noted, “many of the major nodes of thought and knowledge in twentieth-century Western culture as a whole is structured – indeed, fractured – by a chronic, now endemic crisis of homo-heterosexual definition, indicatively male, dating from the end of the nineteenth century.” This is nowhere more true than in conversations about the appropriate policy response to persons in the workplace who happen to have been infected by HIV. Jensen (1991: 660) offers perhaps the best closing to this discussion of policy alternatives relating to AIDS in the workplace: “In all epidemics, fear stimulates isolation and responsibility requires inclusion – this might even be called the moral law of epidemics.”

### Bibliography

- Barr, J. K., Waring, J. M., and Warshaw, L. J. (1992). Knowledge and attitudes about AIDS among corporate and public service employees. *American Journal of Public Health*, 82 (2): 225–8.
- Brady, F. N. (1990). *Ethical Managing: Rules and Results*. New York: Macmillan.
- Cohen, E. D. and Davis, M. (eds.) (1994). *AIDS: Crisis in Professional Ethics*. Philadelphia, PA: Temple University Press.
- Deka, D. (1994). “AIDS in the workplace.” Graduate thesis: College of Business Administration, San Diego State University.
- Feldblum, C. R. (1991). The Americans with Disabilities Act: Definition of disability. *The Labor Lawyer*, 11: 11–26.
- Gilbert, D. R. and Freeman, R. E. (1994). AIDS in the workplace: A critique from lesbian/gay theory. Presentation within Social Issues in Management Division, Academy of Management Annual Meeting.
- Gini, A. and Davis, M. (1994). AIDS in the workplace: Options and responsibility. In E. D. Cohen and

- M. Davis (eds.), *AIDS Crisis in Professional Ethics*. Philadelphia, PA: Temple University Press.
- Heacock, M. V. and Orvis, G. P. (1990). AIDS in the workplace: Public and corporate policy. *Harvard Journal of Law and Public Policy*, 13 (2): 689–713.
- Jonsen, A. R. (1991). Is individual responsibility a sufficient basis for public confidence? *Arch Intern Med*, 151: 660–2.
- Ngwena, C. (n.d.). Constitutional values and HIV/AIDS in the workplace: Reflections on *Hoffmann vs. South African Airways*. *Law and Bioethics* (<http://www.blackwell-synergy.com/links/doi/10.1111/1471-8847.00007/abs/>).
- Paul, R. J. and Townsend, J. B. (1997). AIDS in the workplace: Balancing employer and employee rights. *Review of Business*, 18 (2), 9–14.
- Sedgwick, E. K. (1990). *Epistemology of the Closet*. Berkeley: University of California Press.
- Stone, R. A. (1994). AIDS in the workplace: An executive update. *Academy of Management Executive*, 8 (3): 52–61.

## Alliances

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“Forming alliances” is a phrase often used in today’s business environment. While the concept seems simple – unite with other individuals within a company or with another organization – to collaborate rather than compete, not all alliances are really alliances. The word is fashionable to use, and used liberally within companies, but the philosophy behind a *true* alliance is anything but business as usual.

### DEFINING AN ALLIANCE

An alliance is a close, collaborative relationship between two (or more) firms with the intent of accomplishing mutually compatible goals that would be difficult for each to accomplish alone (Spekman and Isabella, 2000). This definition is carefully worded. An alliance implies that the relationship between the parties is not competitive, it is strategic, each needs the other to accomplish a business objective, and goals are complementary (though not necessarily identical). At its core, alliances are about shared control and decision-making. In a business world frequented by competition and transactions, alliances require a different mindset for action and interaction.

What can be confusing is that, given this definition, alliances can take a number of different forms and still be alliances. The most “organized” alliance is a joint venture (JV) between two firms in which a third and separate firm is created. Such an alliance, governed by a board of directors represented by both partner companies, is often formed to bring specific strategic capabilities of each partner to a new or existing market. At the other end of the alliance continuum might be co-marketing arrangements, through which two companies market each other’s products. In between, other alliance forms can include channel partnerships or manufacturing alliances.

### COMMON CHARACTERISTICS

Despite their appearance each of these types of alliance share certain characteristics. An alliance is not a transaction. Transaction implies an exchange, such as money for services or products. True alliances are not simply an item-for-item exchange but include:

- *Goal complementarity*: Both parties in an alliance give and get something from the partnership. While they may be different things, the goals for which each member of the partnership is striving are compatible.
- *Recognized interdependence and coordination*: Within an alliance each partner must recognize that their actions may have implications for their partner, making each partner interdependent with the other. As a result, coordination between alliance partners must be high in order to ensure true collaboration and cooperation.
- *Trust and commitment*: By definition, alliances require relational trust and commitment. Both partners must work hard to ensure that trust is nurtured and commitment ensured. Without trust and commitment, there can be no alliance.
- *Symmetry*: Alliances are about equity over time, not necessarily at any one moment in time. Partners want an equitable share of the decision-making, share of the rewards and share of the success. Without symmetry or with a banker’s mentality (meaning