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The moral price of the profit motive in medicine

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Abstract

The Moral Price of the Profit Motive in Medicine

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Committee members: Dr. Jessica Flanigan, Dr. Terry Price, Dr. Javier Hidalgo

My thesis argues that a medical profit motive is immoral because medical care influenced by a profit motive can undermine the value of patient health. In Chapter I, I develop a moral critique of the medical profit motive while arguing that doctors have a moral obligation to promote patient health and well-being. Additionally, I demonstrate that a medical profit motive can theoretically exist in medical decision-making and be permissible. In Chapter II, I explore the medical profit motive on the organizational level. I argue that the structure of modern medical care allows for a profit motive to regularly be introduced into medical decision-making. I also demonstrate that an organizational medical profit motive is more morally impermissible at the administrative level. I will offer suggestions on how to better align modern medical care with moral medical care—both on an individual level and a structural level; in addition, I then offer suggestions on how health care systems and medical groups can change current practices to either diffuse a medical profit motive or align pecuniary profit motives with proper medical care. In Chapter III, I focus on the application of my argument into health care policy, and from this application, I forward a theory of *values-centered health care*.

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Introduction

The profit motive in medicine, which is the desire to maximize pecuniary profit as a primary motivation in patient care, is unethical. Regardless of whether the functional body outputting a medical profit motive is a physician, a group of physicians, or a large hospital, proper medical care should not be undermined by a desire for monetary gain. To say that medical care should not concern itself with money (i.e. costs, budgets) would be foolish; rather, I am asserting that treating medicine like any other business is disrespectful to the core values that predicate patient care. Human health is too important of a currency to be thrust into a system of financial modeling and cost/benefit analyses that aim to yield maximal gains; medical practitioners should be primarily motivated by maximizing patient health and wellness.

My thesis argues that a medical profit motive is immoral because medical care influenced by a profit motive can undermine the value of patient health. In Chapter I, I develop a moral critique of the medical profit motive while arguing that doctors have a moral obligation to promote patient health and well-being. Additionally, I demonstrate that a medical profit motive can theoretically exist in medical decision-making and be permissible. In Chapter II, I explore the medical profit motive on the organizational level. I argue that the structure of modern medical care allows for a profit motive to regularly be introduced into medical decision-making. I also demonstrate that an organizational medical profit motive is more morally impermissible at the administrative level. I will offer suggestions on how to better align modern medical care with moral medical care—both on an individual level and a structural level; in addition, I then offer suggestions on how health care systems and medical groups can change current practices to either diffuse a medical profit motive or align pecuniary profit motives with proper medical care.

In Chapter III, I focus on the application of my argument into health care policy, and from this application, I forward a theory of *values-centered health care*.

Chapter I: The Problem with the Medical Profit Motive

"Either perspective is by itself stubbornly one-sided in its view of physicians simply as self-interested economic accumulators or as devoted altruists. We favor a view which recognizes that these two perspectives are *not* incompatible and accepts the elements of truth in each of them."[1]

The medical profit motive allows medical practitioners to privilege monetary profit over human health and well-being. For this reason, the profit motive is immoral. My goal in this chapter is to propose guidelines for how physicians can permissibly act on profit motivation in clinical practice. Patients have certain justifiable expectations from their physicians, and those expectations are part of what generates a physician's obligations to their patient. Even absent from expectations, there are ways that a doctor ought to treat their patient populations based on the role they assume (a medical doctor), the value that is at stake in operating through their role (human health), and the uniqueness of the physician-patient relationship (or, at least, what is at stake within the relationship). Given that a physician truly has strong moral reasons—or an obligation—to promote patient health and wellness, it is morally impermissible to bypass those obligations through an ulterior motive. This is especially the case when the currency at stake—the currency that could potentially be lost in a coercive transaction—is of value so supreme, that it is morally abhorrent to disrespect.

The argument is as follows:

P1: Doctors have a moral obligation to promote patient health and well-being.

[1] Brock, Dan W., and Allen E. Buchanan. "The Profit Motive in Medicine." *The Journal of Medicine and Philosophy* 12 (February 1987): 1-35. doi:10.1093/jmp/12.1.1.

P2: In some instances, a medical profit motive acts antagonistically against the moral obligations obtained by physicians.
C1: *Pro tanto*, a medical profit motive is immoral.
P3: Outcomes can outweigh morally impermissible motives.
P4: When a medical profit motive is pursued to promote patient health and well-being in the most optimal manner, the outcomes of the medical profit motive align with the outcomes of moral medical care.
C2: Beneficial health outcomes can outweigh an immoral profit motive, though the profit motive remains impermissible.

In Section I, I demonstrate why doctors have obligations to their patients, and why these obligations amount to a medical doctor being required to promote patient health. Doctors have general duties to several different parties that they encounter as well as obligations generated through the physician-patient relationship. I will explore how these obligations are generated and what importance they have relative to other obligations. Even if one does not subscribe to the existence of special obligations in medical care, physicians still have strong moral reasons to promote patient health and well-being. In Section II consider a particular reason that strong obligations are generated in medical decision-making: the unconditional value of health. In Section III, I then show that the obligations that physicians have to their patients are sometimes violated when physicians consider profit obtainment during medical decision-making. Through the discussion in Section II and III, I argue that human health has unconditional value whereas monetary profit is only conditionally valuable. For this reason, a medical profit motive is *pro tanto* immoral to uphold in medical decision-making. A medical profit motive can exist when the motive is utilized to promote patient health in the most optimal way possible, but the moral obligations of physicians *must* be considered over medical profit motives when the two conflict. In Section IV, I apply these principles into the doctor-patient relationship as it exists in the current medical environment. In Section V, I discuss the implications of this position and consider relevant objections to my argument.

I. Obligations in Medical Practice

When a parent takes care of her child, there are obligations that the parent has to her child. When someone signs a contract with you, that individual has an obligation to you to uphold the terms of that contract. The existence of obligations is relatively uncontroversial; what is more debatable is the basis of obligations, the kinds of obligations that can exist, and the extent to which particular obligations *matter* over other obligations or other considerations. For example, one might believe that a parent's obligation to take care of their child would be stronger than an obligation to pick up a friend from the airport. That plausible position must be defended by claiming that the value of the parent-child relationship—or what is at stake when violating that relationship—is more valuable than what is at stake in a particular friendship. Through an analogous weighing of values, I will argue that medical doctors have an especially strong moral obligation to their patients, and this obligation is to promote patient health. My argument does not hinge on the existence of special obligations. Even if one were to claim that unique obligations did not exist in medical care, I will still be able to demonstrate that doctors have strong moral reasons to promote patient health and well-being before considering any non-medical factors in medical decision-making.

To illustrate the basis of obligations, consider the following case:

The Basketball Game. 100 individuals are present at a basketball game and are currently occupying the bleachers. Suddenly, one person (C) collapses in the stands and is showing the signs of having a heart attack. Assume that only one individual may assist C before the paramedics arrive. You are also one of the individuals in the stands.

This case illustrates that we all have moral obligations to assist people in need. If it were true that obligations did not exist between human beings, there would be no *binding* reason that any of the 99 other individuals would have to make an attempt to save C's life. If no obligations

to assist existed, no one would be morally blameworthy for C's negative medical outcome (or failing to aid C). Without duties to assist, someone could still make an attempt to save C's life because it would align with their desires/ends or would be—for some reason—desirable to them. But people should not just save C's life because of their desires, but rather because a general duty of beneficence exists in society. Under a general duty of beneficence, which stems from multiple prominent moral theories, there are strong moral reasons to assist those in need when assisting is possible.[2] If we acknowledge a general duty of beneficence exists, then the obligation to attempt to save C's life stems from the fact that C is another person in need (so C should be saved if it is possible and reasonable).

Given that C should be saved, who should save C? One plausible way of allocating the obligation to save C is *proximity*. Imagine you are one of the individuals in the stands, so perhaps you should make an attempt to save C. Unfortunately, you are on the absolute far left side of the bleachers, and C collapsed on the absolute far right side of the bleachers. The person directly next to C is G, and G happens to have the same medical knowledge as you. Moreover, C requires immediate medical attention, and by the time you are able to reach C, his condition will significantly worsen. If this were the case, G has a greater duty to save C's life, especially if C has a time-sensitive ailment. From this, we can see that there is sometimes a spatial component to obligations. Still, this obligation is not supreme to all other considerations that G may hold; it was simple chance that G was placed next to C. If G had some "special" or unique obligation to C, G would also have a "special" obligation to every adjacent individual in the bleachers if they

[2] Beauchamp, Tom, "The Principle of Beneficence in Applied Ethics", The Stanford Encyclopedia of Philosophy (Winter 2013 Edition), Edward N. Zalta (ed.), URL = <http://plato.stanford.edu/archives/win2013/entries/principle-beneficence/>.

happened to show signs of having a heart attack and nothing would oblige G to treat C before any adjacent person.

Or, imagine that C happened to attend the basketball game with a spouse, S. We might also think that S has a stronger obligation to save C's life over saving your life or G's life because S has an established relationship with C. If this is true, S would have an obligation to save C's life before saving your life or G's life, even if you or G happened to collapse in a similar moment with a similar medical ailment. How can we explain that belief? S has a special relationship with C, and S is uniquely positioned to recognize the needs of C. S has a legitimate reason to favor the medical needs of C over adjacent persons when another individual may give medical attention to C.

Or, imagine that G made a promise to act in the best medical interest of C, or let us even say that G signed some sort of contract with C in similar terms. This seems to be the most compelling case yet for which an individual has a particularly strong obligation to promote the health of C. If there was a promise or contract involved, G would be especially at fault for not attending to the medical needs of C compared to other bystanders.

Before G rushes to action, consider another case:

> *The Basketball Game, Part II.* 100 individuals are present at a basketball game and are currently occupying the bleachers. Suddenly, one person (C) collapses in the stands and is showing the signs of having a heart attack. Assume that only one individual may assist C before the paramedics arrive. You are one of the individuals in the bleachers. The individuals in the bleachers include G (who has signed a contract with C to act in C's best medical interest) and D, who is a medical doctor.

Regardless of where D is seated, whether D was familiar with C before this occurrence, or if G signed some sort of contract with C with the terms mentioned above, D is the best positioned to

promote the medical needs of C. Therefore, D should be the individual to assist C. In general terms, D has an obligation—as a medical doctor—to promote the medical needs of any individual in close proximity and in an emergency situation.

Interestingly, a doctor's obligations trump the general duties of beneficence that any other individual may have towards C (I will further argue for this position later on). It does not necessarily *change* the obligations that other individuals have towards C; it instead allows the obligations that other individuals have towards C—the obligations to promote C's health (or life)—to be an obligation to allow D to perform some action of medical assistance. In cases of human health, the role that a doctor assumes comes along with powerful obligations, obligations that may even outweigh the obligations of other agents. These obligations apply equally to anyone at the basketball game, and they could still hypothetically be subdued by a further, more powerful obligation: a doctor's unique obligation to one of their patients.

Thus, consider a third—and final—case:

The Basketball Game, Part III. 100 individuals are present at a basketball game and are currently occupying the bleachers. Suddenly, one person (C) collapses in the stands and is showing the signs of having a heart attack. Assume that only one individual may assist C before the paramedics arrive. You are one of the individuals in the bleachers. The individuals in the bleachers include D, who is a medical doctor. C also happens to be a patient of D.

Since C is D's patient, D is indisputably the one who must act on C's behalf. The doctor-patient relationship generates obligations that the physician has towards the affected individual, C. Not only do doctors have obligations towards members of society from duties of beneficence—similar to other citizens—and obligations to care based on their role as a medical doctor, they also have special relationships with their patients, which generate strong obligations. These successively developing cases demonstrate that strong obligations relating to human

health exist in society, and further, these cases demonstrate that a medical doctor reliably incurs these strong obligations in the same way that a spouse incurs obligations (or how proximity can generate obligations).

These basketball cases may not have demonstrated the strength of a physician's obligations conclusively, but there are several other reasons to believe that the doctor-patient relationship can generate obligations that carry great moral weight. Before I turn to the exact nature of these obligations—what a medical doctor is obligated to do—I want to explain why medical doctors possess strong obligations to their patients. Below, I will list and describe five ways that an individual can gain obligations, and from the list, I will explain how each situation applies to a medical doctor in the doctor-patient relationship. (Note: this list is not exhaustive, but it is certainly a list of several conspicuous reasons.)

First, strong obligations can be generated when someone assumes a distinct role; we shall call these obligations *role obligations*.[3] Individuals in certain roles have obligations to persons, groups of persons, or even society. When someone assumes a role—willingly or unwillingly—he accepts that obligations come packaged with the role. At least when roles are assumed willingly, so too are obligations. Even if one believes that obligations are only generated when an individual assumes them *voluntarily*, some roles and their attending obligations are voluntary.

For example, if someone chooses to become a firefighter, he has assumed the role of "firefighter". Normally, we do not have an obligation to run into a burning building and save people and possessions, but we do have a duty to save someone's life (if possible). But, we could not reasonably be expected to run into a burning building without training or equipment. Luckily,

[3] Jeske, Diane. "Special Obligations." Stanford University. October 17, 2002. Accessed March 27, 2014. http://plato.stanford.edu/entries/special-obligations/#4.

the person who has assumed the role of firefighter is required to uphold his obligation to fight fires, and in doing so, he is upholding the general duties of beneficence for the rest of society (a sort of division of moral labor).[4]

The division of labor for society's general duties is morally relevant, and this idea also demonstrates the true importance of a division of moral labor in other situations. When someone willingly assumes a role that generates unique or necessary obligations, she is accountable for upholding those obligations. If someone chooses to become a teacher, she must be in the business of promoting the rational capacities of the people she is instructing; that is one of the obligations that teachers must have. The obligations stemming from being a teacher are directly linked to the act carried out from her role as teacher. If a teacher does not uphold the obligation to educate, it cannot be said that she is a morally sound teacher.

The role of a doctor also generates strong obligations—obligations that are directly linked to the doctoral identity. When someone becomes a doctor, he obtains special responsibilities and obligations that normal citizens would not have based on their medical training, access to relevant information and technology, and the other features of a career in medicine. Doctors willingly assume that role, and in doing so, consent to upholding certain principles of proper patient care. It is clear that doctors consent to their role and the obligations that go with it because they pledge to act in their patient's best medical interest.[5] Whenever people voluntarily enter into the role of medical doctor, they are fully aware that being a doctor means having special responsibilities within patient care.

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[4] For more on the concept of "Division of Moral Labour", please see: Scheffler, Samuel, and Véronique Munoz-Dardé. "The Division of Moral Labour."*Proceedings of the Aristotelian Society, Supplementary Volumes* 79 (2005): 229-53. http://www.jstor.org/stable/4106941.

[5] Orr, R. D., N. Pang, E. D. Pellegrino, and M. Siegler. "Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993." *Journal of Clinical Ethics* 8.4 (1997): 377-88. Print.

Similar to the fireman scenario, the role obligations of medical doctors are important because they uphold society's intrinsic duty to promote health and livelihood, the most concrete and essential realization of a duty of beneficence. Just like you or I would not be expected to run into the burning building, we cannot be expected to pick up a scalpel and perform surgery. Does that mean we are not obligated to promote health? No, but non-physicians certainly do not have a strong obligation to promote health based solely from our role in society.[6]

Second, role obligations are particularly strong when they are premised on providing public goods, as opposed to a role that is premised on providing instrumental goods, private goods, or conditional goods. A firefighter has strong obligations to fight fires, but one can also imagine that, for example, a landscaping company has a unique obligation to maintain your external property if you are a customer of their company. Apart from considerations of the impact from not upholding these sets of obligations, maintaining the aesthetics of a property is not a public good—it is an instrumental good. By "public good", I mean a good that is shared by the largest set possible of individuals in a community with the largest net benefit to the community.[7] Public goods are provided by a subset of individuals within a community, and I further define a public good as some good that is owed to a community based on the intrinsic rights of the people within that community. Within this definition of a public good, landscaping services are not a public good. Certainly, it is *good* that the company upholds their obligations to you, but that is merely contractual. One may claim that a landscaping company has an obligation not to destroy your property or harm any person on your property, but individuals are already

[6] Other patient care professionals may have a similar strong obligation, but I am not concerned with that idea in this thesis. Here, I am looking at the moral significance of profit motivation forwarded by doctors in the doctor-patient relationship. Future work may explore profit motivation on a variety of levels in patient care, but this argument will not.

[7] Shue, Henry. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. Princeton, NJ: Princeton UP, 1980. Print.

owed this level of respect, protection, and consideration from every individual member of society. Within the realm of public good-promoting obligations, one can imagine that even this set of obligations can be graded based on importance—and thus some can be morally worse for failing to uphold. As mentioned above, everyone cannot be expected to fight fires (even if everyone ought to promote safety and well-being in society through a duty of beneficence), so providing for this public good is a necessary condition of being in a civilized society.

Given this distinction, doctors are more like firefighters than landscapers because they provide for public goods rather than instrumental goods or private goods. Medical doctors are responsible for promoting the health of the human population, which is a necessary precondition to satisfy almost any other public good.[8] To further illustrate the distinction between public goods and instrumental goods, examine the following case:

> *The King's Dilemma*. King Arthur has a finite amount of gold pieces that he must spend on his castle, and his advisors assure him that the gold can only be spent in one of two ways. One way that King Arthur can spend his gold is to build a state-of-the-art educational institution that will develop the rational capacities of his citizens. On the other hand, King Arthur can also choose to spend the gold on a combination of sanitation, hygienic, and medicinal purposes. The kingdom can noticeably benefit from additional education. In addition, severe health issues already exist within the castle walls, but can be cured through the implementation of purposes listed above.

This thought experiment is introduced to show that some public goods are more morally urgent than others, and therefore they should have priority over other goods when considering how to allocate resources in order to promote such goods. Knowledge development is a non-excludable public good that everyone benefits from, and for that fact, we have reasons to uphold or promote

[8] Shue, Henry. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. Princeton, NJ: Princeton UP, 1980. Print.

that good in society.[9] What is proper education without adequate human health among an educated population? Citizens can still be educated, but if a population is not healthy and is lacking a particular quality to life, it is hard to justify spending a majority of resources on developing rational capacities when a majority of resources can be allocated to combat active health threats to the population. This is not to suggest that promoting rational capacity should be forfeited in health crises, but in essence, promoting health and well-being is instrumental to—or a necessary condition of—promoting any other public good, including education.

Even if one does not believe that human health and well-being is a public good that everyone is obligated to promote, they can at least see how health can be instrumental to maintaining other public goods. Klosko introduced a theory of political obligation towards lesser discretionary goods that stems from a society benefitting from presumably beneficial public goods. In his argument, if a scheme of government X provides a non-excludable public good A (along with a set of other goods that may not be presumably beneficial in the same way), as long as the cost to maintain A with discretionary goods does not come at the same cost as failing to be provided A, one can have an obligation to promote those discretionary goods.[10] In this way, if we have obligations to promote non-excludable public goods that we benefit from, we may have obligations to promote public goods that are preconditions of those certain non-excludable public goods being maintained or promoted. I assert that health and well-being count as public goods that are necessary to promote in order to preserve other non-excludable public goods in our society.

[9] Klosko, George. "Presumptive Benefit, Fairness, and Political Obligation." *Philosophy and Public Affairs* 16.3 (1987): 241-59. Print.
[10] Ibid., 241-59.

However, as it has been demonstrated already, we cannot all be expected to directly promote human health (even though we all have that obligation in some form or another). Consider this: just like we have obligations not to interfere with national defense, we do not necessarily have to actively promote or maintain national defense—even if we benefit from it. This might not change our obligations to promoting or maintaining the public good of national defense, but regardless, I believe that it is still obligation-inducing. To examine this in a different light, we have obligations of not interfering with non-excludable public goods that juxtaposes with our obligation to promote non-excludable public goods. We may not have obligations to directly promote national defense (but we have obligations to refrain from internally threatening public safety), so too citizens may not have obligations to promote health directly while still having obligations not to degrade health (I will soon argue for this in more detail).

Fortunately, some individuals can directly fulfill their societal obligations to promote public goods. Just as the soldiers in our military *actively* incur the public good-promoting role obligation related to national defense, so too, doctors are the guardians against the threats towards society's health and well-being. If it is not the most important public good to promote, the right to be healthy—to a reasonable degree—is one of the most important public goods to promote. Since doctors, from their role, are charged with this task, they are given strong obligations to promote well-being in their communities. This set of obligations is not necessarily stronger when the individual being treated is the patient of the doctor, but the public good-promoting obligations are definitely more *salient*.

Third, as the basketball case illustrated, strong obligations may be generated when we are *well positioned* to provide some form of a good. Physicians therefore have especially strong obligations to promote health because they are well placed to do so. Peter Singer's classic

example of a baby drowning in a pond illustrates this intuition. If a baby is drowning and you are standing right next to the pond where it is drowning in, your obligation to help the child is especially strong because you are *well positioned* to provide a good that is essential to the child's existence.[11] I simultaneously agree and disagree with the position that Singer has presented. I think that distance (from the pond, from a patient, etc.) must be normatively relevant; the fact that you are standing beside the pond does not change your general obligation to save the child's life, it just makes that obligation more prominent. In other words, the fact that you happen to be standing next to the pond does not spontaneously create a new obligation to save the child's life when it comes as a minimal cost or risk to you. Nevertheless, you may be less blameworthy for allowing a similar child located 300 miles away to drown in a similar pond. Proximity does not change one's obligations, but it does alert us to those obligations. Singer would contend with this belief, but where I agree with Singer is the idea of someone being *well-positioned* to provide a certain good or beneficial action. Being well-positioned can be translated through different media. In Singer's case, being well-positioned can mean having the ability (assuming little risk is undertaken by the acting agent) to aid the drowning child, which is a more literal interpretation of "well-positioned". Well-positioned can also be interpreted to mean having a knowledge base or a skill set that can allow one to aid—with minimal risk obtainment—someone in need.

In this way, like the bystander near a drowning child, physicians are well-positioned to provide a good that is essential to human existence. Having a library of medical knowledge and knowing how to treat an array of human ailments, the medical doctor possesses a number of obligations towards human health promotion that other individuals without that knowledge cannot be at fault for not upholding. As in the basketball case (II), the fact that D, the doctor, had

[11] Singer, Peter. "Famine, Affluence, and Morality." *Philosophy and Public Affairs* 1.3 (1972): 229-43. Print.

the knowledge and skill necessary to properly treat C was the true reason that D was morally required to treat C, not just because D was the "doctor" present. Having the proper medical knowledge and skill set to treat medical ailments is an intrinsic component of being a doctor, but we can also separate it to show that even without the title, the same set of abilities generates a set of strong obligations. For example, consider a scenario where D is an individual who is present and is not a medical doctor. While he is not in this role, he has studied heart attacks for years and happens to have the proper knowledge and skills necessary to effectively treat C. By having that knowledge—without being a physician—D still has an obligation to treat C. Taking this further, when a person with an exceptional knowledge of proper human health is engaged in a relationship with someone who is seeking counsel on proper human health, it would be morally reprehensible for the expert to not utilize, to their fullest capacity, their medical knowledge or skill; increased responsibility—and therefore moral accountability—can be assigned when an agent with medical expertise is willingly engaging with an agent who is forfeiting a portion of their agency (in medical decision-making) to the individual with medical expertise.

Fourth, obligations can be generated when individuals willingly enter into an obligation-generating relationship, which would bestow particular *voluntary obligations* upon the respective agents in the relationship. As mentioned before, it is easy to see how one can incur strong obligations when he knowingly consents to having them; assuming that an agent is fully informed about what obligations will come along with entering into an obligation-generating relationship (and he agrees to enter into the relationship), he is culpable if he does not uphold those obligations. Thus, this form of obligation generation is important because it is widely agreed as being true, even by the non-voluntarist school of thought on obligations.

A classic example of this type of obligation generation is when an individual signs a contract to uphold certain obligations to another individual (or a group of individuals). For example, if I sign up for a cellular phone service, I agree to pay a cellular phone company every month to provide me various instrumental goods related to having a cellular phone; this agreement is in the form of a contract that I sign. If I no longer wish to have an obligation to pay the cellular phone company, I can opt out of the contract (and forfeit my ability to receive services from that particular company), but while I am bound by the contract, I must uphold my obligation to pay the company. Assuming that I have read the terms of the contract and understand their implications, there is no reason that I should be surprised that I have an obligation to uphold the contractual terms.[12]

Employment relationships are another example of how voluntary agreements can generate obligations. When one agrees to be an employee in an organization or for another person, there are unique obligations that the employee has towards their employer. Similar to the contractual argument, if the employee is not coerced into an employment relationship (it is truly voluntary), then the employee has obligations to her employers. This principle applies as long as the agreement and nature of work are morally permissible (i.e. an employee is not coerced into employment and voluntarily accepts employment terms that they are aware of, or a hit man would not be morally obligated to murder just because the hit man was under a contract).[13]

Like customers or employees, doctors are fully aware what obligations come along with agreeing to be a medical doctor, and therefore they implicitly consent to these obligations (otherwise, they should not participate in patient care). Consent-based obligations are strong,

[12] Fried, Charles. Contract as Promise: A Theory of Contractual Obligation. Cambridge, MA: Harvard University Press, 1981.
[13] Macleod, Alistair. "Moral Permissibility Constraints on Voluntary Obligations." *Journal of Social Philosophy* 43.2 (2012): 125-39. Print.

voluntary obligations when the values and obligations at stake within the voluntary relationship are clear and well-known upon engaging in such a relationship.[14] When someone is graduating medical school, he has an understanding of the ethical implications of being a medical doctor. To affirm this belief, graduating medical students often take some sort of oath (whether it be the Hippocratic Oath or the Oath of Maimonides) to not harm patients and to operate in the patient's best medical interest.[15]

One may object that consent-based obligations are established through knowledge of the profession, knowledge of the values at stake in medical care, and knowledge that primary motivator for medical decision-making ought to be patient health and well-being. Yet there is strong evidence that any reasonable knowledge conditions are met because new medical doctors experience a period of residency after their academic medical education, a period of observation and understanding of the true medical profession that compliments years of clinical observation, medical ethics education, and interactions with other physicians. Therefore, a medical doctor is fully aware of what obligations he will be incurring in a medical career and the value of patient health that is at stake in medical decision-making. From this, it would be unreasonable for a physician to claim that he did not voluntarily consent to promoting patient health and well-being. That is like saying a police officer does not consent to upholding the law when she becomes a police officer. The voluntary obligations of physicians are fundamental to their profession, and if

[14] A view on consent to obligations based on consent and knowledge can be seen in "Pacuit, Eric, Rohit Parikh, and Eva Cogan. "The Logic of Knowledge Based Obligation."*Synthese* 149.2 (2006): 311-41. Print." Here, the authors support a model of knowledge and consent based obligation generation—with particular emphasis on (1) the existence of knowledge as a necessary condition for a *primary obligation* to be generated, and (2) a *secondary obligation* on the recipient of the primary obligation to ensure the knowledge necessary for obligation generation is in place.

[15] Orr, R. D., N. Pang, E. D. Pellegrino, and M. Siegler. "Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993." *Journal of Clinical Ethics* 8.4 (1997): 377-88. Print.

a physician acts outside of obligations he knowingly consented to, he is not acting as a morally sound doctor ought to act.

Fifth, a fiduciary relationship can generate obligations.[16] A fiduciary relationship is one that is established based on a differential of influence and agency capacities; in the relationship, one agent has *weak agency*, or when "an agent who is either ignorant of the consequences of his actions or is not directly involved in the transaction [and] relies on another person to transact on his behalf (for example, children in child labour agreements, citizens in agreements between countries)."[17] In a relationship based upon dispensation of decision-making action to an agent in a better position to make decisions, the agent on the top of the power differential is called the "fiduciary". A classic example of a fiduciary relationship is when someone hires a stockbroker to invest a set amount of money. When you give a stockbroker your confidence (in the form of a large sum of money), you are forfeiting your ability to have complete control over your assets in the hope that your stockbroker will make decisions with the given amount of assets in your best financial interest. In this relationship, the stockbroker possesses not only a significant portion of your property, but also a great deal of trust from you, his client. This concession of trust generates strong obligations on the fiduciary's behalf.[18] If I believed that my stockbroker would be self-interested during a time period when they made investments with my money, I would not give them my money in the first place. Placing the needs of the non-fiduciary agent *first and foremost* in a fiduciary relationship is a necessary requirement for that relationship to justly remain intact. If the fiduciary does not place the needs and concerns of the affected agent before

[16] Easterbrook, Frank H., and Daniel R. Fischel. "Contract and Fiduciary Duty." *The Journal of Law and Economics* 36.1 (1993): 425. Print.
[17] Satz, Debra. "XIV-The Moral Limits of Markets: The Case of Human Kidneys." *Proceedings of the Aristotelian Society (Hardback)* 108, no. 3 (2008): 269-88. doi:10.1111/j.1467-9264.2008.00246.x.
[18] For more on trust-based obligations, specifically in medicine, see: Miller, P. B. "Trust Based Obligations of the State and Physician-researchers to Patient-subjects." *Journal of Medical Ethics* 32.9 (2006): 542-47. Print.

his own needs, substitutes the needs of the affected agent for less important or beneficial needs, or just disregards those needs, the fiduciary is taking advantage of the special relationship—and thus the fiduciary loses credibility (and should lose influence).

The doctor-patient relationship is also a fiduciary relationship, which is yet another reason that doctors have strong obligations to act in the best medical interest of their patients. When it comes to medical decision-making, individuals are naturally weak agents. A vast majority of individuals do not have the medical knowledge or expertise to make informed decisions about their health care.[19] When someone seeks counsel from a medical doctor, they are doing so under a set of implicit assumptions about the doctor's intentions. Operating under implicit assumptions in a fiduciary relationship comes along with obligations to act in accordance with those assumptions, so long as those assumptions are reasonable, moderately uniform across similar relationships, and the fiduciary is aware—going into the fiduciary role assumption—of the responsibilities they possess that generate these assumptions.

For example, if I visit my doctor with knee pain under the assumption that he will avoid touching my knee during his clinical assessment, I cannot reasonably expect this. Therefore, my physician would not be at fault for conducting a physical examination of my knee. In contrast, if I visit my doctor with knee pain and expect the physician to treat my (potential) injury in my best medical interest, this is a very reasonable expectation. Another reason to believe that fiduciary duties are formed within the doctor-patient relationship is because a patient consents to medical

[19] This is why the role of the physician, or the "healer", has persisted throughout history. Being able to adequately take care of oneself requires an extensive knowledge of human health and physiology that an average person cannot reasonably be expected to hold. I am not claiming that human beings "should not" have the ability to take care of themselves; I am claiming that with all thing considered in the modern world, this is not a reasonable principle to maintain. Medical doctors and medical facilities are typically well-equipped to promote human health, and if it were somehow the case that an individual could (1) diagnose, (2) plan a treatment discourse, and (3) evaluate treatment effectiveness themselves, I would hastily withdraw this assertion.

care from the doctor, thereby forfeiting a significant portion of their agency in the medical decision-making process. However, when consenting to medical care and forfeiting this agency, it is vital that individuals consent to this process willingly. Assuming this occurs, individuals can reasonably expect a medical doctor to be making medical decisions with their best medical interest in mind, just like a client can expect a lawyer to be making legal decisions for them in the best interest of the client. If a physician does not act out of those intentions, he is acting coercively. If a patient forfeits agency in the medical decision-making process and is naturally a weak agent in the field of medical decision-making, it can be said that a medical doctor—responsible for their care—gains fiduciary duties.

The foregoing arguments all support the claim that physicians can have obligations to their patients. Role obligations, public good-promoting role obligations, favorable positions, voluntary obligations, and fiduciary relationships relating to medical care all generate obligations, and medical doctors have obligations to patients for these five reasons. I now turn to the question of *why* health promotion is so important. Why are the obligations of physicians premised on human health promotion before all other considerations? To answer this question, and to explain how this answer is foundational to our understanding of proper medical care, I will now address the value of human health, a value that is so resilient, it has been able to bolster my arguments for doctoral obligations—and even *prima facie* generate obligations for physicians.

II. The Unconditional Value of Health: Characterization and Obligation Generation

To say something is *unconditionally* valuable means that it is valuable regardless of whether or not an agent subjectively values that item. For example, regardless of whether

someone values my autonomy, it can be said that my autonomy is valuable—irrespective of what moral theory informs that value assignment. The mere fact that my autonomy exists makes it valuable, and without my autonomy, I am not able to access and pursue personal projects.[20] The counter to something being unconditionally valuable is for that something to be *instrumentally* valuable; when an item is instrumentally valuable, the value of that item depends on the individual assessing the value of that item. Even if the individual may place a high value on an instrumentally valuable item, it does not mean that it must be uniformly respected and not interfered with (and vice versa). For example, if you happen to value a slice of pizza, it is valuable to you, but a slice of pizza is still just instrumentally valuable. There is nothing unconditionally valuable about pizza, and it is completely reasonable for someone to not value pizza.

This distinction is morally significant because it illustrates the reasons in favor of respecting certain things. If I do not value a slice of pizza, I cannot prevent you from eating pizza, but not because of the value of pizza. Rather, in doing so, I would not be valuing (read: would be disrespecting) your unconditionally valuable autonomy, and as long as you eating pizza does not interfere with the unconditional values of others, you are free to respect that instrumental value. Still, we needn't respect all autonomous choices. Imagine you want to murder a pizza vendor in order to gain a free slice of pizza. This is not permissible; you may value pizza and see a net positive in personal value from having the slice of pizza, but this cannot be valued the same as ending the pizza vendor's life—it can't be equated, and therefore can't be considered a moral decision. This case illustrates that values must be balanced, and that

[20] Korsgaard, Christine M., and Onora O'Neill. *The Sources of Normativity*. Cambridge: Cambridge University Press, 1996.

unconditionally valuable things like autonomy should generally outweigh instrumentally valuable things.

Now, suppose that you happened to be starving so badly that you were on the brink of death and the only food that you had access to—before your impending death—was a slice of pizza. Even if you did not subjectively value that slice of pizza, the slice would become more valuable within the moment that it had the immediate potential to save your life. Lifesaving pizza is still instrumentally valuable, but it becomes instrumental to promoting a higher order value (something unconditionally valuable): your health and well-being. Your situation changed the value of the aforementioned pizza because the slice of pizza is necessary to preserve other values within your life (and the essence of your life); something instrumentally valuable like a slice of pizza is able to become at least *more* objectively valuable because it is promoting value of a higher order.

It may be ironic that I am discussing pizza in a section about human health and life, but these cases illustrate how values like autonomy or human health should not be weighed against other conditionally valuable things. As a baseline argument from the lifesaving slice of pizza example, if one maintains that health is an instrumental value, there are still reasons to think that health promotion can still *matter*. Beyond that, I believe that health promotion is instrumentally valuable to promoting the unconditional value of health.

My claim is that health is unconditionally valuable. This idea is informed by a Kantian moral theory: human health is unconditionally valuable because it is a necessary condition for one's rational will to exist (and to be properly maintained and fostered, for that matter). Without proper health, one cannot fully pursue personal projects—and cannot fully exercise their rational

capacities. For that reason, human health is a value that exists within each human being, and that value exists regardless of the individual perspective on that value. David Velleman, in his paper entitled *A Right of Self-Termination?* explores this idea. Velleman supports the notion that human health—in the form of human life—is valuable regardless of subjective opinion. He rejects the idea that human life can never be ended, but he supports the idea that human life cannot be ended based upon one's own valuation of a life (or, in other words, a substitution of an instrumental value for an unconditional value). Velleman introduces that idea here:

> "That's what I miss in so many discussions of euthanasia and assisted suicide: a sense of something in each of us that is larger than any of us, something that makes human life more than just an exchange of costs for benefits, more than just a job or a trip to the mall. I miss the sense of a value in us that makes a claim on us—a value that we must *live up to*."[21]

Velleman is speaking about the inherent value within us that exists objective to our individuality, something that not only we must "live up to," but—as he further explores—that we must respect. When I say respect, I mean not only in the sense of non-interference (our negative duties in regards to the value in others), but also in the sense of aid and value promotion (our positive duties in regards to the value in others).

This value that we must respect is our rational will and livelihood. When we are in a state where our rational will and livelihood are above a reasonable, baseline level that does not hinder our essential activities or projects, it may be said that we are *healthy*.[22] Surely, one may have a definition of *healthy* that includes the necessity of proper diet, consistent exercise, and maybe even a certain degree of mental stimulation, but the exact definition of human health is not what I

[21] Velleman, J. David. "A Right of Self-Termination?" Ethics 109, no. 3 (April 1999): 606-28. doi:10.1086/233924.
[22] Murphy, Dominic, "Concepts of Disease and Health", The Stanford Encyclopedia of Philosophy (Summer 2009 Edition), Edward N. Zalta (ed.), URL = <http://plato.stanford.edu/archives/sum2009/entries/health-disease/>.

am trying to clarify in this argument. However minimally a definition of human health may be structured, my only claim about health is that it is *better* to be healthy.

Some parameters of human health are uncontroversial. For instance, simply maintaining basic organ functioning does not mean you are healthy; I would not consider someone in a persistent vegetative state to be healthy. On the opposite side of the spectrum, I do not think it is fair to include something like a particular amount of muscle mass or a cosmetic feature to be included in a definition of health. For the sake of the argumentation, the definition of health that I will be using is as follows: If someone is free of disease and illness, is not living a life that will inevitably lead to preventable disease or illness, and can carry out normal species functioning on a day-to-day basis without aid, I will consider that individual "healthy".[23] Thus, when I am speaking about health promotion, I am referring to aiding a return to the conditions mentioned above (or, in cases where that may not be possible, the best effort possible in order to attempt to return an individual to the conditions mentioned above).

With that established, I want to reintroduce the point made prior to the preceding paragraph. As Velleman has explored in his argument on self-termination (and something explored by many philosophers writing on Kantian ethics), we have value intrinsic to our humanity that cannot be interfered with for something of lesser value (i.e. happiness, money) to be promoted. Further, we have a duty—as fellow human beings—to respect the rational will and existence of other human beings, with the idea of "respect" being actualized in two forms. Taking that idea to the arena of human health and well-being, according to a deontological affirmation that we must respect—in more than one way—the rational will and livelihood of

[23] I want to emphasize that I must take a definition of health to further my argument. I am not trying to argue for a particular definition of health, I am simply taking a definition that I believe is the least controversial and will be easiest to include within my main argument.

others, from the previous argument, it then follows that we have an obligation to "respect" human health and well-being.

This fact is much easier to comprehend from the perspective of negative duties; surely, I have an obligation to *not* interfere with the health or livelihood of some other individual. It is more difficult to assert that we have a positive duty to promote—or maintain—the health and well-being of other human beings. To see why both are true, consider re-stating this principle as an obligation to promote human health and well-being through non-interference and positive provisions. This argument is another way of approaching the topic of a general duty of beneficence; from this line of reasoning, we have additional moral reasons to promote societal well-being. If someone standing next to me has a heart attack (like in the case of *The Basketball Game*), I have an obligation to promote their health. That does not change, even if I do not have the skills necessary to effectively carry out that health promotion. But, as explored when talking about obligations in the basketball game case, this shortcoming can be mitigated by another individual—the aforementioned "division of moral labor" facilitated by medical doctors.[24]

Thus, we arrive at what I believe to be the strongest case for strong obligation generation in medical care: the fact that medical doctors are responsible for promoting an unconditional value embodied in human health, well-being, and livelihood. Medical doctors are the individuals responsible for maintaining and promoting the essence of human life: human health. That, I

[24] There is no normative difference between an individual's positive and negative duties related to human health promotion, but I do not maintain that no difference exists between positive and negative duties in all of ethics; it is easier to see how someone's positive or negative duties in the subject of health promotion both tell in favor of a division of moral labor. To not interfere with human health promotion is only half of what is morally at stake in medicine, and apart from an ability to actively promote health and well-being, there are reasons to believe that health promotion is an obligation that society inherently maintains.

believe, generates strong obligations that must hold doctors accountable for not making efforts to maintain or promote human health.

Sam Scheffler has argued that unconditionally valuable goods generate obligations to promote or advance those goods.[25] Take, for example, a non-instrumental relationship (like a close friendship). The relationship is not maintained "solely as a means to some independently specified end," so there are reasons to believe that my friend makes non-instrumental claims on me that would otherwise be unreasonable for a miscellaneous person to make on me. This is permissible because of the nature of the relationship; for something to be able to non-voluntarily formulate responsibilities for me, it must be of a higher-order, unconditional value. Further, there would be something wrong with turning my non-instrumental relationship into something instrumental (or having it be formulated on an instrumental basis). Now, let us assume that my close friend was assigned to me through giving money to an agency that leases out close friendships. There seems to be something inherently wrong with commodifying something of non-instrumental value.

Health is an unconditionally valuable good, and from Scheffler's argumentation, it follows that medical doctors are therefore obligated to provide for human health promotion. One advantage of an unconditional value approach to justifying obligations in medical care is that it is informed and supported by the preceding arguments for obligations while simultaneously providing justification for those obligations. From Scheffler's argument, there are also reasons to believe that commodifying patient health—based on its non-instrumental nature—is wrong. To gain something of instrumental value from a relationship of a non-instrumental nature is like

[25] Scheffler, Samuel. "Relationships and Responsibilities." Philosophy and Public Affairs 26, no. 3 (Summer 1997): 189-209. doi:10.1111/j.1088-4963.1997.tb00053.x.

paying for a close friendship or taking advantage of a spouse for profit: there seems to be something non-instrumental undergoing degradation in these transactions.

A doctor is the individual responsible for human health promotion, a *role* that they willingly assume. Doctors are the embodiment of a "division of moral labor" in human health promotion (also an idea also explored by Samuel Scheffler).[26] Further, human health is not only a necessary public good, but a value that is fundamental and *unconditionally* valuable. And, if nothing else, doctors are *well-positioned* to promote the unconditional value of human health.

III. The Medical Profit Motive is Inconsistent with Physician Obligations

Recall the discussion about the value of pizza. At one point, I introduced a hypothetical situation where you wanted to kill a pizza vendor to obtain a free slice of pizza, which may have seemed like an absurd situation to propose. Yet it is not so absurd when we acknowledge that physicians consider monetary profit over human health promotion. These practices are both morally unsound for a similar set of reasons. After all, in both cases, a rational agent would be disrespecting an unconditional value for their own pursuit of an instrumental value like pizza or money. Both of these cases are therefore impermissible ways of responding to unconditional values. Doctors, especially with their set of strong obligations towards patients to promote health, are morally blameworthy for not considering patient health over monetary gains (when the two values are pitted against one another). Thus, physician obligations are *pro tanto* incompatible with a medical profit motive, and thus, a medical profit motive is *pro tanto* immoral.

[26] Scheffler, Samuel, and Véronique Munoz-Dardé. "The Division of Moral Labour."*Proceedings of the Aristotelian Society, Supplementary Volumes* 79 (2005): 229-53. http://www.jstor.org/stable/4106941.

I have established that health has unconditional value, but I would like to speak briefly about the "profit motive" as mentioned in this paper. Philosophers, including Buchanan and Brock, have also addressed this topic and their analyses will be discussed later in this argument.[27] To reiterate, I define a *medical profit motive* as the desire to maximize pecuniary profit from patient care as a primary motivation in patient care. A medical profit motive is not the same as medical cost considerations; I am asserting that the former is unethical and the latter is responsible (when taken in isolation from one another). If a medical doctor is considering costs to patients, costs to other patients, and costs to society when making medical decisions, this can more easily be morally permissible. The situation changes when for-profit medical providers, including doctors, go beyond cost considerations to consider their own monetary gains.[28]

When profit motivated reasoning is injected into patient care, a medical provider is objectifying the patient and performing a commodification of that patient's health and well-being. To "objectify" a patient is to reduce the patient to something instrumental, like a commodity. Patients are human beings, and their humanity should disallow a commodification process to take place towards something fundamental to their humanity. The doctor-patient relationship is a non-instrumental relationship that generates strong obligations, and it is wrong to take advantage of it to produce instrumental goods. Patient health must exist outside the realm of commodification; it is of a higher-order, unconditional value.

Throughout this discussion, I have assumed that whenever something is of unconditional value, it carries significant moral weight. If two things of value are pitted against one another

[27] Brock, Dan W., and Allen E. Buchanan. "The Profit Motive in Medicine." *The Journal of Medicine and Philosophy* 12 (February 1987): 1-35. doi:10.1093/jmp/12.1.1.

[28] I define "for-profit" healthcare organizations to be for-profit organizations (in the traditional sense) and non-profit healthcare organizations with a Board of Trustees. Essentially, I am excluding charitable healthcare organizations and community healthcare organizations.

(meaning that promoting one value will disrespect or undermine the other value), the thing of higher value must be promoted. I realize that sounds nebulous, so allow me to clarify this determination. Even if, all things considered, item A is of a higher value than item B, does that necessarily justify promoting item A over item B? Fortunately, human health can escape from this tenuousness when being pitted against a medical profit motive because a medical profit motive is something of *instrumental value*. No matter which way it is dissected, the desire for medical providers to gain additional revenue is a relative, conditional value. Hardly anything about our moral intuitions or any predominant moral theory would justify a model of the medical profit motive being unconditionally valuable.[29]

In other words, when something of unconditional value is weighed against something of conditional value (and one must be promoted over the other), we should preserve the thing of unconditional value. For example, slavery is immoral because slavery substitutes something of conditional value (free labor) with something of unconditional value (autonomy, respect). This is even true in cases where the "things" of unconditional value are weighted heavily in number against the "things" of conditional value. Consider the case where a building is up in flames, and in this building, the human race has managed to gather all of the greatest artistic achievements over the last century. However, there is something else within the inflagration: a human baby.[30] You must choose to save the body of art that has been collected in the building or the human baby, and you cannot save both. What would you save? There is no question that the art is valuable, but I believe that most would agree that we would be morally required to save the

[29] Velleman, J. David. "Beyond Price*." *Ethics* 118.2 (2008): 191-212. Print.
[30] Buss, Sarah. "Needs (Someone Else's), Projects (My Own), and Reasons." *The Journal of Philosophy* 103, no. 8 (August 01, 2006): 373-402. Accessed April 16, 2014. http://www.jstor.org/stable/10.2307/20619955?ref=search-gateway:5a573eb9f71faa9025c10bd36400855a.

child's life.[31] Here, we can see that what must be at stake in value considerations—and choices within those considerations—are not just considerations about the quantity of competing values, but the types of values that are at stake. Applying this into the health vs. profit debate, it would not be appropriate to consider the *amount* of profit at stake in medical decision-making when unconditional values like health are in jeopardy of being undermined.[32]

One may justify a medical profit motive in patient care, insofar as it does not undermine proper patient care—which is the essence of a physician's obligations. Yet I have argued that if a doctor acts on a medical profit motive, and that motive is antagonistic towards the health of the patient, in every case, the profit motive is morally impermissible. An unconditional value (like patient health) cannot be valued over a conditional value (like profit). Even if a medical profit motive is in accordance with promoting patient health, it is still immoral in this case because it is *pro tanto* immoral to consider monetary profit in medical decision-making, but that immoral characteristic can be overcome by beneficial patient outcomes. The fact that a profit motive is prevalent in patient care is morally permissible so long as the medical doctor responsible for patient care is promoting patient health to the fullest extent possible (again, independent of a profit motive). In the negative interference cases, if doctors decide to undermine proper patient care, they are not only acting against what is morally required from them, but they also are

[31] A view that supports this intuition can be found in: Singer, Peter. "Famine, Affluence, and Morality." *Philosophy and Public Affairs* 1.3 (1972): 229-43. Print.

[32] Some would argue (such as Judy Thompson in her work "A Moral Defense of Abortion") that just because one can prevent a wrongdoing or benefit someone with minimal effort does not necessarily lead to an obligation to prevent that wrongdoing or benefit that individual. While acknowledging her position, I believe this is an overgeneralization and misguided. I think that the circumstances do matter when considering moral blame for not benefitting someone; if the values at stake are unconditional and the effort required to prevent wrong/benefit are miniscule, one can be held morally accountable for failing to act with beneficence. To use Thompson's examples while applying my own beliefs, Henry Fonda can be held morally accountable for not touching the feverish brow when he is a walking distance from the ill patient (and a patient could be conceived as having a right to his cool hand). I do not believe that the same right would be generated when Henry Fonda is a plane ride away from that same patient; it would be more unreasonable to claim this.

undermining the fundamental, implied mechanisms predicating medical care. If a medical doctor does not act in accordance with the fundamental obligations that predicate moral patient care, it cannot be said that they are an ethical doctor. The cases where a medical profit motive interferes with and undermines the value of human health are enough to suggest that a medical profit motive should not exist in medical decision-making, but some situations may permit such a motive.

IV. Profit Considerations in the Modern Doctor-Patient Relationship

I have developed a theory of value assignment and assessment in medical care related to pecuniary profits. I will now show how this theory applies in real-world medical decision-making. Aspects of the modern medical field are sometimes driven by profit motive considerations over considerations of patient health, and profit motive-driven care undermines patient health more than is often perceived. A medical profit motive undermines patient health in three ways: a medical profit motive—maintained by a medical doctor—compromises the health of that doctor's patient, compromises the health of other potential patients, and undermines the standard of care that particular patient groups morally ought to receive.

First, a medical profit motive can compromise the health of individual patients. For example, a physician or for-profit health system could benefit greatly (in the economic sense) from over-treating particular medical ailments or conditions (another name for this case being *polypharmacy*).[33,34] In some cases, physicians are driven to keep patients on sustained treatment

[33] A formal definition of "polypharmacy" is "when an older adult patient, often over the age of 65, is prescribed—and is taking—five or more medicines or treatments at one time." Although this definition exists, there is no exact medical definition of the term "polypharmacy". Thus, when I refer to polypharmacy in this argument, I am referring to the instance where a patient is prescribed—and is taking—more than one pharmaceutical at a time. Additionally, I will use the term "polypharmacy" and

plans because they receive higher profits from having their patients stay on these treatment plans. Jerome Schofferman addresses this issue in the field of Interventional Pain Medicine. As a pain doctor, Schofferman makes the claim that "profit is an incentive to provide the best care possible…[but] it is when profit becomes unreasonable that there is a problem;" Schofferman goes on to say:

> "Pain specialists may limit their practice to the most profitable patients—those who require interventions such as injections or neuromodulation. They might decline to see those patients who need only pharmacological management, counseling, rehabilitation, or just support and advice. They may rationalize this practice style by thinking, "it's what I do best," "it's what I like to do," or "it's what I was trained to do." More disturbing might be, "I've got a lot of overhead," or "I've got to make a living."[35]

To prefer certain patients over others on an economic basis (even assuming that all patients being considered are insured and can pay) is the ugly realization of the medical profit motive: choice medical care that affects the livelihood of patient populations.

Within these cases, there are instances where physicians have the same motivations, but they come at a *higher* additional cost to the patient: their health. Physicians may have an economic interest to not only treat patients on a continual basis, but also to recommend treatment plans or pharmaceuticals that they will receive a higher profit from prescribing. Profit-motivated physicians could prescribe drugs even if the drugs are not the most effective defenses against patient ailments, or even if some sustained treatment plans have additional health costs to a patient (such as known or unknown negative health side effects). In these cases, side effects

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"overprescription" to refer to the increased use of prescription medicine to treat medical ailments (so the term may also be used to refer to a systemic issue).

[34] A great article that introduces the concept, problem, and scale associated with polypharmacy is: "Gorard, D.a. "Escalating Polypharmacy." *Qjm* 99.11 (2006): 797-800. Print."

[35] Schofferman, Jerome, MD. "Interventional Pain Medicine: Financial Success and Ethical Practice: An Oxymoron?" *Pain Medicine* 7, no. 5 (2006): 457-59. Accessed November 21, 2013. American Academy of Pain Medicine.

alone should be enough to caution medical doctors from over-treating their patients, because to do so is harmful.[36] Several more focused studies confirm that polypharmacy negatively impacts patient health.[37,38] When a medical profit motive starts to negatively impact patient health on a direct level, the medical doctor facilitating the impact is at fault. In these cases, a medical profit motive cannot justify over-treatment when patient health is at stake.

Second, a medical profit motive can compromise the health of larger patient populations or other patients that a medical doctor might not have direct contact with. Consider the following case to demonstrate the concept of a medical doctor imposing social costs:

> *The Prodigal Physician*. A medical doctor M works for a hospital, so Dr. M does not directly bear the costs associated with medical decision-making. Dr. M is especially wasteful in medical decision-making, always keeping his patients within the hospital as long as possible, prescribing the most expensive treatment plans for his patients, taking the longest amount of time to see patients as possible, and performing other tasks associated with medical care with no regard for costs. Dr. M receives increased profit from increased medical cost.

When a medical doctor is imposing *social costs* on a system or on society as a result of a medical profit motive, that profit motive should not be present in patient care. The idea of a social cost is relatively simple: a social cost is a cost that is borne by a community, a system, or society rather than a *private cost*, which is borne by an individual.[39] Certain medical decisions affect more than just a single patient or the medical doctor making the decision. For instance, if a doctor were to see a patient continually if it is not clinically indicated that a patient needs constantly renewing visits, a doctor may monetarily benefit from that constant stream of visit costs. The monetary

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[36] Hsiao, W. C. "When Incentives And Professionalism Collide." *Health Affairs* 27.4 (2008): 949-51. Print.
[37] Unsworth, D. J. "Controversy: Adrenaline Syringes Are Vastly over Prescribed." *Archives of Disease in Childhood* 84.5 (2001): 410-11. Print.
[38] Zarowitz, Barbara J. "Anticoagulant Polypharmacy." *Geriatric Nursing* 32.3 (2011): 198-202. *ScienceDirect*. Web. 11 Mar. 2014.
[39] Coase, Ronald H. "The Problem of Social Cost." *Law & Economics* 3, October 1960. Print.

costs of continual patient visits are not the only costs to be considered in this situation; we must also consider the time lost for the doctor to see other patients, patients who may *require* medical attention. In other words, this example highlights that the profit motive can compromise *overall patient care* if doctors allocate their time on the basis of monetary considerations rather than good patient care.

Although doctors legally have the right to decide which patients to see, patients who have the proper insurance have the right to see a physician if they so choose, and physicians can only work a certain amount of hours within the day, I deny that these considerations are appropriate enough to defend a profit-motivated model of patient care. Doctors—along with patients—need to be more responsible and consider costs to the health of others as a result of prolonged (and unnecessary) medical care.

The medical profit motive leads to additional negative health effects, some that may materialize in more indirect ways (but are nonetheless caused by a physician being profit-motivated). Medical doctors have a monetary interest in becoming highly specialized within the medical field, which has led to a shortage of primary care physicians.[40,41] In the United States, the population is aging rapidly, which will require an increased number of primary care physicians to address in the future. The United States is also expecting a huge increase in the need for primary care physicians when the Affordable Care Act comes into full fruition.[42] Along with the aging population and patient populations increasing, the country is experiencing a

[40] Cross, MargaretAnn. "What the Primary Care Physician Shortage Means for Health Plans."*Managed Care Magazine Online*, June 2007. http://www.managedcaremag.com/archives/0706/0706.shortage.html.
[41] Giang, Vivian. "There Is A Serious Shortage Of Primary Care Doctors And It's Only Getting Worse." Business Insider. September 10, 2013. http://www.businessinsider.com/there-is-a-serious-shortage-of-primary-care-doctors-and-its-only-getting-worse-2013-9.
[42] Peckham, Carol, and Perry A. Pugno, MD, MPh. "The Impending PCP Shortage: How Bad Is It?" *Medscape*. N.p., 17 Sept. 2013. Web. 12 Mar. 2014.

decrease of primary care physicians available and a decrease in the number of medically trained individuals entering into primary care.[43] Here also, profit motivation affects the entire health care system. As Arnold Reiman writes, the economic incentives of specialty practice "are attracting the great majority of physicians into specialty practice, and these incentives, combined with the continued introduction of new and more expensive technology, are a major factor in causing inflation of medical expenditures."[44] Again, medical doctors should have the autonomy to decide what specialties within the medical field to focus their attentions towards, but that decision cannot be irresponsible and void of societal considerations. A lucrative occupational choice is not always the most moral choice even if it is morally permissible. No matter what field a medical doctor decides to focus in, he must examine the condition of the medical field—and thus the needs that the medical field displays. If there will be a deficiency of primary care doctors moving forward with health care reform, there will be a large social cost associated with that deficiency.[45] The responsibility to address this shortage falls—at least in the short-term—on the doctors within the medical field. It is necessary that some doctors suspend their medical profit motive for the social costs that may be resultant from increased medical specialization.

Third, a medical profit motive negatively impacts the entire medical field because a profit motive can detract from—or sometimes can prevent—considerations about alternative treatment plans or a focus on preventative medicine. Thus, some medically preferred treatment plans can be overridden by monetarily preferred treatment plans. Based on our current medical incentive structures, preventative medicine does not provide for increased profits, even though a focus on

[43] Mercer, Marsha. "How to Beat the Doctor Shortage." *AARP*. N.p., Mar. 2013. Web. 12 Mar. 2014.
[44] Relman, Arnold S. "Eliminate the Profit Motive in Health Care." Physicians for a National Health Program. September 28, 2011. http://www.pnhp.org/news/2011/september/eliminate-the-profit-motive-in-health-care.
[45] Cross, MargaretAnn. "What the Primary Care Physician Shortage Means for Health Plans." *Managed Care Magazine Online*. N.p., June 2007. Web. 12 Mar. 2014.

preventative medicine is undoubtedly in the best medical interest of most patients. Here, you can see a situation where the interests of for-profit medical providers are in direct tension with the obligations that medical providers have to promote patient health.

To see how this tension pans out in real-world medical care, consider treatment regimes for Celiac disease (and its resultant gluten intolerance) that are premised on the idea that preventative medicine is not as profitable as lifelong treatment, and therefore lifelong treatment should be the governing model of patient care. According to The Celiac Disease Center at the University of Chicago, Celiac disease afflicts "an estimated 3 million Americans," yet only three percent of the people afflicted by it are aware of the nature (and cure) of their illness.[46] If Celiac disease is correctly diagnosed, the effective treatment is simply a gluten-free diet.[47] Doctors theoretically have a monetary interest in treating the symptoms of Celiac disease, though, because they do not see a monetary gain from advising gluten-free diets or championing awareness of Celiac disease within relevant patient populations.

This is just one example of a problem with the medical profit motive in treatment of medical ailments; treatment correlates with profit, regardless if it is clinically indicated that treatment is needed or not. Alternative or less burdensome treatment plans (such as a diet change) do not produce a profit, so the incentive to pursue such plans is not concrete. The incentive, truly, should be a moral one, not one based on profit. This is not only an issue because the commodification of human health—by placing health against monetary profit—is immoral in the sense that disrespecting an unconditional value by promoting an instrumental value is *pro*

[46] Celica Disease Center. "Celiac Disease Facts and Figures." *The University of Chicago Celiac Disease Center*. August 2005. www.uchohospitals.edu/pdf/uch_007937.pdf.
[47] Briani, Chiara, Diana Samaroo, and Armin Alaedini. "Celiac Disease: From Gluten to Autoimmunity." *Autoimmunity Reviews* 7.8 (2008): 644-50. Web.

tanto wrong, but the profit motive often leads to worse patient health outcomes. This situation is absolutely impermissible.

V. Some Objections to my Argument

In this section, I will address some arguments in opposition to my thesis. First, one may argue that a doctor is merely a businessman. On such a view, if a doctor wishes to maintain a medical profit motive and consider costs associated with medical care, that motive is not in tension with his obligations. Proponents of this view may argue that for a medical doctor to be fully autonomous and provide excellent patient care, he must be able to maintain a profit motive.

This objection prompts a clarification. When I claim that a medical doctor should not consider monetary profit in patient care, I am not trying to suggest that he should not consider the costs associated with medical care; that would be an inaccurate extension of my thesis. I fully believe that cost considerations can exist within patient care because I believe that cost consideration is one of the obligations that doctors have to patients and the health care system. A fully responsible physician will be able to weigh cost considerations against treatment effectiveness and patient health without compromising an ethical principle outlining patient care.

I argued above that a doctor is not foremost a businessman because he has especially powerful obligations to promote patient health. Even if doctors are somehow businessmen within the medical field, it does not necessarily follow that doctors gain the right to maintain a medical profit motive—as demonstrated by the potential for a medical profit motive to undermine the value of patient health. Medicine should not be considered a business. It is still morally not ideal for a profit motive to exist in patient care, as evidence of a *pro tanto* wrongdoing that is associated with any medical profit motive. When a doctor incurs professional obligations, he

forfeits some of his autonomy (to make any medical decision, regardless of patient outcomes) in exchange for patient trust and the power to make medical decisions for a patient.[48]

As I have indirectly mentioned throughout this argument, there are still situations where a profit motive can exist in patient care. My argument does not seek to prevent all cases of profit motivation in *individual* medical care (or, in other words, within the doctor-patient relationship). The following case illustrates a scenario when the profit motive may be morally acceptable all things considered:

> *The Greedy Neurosurgeon*. Dr. Cash is the top neurosurgeon in the world, so when a relevant patient is treated by Dr. Cash, they receive the best possible medical care. However, Dr. Cash is not *motivated* by promoting patient health and well-being; Dr. Cash happens to charge large sums of money for his services, and he is driven to provide excellent patient care solely based on large profits.

Based on the foregoing arguments, there is still something wrong with medical care being driven by profits, but *The Greedy Neurosurgeon* case illustrates that medical outcomes can overcome the wrongness of commodifying health. If a medical doctor avoids profit considerations in medical decision making, it would be morally ideal; this scenario, of course, should be weighed against the scenario where profit considerations are abolished along with optimal patient health outcomes.

I acknowledge that completely removing the potential for a medical profit motive in patient care would remove a significant portion of motivation for physicians to provide excellent health care services, even though this is not morally ideal. In the case of *The Greedy Neurosurgeon*, a profit motive can exist because it is utilized to promote the most optimal health

[48] No need for this point to be ethically troubling. If someone voluntarily forfeits their autonomy to you, it is permissible to violate that portion of autonomy they conceded. This exists in medical care through the autonomy forfeiting that results from informed consent to medical treatment.

outcomes for his patients. But insofar as a medical profit motive exists and acts antagonistically towards promoting optimal patient health outcomes the profit motive is morally impermissible.

One may also object that medical doctor is simply a health consultant for a patient. If so, then doctors do not have a responsibility to promote patient health in all situations. One may ask, "Doesn't patient satisfaction and happiness matter too?" Proponents of this position assert that an individual's well-being is their own value to selectively maintain, and it would be a violation of preventions towards medical paternalism to try and claim that patient happiness should not be the motivating factor in medical decision-making. In this argumentation, it would be unethical to make a claim on the value of another individual's health.

Patient happiness and satisfaction is significant, but it would matter more if it were not for the fact that patients are often "weak agents" in the medical decision-making process. Debra Satz, in a paper discussing the moral considerations behind organ markets, defines "weak agency" as the situation where "an agent who is either ignorant of the consequences of his actions or is not directly involved in the transaction…relies on another person to transact on his behalf."[49] In this definition, patients seeing a medical doctor are weak agents over medical decision-making relating to their own health. A patient may desire a particular treatment plan, but since they—on balance—have limited knowledge about human medicine, they cannot make a fully informed and appropriate decision about their treatment, albeit they cannot carry out most treatment plans without the counsel or action from a medical doctor.

Since it has been shown that patient health is of unconditional value, if a medical doctor operated with a primary motivation being patient happiness and satisfaction, it could be possible

[49] Satz, Debra. "XIV-The Moral Limits of Markets: The Case of Human Kidneys." *Proceedings of the Aristotelian Society (Hardback)* 108, no. 3 (2008): 269-88. doi:10.1111/j.1467-9264.2008.00246.x.

that they would be acting impermissibly because they could allow patient health to be compromised for something else of conditional, instrumental value: happiness.[50] For this reason, if patient happiness is something of instrumental value, then the argument that I have developed throughout this chapter applies, and patient happiness then cannot be promoted over patient health. This does not mean that a medical doctor should disregard patient happiness and satisfaction completely; there is still an element of respecting patient happiness that comes along with moral patient care. Something of instrumental value is still something valuable to an agent. It is when this instrumental value could potentially undermine the value of something unconditionally valuable, like human health, that a problem arises.

VI. Conclusion

In this chapter, I have demonstrated that a medical profit motive is incompatible with ethical patient care, but may be able to still exist when considering patient health outcomes. I first outlined the ways in which a medical doctor has strong obligations towards his patients, and from that discussion, I showed that these obligations are premised on promoting patient health and livelihood. Due to the nature of these strong obligations, medical doctors cannot simultaneously maintain a medical profit motive and consider patient health; patient health should be their primary consideration.

[50] This position may be interpreted to be at odds with a prevention of medical paternalism, and I am endorsing medically paternalistic action. First, consider that I am simply discussing this idea in the context of patient happiness being a primary motivation. I firmly believe that patient happiness matters in medical decision-making, but it cannot be what drives physicians to treat ailments and choose patient discourses. If that were the case, medical decision-making would lose effectiveness. If patient happiness was the ultimate barometer to guide physician decision-making (i.e. the happiest patient was the one that was treated most effectively), doctors would become glorified drug dealers: prescribing patients nothing but morphine to combat their medical ailments would produce the happiest patients. Clearly, our intuitions tell us that there is something wrong with this situation. In addition, this position should not be interpreted to mean that patient happiness—materialized into medical decisions—should not be factored into treatment plans; my argument considers that *refusal* to care is a legitimate and important check on paternalistic decision-making in medicine.

From this discussion, it may seem as though I am being very critical towards medical doctors. Despite the foregoing ethical argument against a medical profit motive, I acknowledge that medical doctors operate in a complex field driven by a large number of considerations and responsibilities. I do not believe that the existence of a medical profit motive is *entirely* the fault of the medical doctor, so in the next chapter I will explore the existence and unfortunate fostering of the medical profit motive by agents other than the medical doctor. There, I argue that physician incentive structures are ethically flawed, and they ought to change to act in accordance with relevant moral principles in patient care. On a systemic level, new issues arise that further suggest that a medical profit motive is immoral to maintain when administering over patient care.

Chapter II: The Medical Profit Motive in Medical Administration

"It is undeniable that for-profit health care involves potential conflicts between the interests of providers (physicians, managers, administrators, and stock-holders) and those of patients. In the most general terms, the conflict is simply this: an institution with a strong, if not an overriding, commitment to maximizing profit may sometimes find that the best way to do this is not to act in its patients' best interests."[51]

In the previous chapter, I discussed cases where a medical profit motive is carried out by a singular medical doctor. There, I suggested that the negative outcomes that result from certain medical profit motives are enough to tell against the existence of a medical profit motive in all medical care. The elimination of profit motives would be an ideal scenario if we, as a society, could uphold all moral principles strictly (that is, if we could be moral saints).[52] However, even though a medical profit motive commodifies patient health and is *pro tanto* wrong, we cannot halt these motivations or criticize any singular medical doctor for operating within our current medical system so long as they are optimally promoting patient health with a profit motive.

The same logic does not apply to bodies of medical doctors or to administrators of large medical organizations with direct patient impact. For these agents, maintaining a medical profit motive on a meta-patient, organizational level introduces new levels of moral concern that afford them fewer excuses to commit the wrongdoings associated with a medical profit motive.

My thesis in this chapter is that a medical profit motive—pursued by organizations or maintained on an organizational level—is morally worse than a medical profit motive maintained within a patient-doctor relationship. A medical profit motive on an administrative level is

[51] Brock, D. W., and A. E. Buchanan. "The Profit Motive in Medicine." *Journal of Medicine and Philosophy* 12, no. 1 (1987): 1-35. doi:10.1093/jmp/12.1.1.
[52] Wolf, Susan. "Moral Saints." *The Journal of Philosophy* 79.8 (1982): 419-39. *JSTOR*. Web. 25 Feb. 2014. <http://www.jstor.org/stable/2026228>.

especially morally wrong because it fosters and facilitates further systemic wrongdoing. When a medical organization maintains a profit motive, they not only commodify patient health, they coerce medical practitioners into committing a similar commodification and pressure one another into considering monetary gain over optimal patient health promotion. This profit motive is especially wrong when the individuals maintaining the medical profit motive are not medical professionals, thereby rendering them almost entirely unable to properly value human health and well-being in medical decision-making.

The medical organization operates in two separate "firms"—the medical staff and the administrative staff. Each face different challenges, require different criteria for performance, and are normatively different.[53] The leadership structure of medical organizations do not face the same type of pressures that medical practitioners face, so it is harder to justify operating in an immoral system when changes could feasibly be made to align profit-driven practices with medically optimal practices.

Some may reply that this position would be an impossible business model to uphold or would be overzealously attacking the issue of business considerations within medical care. This thesis is not directly concerned with business considerations; the moral travesties that result from a *systemic* medical profit motive defeat any considerations of profit. I am engaging in *ideal theory* in this chapter, which intends to lay out the moral facts behind administrators' medical profit motives.[54] These moral facts can—and will be—engaged and interpreted differently, and I am not attempting to outline the exact ways that a moral medical organization ought to weigh

[53] Harris, Jeffrey E. "The Internal Organization of Hospitals: Some Economic Implications."*The Bell Journal of Economics* 8.2 (1977): 467-82. *JSTOR*. Web. 13 Mar. 2014. <http://www.jstor.org/stable/10.2307/3003297?ref=search-gateway:056ba3079cdac1571a6495bf9e702c88>.

[54] This concept was introduced by John Rawls. See: Wenar, Leif. "John Rawls." Stanford University. March 25, 2008. Accessed March 24, 2014. http://plato.stanford.edu/entries/rawls/#IdeNonIdeThe.

pecuniary considerations against patient care decisions. I will offer some suggestions for medical organizations, but my mission here is to tease out the moral facts within an administrative medical profit motive so that they can be prepared for real-world application.

To clarify the role of ideal theory in our moral reasoning, consider the following thought experiment from David Estlund. Imagine the morally ideal reality of a situation (M) as a "picnic spot" on a distant—yet visible—hill. If we desired to find the best picnic spot to have a picnic, we would surely want to reach the best picnic spot, M. Now, suppose that the M picnic spot was unreachable because the hill was surrounded by a terribly lethal fog that instantly killed any morally imperfect individual who passed through it. Since we could not reach M or it would not make sense to try to reach M, that does not mean we should deny the fact that M is the best picnic spot. Knowing about M also has value because we can still find and analyze other picnic spots based on the qualities that we see in M.[55] In the same way, determining how the morally ideal medical organization should be organized does not call for a medical organization to completely overhaul their existing structure. This analysis is pursued so that the moral facts of their operation can inform future action, invoke self-reflection, and create an ideal for moral reference.

In Section I, I further explore the case of *The Greedy Neurosurgeon* from Chapter I. I then compare it to a new case that intends to introduce an organizational medical profit motive in order to uncover what truly separates the profit motives of these different agents. From this analysis, I delineate what I believe to be the most compelling reasons that an organizationally maintained medical profit motive (which I will abbreviate as an "OM medical profit motive") is

[55] Julius, A. J.. "David Estlund, Democratic Authority: A Philosophical Approach." *Philosophical Review* 119, issue 2 (2010). 256-58.

more morally wrong than an individually maintained medical profit motive (which I will abbreviate as an "IM medical profit motive"). In Section II, I demonstrate how the wrongdoing of a profit-motivated medical administrator is heightened due to the leadership position (and resultant agency) that the administrator holds. Leaders of a medical organization are more morally blameworthy due to their responsibility for collective wrongdoings. In contrast, doctors are coerced by leaders—directly or indirectly—into wrongdoing.

In Section III, I argue that medical administrators are afforded fewer excuses for wrongdoing and can more reasonably be expected to change a system predicating immoral medical decision-making, rather than simply operating within it and accepting some moral blameworthiness in order to come out with optimal patient health and well-being. For this reason, an administrator's maintaining of a profit motive is especially wrong. In Section IV, I argue that besides the patient, medical decisions (or decisions impacting patient health and well-being) should be made by medical experts, and when non-medical experts commodify human health and well-being in order to compare patient outcomes against a profit motive, they are especially susceptible to wrongdoing. In Section V, I consider two objections to my position that challenge the obligations within medical administration and the practicality of my position. In Section VI, I offer suggestions on how medical administration can be revised—and can commit—to promote ethical medical practices and decision-making processes.

I. The Medical Profit Motive Revisited: Does The Agent Matter?

In Chapter I, I argued that *The Greedy Neurosurgeon's* profit motivations are *pro tanto* morally wrong, but the wrongness of the situation is outweighed by the value of good medical outcomes for Dr. Cash's patients. While cases where a medical profit motive positively

correlates with patient health and well-being allow for moral excuses in particular cases, the same cannot be said for the systemic issues that are presented from a medical profit motive. Consider a similar case:

> *The Greedy Administration.* Cash for Health Hospital is the top hospital in the world for cardiac surgery, so when a relevant patient is treated in Cash for Health Hospital, they receive the best possible medical care. However, Cash for Health Hospital is not motivated by promoting patient health and well-being; Cash for Health Hospital happens to charge large sums of money for their services, and the administration is driven to provide excellent patient care solely based on large profits.

Obviously, this scenario is a bit unrealistic considering hospital administrators must be concerned with *at least* a baseline of patient health and safety (in order to exist and function as an organization, let alone a hospital). Nevertheless, the administrators of Cash for Health Hospital are an instructive caricature of some modern healthcare institutions.

In contrast to *The Greedy Neurosurgeon*, *The Greedy Administration* is more culpable for the moral penalties associated with a medical profit motive. In Chapter I, I established that medical doctors have a strong obligation to promote patient health and well-being based on non-profit motives. This idea was challenged by the case of *The Greedy Neurosurgeon*. On one hand, profit-motivated medical doctors are morally blameworthy for commodifying patient health and valuing it against profit, and on the other hand, medical doctors are morally blameworthy if they do not optimally promote patient health and well-being. Thus, *The Greedy Neurosurgeon* forces one to concede that, aside from the *pro tanto* wrongness that is associated with health commodification, physician profit-motivation can be justified only when it is maintained in order to uphold the strong obligation to promote patient health. Even then, it is not as though a profit-motivated physician is praised for being self-aware of their ability to on-balance justify a profit motivation; there is still a component of wrongness to health commodification that is undesirable.

This component is teased out and amplified in cases such as *The Greedy Administration* because health commodification on a systemic level comes at a higher moral price. The obligation to promote patient health and well-being is shared among medical practitioners and medical administrators, but the role obligations that develop from these respective positions are also inherently different. Administrators in medicine segment their attention between providing excellence in patient care with *running a business*. I am not suggesting that medical doctors who practice on an individual level are not concerned with running a business; I am simply claiming that administrators in medical organizations have a unique, impersonal *obligation* to sustain their business. An adminsitrator's obligation is unique because it is further removed from direct patient care and is a crucial aspect of his role and function in medical care. If medical doctors or groups of medical doctors maintain a business, they have no obligation (per se) to run a profitable enterprise. They might maintain a profit motive, but their strongest obligations are to promote patient health and well-being. Medical administrators have obligations, based on their position, to maintain a profitable enterprise. These obligations do not reflect the moral facts of patient care, however. Obligations from an administrative role cannot be confused with obligations that stem from the unconditional value of patient health (and the unconditional value of the doctor-patient relationship). Unfortunately, this is what links their role with the wrongness of a systemic profit motive: the agents that lead the business of medicine—the immoral aspect of medical practice—are absolutely more culpable for the wrongdoing which stems from commodifying and improperly valuing patient health.

In the following three sections, I will introduce the main reasons that I believe an OM medical profit motive by a medical administrator is more wrong to maintain than an IM medical profit motive by a medical doctor.[56]

II. Responsibility

The first aspect of an OM medical profit motive that distinguishes itself morally from an IM medical profit motive is the idea that there can be a hierarchy of culpability when a leader is overseeing a collective wrongdoing. When considering acts of wrongdoing, it is not always adequate to conduct an examination under the lens of individual actions. Sometimes, actions carried out from groups or organizations are immoral, but it is not always immediately obvious when we look at individual effort/action that each member of the group takes an equal (or any) share of moral blame for the immoral action.[57]

Take, for example, a case where three individuals (A, B and C) work together in order to stab another individual, D, to death.[58] The individual contribution from A, B, or C would not, in isolation, be enough to actually murder D. In a way, we cannot morally accuse A, B, or C with murdering D because assuming other contributions were not made to the murderous action, not one of the attackers would be considered a murderer. This example challenges our idea of individual responsibility in wrongdoing because we intuitively know that all of the three participants should be morally responsible for murder, but no single individual's action killed

[56] I will disregard arguments supporting leaders in a medical organization with an IM medical profit motive because I do not believe that any argument supporting this position could be a sufficient moral defense; an IM medical profit motive held as a medical administrator is the product of individual greed and desire towards commodifying patient well-being (without any rational basis), and this immoral motive should not be confused with the desire for a medical administrator to have an OM profit motive.
[57] Pettit, Philip. "Responsibility Incorporated." *Ethics* 117.2 (2007): 171-201. Print.
[58] Lawson, Brian. "Individual Complicity in Collective Wrongdoing." *Ethical Theory and Moral Practice* 16.2 (2013): 227-43. Print.

D.[59] To account for this shortcoming, we must analyze individual responsibility within collective action.

In *Individual Complicity in Collective Wrongdoing*, Brian Lawson addresses the responsibility of individuals for collective wrongs.[60] Lawson's position is that any contributor, no matter the degree, is accountable for the wrongdoing of a group if they knowingly contribute to a harmful outcome that stems from the group participation. This position, Lawson acknowledges, is met with some hostility. His "Modified Complicity Principle" seems to assign equal blame to wrongdoing that stems from participation among active group leadership and minimally participative group members alike.[61] To counter this objection, Lawson replies that a causal approach to harm assessment does not fully capture what is important when assigning moral blame for contributions within a collective action.

I agree with this general analysis, but I do not agree with the final position adopted by Lawson. A minimalist model of individual responsibility within organizational action cannot properly account for external factors that have influence over the agency within collective action schemes. On Lawson's view, if a company is accused of deceiving their shareholders, the executive council, the managers within the company, the human resources department, and the individuals working in the mailroom (who ultimately send and receive postage relating to this wrongdoing) share the same share of wrongdoing. For this reason, I reject the notion that the

[59] Parfit, Derek. "Five Mistakes in Moral Mathematics." *Reasons and Persons*. Oxford: Clarendon, 1984. N. pag. Print.
[60] Lawson, Brian. "Individual Complicity in Collective Wrongdoing." *Ethical Theory and Moral Practice* 16.2 (2013): 227-43. Print.
[61] The "Modified Complicity Principle" is as follows: (Basis) I am accountable for what others do when I knowingly contribute to a harmful outcome that results from our collective contributions. (Object) I am accountable for the harm or wrong we do together, independently of the actual difference I make.

characteristics of a particular collective of individuals have no influence on the method of which we should assign individual moral blame.

There must be a division of responsibility in collective wrongdoing, but it need not be equal. On my view, group leadership ultimately must accept a larger portion of moral blame for collective wrongdoing in most scenarios. This position is similar to Kutz's model of individual responsibility within collective action, which separates agents within collective action schemes into those with *executive intentions* and those with *subsidiary intentions*.[62] Agents who fall into the category of having *executive intentions* ultimately drive collective action by setting collective goals and determining individual actions, while those with *subsidiary intentions* "rationalize their activity with reference to the executive intentions."[63] I will not argue that those with executive intentions, whom I am calling leaders, are the only ones who can accept blame for collective wrongdoings. I do believe that leaders must be held more accountable for the moral penalties associated with collective action.

As a modification of the above thought experiment, let us take the same three individuals with murderous intentions (A, B, and C) and assume that, within their collective, A is the leader. A has determined and directed that the three will stab D at the same time, and because B and C are subsidiaries to A (for whatever the reason may be; we can assume that they are employees), they follow direction from A. It is unreasonable to assume that B and C do not accept any moral blame just because they are following direction from A, but at the same time, it is reasonable to place more moral blame on the one who directs the efforts of the two stabbers, or in general, the one who directs the efforts that collectively result in wrongdoing. Lawson tries to accommodate

[62] Kutz, Christopher. *Complicity: Ethics and Law for a Collective Age*. Cambridge: Cambridge UP, 2000. Print.
[63] Ibid.

this intuition in his Modified Complicity Principle, but I believe that he falls short—at least in the fact that his principle lacks practical application. The earlier case about the deceitful company displays not only that Lawson's account does not align with our intuitions, but that it is an unreasonable position to maintain when trying to apply a theory of wrongdoing in collective action. Applying Kutz's account into this case, the wrongdoing would be reasonably split between the vastly different agents in the scheme of wrongdoing: the executives and the subsidiaries.

Lawson also argues that accountability in collective wrongdoing can only be assigned to agents who knowingly contribute to collective wrongdoing. This is also a misguided position because it also falls short in application to theoretical cases (so staying within ideal theory). In theory, if stabbers B and C have no idea that murder is immoral or do not realize that their stabbing action can murder someone, some might be ready to state that they are not culpable for the murderous action. This situation happens to be premised around a wrongdoing that hardly any moral theory would agree is morally reprehensible: murder. When the wrongdoing becomes less clear if it is morally reprehensible (or it is not generally known that a collective action is morally wrong), individuals within those collective action schemes can still be held morally responsible. For instance, if a hunter believes that a deer does not have a moral status (because it lacks a rational capacity) and proceeds to hunt it for food, if we discovered that the deer had a moral status similar to human beings, it would not let the hunter off the hook morally. This is a similar claim to stating that the slave owners of the past were still morally accountable for enslaving other human beings, even though the popular held view was that those subject to becoming enslaved peoples lacked the inherent right to autonomy.

Lawson believes agents in collective action are separated into the ignorant and the informed related to the moral facts predicating a certain collective action scheme. Even though ignorance towards wrongdoing is more complex than Lawson argues for, it cannot be a justification for wrongdoing. This is the wrong way of approaching the situation, especially because ignorance is not morally ideal if it can be overcome. In administration of medical services, administrators may not know that maintaining a profit motive is immoral, but it does not necessarily let them off the hook morally. Individuals with an IM profit motive and an OM profit motive are both morally required to not commodify patient health and well-being by pitting those values against something of conditional value like money. When dealing with unconditionally valuable things in a morally risky environment, there is an obligation to inform oneself about the moral facts of action in that environment. This is especially true when an individual is responsible for directing organizational action (in the medical field, when an individual has an OM medical profit motive) and has access to information conveying the relevant moral facts is accessible.

When one leads others with a conflicting motivation to obtain pecuniary profits, a motivation that results in an *expectation* of medical practitioners to pursue a similar commodification process, it is far more immoral because of the scope and moral risk involved in this motivation. Leaders are especially responsible for collective wrongdoing in part because they oversee many different agents who potentially act wrongly. Similar to the case of the three stabbers, medical administrators with an OM medical profit motive are responsible for directing the efforts of their subsidiaries to create a collective wrongdoing. Yet, administrators may even be worse than the stabbers because with an OM medical profit motive, collective action does not

produce one singular wrongdoing. Rather, repeated wrongdoings are the consequence of leadership actions towards directing profit-influenced patient care.

This difference in attribution of moral wrongdoing is especially true when considering collective wrongdoing in large organizations where things of great value, such as health, are harmed within broader schemes. While the stabber case is not directly analogous to *pro tanto* wrongdoing within patient-doctor relationships being overseen by medical administration, it is sufficient for us to imagine in this way. Leaders are uniquely responsible because even if *pro tanto* wrongdoing by individuals is justified when considering all relevant factors that are inputted into a decision, if that *pro tanto* wrongdoing can be avoided by a leader, then it is not all things considered justified for the leader to encourage behavior that is *pro tanto* wrong.

In sum, collective wrongdoing in medical organizations is actually an aggregate of several wrongdoings that is overseen by leaders who have leadership obligations acting antagonistically to values that should be upheld. It is not enough to suggest that culpability can be assigned to those who are aware of collective wrongdoing. Profit-driven medicine is inherently immoral, and agents acting within this scheme of medical administration should be mindful of their responsibility to optimally promote patient health (or avoid harming patient health), even if it is in tension with their role as business leaders. Medical administrators are responsible for wrongdoings within organizational medical care, even if individual doctors are only guilty of *pro tanto* wrongdoings. Additionally, as the agents responsible for cultivating the structure of immoral practices in patient care, administrators are more morally accountable for wrongdoing than individual medical practitioners.

Leadership is premised on accepting greater responsibility for collective action. Leaders must expect a heightened attention to morality when engaging in acts of leadership.[64] The moral stakes are higher for collective actions, whether it is morally beneficial or morally reprehensible. In medicine and other areas that involve tremendously valuable and essential objects, this is especially the case. The livelihood and well-being of human beings are at stake in medical decision-making, and when someone leads an organization that oversees these decision-making processes, they *must* accept more moral accountability, even if their direct actions do not produce the morally reprehensible outcomes. That is the moral price paid for leading a medical organization: less justification for wrongdoing and more responsibility in maintaining—through a profit motive—the wrongdoing that results from medical practice influenced by financial considerations.

III. Excuses

The second reason that those with an OM medical profit motive are more morally blameworthy for allowing a medical profit motive to influence decision-making is the fact that these individuals have fewer excuses for acting wrongly (in the context of the profit motive). It goes without saying that medical practitioners are not victims or helpless in schemes of wrongdoing. As I delineated in Chapter I, there are moral standards that must be upheld when engaging in the doctor-patient relationship. Nevertheless, doctors and administrators operate under different pressures and are afforded moral excuses in different ways. In the environment of the medical organization, a medical administrator does not have the same ability to justify maintaining a profit motive as a physician.

[64] Ciulla, Joanne B. "Ethics and leadership effectiveness." *The nature of leadership*(2004): 302-327.

There are several ways to think about excuses within schemes of wrongdoing. I intend to demonstrate that those with IM medical profit motives have more excuses for their wrongdoings. Agents within collective action schemes are more or less excused for wrongdoing insofar as those with heightened agency in organizations can influence action. More specifically, coercion can influence collective action, and if a collective action—or an individual action—is coercively forwarded, it influences where blame should be assigned for wrongdoing.

The concept of coercion exists in many different contexts, so I will introduce what I believe to be the conditions necessary for when coercion exists:

> *Values-centered coercion*: An action A is coercive if it forces an agent to choose between two things of morally disproportionate value.

On this account, a coercive act forces an agent to choose between something of conditional value and something of unconditional value, which is wrong because of its lack of fairness and respect towards unconditional values, such as the affected individual's agency. If a mugger points a gun at you and exclaims, "Your money or your life," the mugger is coercing you because he is pitting the unconditional value of your life against the conditional value of money, something that is immoral for him to do.[65] If two things of unconditional value are being pitted against one another in a coercive act (something such as a mugger proposing "your agency or your life") is also a form of values-centered coercion; forcing a choice even between two unconditionally valuable things—things that ought not to be given value so as to weigh them against other values—is coercive in nature. If two things of conditional value are being pitted against one another, on my account, I do not believe there is coercion taking place.[66]

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[65] This case is taken from: Pallikkathayil, Japa. "Your Money or Your Life Coercion in Personal and Political Contexts." Diss., Harvard University, 2008.

[66] There may be something wrong taken place (like the improper use of force), but in this scenario, I would not introduce the concept of "coercion". For instance, if one were to approach you and say, "give

In the stabbers case, without considering the nature of leadership that exists between A and his followers, we can recognize wrongdoing that is shared by all the stabbers. We have not even at this point considered *why* B and C were acting antagonistically or how they came to act in such a way. Suppose that A threatens B and C with the potential of ending their lives if they do not stab D. This case is clearly a form of coercion; B and C, without any other choices, are faced with a difficult decision that seems to free them of *at least* some portion of moral blame. B or C must choose between two unconditional values to disrespect, and because A is forcing that choice, they are utilizing values-centered coercion. It cannot entirely justify B or C's decision to stab D, but knowing that B and C were coerced into acting in this manner helps us understand that the normative nature of leadership can have influence on the culpability for wrongdoing in collective action—especially in the light of unconditional and conditional values. Thus, we can see how B and C could have some form of moral *excuse* for operating under coercive leadership.

This idea is applicable to an argument on responsibility for wrongdoing in organizations introduced by Philip Pettit in which Pettit identifies three conditions that must be in place to consider an agent fully responsible for wrongdoing: *value relevance*, *value judgment*, and *value sensitivity*.[67] Pettit then explains that upon one or more of the conditions for responsibility not being met, one can begin to assign "partial responsibility," a concept that is tied to moral excuse in the proper context.

The concept behind an agent needing *value reference* is relevant because that means something of moral importance must be at stake within a wrongdoing for this argument to apply; I have established that this is the case when discussing the profit motive in medicine (health is unconditionally valuable), so I will not further discuss the *value reference* condition. Next, *value*

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me $100 or I will break your car windows," it may be a wrongful use of force, but on the values-centered account, that would not be considered a coercive action.

[67] Pettit, Philip. "Responsibility Incorporated." *Ethics* 117.2 (2007): 171-201. Print.

judgment is the idea that an agent has the capacity to make value assessments for decisions that are under moral assessment. I will discuss this condition later. The condition that I am concerned with in relation to the aforementioned case of coercion is the condition of *value sensitivity*, which states that an agent "has the control necessary for being able to choose between options on the basis of judgments about their value."[68] This is related to coercion because coercion, by definition, "diminishes [a] targeted agent's freedom and responsibility."[69] This definition comports with the account of coercion I defended above. On both accounts, value assessment is at the heart of coercive action, and if this assessment is hindered by an action or an action creates an inappropriate comparison between values, that action is coercive in nature.

Medical practitioners are not coerced through a violation of their bodily integrity, but they do face differing forms of values-centered coercion in medical organizations, forms of coercion that medical administrators do not face. If a doctor approaches the doctor-patient relationship while being observed or analyzed—through the medium of monetary value—by organizational leadership, it creates an inorganic, morally risky environment for patient care. Medical practitioners are in the best position to know what treatment plans are medically necessary for patients, and within reason, administrators ought not to interfere with this process. (This is assuming that we are also dealing with medical practitioners who are responsible and socially conscious, factors that are vital for doctors to exhibit in order to strive for a more morally sound medical organization.) When "greater control by management"—or more actualized forms of coercion in verbal formats—begins to seep into a physician's actions, it makes it more difficult on the medical doctor to uphold his role obligations. In these cases, the physician's wrongdoing is in part the fault of medical administration.

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[68] Ibid., 171-201.

[69] Anderson, Scott, "Coercion", *The Stanford Encyclopedia of Philosophy* (Spring 2014 Edition), Edward N. Zalta (ed.), forthcoming URL = <http://plato.stanford.edu/archives/spr2014/entries/coercion/>.

To introduce some examples of this, one might imagine that an administrative order is related to patient volumes in a certain clinical services sector of a hospital (i.e. the radiology department, a pain treatment center, etc.). The administration realizes that the sector is not receiving enough patient volume, so they try and competitively incentivize physicians to direct a portion of their patient traffic—through a treatment plan—through this sector of the hospital, even if may not have been medically necessary in isolation of a competitive incentive (especially if that sector is normally profitable) and even if there is some health risk involved with treatment from that sector of the hospital. Additionally, if an administrative body agrees to prescribe X amount of pharmaceuticals or they have purchased a large number of a particular brand of pharmaceuticals, there may be administrative actions in place that incentivize physicians to utilize these medical resources, even if would on balance lead to worse health outcomes. In these cases, if a medical doctor is a victim of values-centered coercion, he is relieved of some moral blame. The classic case of the mugger can be related to patient care; a doctor may be forced to choose between "your job/pay or patient health", "your autonomy or your patient health", etc., situations that are not morally favorable.[70]

In medical administration, leaders can act coercively to produce desired pecuniary outcomes, so medical practitioners are coerced by administrators to perform morally reprehensible actions.[71] Theoretically, a medical organization is organized to try and separate the

[70] These accounts of coercion can lead to decreased culpability in patient care, but the same cannot be said on the administrative level. On the administrative level, the decision that must be made—by the administrator—from external pressure could theoretically reduce down to "your job or profit," which are two conditionally valuable things. Thus, my account of coercion does not apply to the medical administrator.

[71] I will refer to a case based in economic theory: "If, for example, administrators find the hospital to be underutilized and losing potential revenues, then they would want doctors to admit more patients and increase their established margins over the scientific minimum. But such an improvement in "quality" may create pressure on capacity which the medical staff would find uncomfortable."[3] In this example, you

costs borne and the profits made by medical practitioners and medical administrators, something that is akin to "(making) doctors look like individual entrepreneurs who happen to conduct their business on the hospital's premises."[72] In actual practice however, these two entities are economically linked. Administrators do not have an influence in direct patient care, but they indirectly have influence via external pressure on a practitioner to meet a standard or a benchmark relating to patient care or the *preemptive interference* resulting from administrative practices. This influence can be enough to raise moral alarm and force us to reconsider blame for collective wrongdoing.

Intentions behind profit-motivated actions can also offer moral excuses to certain agents. The intentions of those in *The Greedy Administration* are more inexcusable than those of doctors for two reasons. First, a motive of this nature is sustained due to one thing (similar to the IM profit motive): increased profit.[73] Those with a profit motive—like the *Greedy Neurosurgeon*—will never be fully justified, but the moral harm involved can be somewhat mitigated because the neurosurgeon provides optimal patient care and acts on an individual basis. In contrast, at an administrative or organizational level the profit motive more often than not negatively impacts patient health and well-being and affects more people.

Second, the intention to make a profit is not enough to justify profit-motivated action considering the moral risk involved in profit-motivated organizational decision-making in the medical field. An OM profit motive is especially risky compared to an IM profit motive due to

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can see how an organizationally-maintained desire for profit resultant from patient care conflicts with the obligations of physicians to promote the well-being of the patient

[72] Harris, Jeffrey E. "The Internal Organization of Hospitals: Some Economic Implications."*The Bell Journal of Economics* 8.2 (1977): 467-82. *JSTOR*. Web. 13 Mar. 2014.

[73] That is not a controversial claim; I am simply stating that the leaders of a medical business desire to make money for their business. To be fair and to place the overarching ethics behind the medical business aside, profits in a medical organization can be utilized to promote more advanced methods of patient care or to construct more optimal facilities for better patient care.

the scale that an OM profit motive is maintained on. An OM profit motive involves countless medical transactions and has the potential to harm patient health on a much larger scale. Thus, it involves a degree of moral risk that is undesirable. As Dan Moller has argued, when something involves moral risk and can be avoided, it ought to be avoided.[74] An OM medical profit motive has no morally sustentative defense that would tell in its favor, and the risks associated with maintaining an OM medical profit motive are not worth the moral cost.

Another major difference between the administrator and the practitioner that allows the latter the opportunity for moral excuse in medical decision-making is the amount of agency—or the degree to which one can impact *change*.[75] Medical practitioners are decision-makers, but medical decisions are only made in the medical organization under the umbrella of administrative practices. A doctor must be allowed to make what decisions he deems medically necessary, so the patient-doctor relationship should be free from direct administrative control. Even well-motivated doctors still cannot resist indirect controls on medical decision-making (such as administrative policies, capacity issues, asset management) without being deemed as "disobedient" or resisting administration. For indirect controls on patient care that produce morally harmful outcomes, doctors have the excuse of decreased agency in the management of the medical organization that denatures their portion of culpability for those wrongdoings.[76] Those who set immoral policies in place or administer through the medium of immoral policy do not have the excuse of being under immoral regulation; they have the ability to change policies

[74] Moller, D. "Abortion and Moral Risk." *Philosophy* 86, no. 03 (July 2011): 425-43. doi:10.1017/S0031819111000222.
[75] Ibid., 425-43.
[76] There are areas in the medical organization that doctors have increased responsibility when compared to the administration, such as the responsibility associated with direct patient care and the responsibility of proper utilization. Utilization can be interpreted as the proper use of scarce medical resources, which can include physical resources or intangible resources (like time).

in the medical organization. This ought to be the ultimate responsibility of medical administrators.

IV. Expertise

The final reason I believe that an OM medical profit motive is more immoral than an IM medical profit motive is because of the amount of medical expertise required for *moral* medical decision-making. Under the current system, influence over medical practice does not correlate with the amount of medical expertise one holds. Here, I am troubled by the fact that the individuals with the most agency in medical organizations are largely not medically trained. With medical training comes a particular ability to value human health, and if a role associated with large-scale health commodification (an inherently immoral practice) does not require medical training, that allows for a heightened degree of wrongdoing to be associated with that role. An OM medical profit motive that is forwarded by a non-medical professional is a recipe for exacerbated wrongdoing in patient care.

The role of the non-medical medical leader has developed within the healthcare environment of hospitals. According to Alison Dwyer, medical administrators initially functioned "as Medical Superintendents, who were often senior clinicians and statesmen within the organization." Initially, "these positions were usually well-defined, focussing on overseeing clinical services of the hospital with the matron, and with little interaction with the finances of the hospital." Unfortunately, "in response to the increasingly complex healthcare system, burgeoning new technologies and high cost of healthcare, the role and responsibilities of a Medical Administrator have subsequently diversified" to encompass more business

considerations.[77] Today in the United States, the majority of hospitals are led by non-medical professionals; a study in 2009 found that "of the 6500 hospitals in the US, only 235 are led by physicians."[78]

Given that this is a prevalent phenomenon, hospital administration is an important moral issue. Imagine if a law firm was led by someone who has never attended law school and this individual—along with a team of firm administrators with a similar skill set—was responsible for determining best practices and policies for the firm and growing the business of the firm. Something about this dynamic is unsettling. Although the firm is a business at its core, the idea of a non-legal professional overseeing the operations of a legal group is counterintuitive.

I will not try and defend legal licensing as being unconditionally valuable, but imagine if this same scenario involved decisions affecting unconditional values (which is where the analogy to medicine and medical administration can then be drawn). Human health is unconditionally valuable, and even though someone like myself—void of medical expertise—can recognize that fact, without medical experts, the value of health cannot be *properly* recognized and cannot be recognized on a case-to-case basis, a condition necessary for moral medical decision-making. A medical expert is in a unique position to recognize the health state and health needs of a patient because they have spent years understanding human physiology and the nature of human health. This intimate knowledge of biological humanity allows someone to not only further appreciate that humanity, but understand what is truly affected by a medical decision (on the physiological level).

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[77] Dwyer, Alison J, MBBS, MBA, MHSM,F.R.A.C.M.A., F.C.H.S.M. "Roles, Attributes and Career Paths of Medical Administrators in Public Hospitals: Survey of Victorian Metropolitan Directors of Medical Services." Australian Health Review 34, no. 4 (11, 2010): 506-13. http://we4mf3mv5e.search.serialssolutions.com/docview/849563730?accountid=14731.

[78] Gunderman, R., & Kanter, S. L. (2009). Educating physicians to lead hospitals. Academic Medicine, 84, 1348e1351.

Considering the importance of expertise, it is even easier to see why *The Greedy Neurosurgeon* permissibly operated despite his health commodification practices whereas *The Greedy Administration* acted impermissibly. The administration is profit-driven without reference to the scientific appreciation and knowledge of what drives their business functions. A non-medical professional with an OM medical profit motive may try and supplant knowledge of health administration for knowledge of human health, but that cannot succeed in a moral domain.

One might object that the fact of a medical administrator having little to no medical expertise would lend itself to *decreased* culpability in medical profit-motivated wrongdoing. This thought can be derived because one might link knowledge of wrongdoing with culpability for wrongdoing. However, ignorance does not morally justify a non-medical professional overseeing medical decision-making (as I have argued in the earlier section about responsibility).

Consider the following example, which illustrates the relationship between ignorance and culpability. If a six-year-old child is placed into the driver's seat of a car and is allowed to operate the motor vehicle on a road, and if that child runs over someone, you cannot hold the child culpable for that wrongdoing. This position seems to be at odds with the account of excuse in wrongdoing I have previously argued for, but it is not. The child may be entirely non-culpable not because of ignorance to the moral facts behind running other human beings over with a car, but also because of incapacity to understand the wrongness of their initial position or role as car-operator. There is no reliable reason why a child—lacking the capacity—could be expected to exit a state of ignorance towards the moral facts of vehicle operation (i.e. you can end someone's life, and that life is unconditionally valuable). Yet the same cannot be said about a medical administrator; they may be ignorant to the moral facts of medical care if they do not possess a

certain degree of medical expertise, but they are not incapable of examining or changing their role based on the moral facts they should become informed about.

Reversing this argument, one might claim that a medical doctor must accept *increased* culpability for wrongdoing because of their unique position (their medical knowledge) to recognize the degree of wrongdoing occurring in profit-motivated medical decision-making. Medical knowledge is significant, which is why it would be better for medical doctors to be more accountable in *administrative* roles. However, individual physician profit-motivation in a clinical, individual context can often be excused, for the reasons stated above. On the other hand, once a medical professional assumes an OM medical profit motive, they are not afforded the same moral excuses and they are more accountable for upholding the values at stake in organizational medical decision-making.

Another difference between a medical professional in this role and a non-medical professional in this role is that the medical professional morally ought to be in the administrative role. Doctors can assume the role and be morally justified while the non-experts cannot. Moral ignorance cannot excuse the fact that the non-expert administrator ought not to be in that position without adequate medical knowledge. In theory, to be a medical administrator without medical expertise is like being a physician without a medical license. In the latter case, there is something wrong with a physician who is not medically licensed; not only does it diminish (or abolish) patient trust (if if is even established in the first place), it signifies that someone attempting to assume the role of the medical professional is not qualified enough to earn a license to practice medicine. Why do we not think about medical administration in a similar way? There should be some component of medical expertise—similar to gaining a medical license—that ought to be

required for a role that oversees multiple medical decision-making transactions and the larger practice of medicine.

Given its prevalence in modern medical administration, and the moral significance behind non-medical professionals overseeing patient care and medical organizations, there is reason to think that serious revisions should be enacted in order to have hospitals and other large medical organizations led by medical professionals. If it is the case that one with an OM medical profit motive *must* be at the helm of a medical administration, it ought to be a medical expert. This should not be a troubling idea. In fact, having a physician-leader of a hospital or a medical organization improves quality-of-care and hospital rankings.[79,80]

One challenge to this idea is that clinicians and other medical experts may feel inclined to stay in individual, autonomous practice and just engage in the doctor-patient relationship. But these experts must also recognize that improved, moral medical care is dependent on medical expertise in administrative practices. It may be the case that a poorly developed physician management infrastructure (a lack of administrative accountability for physicians and the responsibility of solely patients) is the cause of resistance to expert led care, so in order to move forward, this infrastructure must be modified.[81]

In sum, it is far more immoral to maintain an OM profit motive when compared to maintaining an IM medical profit motive because of administrators' lack of medical expertise, in

[79] Candace, I., & Giordano, R.W. (2009). Doctors as leaders. British Medical Journal, 338, b1555.
[80] Goodall, Amanda H. "Physician-leaders and Hospital Performance: Is There an Association?"*Social Science & Medicine* 73 (2011): 535-39. doi:10.1016/j.socscimed.2011.06.025.
[81] Pronovost, P. J., and J. A. Marsteller. "A Physician Management Infrastructure." *JAMA: The Journal of the American Medical Association* 305, no. 5 (2011): 500-01. doi:10.1001/jama.2011.71.

combination with their heightened agency, increased responsibility in the medical organization, and the absence of moral excuses.

V. Objections

I will now consider two relevant objections to my argument in this chapter. First, one may argue that my discussion of the economic coercion and domination from medical administrators towards those involved in patient care in the medical organization is unfair because medical administrators—in for-profit health systems—face similar pressures from those with even more agency in the medical organization (such as a shareholder or a trustee).

While I realize that medical administrators face similar pressures from stock-holders or trustees in for-profit medical care, they are not afforded the same moral excuse because of economic pressure. If stabber A is being forced by stabber A* to coerce B and C to act in accordance with A*'s plan, and A*'s forcing of A is one of a purely economic nature, it doesn't provide the same moral excuse as B or C may be afforded if their health and livelihood are in jeopardy. This is not to say that for-profit higher administration is not wrong, because an OM profit motive at this level is still morally wrong. Rather, I don't believe that the role obligations of medical administrators (to maximize profit) can justify acting under economic (or other forms of) pressure; medical administrators must be morally responsible through business practices by acknowledging their influence on patient care and their ability to correct for moral wrongness in medical operation, especially considering the level of agency a medical administrator holds in the medical organization.

One may also object to my position by denying the plausibility of my argument when applied into real-world medical administration. To claim that medical administrators ought to be

medical experts and that an OM medical profit motive is morally risky is not the most "practical" position, but being most practical and being most morally correct do not sometimes align. I understand that administrators in healthcare organizations are valued because of their efficiency and business knowledge (and medical organizations, in some ways, can benefit from that mindset), but these assets should not conflict with an administrator's ability to properly manage a moral medical organization. Ethics should not be compromised for effectiveness. For example, if it were the case that students with black hair were shown to perform significantly better throughout college, it would not be the right decision to admit only students with black hair because the moral decision would be to admit a diversity of students while considering factors that—on balance—lead to success. Similarly, it is not necessarily the right decision to have the most efficient medical administrators leading medical organizations. Business considerations cannot justify the OM medical profit motive; as established in Chapter I, because these considerations are conditionally valuable, and when compared to the unconditional value of human health at risk, business and profit considerations are always less morally significant.

VI. Implications

There are several implications that can be drawn from my argument. I will offer two major recommendations that I believe to be the most important interpretations of the above analysis on the medical profit motive in the medical organization. Before I begin, I want to stress that for any of my argument to have application into real-world medical administration, administrative policy must change, and as I have mentioned above, this responsibility falls on the shoulders of the medical administration. Thus, any digestion and application of my position requires (1) self-reflection on the behalf of current (or rising) medical administrators, and (2)

effort on the behalf of medical practitioners to utilize these arguments towards pursing a more morally sound medical administration.

As I have stated before, I believe that medical experts would make for more morally sound medical administrators; they would be able to properly value human health in the context of decision-making. Medical experts as administrators could apply this trait into administrative decision-making and would be able to make more morally sound health-cost tradeoff analyses. In some instances, these analyses may provide for economically favorable outcomes, but in other instances, a moral decision could be made based on the value of health assessed to be potentially lost from an administrative decision.

Though still operating within an inherently immoral practice, expert-administrators would provide for the most morally sound-yet-practical outcome: administrative practices in the medical organization guided by those with the ability to adequately value human health. This recommendation is stronger when also taking into account that research has demonstrated a significant increase in the quality of a medical organization when being led by a physician.

If current administrators—or those with an OM medical profit motive—are to remain in place, and assuming that profit motivations remain intact despite moral analyses, I recommend that hospital and physician profits be aligned with quality-of-care directly. This is a similar model to “accountable care” and “Accountable Care Organizations (ACOs)” that are being implemented though the realization of the Affordable Care Act. ACOs are “collections of doctors and hospitals that are paid to coordinate care, eliminate unnecessary tests and treatments, and

keep people healthy and out of the hospital" through revised incentive and savings programs.[82] At its core, the ACO model is able to succeed because it is able to "incentivize hospitals, physicians, post-acute care facilities, and other providers involved to form linkages and facilitate coordination of care delivery."[83] For example, within an ACO, a physician would be monetarily incentivized to keep their patients out of the hospital or reduce the amount of days their patients spend in the hospital. This is different than a fee-for-service model of medical reimbursement that would incentivize physicians to maximize the amount of medical visits they carry out and the amount of medical treatment they provide. Further, if a hospital is able to save money on treatment plans while maintaining treatment effectiveness, they are able to share in a portion of those savings with a government-sponsored health care program (like Medicare).

In theory, a shared savings/quality-of-care model of physician and hospital profit derivation resolves—or at least mitigates—several of the moral issues mentioned above. On the individual doctor-patient level, doctors are incentivized to provide the highest quality care possible through monetary compensation (assuming that, all else not considered, they are like *The Greedy Neurosurgeon* and only value money). On the administrative level, it is also morally beneficial to align profit motivation and quality-of-care because medical administrators will strive, based on their role obligations and collective motivations, to foster an environment where patient health and well-being is on-balance being optimally promoted. If a hospital administration were to adopt a shared savings/quality-of-care incentive model for medical operations, they can enter into a similar state (morally) as *The Greedy Neurosurgeon* at the

[82] Emanuel, Ezekiel J., M.D. "The Beginning of a Health Care Revolution." The New York Times. March 20, 2014. http%3A%2F%2Fwww.nytimes.com%2Froomfordebate%2F2014%2F03%2F20%2Fobamacares-four-year-checkup%2Fthe-beginning-of-a-health-care-revolution.

[83] McClellan, Mark, et al. A National Strategy to put Accountable Care into Practice. Health Affairs. 29(5). 2010. 982-990.

conclusion of Chapter I: *pro tanto*, health commodification through administrative practices is still morally wrong, but while acknowledging that some practices must be place in order to benefit patient health and well-being, the other remaining administrative policies and practices ought to align profit motivation with quality-of-care. Indubitably, the promotion of patient health and well-being is the intention behind the moral critique of the profit motive, so when keeping that in mind, I support a solution that may include a portion of *pro tanto* wrongness but can benefit patient care in the long run; thus, I assert that accountable care is the most morally desirable model of medical profit derivation.

Chapter III: Values-Centered Health Care

If I am right about the profit motive in medicine, what does that mean for health care policy and health care reform?

In this chapter, I apply my thesis into the political and broader societal arena, looking at morally-motivated medicine and how it can be applied throughout the overarching system of health care in the United States. I have already examined clinical practice and administrative practice through the medium of the profit motive, so to conclude this argument, I carry the examination towards health care policy and discuss how policy may be shaped to help a moral medical organization with reduced profit motivation to become a realistic benchmark.

Starting with a reflection on the previous chapters, I then introduce a theory *values-based health care*. I then delineate several principles that I believe to be vital to moral health care reform moving forward, principles that I further explore in the first three sections, respectively. In Section IV, I address an objection to my position: a view on health care that is pro-market and supports promoting quality-of-care through decreased economic regulation. In Section V, after the explanation of a particular pro-market argument, I show how pro-market health care discourse misses the moral facts at stake almost entirely. To be fair, I also discuss particular aspects of a pro-market model for health care that approach areas of needed attention with reason and legitimacy. In Section VI, I apply this debate into the sphere of health care policy. I address areas of health care that are in particular need of moral examination either due to their inherently morally risky nature or current immoral practices within the area. To conclude, I discuss the need for reform within every tier of medicine.

Preface

For-profit medical organization began to emerge as a prominent model for organization in the mid 1950's when conversations began to surface about the ethical implications of the hospital, or other for-profit medical setting, acting simultaneously as a business.[84] Dan Brock and Allen Buchanan were among the first to discuss the medical profit motive in a negative context in their work *The Profit Motive in Medicine*.[85] The authors introduce the sheer complexity of the ethics surrounding health care and the medical organization, a sentiment that is shared by all parties within the anti-profit v. for-profit debate. They frame their argument around two central criticisms against for-profit medical care that were voiced at the time:

> (1) For-profit medical organizations did not do enough for the poor or did not provide enough charitable service to warrant themselves being enumerated as a "hospital" or medical organization.[86]
>
> (2) A profit motive could be risky in a clinical context because of the inherent conflicts-of-interest that could arise from "profit-seeking" practices.[87]

I agree with the essential dismissal of the Brock and Buchanan's first concern; in their argument, they state that a large portion of patients in the medical organization receive care without paying, which acts in accordance with the relevant laws on hospitals treating patients regardless of paying. Further, the authors state that a for-profit health care organization dismisses their *general* obligations to provide for patient health and well-being because, like an individual, they pay taxes (that fund physician care) and support health care. However, Brock and

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[84] Light, Donald W. "Corporate Medicine for Profit." *Scientific American* 255, no. 6 (1986): 38-45. doi:10.1038/scientificamerican1286-38.
[85] Brock, D. W., and A. E. Buchanan. "The Profit Motive in Medicine." *Journal of Medicine and Philosophy* 12, no. 1 (1987): 1-35. doi:10.1093/jmp/12.1.1.
[86] Ibid., 3-17.
[87] Ibid., 17-33.

Buchanan's analysis of the second concern is circular and tenuous. They raise several valid reasons why we should believe that for-profit medical care is damaging to clinical practice, including the claim that the "consumer in health care…is in an especially vulnerable position," and the incentive of overutilization can introduce "serious and widespread health harms to patients."[88]

Even still, Brock and Buchanan fail to take a definitive stance on the issue. While they started the battle, they hardly won the war against the medical profit motive. My pursuit builds on their work. What ideals or principles would be of the utmost importance for those with power in medical decision-making to consider throughout their functioning in health care? Brock and Buchanan left a great deal to be answered in their initial analysis, and although the foundation for sustained criticism is there, they chose to signpost the moral risk involved in medical profit motivation rather than take a definitive stance.

Considering and expanding on Brock and Buchanan's argument, I support the following principles:

> *Principle 1*: The sovereignty of the medical professional should remain intact.
>
> *Principle 2*: Those with administrative privilege or systemic decision-making capacity should make efforts to reduce pecuniary conflicts-of-interest in medicine, when possible.
>
> *Principle 3*: Quality-of-care should be our guiding factor; patient health outcomes are what truly matter.

[88] Brock, D. W., and A. E. Buchanan. "The Profit Motive in Medicine." *Journal of Medicine and Philosophy* 12, no. 1 (1987): 1-35. doi:10.1093/jmp/12.1.1.

These three principles prompt several medical reforms. Foremost, moral medical reform should be *values-centered*. Thus, I take these three principles to be the guiding principles of *values-centered health care*, a theory of how health care reform morally ought to be based on the value of human health. In values-centered health care, health becomes a deontological constraint on medical decision-making and policy formation; those with heightened agency in the medical field must consider action through the lens of the unconditional value of health. Apart from justice discussions in health care or market discussions in health care, values-centered health care is concerned with disallowing profit considerations—or instrumental values—to govern effects on the non-instrumental values at stake in patient care.

Values-centered health care exists in the realm of *perfectionism* when considering its place in moral and political philosophy. Perfectionism means that one "advance[s] an objective account of the good and then develop[s] an account of ethics and/or politics that is informed by this account of the good."[89] That is exactly what I am doing here; values-centered health care is premised on the moral facts that ought to make up the skeleton of the moral medical organization or a portion of moral health care policy. The theory of values-centered health supports ethical conclusions that should influence medical practitioners or current medical policies.

The following three sections will engage with values-centered health care in distinct ways, with each engagement leading to important conclusions about moral patient care and the pursuit of the moral medical organization.

I. The Sovereignty of the Medical Expert

[89] Wall, Steven. "Perfectionism in Moral and Political Philosophy." Stanford University. February 13, 2007. Accessed April 03, 2014. http://plato.stanford.edu/entries/perfectionism-moral/.

The first principle is derived from Brock and Buchanan's attention to the patient-doctor relationship and the degree to which patient trust generated strong obligations in medical. My first principle to guide health care and medical reform is:

Principle 1: The sovereignty of the medical professional must remain intact.

Without the sovereignty of the medical professional being intact, a medical organization is subject to unnecessary moral risk. As I have discussed, the medical professional is in a unique position to recognize the values at stake in medical decision-making, especially in the clinical setting. As soon as an act of reformation attempts to remove some portion of physician sovereignty to account for increased costs or increased regulation, that act is removing what makes moral medical care possible.

I am not, however, advocating for a complete removal of administrative privilege over the medical professional. To allow for physician sovereignty is partly a function of what already occurs in a standard medical organization; the "typical" hospital is comprised of "a nonprofit corporation with a board of trustees as the ultimate authority…although the trustees delegate operating responsibility to the hospital's administration, there is also a second separate line of authority emanating from the medical staff, which constitutes the hospital's affiliated physicians."[90] The classical medical organization intends to separate clinical care from administrative work, something that is a necessary condition for physician sovereignty to begin its establishment in the medical organization. If this were not the case, an administrator could veto medical decisions (i.e. all prescriptions, procedures, and clinical treatment plans could be

[90] Harris, Jeffrey E. "The Internal Organization of Hospitals: Some Economic Implications."*The Bell Journal of Economics* 8.2 (1977): 467-82. *JSTOR*. Web. 13 Mar. 2014. <http://www.jstor.org/stable/10.2307/3003297?ref=search-gateway:056ba3079cdac1571a6495bf9e702c88>.

passed through to an objective medical administrator who only gives approval to means of treatment that are monetarily desirable); there would be something fundamentally wrong with that. It may seem redundant to mention that this aspect of physician sovereignty must be in place, but keep in mind that these principles of values-based health care are not only retroactively analyzing health care, they are in place for future reform to base action off of. In some future policy decision, the line between administrative sectors and patient care sectors could blur, and this principle would tell against such a decision.

Unfortunately, the line is blurring as health care organizations sift through reform and increased mindedness towards pecuniary matters. There is only partial truth within the classical organization of the hospital because direct clinical effect should not be the only measure of practitioner sovereignty. As previously discussed, administrative decisions can also have significant effects on patient care, an idea that extends to medical policy. A policy decision can be viewed as restricting physician sovereignty, although to a lesser degree; I would be more willing to claim that policy decisions end up affecting medical administration (which, in turn, ends up affecting medical practitioners, but the connection is less direct). Due to this reality, attention towards maintaining physician sovereignty must increase in health care. This idea tells in favor of a previous argument for medical professionals to assume administrative roles in the medical organization; if this were possible, physician sovereignty would inherently be promoted because physicians would assume the roles that might otherwise be suppressing medical decision-making. With or without a physician in an administrative role, medical expertise is an indispensably valuable item in the medical organization. The same is true in medical policy decision-making; health care policy must not overlook or stampede upon the moral uniqueness of the medical professional.

This principle will not be effective if physicians are not responsible; an indispensable characteristic of the moral physician is responsibility (which includes awareness of the complex organization that they operate within, accountability for wrongdoing, and the respective sovereignty of the patient population in medical decision-making). Assuming the moral physician is able to operate within a medical organization, efforts should be made to *increase* physician sovereignty, even if that does not translate to overhauling current administrative bodies for replacement. This should especially be a guiding principle when framing health care reform around erroneous characteristics of clinical care through modern health care organizations.

In policy decisions, this principle can materialize in a number of ways. In essence, I believe that the same arguments for medical expertise in administration should hold true for medical policy makers:

> P1: Hospital administration should require a certain degree of medical expertise.
> P2: There is no morally relevant difference between hospital administrators and certain public policy administrators.
> C: Some policy administrators should require medical expertise.

When making decisions that will significantly impact systemic medical decision-making, fundamentally understanding the value of human health is a necessary consideration for a policy maker. From this argument, there are several revisions to current health care policy formation that should be made. It may be ludicrous to claim that all health care policy makers should have a medical degree or be medically trained, but those are the moral facts within values-centered health care. This does not mean that this should be carried out towards full realization, but it does tell in favor of moving the structure of policy making towards valuing medical expertise. This can be achieved by having independent agencies comprised of medical professionals aiding in policy formation, having medical policy be filtered through a similar agency before being passed

into law, or even having the AMA (American Medical Association) appoint medical professionals to particular roles that are responsible—in portion—for the creation and fostering of health care policy.

II. Reducing Conflicts-of-Interest

The second principle (distilled from my medical profit motive discussion) is related to the profit motivation itself:

> *Principle 2*: Those with administrative privilege or systemic decision-making capacity should make efforts to reduce pecuniary conflicts-of-interest in medicine, when possible.

This principle applies to all agents in the medical organization; as I have demonstrated, an amalgamation of responsibilities in the medical organization is undesirable. With increased external pressures—from society, from government regulation, and from other factors—on the modern health care organization can lead to an increased willingness to implement regulatory practices, some which may be detrimental to patient care or the patient-doctor relationship. This principle is—in some ways—analogous to a principle that permeates clinical research ethics; in clinical research ethics, conflicts-of-interest are undesirable, especially those of a financial nature. Conflicts of interest in clinical research "point to a tension between relying on profits to motivate business versus insulating drug development and testing from the profit motive as a way of protecting research subjects and future patients."[91] Because of this, profit-motivated conflicts of interest "may not be amenable to the commonly pursued remedy of addressing ethical concerns

[91] Psaty, B.M., and R.A. Kronmal, 2008. "Reporting mortality findings in trials of rofecoxib for Alzheimer disease or cognitive impairment: A case study based on documents from rofecoxib litigation," *Journal of the American Medical Association*, 299: 1813–7.

in clinical research by promulgating a few new guidelines."[92] I believe the same concern arises in standard patient care, and a similar motivating principle should be applied in order to protect not only patient populations, but the medical doctor in the medical organization.

Of course, patient populations are the primary reason that this motivating principle is in place. Research ethics acknowledges the moral risk involved with participation in clinical research, and the same can be done in cases of profit-derived medical actions. While this quote is not exactly similar to what has been discussed in profit-motivated patient care, consider the following quote from David Wendler's *The Ethics of Clinical Research*:

> "The process of conducting clinical research involves the threat of exploitation of a particular kind. It runs the risk of investigators treating persons as things, devoid of any interests of their own. The worry here is not so much that investigators and subjects enter together into the shared activity of clinical research with different, perhaps even conflicting goals. The concern is rather that, in the process of conducting clinical research, investigators treat subjects as if they had no goals at all or, perhaps, that any goals they might have are normatively irrelevant."[93]

We can begin to see increased similarities between what is morally at stake in research ethics and what is morally at stake in patient care; the "threat of exploitation" is of the same particular kind: unconditional value commodification. The difference between commodification in these two areas of clinical activity relates to the shared or distinct "goals" relating to patient involvement. In clinical research ethics, it is easier to see how shared goals may be reached; profit-motivated clinicians seek treatment that works (and, will hence, deliver a profit). In profit-motivated standard patient care, shared goals seem more nebulous of a concept; I have explored the inherent tension between cost cutting and profit derivation versus quality-of-care in my previous arguments, and it will be more difficult to remedy that divide. Moreover, this disparity in patient

[92] Wendler, David. "The Ethics of Clinical Research." Stanford University. January 30, 2009. Accessed April 04, 2014. http://plato.stanford.edu/entries/clinical-research/.
[93] Ibid.

care can lead to moral travesties on a systemic level. This is not to suggest that it is not possible for clinical ethics to cause great wrongdoing (i.e. if a risky treatment plan is heavily pursued and ends up harming a large volume of patients), but wrongdoing is more easily accounted for and justified in the context of clinical research ethics. The field is premised on some deal of risk and *consent* to risk.

This principle is in place to also protect the medical professional from making morally risky decisions. Physicians may feel inclined to cut costs or seek more expensive treatment plans in medical care in order to make more money, something that also can prove to be detrimental in the clinical setting. Both of these situations are unattractive for a moral medical organization. It may not be the most ideal solution, but to inject practicality into what has been discussed in my engagement with ideal theory, a way to pursue a more moral medical organization is to reduce economic conflicts-of-interest. This can be done a number of ways; I have mentioned accountable care (or quality-of-care/shared savings profit derivation) as a potential model to reduce economic conflicts-of-interest, but this is not the only solution.

On a general level, if we were to borrow "advice" from principles in place within clinical research ethics, it has been suggested that moral clinical research can be pursued if patients and clinicians share similar goals. Accountable care is one approach to addressing this general principle, but there can be other ways that clinical goals can join together. It would be hard to imagine that patients could share a goal of profit motivation in the clinical setting, so I support the notion that patients have the goal of increasing their health or well-being when willingly engaging with a medical professional. Even if one wanted to claim that physicians and patients could share the goal of wanting to make or save the most money in a treatment plan, these are still incongruent goals. Patients would want to save money because of their financial health,

while physicians (who wanted to save money) would want to save money because of the health of their institution; physicians do not make more money if they save money for their medical organization—unless, of course, their medical organization happens to be an Accountable Care Organization.

The Accountable Care Organization seems to be the most logical way to account for the immoral nature of profit motivation, something that policy makers have been—and should continue to be—mindful of. In the ACA, the Accountable Care Organization was introduced as a prevalent model of health care maintenance for Medicare patients; large medical organizations are incentivized to uptake this model of health care because of the "shared savings" potential they can take in (that is, a share of the savings they obtain through caring for their Medicare patients without sacrificing current standards of patient care). If the ACO model of health care proves to be successful with lowering costs and improving patient health, it should be implemented into further areas of health care. Even if the ACO model is not successful, policy makers must be mindful of the inherent tension between profit and health promotion that exists in a fee-for-service model of health care.

To reduce economic conflicts-of-interest in health care is not only desirable because of the promotion of the value of human health, but because economic conflicts-of-interest may contribute to a degradation of the trust within the doctor-patient relationship. Take the following case as an example:

> *The Conflicted Oncologist*. Dr. L is conflicted between satisfying two interest groups in medical decision-making. On one hand, Dr. L wants to prescribe his patients the most effective (cost-effective and for health) pharmaceutical to treat their cancer. On the other hand, Dr. L is receiving money from a large pharmaceutical company to prescribe a different, less effective pharmaceutical.

This is morally troubling, especially if Dr. L's patients were aware of this conflict. In one regard, this economic conflict-of-interest could directly impact patient health, but indirectly, there are additional ways that patient health could be affected. Consider, now, that a patient was aware of Dr. L being funded by a large pharmaceutical company. If this were the case, there is a chance that the patient would lose trust in Dr. L, which could then directly affect the treatment of that patient; it is difficult for patient well-being to be optimally promoted without patient trust being intact because compliance with advised treatment and obtaining relevant information to make informed medical decisions *requires* patient trust. In both of these ways, pecuniary conflicts-of-interest are undesirable. Unfortunately, Dr. L is not an anomaly in the medical field, as evidenced by a database compiled by ProPublica that displays the amount of "industry" dollars being funneled to physicians for "promotional talks, research, and consulting."[94]

III. Goal-Mindedness Towards Patient Outcomes

The third principle—perhaps the most important for health care reform to be mindful of—is based on the "commodity" at stake in health care: human health and well-being. With all of the conversation on health care reform relating to economic feasibility and political tension, I feel as though the moral purpose of medical reform is sometimes lost in the fray. Thus, I have generated my third principle for health care reform to be mindful of:

> *Principle 3*: Quality-of-care must be our guiding factor; patient health outcomes are what truly matter.

If a more moral medical organization comes about, it is ultimately because they are able to promote patient health and well-being to the optimal level. This principle grounds values-centered health care; the value of patient health and well-being ought to be what invokes

[94] This database can be found at: "http://projects.propublica.org/docdollars/".

conversation in the forum of health policy, and if a policy detriments this value, policy-makers or relevant individuals in that sphere ought to consider revision towards a more moral policy. This principle was derived from my arguments in Chapters I and II, where I have exemplified the sheer importance of patient health outcomes and championed them in the clinical/administrative spheres of the medical organization. With this principle, I intend to do the same at the policy level.

At the policy level, there are a number of ways that quality-of-care can be the "guiding factor" in how policy is developed and how policy is evaluated. To name a few, quality-of-care measures can be instituted that provide feedback on how policy decisions are affecting quality-of-care. To reduce the impersonal nature of this data, the feedback should include some form of direct patient response or patient testimony. That way, quality-of-care can avoid being commodified as much as possible. Another way for quality-of-care to remain at the forefront of consideration in policy formation is for policy makers to develop some "code of conduct" or statement of ethics that they must swear to upon entering their role as a policy maker, something that would be analogous to the Hippocratic Oath (but would be relevant for policy making). As a general rule, if policy can be directed away from making health care into more of a market place (to avoid health commodification) and closer to respecting the value of patient health and a proper quality-of-care, that would be morally desirable.

Quality-of-care is not intended to simply mean the quality of individual patient visits; I am referring to a systemic quality-of-care. In these terms, we can start to think about quality-of-care in a faux-consequentialist mindset. We would not be able to articulate this principle in pure

consequentialist terms because it would diminish what is important about moral medical care.[95] Let us say that a health care reform is looking to implement one of two policies to aid some aspect of patient care, A and B. Through pure consequentialism, we would desire to produce the maximum amount of utils (of patient happiness or even health outcomes) with a given decision, regardless of how it may be structured. If policy A produces 120 utils as opposed to the 100 utils produced by policy B, policy A is preferred in this mindset. Now, let us assume that these policies affect 10 individuals, and while policy B produces 10 utils of health outcomes per individual, policy A produces 80 utils of health outcomes for one person (and the rest are divided evenly among the remaining 9 patients). This would be an unjust way to frame optimal health care reform; we must consider that maximizing health outcomes—in a *purely* consequentialist set—is not our mission. I support a baseline of health outcomes for as many individuals as possible, and after that condition is met, I can understand being concerned with health outcomes. If a reform practice is detrimental to health outcomes, it need not be pursued.[96]

The patient, similar to the medical professional in *Principle 2*, must also be a responsible agent in medical decision-making; a moral medical organization cannot be a practical benchmark if the effort towards moral medical decision-making is one-sided. It is harder to generalize or characterize patient responsibility in health care because of the inherent complexity and subjectivity of the patient experience. Still, patient responsibility must include self-reflection

[95] If we were to think about promoting quality-of-care through consequentialist health care policy, it may lead to some conclusions that would disregard the unconditional value of human health.

[96] It may seem as though I am forwarding a view of health care through distributive justice rather than through values-centered health care, but that is a misleading interpretation of my analysis. Through the analysis of the pure consequentialist position, I show that it is the wrong way to think about patient quality-of-care. The value of patient health calls for a baseline of health to be promoted, so in a way, I forward a sufficientarian account of health distribution. When considering this, understand that it is informed by a values-centered account of health care; the value of human health is what informs this distributive conclusion.

about health care utilization and effort towards maintaining quality care (so efforts to remain steadfast in appropriate treatment plans). Patients must be active participants in their treatment plans for moral medical reform to be effective. A medical policy may have the proper intentions and may increase quality-of-care with compliance from patient populations, but it cannot be criticized if the policy fails because of patient noncompliance.

Here, I am not saying that patient must abide by medical policies or succumb to treatment plans if they are prescribed by their physicians; I am just trying to relieve some portion of blame from medical professionals and medical policy makers if they are acting ethically. In some cases, patients might reject a treatment plan for other motivations (to save money, they do not value their health, they want to die, etc.). I will not criticize their decision here because I am concerned by those with heightened agency in medical decision-making taking advantage of weak agents to pursue something undesirable in medical care. For example, if an elder woman who is afflicted with terminal cancer decides to discontinue further cancer treatment in order to save money for her relatives, this is permissible. I think that this woman is mistaken about the value of her own life by commodifying her health, but (assuming it was free from coercion) it is a decision that she has made on her own volition—a decision that she is entitled to make. This is not the same case as a commodification process that is forwarded by a health professional and takes advantage of a weak agent.

Keep in mind, patient responsibility in medical and health care ethics is minimal for a reason: the particular vulnerability of the patient in medical decision-making and the fear towards medical paternalism suggest emphasizing professional responsibility over patient

responsibility.[97] Without at least some component of patient responsibility in health care reform, however, it would not be fair to attribute all of the moral blame towards a medical organization striving for more morally sound operation.

IV. "Wal-Mart" or "Southwest" Healthcare

Values-centered medical reform is antithetical to ideas about promoting free-markets in health care. I support reducing market-mindedness in health care through value attribution and promotion towards human health, but others have approached this same issue—and have reached the same conclusion—through different (sometimes related) discussions. Others, still, have not reached the same conclusion.

Market thinking in health care within the United States is "easy to see…the emergence of the market frame among elites is having crucial influence on the evolution of contemporary American health policy;" while it is tempting to pursue for pecuniary purposes, it is simultaneously "luring health policy voyagers to destruction on the shoals of clashing values."[98] This quote is from Mark Schlesinger's argument in *On Values and Democratic Policy Making: The Deceptively Fragile Consensus around Market-Oriented Medical Care*, where Schlesinger approaches the market debate in medicine from a political standpoint. Even here, Schlesinger concedes that pro-market health care reformation introduces morally troubling conflicts-of-interest. His central claim is that a "divergent [notion] of fairness" is what has led market-based health care reform to implement questionable or objectionable health care policy. Schlesinger's argument is empirical and demonstrates (in conjunction with the apropos title) that market-

[97] Kelley, Maureen. "Limits on Patient Responsibility." *Journal of Medicine and Philosophy*30, no. 2 (2005): 189-206. doi:10.1080/03605310590926858.
[98] Schlesinger, M. "On Values and Democratic Policy Making: The Deceptively Fragile Consensus around Market-Oriented Medical Care." *Journal of Health Politics, Policy and Law* 27, no. 6 (December 2002): 889-926. doi:10.1215/03616878-27-6-889.

directed medical reform is not supported as strongly by political and authoritative elites as one would imagine, based on the market-directed medical reforms that have been implemented over the recent history of American medicine. In his concluding remarks, he takes a weaker position on the issue by suggesting this:

> "Proponents of managed competition and market-oriented medical care therefore need to develop strategies that can both acknowledge the risks of greater disparities and mitigate those risks in a meaningful manner. To date, policy makers have largely ignored these obligations. In my assessment, this reflects the connection that they draw between market reforms and norms of equity, connections that are not shared by all the elites who favor markets, and which are rejected by most of the public."[99]

His analysis raises the question: why are market-directed efforts towards health care reform so vehemently rejected by the public? Keeping this in mind, we will now examine a particular pro-market argument.

John H. Cochrane introduced a fervent, sometimes abrasive argument towards a free-market model of medicine in his work *After the ACA: Freeing the market for health care*; he believes that a "much less regulated" health care system is "possible, and necessary," and in general, he argues for a market-based health care model.[100] Cochrane is a professor of finance at the University of Chicago, someone very qualified to be discussing market principles and ways to implement strategies that result in more effective marketplaces. Unfortunately, Cochrane is missing the point of the medical "marketplace": the idea in itself is immoral, and he—along with myself or any other non-medical professional—is the last person apt enough to be making values-based decisions about patient health and well-being. The moral decision is to turn away

[99] Schlesinger, M. "On Values and Democratic Policy Making: The Deceptively Fragile Consensus around Market-Oriented Medical Care." *Journal of Health Politics, Policy and Law* 27, no. 6 (December 2002): 889-926. doi:10.1215/03616878-27-6-889.
[100] Cochrane, John H. "After the ACA: Freeing the Market for Health Care." February 6, 2013. Accessed March 21, 2014. http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf.

from health commodification, something that Cochrane *embraces* in his analysis. Apart from the inherently immoral nature of a market-based argument for health care, there are other reasons to believe that Cochrane is mistaken about the moral facts behind patient care (which will be depicted in the next section).[101]

Cochrane initiates his analysis in a beneficial manner, but quickly turns his analysis awry; he states, "we all agree what we'd like to see: Health care needs to become efficient, innovative, and provide high quality of care at a reasonable cost," an idea that anybody could support. Those factors of ideal medical care are linked to what drives individuals to debate medical ethics in the first place: we care about providing the best medical care possible because there is something special—yet ethically fragile—in the scheme of medical decision-making. I will not attempt to show that Cochrane's intentions are misguided because I believe that is adverse to his pursuit in the first place; I will instead demonstrate how Cochrane's approach, evidence, and conclusions are all ethically misguided. Even ethically misguided analyses are important because they help us affirm the moral facts that are essential to promote or uphold.

His paper is structured around fundamental economic principles, so he begins by discussing the "supply" side of health care. Here, Cochrane is angered by the lack of process efficiency in health care, something that he suggests could be remedied by looking at other "complex service-oriented industries" and applying their efficiency principles. After all, "the Cheesecake Factory delivers a complex service-oriented product with remarkable quality, efficiency, and cost…why can't hospitals do the same?" The problem here is that the complex

[101] A good portion of Cochrane's argument is about the way our health insurance is structured in the United States and how that affects the medical marketplace. As much as I am able to (because really, they are intertwined), I attempt to stray away from this argument; I do not discuss the ethics of health insurance in this paper. Thus, I will fail to mention a significant portion of what Cochrane is angered about by our current health care system.

service-oriented industry that Cochrane is comparing medicine to is not even close to being as valuable or subjective as medical care is. The author continues his attempt to liken health care to other industries because of their ability to optimize quality and service, next by positing to the reader that "the iPhone error rate is a lot lower than the medical error rate."[102] It is one thing to make claims about how the medical field can benefit from economic industry principles, but I have an issue with when these suggestions are intentionally misleading. Of course the medical error rate is higher than the iPhone error rate; the premise of medicine is fixing error in human well-being. The premise of an iPhone sale is to provide an excellent product, and if that was associated with a high error rate, the business of the iPhone would diminish. Medical care is premised on fixing medical ailments, and often, procedures or acute care treatment plans are complex in nature. Thus, one must expect medical error to be relatively higher—it exists in a completely different context. I am not saying that high medical error is acceptable; I am saying that making a claim that likens medical error to technological error is not only cold and dehumanizing, but incorrectly assessing the moral realities behind the two kinds of error.

Cochrane continues his analysis by focusing on competition in the medical "marketplace". He introduces some valid points about not enough competition existing between medical insurance companies, but when he extends this debate into the medical organization, it is erroneous. At times, he focuses on the consolidation of the medical organization, something that is inevitable with future health care reform. This is not where I raise an issue with Cochrane's point; the reality is such, and we must be even more mindful of how we separate clinical care with administrative practice. Instead, Cochrane incorrectly criticizes the "fragmentation" of the medical organization. He fails to take notice of the specialty and specificity of each medical

[102] Cochrane, John H. "After the ACA: Freeing the Market for Health Care." February 6, 2013. Accessed March 21, 2014. http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf.

branch, and while I agree that some areas in medicine could be theoretically consolidated (to "streamline" medical care in a pursuit of efficiency without jeopardizing patient well-being), fragmentation is in place because of medical specificity; to consolidate all medical branches under one umbrella through a profit motive could be detrimental to patient care.

When discussing health care policy on a broader scale, Cochrane does not feel too optimistic, suggesting that "government-imposed efficiency" of markets are, "to put it charitably, a hope without historical precedent."[103] Primarily, let us not forget that health care should not simply be a marketplace (based on the unconditional value of human health), and even if we think about health care as a standard marketplace, historical precedent of effectiveness is not the way we should be framing moral medical reform. Medicine needs some form of regulation because of what is at stake in medical decision-making. Moral medical reform should be forward-thinking and should examine the aforementioned "picnic spot"; even if it cannot be fully realized, the moral medical organization can be pursued, and this is apart from historical precedent.

Cochrane then examines the "demand" side of the health care market, which further distorts the application of Cochrane's analysis (because health care is a desirable commodity, correct? Ironically, if demand for health care was at an all-time low, that would be an optimal scenario, something that Cochrane's analysis could not account for).[104] In this examination, Cochrane raises an interesting and controversial scenario that he recommends as being useful to think about when examining the economics of medical care. His case is as follows:

[103] Cochrane, John H. "After the ACA: Freeing the Market for Health Care." February 6, 2013. Accessed March 21, 2014. http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf.
[104] Here is what I mean: according to a market model of health care, the health care market would be "at its best" and thriving with tremendous patient volumes in a sickly society. Clearly, our moral intuitions do not say the same. In a moral model of the health care market, no individual would require medical attention. This is the root of why market-mindedness and health care are ethically counter-intuitive.

> "So what does "need" really mean for services like these? The only sensible economic definition I can think of is that "need" is the bundle of services you would choose if you were paying with your own money at the margin. You "need" that MRI to make sure your back pain won't just heal after 6 weeks of ibuprofen if you'd be willing to shell out $1,000 of your own money to get it. (I am!) And you "need" it delivered at a convenient hour, tomorrow, rather than next week across town if you're willing to pay that extra cost…As economists, we are expected to avoid that confusion. A good way to do so is to pose the question in the positive rather than the negative: Suppose we offered each patient the choice, 'Your doctor prescribed this MRI. You can have the MRI or you can have $1000 in cash.' The patient "needs" the MRI if he or she foregoes the cash and goes through with the MRI."[105]

Cochrane's thought experiment seems to be—in his frame of reference—proposing an unsettling reality of what medical "need" truly is, and I have an issue with the structure of this thought experiment in the first place. His thought experiment qualifies as *value-centered coercion,* a theory I forward in Chapter II. An action—according to values-centered coercion—is coercive when it forces an agent to choose between something of conditional value and something of unconditional value. Whoever "we" is in this thought experiment, the "we" offers the patient the choice between a treatment that can have potential health benefit or money, something of conditional value. If the MRI is not clinically indicated or necessary, I will withdraw my critique, but if it is, it assumes an unconditional value—it may be necessary to preserve the health and well-being of the patient. Therefore, it would be coercive for this option to be given to the patient. So, I would not think that a valid conclusion could be drawn from a thought experiment premised on coercing an agent.

The essence of the disparity between Cochrane's pro-market position and my position is realized when Cochrane asserts that "health care *is* an economic good…health care is not that different from the services provided by lawyers, auto mechanics, home remodelers, tax

[105] Cochrane, John H. "After the ACA: Freeing the Market for Health Care." February 6, 2013. Accessed March 21, 2014. http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf.

accountants, financial planners, restaurants, airlines or college professors."[106] With the potential exception of lawyers, I entirely disagree with Cochrane. This disagreement is at the core of *values-centered health care*.

V. A Values-Centered Response to the Pro-Market Position

Cochrane's argument is mistaken about the moral facts of medical care. To begin, he is so adamant about the idea of the "for-profit" health organization being distinct from the "nonprofit" medical organization, and it is not when considering the ethical wrongdoings relating to patient care. As he acknowledges, for-profit medical organizations must answer to stockholders and pay attention to their position as a publically-traded entity, but just because a medical organization does not have stockholders does not mean that they do not maintain a profit motivation; a board of trustees or governing body can just as easily desire profit and jeopardize patient and well-being. There is still something fundamentally wrong with a medical profit motivation regardless of the medical organization maintaining it, so health care policy in this area should be directed towards *all* medical organizations. I would say that the profit-motive is more dangerous and alarming in the for-profit setting, but still, effort should be directed towards all medical profit motivation, regardless of its brand.

In *After the ACA*, Cochrane tries to justify medical reform on a value-neutral account, something that I believe is unavoidable in the medical setting. It would seem that Cochrane avoids a value-based account through a system of economic analysis, but I would disagree. By arguing for increased competition, less regulation, and the promotion of economic or industrial ideals in the medical market, Cochrane is making a claim about the value of freedom and

[106] Cochrane, John H. "After the ACA: Freeing the Market for Health Care." February 6, 2013. Accessed March 21, 2014. http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf.

economic sovereignty. If he was not or did not support this position, why should we have to value his argument? His discussion is premised on the idea that freedom is intrinsically valuable. I agree that freedom is valuable, but we must consider what other values are at stake in the "medical market". Primarily, I am referring to the value of human health; Cochrane avoids making a claim on the value of health by analyzing health care as a system of commodities that is subjected to supply and demand curves. This is a mistake, and even with the value of freedom in mind, there are reasons to believe that the value of health can demand promotion over the value of freedom (when the two are pitted against one another).[107]

Cochrane—like others—needs to take a stance on the value of health, because I believe this is the only method of pursing viable, patient-focused health care reform; the "others" I am referring to includes policy makers in health care. Being value-neutral about human health is to deny our humanity. There is no sense in rejecting the fact that human health is too subjective of a value to allow for an unrestricted medial market place to viably emerge (and be morally in place), and there is moral danger in treating health like any other commodity. Promoting values-centered health care is where relevant medical policy needs to be directed towards.

[107] This is not an entirely controversial ideal; in other ways, we are able to sacrifice freedom to promote other higher-order values. For example, we can think of having law enforcement agencies as being an example of some member of society forfeiting some degree of autonomy to protect the autonomy and bodily integrity of all of society. Additionally, we can think about providing tax dollars to provide public goods as forfeiting some of our financial autonomy for the ability to educate our society, protect our citizens, and promote other public goods. We can also think about forfeiting some of our financial freedom in terms of Social Security: throughout our lives, we pay into a system that forces us to concede some monetary freedom in order to help promote financial freedom in the future. There are several ways that we forfeit freedom to promote unconditional values, an idea that sounds more controversial than it actually is.

Conclusion

I decided to pursue this project after I was able to reflect upon my personal experiences with patient care and hospital administration. I plan on pursuing a career in medicine; as a result, I have attempted to gain as much perspective into medical decision-making as possible. This journey eventually led me into an internship under an administrator in a large medical organization. From this experience, I was angered. I was angered by the commodification of patient health I was witnessing. Patient health and well-being were the values that have motivated me to pursue a career in medicine, and to see those be degraded by administrative decision-making was frustrating. I have been fortunate enough to learn about and appreciate the uniqueness, subjectivity, and importance of human health, realized though discourse with medical professionals and patients with medical ailments. Even though my experiences with medical administration have been frustrating, I am also thankful for having them. Otherwise, I would not have been intrigued by the tension between business considerations and medicine, and thus, I would not have pursued this defense against profit-motivated health commodification in health care.

In this thesis, I have championed the unconditional value of human health in all tiers of health care. I have shown that there are reasons to believe that doctors have concrete obligations to their patients, and these obligations amount to a physician being accountable for not optimally promoting patient health and well-being. Early on, I introduced “the medical profit motive” as the direct antithesis to doctoral obligation. Within the medical profit motive, an agent would in some way desire monetary profit that would result from patient care. To think about medical profit in this way is a complete rejection of our humanity and the nature of patient care. Although profit motivation can be justified when isolated into a doctor-patient relationship, the same does

not hold true for an administrative medical profit motive. When thinking about leadership and responsibility in collective wrongdoing, the non-existence of normatively significant force (coercion) towards decision-making, and the lack of medical expertise that ought to exist in a role responsible for medical decision-making, it is hard to transpose the justification of a medical profit motive into the administrative sphere. I maintain that an administrative profit motive ought to be abolished because of the moral risk involved, and if it cannot be abolished, it must be accounted for.

This discussion began a larger conversation about values in health care policy. I was particularly dissatisfied with a pro-market argument for health care reform, and I did not believe that thought on distributive justice in health care truly captured what was morally at stake in health care. Thus, I forwarded my own theory of health care: *values-centered health care*. Values-centered health care borrowed the moral facts teased out from the first two chapters and distilled them into three relevant principles for medical policy makers to consider. I believe that health care reform guided by the value of health is the most desirable model of reform, and the value of health cannot be lost though extensive policy debate.

With this, I charge the entire health care field to consider what has been introduced here and in several other places: there is something unique about human health that should invoke pause and caution when making decisions affecting health. For doctors, profit considerations are still not desirable (they are *pro tanto* wrong), but if they are instrumental to providing optimal patient outcomes, they can exist. Doctors should reflect on the value of patient health when deciding how to best treat patients, and similarly, administrators should reflect on the value of human health when deciding how to run medical organizations. If it is not fully possible, it still should be understood that a medical organization led by medical experts is the most morally

desirable model of administration. The medical administrator must use the value of patient health as a bulwark against profit considerations that may be tied to their role in the medical organization. The medical organization will have a very difficult time approaching a moral ideal with a fee-for-service incentive structure in place; I have recommended the Accountable Care model of patient care here, but regardless, there should be a push to reduce pecuniary conflicts-of-interest in medical decision-making.

Those who develop medical policy ought to act through what has been introduced by values-centered health care. In our current state of affairs, health care reform is at the forefront of debate and consideration, so it is a very apt time for a theory of health care to be forwarded. It is also a very apt time for the value of health to be lost in the maelstrom of policy and debate, something that must not take place. When considering my future in the maelstrom of health care, I must also be cautious of profit motivation in patient care. If I do become a medical doctor, I cannot allow for a profit motivation to be at the forefront of my clinical practice. Like other aspiring physicians, aspiring medical administrators, and those aspiring for roles that deal with medical policy, we must recognize that the unconditional value of health is what governs moral medical care.