

**False Promise: From Do No
Harm to Distributive Justice in
Medical Ethics and Why We Are
All Sicker as the Result**

Renewed Trust: Finding Our Way Back From Distributive Justice to Do No Harm in Medical Ethics

Robert S. Emmons, M.D.

March 9, 2018

robertsemmons@comcast.net

Thesis

- Distributive Justice has come to crowd out all other ethical values in everyday clinical practice, in an automatic, unconscious way, thus eroding trust between patients and physicians.
- We can restore trust with our patients by making Do No Harm an expression of humility and a central principle of ethical practice.
- Clinical experience tells us that outcomes improve in an environment of trust between patients and their doctors.

Case Example: Clinical problem or problem of payment mechanism?

My patient “George,” age 55, has developed gastroparesis after forty-five years of Type I diabetes. Because his gut cannot absorb iron, it has been necessary to treat intermittent bouts of severe anemia with IV iron infusions. At a recent visit, George informs me that he has been feeling cold, tired, and down, telltale symptoms of anemia for him. I have treated George for recurrent major depression for twenty years, but now treating him means sending him back to his hematologist, “Dr. Winston.”

At our next visit, I am taken aback to learn that George will not get an iron infusion. His hemoglobin is measured at 10.8; Medicare has determined that the treatment is not “medically necessary” until the hemoglobin falls to less than 10. George is accustomed to paying out of pocket for psychotherapy in my direct-pay practice, and he is willing to do the same to get his iron infusion.

Outline

- 1) Brief review of the place of distributive justice in ethical methodology
- 2) Brief review of the origin of distributive justice in the history of medical ethics
- 3) Clinical implications of making distributive justice, by default, the predominant value in medical ethics
- 4) How to restore trust

A Brief and Selective Overview of Ethical Methodology

What is the purpose of medical ethics?

- A method of clinical problem-solving
- An articulation of the physician's duties to her patients, as a point of reference for conscience
- A source for professional identity
- A social contract: a statement of what patients can expect from their doctors
- A set of rules that can be enforced to protect patients from doctors

Ethical Methodology: The Principle Based Approach

Tom Beauchamp and James Childress

A principle is a statement of some fundamental and universal moral truth that is expressed as an action guide.

- Respect for autonomy (respect the decision-making capacity of autonomous persons)
- Nonmaleficence: Do No Harm (avoid the causation of harm)
- Beneficence (provide benefit and balance it against risk)
- Justice (fairness in the distribution of benefits and risks)

Where do principles come from?

The Common Morality

- Beauchamp: “The morality shared by all serious persons in all societies is not *a morality*, it is simply morality. It is universal because it contains ethical precepts wherever morality is found.”
- If one is made uneasy by the vague and circular nature of this definition of the common morality, then one might look to the clinical situation as the source of principles for medical ethics. Principles that are valid for medical ethics are always compatible, and never at odds with, good clinical practice.

Ethical Methodology: Virtue Ethics

Edmund Pellegrino, M.D. and David Thomasma

- Virtue ethics focuses on the physician as a moral agent in a relationship of trust with her patient.
- A physician who is habitually disposed toward the good and the right can be trusted by her patients.
- The virtuous physician diligently strives to make the right attitude toward patients automatic and reflexive.
- Virtues to cultivate include: compassion, prudence, justice, fortitude, temperance, integrity, and self-effacement.
- Principles are susceptible to distortion if they are not interpreted by reliable moral agents. Virtue is susceptible to moral relativism without concrete guides for action.

Ethical Methodology: Casuistry

Case Based Ethics

Albert Jonsen and Stephen Toulmin

- Moral acts and moral agents are judged on the basis of the effect on the patient.
- In clinical medicine, diagnostic reasoning is based on taxonomy, paradigm cases, and analogy. Clinical inferences are open to revision in light of fresh evidence.
- Similarly, casuists use ethical paradigm cases from which they survey their way to less understood and still disputed cases.
- Marginal and ambiguous cases leave room for honest and conscientious differences of opinion.
- Principles and sound moral character will still fall short if the perspective of the patient is left out; case-based reasoning still needs reference points.

Definitions: Justice

Thomas Aquinas

- **Commutative Justice:** the idea that it is fair for us to give others what they are due and do not take what is rightly theirs. In a one on one relationship, duty can be precisely defined, and it seems plausible to devise fair compensations for transgressions.
- **Distributive Justice:** The idea that advantages and disadvantages ought to be fairly distributed throughout a community. The duty of a community to an individual is hard to define, and no one individual who can be defined as culpable for transgressions or failures to meet need.

Definitions: Social Justice

John Rawls

- Social Justice is the study of the ways in which major social institutions distribute: (1) fundamental rights and duties (due process), and (2) things that are rationally regarded as advantages or disadvantages (distributive justice).
- Everyday, informal, social practice complements the formal institutional mechanisms of distribution.
- In discourse today about medical practice, Social Justice and Distributive Justice get conflated, which sometimes results in denial of due process for patients and physicians, if due process is deemed to conflict with the claims of Distributive Justice.

Social Justice Versus Charity

- If the focus for the distribution of advantages and disadvantages is left exclusively to major social institutions, then the physician's natural impulse to altruism is effectively blunted and outsourced.
- Charity is altruism in the context of a one on one relationship. The giving of charitable care aligns the physician in a stance of virtuous practice. With charity, the distribution of benefits can be tailored precisely to the needs of the individual, in contrast to the one size fits all approach inherent in institutional approaches. Fraud is impossible in the charitable giving of care by individual physicians to their individual patients.

False Justice

- The patient-physician relationship is a two-person (dyadic), one-on-one relationship. Commutative justice is the dimension of justice that can be appropriately applied to a dyadic relationship. We ought to give our patients what they are due, which is fidelity to trust, and we ought not to take from our patients what belongs to them, which means we do not exploit our patients for personal gain.
- In discourse today about medical practice and medical ethics, the concept of distributive justice is inappropriately extrapolated into the dyadic relationship between patient and physician, creating role confusion and the false perception of competing ethical values. Bioethicists tell us to balance Distributive Justice against Do No Harm, Beneficence, and Respect for Autonomy, but that is misguided: in everyday practice, we balance Do No Harm, Beneficence, and Respect for Autonomy. It is not the role of a physician to remedy social inequity, but it is the role of a physician to treat the disease and disability that might result from social inequity.
- The methods used by social institutions to distribute and withhold benefits are incompatible with the requirements of a trusting one-on-one relationship.
- Because distributive justice applies to a relationship between an individual (in the context of medicine, a patient) and the community, all matters of distributive justice can be addressed outside the patient-physician relationship, in order to preserve the principle of fidelity to trust.

The Role of the Unconscious Mind in Medical Ethics, I

- Psychic determinism: our unconscious minds make our decisions and our conscious minds invent rationalizations after the fact.
- Most accounts of medical ethics do not systematically examine the impact of culture and the patient's unconscious mind on the physician's unconscious mind. Our patients influence our unconscious minds by repeatedly telling us stories about themselves, until we believe them and close off possibilities for personal potentials that might be realized if encouraged. Politicians and commercial vendors influence our unconscious's minds by repeatedly telling us stories about ourselves, until we believe them and act in accordance with them.
- When physicians do what they ought not to do, more often than not, it is due to unconscious factors out of reach of reasoning and education. When physicians do what they ought to do, more often than not, it is due to unconscious identifications with positive mentors.

The Role of the Unconscious Mind in Medical Ethics, II

- External regulation can contain the unconscious impulses that lead to bad or ineffective practice by a few physicians, but at the cost of degrading the ability of all physicians to exercise their consciences, because motivation becomes externally motivated rather than internally motivated.
- Systems of care and public policy that center on Distributive Justice rely heavily on third party financial incentives to influence the clinical decision-making of physicians. These incentives work primarily by appealing to the physician's unconscious motivations, thus bypassing moral reasoning.
- There are people out there working day and night to get into your unconscious mind!

A Brief And Selective History of Medical Ethics: Inflection Points

Classical Foundations of Medical Ethics

In the fifth century BC, folk medicine and religious ritual began to evolve into specialized practice based on empirical observation and logical reasoning. Healing began to be called an art and its practitioners craftsmen. This learning coalesced over five centuries into a collection of 70 treatises, known as the Hippocratic collection, which included ideas about how physicians ought to behave.

- Deontology, the classical forerunner of principle based ethics, is a description of what one ought to do, generally expressed in rules or principles, exemplified by the Oath of Hippocrates.
- Decorum, the classical forerunner of virtue ethics, is a description of the outward behaviors that manifest inner virtue

Hippocratic values are derived from clinical practice. A close reading of the Hippocratic Oath reveals that Do No Harm is the predominant principle. Beneficence did not come so much into play because physicians did not have so many effective treatments to offer, and autonomy was not such a major focus of classical philosophical theory. Do No Harm might also be understood as an expression of humility in a newly forming profession.

Utilitarian Theories

Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873)

- Human good is understood to be constituted by whatever satisfies people's desires or preferences or makes people happy. God is taken out of the equation.
- Actions are judged as right or wrong according to their outcomes.
- An act is judged as morally right if it produces as great a balance of pleasure over pain as any alternative action open to the agent.
- Each person is fundamentally morally equal to every other; strangers count the same as friend or family. Any favoritism toward one person, must be justified by overall good consequences for people generally.
- Utilitarianism is routinely, and crudely, interpreted as meaning "the greatest good for the greatest number," and it does not allow for one person to have a special duty to another. Utilitarianism is thus incompatible with fidelity to trust.
- This theory might have something to do with the Industrial Revolution: times of new technology lend themselves to utilitarianism.

The Enlightenment

Immanuel Kant (1724-1804)

- Human beings are rational and can resist desire. One must act not for the sake of an outcome but for the sake of obligation.
- Categorical imperative: “Act only on that maxim which you can at the same time will to be a universal law.” When good reasons support a moral judgment, those reasons are good for all relevantly similar circumstances.
- Morality cannot exist without freedom, so a person should never be used exclusively as a means to someone else’s ends.
- The ultimate end of all action is the “Highest good,” the perfect union of virtue and happiness, guaranteed by God.
- Kant’s deontological approach may represent the flip side of the utilitarian response to the Industrial Revolution.

Human Rights in Medicine

Joseph Fletcher (1905-1991), Professor of Moral Theology at Episcopal Theological School in Cambridge, Massachusetts

Fletcher is credited with popularizing the concept of human rights in medicine in the 1949 Lowell Lectures at Harvard University.

[We] . . . plead the ethical case for our human rights . . . to use contraceptives, to seek insemination anonymously from a donor, to be sterilized, and to receive a merciful death from a medically competent euthanist.

- His 1954 book *Morals and Medicine* made its central theme the "demands a patient has a right and duty to make upon his physicians."
- His 1967 book *Situation Ethics* argued that only the features of a situation determines its rightness or wrongness.
- Professional philosophers disdained Fletcher's lack of rigorous discipline in his arguments, but physicians, whom Fletcher spared from criticism, and the general public found his ideas quite appealing.
- Fletcher grew up in Appalachian mining country, deeply concerned about social and economic inequity, and began his career as a union activist, so we might note the link between the ideas of human rights and social justice.

Rationing of Medical Care by Non-Physicians

In 1960, six years after the first renal transplantation, the Seattle Artificial Kidney Center set up an Admissions and Policy Committee, to select patients. The committee consisted of two physicians and five anonymous non-physicians.

This might be considered the first application of Distributive Justice in actual practice, the injection of a methodology suitable for relationships between individuals and communities into dyadic relationships that are supposed to be based on fidelity to trust.

Triage is the clinical analog of Distributive Justice. Triage is the appropriate method for dividing up benefits in the context of dyadic relationships between physicians and their patients.

Bioethics

- Coalesced by the late 1960's
- An outgrowth of Fletcher's work
- The perceived necessity of rationing preceded the ethical rationale for it
- Multidisciplinary, dominated by non-clinicians
- Distributive Justice takes precedence over procedural justice
- Focus shifts from the patient-physician relationship to technology and society

Bioethics and Autonomy

- Autonomy is more complex than mere choice.
- Kant: autonomous moral agents act upon their own freely and rationally adopted moral policy.
- If one acts upon commands of the state, society, or a deity, then one is not truly autonomous.
- Bioethics offers a cogent and influential critique of physician paternalism, but it does not systematically study institutional paternalism. It is accepted that patients should not be commanded or manipulated by their physicians, and society has have set up a variety of mechanisms for patients to get out from under that kind of paternalism, but no coherent system exists to help patients escape the command and manipulation of the state or society.
- The culture of physician paternalism had to be cleared away before physicians would accept the role of agents for society in resources allocation.

Human Rights and Duties

- Under bioethics, the origin of duty in the physician's promise to be trustworthy to her patient shifts to a duty that originates in the patient's rights, moral demands that a patient is entitled to impose upon his physician.
- Under bioethics, the physician is diminished as a moral agent with a conscience, thus diminishing the relationship of trust between patient and doctor. Pellegrino and Thomasma call this the ethics of distrust: it is an adversarial between a skeptical patient and a doctor stuck in a self-protective crouch.
- This fundamental shift sets the stage for the physician to accept the role of a social agent, prudent steward of society's limited resources. The physician is now a moral double agent, which is incompatible with the virtue of fidelity to trust. Perversely, when physicians do accept the role of guardians of society's limited resources, it only amplifies the ethics of distrust.

Supremacy of Law Over Medical Ethics

- In 1975, the Federal Trade Commission filed an administrative complaint against the AMA, Connecticut State Medical Society, and the New Haven County Medical Association, alleging that an ethical prohibition on advertising amounted to restraint of trade.
- *The Commission noted [in its complaint] that a ban on truthful advertising especially disadvantaged HMOs, an emerging health plan format that needed to advertise precisely because they were unfamiliar to consumers.*

“FTC Milestone: A New Age Dawns for the FTC’s Competition Work.”
Kelly Signs, Bureau of Competition, February 20, 2015. Accessed
9/19/15 at

<https://www.ftc.gov/news-events/blogs/competition-matters/2015/02/ftc-milestone-new-age-dawns-ftcs-competition-work>

Supremacy of Law Over Medical Ethics

In July 1980, the AMA House of Delegates voted to delete Section 5, a prohibition on soliciting patients, Section 6, an affirmation of the primacy of independent professional judgment, and Section 7, an admonition to actively guard against financial influences that could undermine loyalty to the patient.

This change was a response to the FTC ruling.

Supremacy of Law Over Medical Ethics

- By the time the FTC complaint reached the Supreme Court, the AMA was only contesting jurisdictional issues.
- Case settled March 23, 1982. Supreme Court split 4-4, leaving in place the ruling by the Second Circuit that barred AMA from making any prohibitive reference to advertising.
- Ruling went further than just advertising: AMA was barred from “formulating, adopting, and disseminating” *any* ethical guideline without first obtaining permission from the FTC.

This ruling set the stage for the law—which is ultimately political—rather than the profession, to define the rights of patients and the corresponding duties of physicians.

Case Example: Problem of Payment Mechanism or Ethical Dilemma?

George is still suffering from untreated anemia. I phone Dr. Winston to recommend that he let George pay directly for the IV iron infusion, but he refuses, and seems annoyed at my suggestion. Participating physicians like him are prohibited from billing patients out of pocket for covered services determined to be not medically necessary by the plan; coverage provisions like this cannot be appealed. I suggest to George that he seek out a hematologist who has opted out of Medicare, but his medical condition and limited finances preclude travel out of state where one might be located. George goes on to suffer with untreated anemia for months, until he is finally treated with painful intramuscular iron injections.

Distributive Justice Takes Priority Over Other Ethical Values

- How can Dr. Winston's clinical decision be justified ethically?
- This Medicare regulation purports to distribute care only to patients who really need it, in the service of conserving limited resources for all. Care that is deemed to be of marginal value is not reimbursed, but even more, it is prohibited.
- In this case, the only way Dr. Winston's decision can be considered ethical is to recognize the principle of Distributive Justice as paramount over his other ethical duties to his patients.
- This ranking of ethical responsibilities was unconscious, as evidenced by the fact that Dr. Winston never considered a way to arrange needed care for his patient, such as referral to a colleague who had opted out of Medicare. Dr. Winston does not consciously recognize this as distributive justice; he believes that he is complying with the law. In Dr. Winston's mind, a prohibition of reimbursement became synonymous with a prohibition of care.
- Dr. Winston identifies unconsciously as an agent of society, a steward of the community's limited resources, rather than as a clinical agent for George, his patient.

Distributive Justice Takes Priority Over Other Ethical Values

- In this case, Distributive Justice supersedes Beneficence. If Dr. Winston had put Beneficence first, he would have found a way for George to get the IV iron transfusion.
- Distributive Justice supersedes Respect for Patient Autonomy. If Dr. Winston had honored the principle of Respect for Autonomy, he would have given George a choice, with a referral to a colleague who could provide care.
- George's laboratory data is not confidential, to his detriment, so this dimension of Respect for Patient Autonomy gives way to Distributive Justice and its insatiable demand for data to enforce its system of rationing care.
- Distributive Justice supersedes Fidelity to Trust, as Dr. Winston acts as an agent of the state rather than an agent for George's best clinical interests.
- Putting Distributive Justice ahead of other ethical values results in a worse clinical outcome for George.

Accountable Care Organizations: Systems of Distributive Justice

- The Centers for Medicare and Medicaid define ACOs as “groups of doctors, hospitals, and other health care providers, who join together voluntarily to give coordinated, high quality care to their Medicare patients.”
- The Triple Aim of the ACO is “improving the experience of care, improving the health of populations, and reducing per capita costs of health care.”
- Mechanisms of payment include: one-sided shared savings, two-sided shared savings, bundled, partial capitation, global payments, global risk.
- **Hospitals and doctors risk financial penalty if they fail to reduce costs or meet quality standards.**

How Are ACOs doing?

- In an early study of 32 “pioneer” ACOs, the ACOs had a 6.3 percent reduction in hospital readmission and a 3.9 percent reduction in length of stay, as opposed to 3.8 and 2.4, respectively, in the control groups.
- Hospital readmission and length of stay can correlate positively or negatively with individual outcomes, so we don’t really know how patients fared in ACOs versus traditional fee-for-service.
- As of September 2014, 10 out of the original 32 left the program due to unsustainable losses. 18 achieved modest gross savings and 14 sustained losses.

The Problem of Measuring Clinical Outcomes

- The systems of care that are based on the principle of Distributive Justice tend to measure population metrics rather than the individual outcomes that matter to patients. As noted in the example of hospital readmission, most metrics are proxies for actual individual outcomes.
- Patients can sicken and die while waiting for care, or they can get better. Patients who are offered excessive care because they did not wait long enough to get better spontaneously have a chance to evaluate the risk of treatment and avoid it. Thus, longer waits for care are apt to produce worse clinical outcomes. To put it differently, the risk of getting too much care is less, and can be mitigated, relative to the risk of waiting too long.
- The time waiting for an appointment is an indicator of potential individual clinical outcomes, is indirect, to be sure, but it is still superior to population-based metrics in evaluating how individual patients fare in different systems of care. Systems of care based on Distributive Justice control the metrics, and they tend not to publicly report wait times. Advocates for systems of care based on Do No Harm and Fidelity to Trust tend to lack the data to prove that they are getting better clinical outcomes.

More on Measuring Clinical Outcomes

- Physicians can better evaluate patients when they have more face-to-face time, so they are apt to make more accurate diagnosis and offer treatment options more precisely.
- With more face-to-face time, patients feel better understood and trust their physicians more, is an improved clinical outcome in its own right.
- Systems of care that are free of the pressure of Distributive Justice generally offer patients more face-to-face time, another indirect marker of better clinical outcomes.

The Ethics of ACOs

- If the central feature of the ACO is to put hospitals and doctors at financial risk, then the central ethical principle is Distributive Justice.
- The ACO physician who provides a less expensive treatment with higher incidence of side effects, in the service of meeting the global budget, puts Distributive Justice ahead of Do No Harm.
- The ACO physician who withholds potentially beneficial treatment, rationalizing that the benefits are only marginal, or who must schedule patients for followup at excessively long intervals due to excessive case loads, pressed onto her in the service of meeting the global budget, puts Distributive Justice ahead of Beneficence.
- The ACO physician who does not inform patients of superior treatment offered by independent physicians, because that care counts against the global budget, or who submits personal medical information to electronic databases without patient consent, in the service of providing the required metrics, puts Distributive Justice ahead of Respect for Autonomy.
- The physician who balances the best clinical interests of patients against the imperative of stewarding scarce resources engages in double agency that is not compatible with the virtue of Fidelity to Trust.

How do Physicians Lose Their Minds?

- Politically motivated public policy makers and medical corporations use a variety of tactics to get doctors to unconsciously identify with these third party interests, rather than the interests of patients. Tactics include:
- Repeatedly telling doctors stories about themselves and their profession, e.g.: “the system is broken,” “medicine is an industry,” “fee-for-service doctors are driven by volume rather than value.”
- Repeating catch phrases, buzzwords, and slogans, e.g., “health care is a human right,” “provider,” “evidence-based care.”
- Physician leaders are recruited to buy into Distributive Justice (usually enabled by handsome bonuses), and they then influence their employee clinicians who will identify with them: “If my medical director says its good practice, then it must be. I like him better than that mean old managed care reviewer who I had to deal with before I joined the ACO.”

The Preference for Distributive Justice is Unconscious

- The physician who faces financial risk based on clinical outcome favors Distributive Justice over other ethical values in an unconscious, automatic way.
- The physician thinks of it in her conscious mind as evidence-based practice, following practice guidelines, aiming for good metrics, or helping to bend the cost curve.
- When physicians speak favorably of Distributive Justice, they nearly always refer to it as Social Justice, and speak of it at the level of public policy, not at the level of their own clinical decision-making.
- Systems of care and systems of public policy that set up physicians to act as agents of Distributive Justice do not disclose that fact to patients or the public at large.
- When the decision is made to let Distributive Justice into the equation of clinical decision-making, it becomes much less a choice of competing values and much more a default position.

Direct Pay Practice, Part I

In my direct pay psychiatric practice:

- I observe Do No Harm by selecting the treatments that are least likely to cause side effects, free of pressure from third party financial incentives.
- I observe Beneficence by offering treatments that are most likely to provide benefit, unimpeded by financial incentives attached to compliance with practice guidelines. I observe Respect for Autonomy by guarding confidentiality; I do not link to any electronic databases.
- I observe Respect for Autonomy by disclosing my fee at the time of the initial phone call.
- I observe Respect for Autonomy by taking the time to obtain full informed consent, free of pressure from third party payers to limit my time with patients.

Direct Pay Practice, Part II

- I observe Commutative Justice by giving my patients what they are due, fidelity to trust, unimpeded by any obligation to third parties.
- I observe Commutative Justice by not exploiting patients for my personal gain, in pursuit of bonuses paid by third parties.
- Distributive Justice is never observed in my practice, but I am quite happy to help my patients conserve their personal resources by offering them efficient care at fees much lower than the fees quoted by the teaching hospital which is becoming the one and only local ACO.
- I have never had a waiting list in my practice, which is an indirect marker of better clinical outcomes, along with more face to face time with my patients.

Direct Pay Practice, Part III

- I set up my practice model in order to avoid hassle, to have more face to face time with my patients so I can provide higher quality care, and to make more money per hour so I can spend more time with my family.
- My practice is also designed to cultivate the virtue of Fidelity to Trust, by keeping myself clear of the influence of third parties on my unconscious mind.

Distributive Justice Does Not Belong in Clinical Practice

The choice to rank Distributive Justice ahead of other ethical values in clinical medicine is a false choice, because Distributive Justice is relevant to the relationship between an individual and society, not a relationship between a patient and a physician.

Physicians cannot be expected to reliably and consistently interpret non-clinical values in the context of an individual relationship with an individual patient. If the physician is asked to “balance” the needs of the individual against the demands of the “community,” then the physician’s judgments will always be subjective, ad hoc, and arbitrary. This balancing act creates great peril for a sort of thoughtless utilitarianism.

The ethical physician will want to set up an internal moral firewall to keep Distributive Justice out of her clinical decision-making.

The Moral Firewall: How to Settle Competing Ethical Values

- The empirical test: depending on what ethical value is given precedence, what clinical outcome will result for the individual patient? Do not weigh ethical values in the abstract. Take every proposition of ethical principle and translate it into a case example.
- The transparency test: could you disclose your method of weighing ethical values to your patient?

The Moral Firewall: How to Evaluate the Moral Quality of Public Policy or Systems of Care

- Does the public policy or system of care predictably cause harm to some patients? If so, then the policy or system is ethically flawed in its design. Causing clinical harm is different than failing to correct social inequity, because correcting social inequity is not the aim of medicine.
- Does the policy or system strengthen or degrade the ability of the physician to exercise her conscience on behalf of her patients? Physicians are well advised to avoid practice in systems or under policies that degrade them as moral agents. Opting out of flawed systems puts pressure on them to change in the positive direction.
- Coercion, legal or financial, is a cardinal feature of morally flawed systems and policies, because coercion by definition impairs the physician's ability to freely exercise her conscience in her work.

The Moral Firewall: Preserve and Promote Your Ethical Mind

- Repeatedly tell your own stories about yourself and our profession, e.g.: “the practice of medicine ennobles the practitioner,” “medicine is a profession, not a business,” “direct pay practice replaces the focus on productivity with a focus on value for the patient.”
- Do not repeat the catch phrases, buzzwords, and slogans promoted by political commercial interests. Substitute your own: “Hippocratic medicine,” “physician,” “free market medicine.”
- Become a physician leader and be a good role model for your colleagues for ethical practice that is centered on Do No harm and Fidelity to Trust.
- Read about medical ethics and reach your own conclusions: do not let experts interpret ethics for you.

My Ethical Default Position

- For me, Do No Harm is not just a guide for clinical decisions, it is also an expression of humility about the limits of what I can do as a physician.
- I find Do No Harm to be the easiest of all ethical values to interpret reliably: I can know when my interventions cause harm more readily than whether they do any good for my patients.
- Do No Harm rarely conflicts with Beneficence, Respect for Autonomy, or Commutative Justice.
- Do No Harm keeps my mind aligned with the virtue of Fidelity to Trust.
- Know your own ethical default position.