# The Business of Beneficence:
# The Commodification of the Patient–Health Care Provider Relationship

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF MINNESOTA
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

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June 2009

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**Acknowledgements**

First and foremost, I would like to thank my family for their unerring support. To my grandmothers, Mercedes Johnson and Phyllis Campbell, I send a heart-felt thanks for being such wonderful role models. My eldest brother, Sven, for his constant love and support. My sister-in-law, Amber, who has been on this path and always had words of encouragement and optimism for me. My brother, Bo, who always made me laugh and was a source of inspiration. Further, thank you to Bo for editing this work, which made writing it that much easier for me knowing that his keen eye would review the final version. And to my extended family, my aunts, uncles, and cousins, for their welcome embrace and love.

I would like to thank my friends at Plan B Coffee Shop, where most of this dissertation was written. Thank you for giving me a place to work, procrastinate, and feel at home. A special thank you to the employees: Brandon Rouse, Emily Hanson, Gina Harsevoort, Kirsta Johnson, and former employee Mike Browning. And most of all, thank you to Jolane Jones, the owner and my friend.

I would also like to thank my friends and collogues who helped me throughout my tenure in graduate school. Ramona Ilea, my mentor and office mate, for welcoming me into the program. Alana Yu, Tanya Rodriguez, and Kirsten Kringle, thank you for being excellent office mates. To Monica Janzen, Toben Lafrancois, Chung Lee, Kristen Houlton, Barton Moffat, Chuck Stieg, Jack Woods, Mike Rohde, Ian Stoner, Mark Herr, Lisa Hoelle, Yi Deng, Christopher Moore, and Maran Wolston – the best classmates and philosophers for whom a woman could ask. To Josh Kortbein and Nathan Gutt for their honesty, humor, and compassion. To Jovana Davidovic and her husband, Shea Brown, for their support and love, especially when I felt I did not deserve it. To all of my cohort, a special thanks and much love: Susan Hawthorne, Deepanwita Dasgupta, Matt Frank, Devora Shapiro, and Marilea Bramer. Matt has always been a pillar of strength. Devora is one of my closest friends, with whom I have gone through so much. And to Marilea, who always told me that anything was possible and helped me accomplish my dreams. To Matthew Brophy, who never let me rest on my laurels (in fact, he often felt compelled to tell me I did not have any). Thank you, Brophy, for your astuteness and 'tough love.'

Thank you to my professors for helping me see this through. Professor Gerise Herndon, Professor Larry McClain, Professor Sarah Kelen, and Professor William M. Draper Finlaw III were all sources of support and encouragement in my undergraduate years. I would also like to thank Professor Peter Heckman and Professor John Walker, my undergraduate philosophy professors, for their wisdom and direction. Mary Faith Marshall generously allowed me to review a draft of her paper for my application section, and she has been a wonderful mentor for me as I entered into the world of clinical medical ethics.

A special thank you to my dissertation committee members, Professor Ian Maitland, Professor Michelle Mason, and Professor B. Carl Elliott. And thank you to my truly magnificent, encouraging, and inspirational advisors, Professor Valerie Tiberius and Professor Debra DeBruin.

Finally, thank you to Nicadeamus, Dinky, Ozz, and Dakota – my fuzzy babies. And thank you to Tinsel and Niobe; I miss you.

**Dedication**

For my parents.

My father, whose admiration means so much, and whose character even Aristotle would envy. Thank you for your love and support, Pappa.

My mother, who always knew I would accomplish my dreams, even when I was unsure what those dreams were. I love you very much, Mommy Chick.

**Abstract**

I claim that the shift from viewing the patient–health care provider relationship from (A) one of a professional advocating for the welfare of his/her patient to (B) a business transaction is immoral because the primary motivations of the health care provider and the business person are fundamentally different. In support of this position, I offer two arguments. First, I argue that the patient–health care provider relationship is not a business relationship. Second, I argue that the patient–health care provider relationship cannot be altered in order to make this relationship into a business relationship without forcing the health care provider to act immorally.

In order to make these arguments, I illustrate two major points. First, viewing the patient-provider relationship as a business transaction results from a misunderstanding, either of the nature of a business interaction or of the fundamental principles of medical care. This mistaken understanding of the incapability of the two types of interactions leads to the false conclusion that the patient-provider relationship can be viewed as a business relationship. Second, it is immoral to attempt to alter the patient-provider relationship in order to make said relationship a business relationship because doing so necessarily eliminates the essential virtue involved in patient care, namely beneficence.

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**"We [health care professionals] are in the business of beneficence. It's our bread and butter." – Stuart J. Youngner[1]**

## Chapter One: Introduction

My dissertation presents two arguments. First, I argue that the claim that a patient–health care provider relationship is a business relationship is false. Second, I argue that the assertion that a patient–health care provider relationship can be successfully altered in order to be a business relationship is also false. Both of these arguments are based on my assertion that the shift from viewing the patient-provider relationship as (A) one of a professional advocating for the welfare of his/her patient to (B) a business transaction is immoral because the primary motivations of the health care provider and the business person are fundamentally different. A business person is motivated by maximizing profit in his/her interactions with consumers, while a health care provider must act as a fiduciary toward his/her patients. Health care providers ethically are obligated to utilize the virtue of beneficence in their role as fiduciaries, whereas beneficence is not required nor expected of the business person.

It has been clearly documented by both the medical and bioethics communities that medicine, for better or worse, has been treated increasingly as a commodity in the free market for approximately forty years. In 1963 Kenneth J. Arrow published an article analyzing medicine from an economic perspective.[2] Arrow points out that while health care is a type of market, it is not a traditional market. For instance, the patient, unlike an autonomous consumer, lacks information regarding the best possible treatment for his/her condition, and the patient's reasoning and integrity can be compromised because of the nature of his/her illness. The combination of the lack of specialized education required to make informed health care decisions and the vulnerability of the patient's integrity are Arrow's two biggest concerns for the understanding of health care as a market. Arrow also notes that the demand for heath care is erratic and that patients face multiple types of uncertainty when ill. All of these points lead Arrow to conclude that health care is a unique market, and that it should be regulated by professional and governmental forces.[3]

While Arrow's concluding remarks are cautionary in tone, the repercussions of his article did not reflect his concerns. With the passing of Medicare and Medicaid legislation in

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[1] Youngner, Stuart J. Ethics Consultation Service Case Review, Led by Dr. Youngner. Special Ethics Committee Conference. Riverside Park Plaza Auditorium, University of Minnesota Medical Center, Fairview, Minneapolis, MN. December 8, 2008.
[2] Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." *The American Economic Review*. Volume 53 (5), December 1963. 941 – 973.
[3] For a complete treatment of Arrow's work, see Chapter Two.

1965, there was suddenly an influx of money into medicine and health care, and instead of adopting a cautionary hand, the health industry used Arrow's article to further the view that medical care could be viewed as a market, one which now was flush with profit.[4]

In addition to the increase of health insurance, most notable Medicare and Medicaid, a number of other factors including, but not limited to, increase of cost for medical care, increased use of health insurance, variance among types of health insurance, the advent of health care savings accounts, increased cost-share between employers and employees in an attempt to drive down costs of medical care, etcetera, has shifted medicine further into the realm of a free market than ever before. One of the results of this shift is that it is no longer uncommon to view the patient-provider relationship as a business interaction, not unlike the relationship between an auto mechanic and a customer.

Regardless of how the commodification of the patient-provider relationship has arisen, I argue that viewing the patient-provider relationship as a business interaction should not occur for two reasons. Firstly, viewing the patient-provider relationship as a business transaction results from a misunderstanding either of the nature of a business interaction or of the fundamental principles of medical care. This mistaken understanding of the incompatibility of the two types of interactions leads to the false conclusion that the patient-provider relationship can be viewed as a business relationship. Secondly, it is immoral to attempt to alter the patient-provider relationship in order to make said relationship a business relationship because doing so necessarily eliminates the essential virtue involved in patient care; most conspicuously missing from a business understanding of the patient-provider relationship is beneficence on the part of the provider.

Most of the academic investigations done regarding these changes focus on the changes to medical care due to this shift, while very little is mentioned about the ethical ramifications of this alteration. My work concentrates on the essential moral components of the patient–health care provider relationship that are lost when the relationship is reduced to a business relationship. I shall argue that the virtue health care providers are morally bound to exhibit, beneficence, is lacking in a business interaction.

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[4] Relman, Arnold S. "The Health of Nations: Medicine and the Free Market." *The New Republic*. March 7, 2005. 23 – 30. Arrow himself viewed health care as a market, as I will explain in Chapter Two. While Arrow cautioned against treating health care as a classic market, he did argue that it was a type of market and that part of the commodity sought by patients was the patient–health care provider relationship. I will explain Arrow's position and why I object to his commodification of health care and the patient–health care provider relationship in Chapter Two.

A business interaction is loosely governed by the principle of *caveat emptor*, or "let the buyer beware." It consists of two rational individuals attempting to achieve their self-interested ends with as little sacrifice as possible. The consumer is solely interested in attaining the best product for the lowest price, while the merchant is attempting to maximize profit. A patient–health care provider relationship, on the other hand, is not one of mutual self-interest. The provider's first and foremost concern is to advocate for and attempt to secure the welfare of his/her patient. While the exchange of money (or goods) is central to the business model, it is irrelevant to the patient-provider model; the exchange of money is neither necessary nor sufficient to create a patient-provider relationship. For instance, all patients are granted access to federally funded emergency care regardless of their health-insurance status or ability to pay.

As I shall argue, the obligations of the health care provider that place him/her outside of the business world can be recognized as virtues, primarily the virtue beneficence, which is the virtue required of one acting as a fiduciary. Thus, virtue theory seems the best equipped moral theory to assess this particular dilemma precisely because of its reliance on virtues with which one morally evaluates both individuals and their actions. In the case of health care, a virtuous health care provider necessarily must act in accord with beneficence, which is clearly beyond the scope of a business relationship. Because of this, virtue theory allows us to easily delineate between virtuous and vicious health care providers, and utilizing the theory will allow me to further support my arguments.

My argument against the commodification of the patient-provider relationship will take the following form. In my second chapter, I will present an overview of Arrow's work on the possibility that health care can operate in the free market.[5] Arrow concludes that health care is a unique commodity because of the uncertainty unique to health care, which includes uncertainty as to when/if one becomes ill, uncertainty of the patient regarding treatment, and even uncertainty regarding the recovery time after being treated.[6] In order to highlight the uncertainty facing patients seeking health care for acute illness, I present an overview of studies done on what patients desire of their interactions with their health care providers. These studies verify Arrow's interpretation of the patient–health care provider relationship, as well as support my claim that patients rely heavily upon their health care providers when seeking health care.

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[5] Arrow. *Op. Cit.* note 2.
[6] Ibid. 959.

Patients view their health care providers as partners, and they trust that their providers will act upon their specialized education in assisting the patients in making health care decisions.

Arrow's work illustrates some of the special circumstances of patients, and I use his work as a basis for analyzing the patient–health care provider relationship. However, I make fundamentally different conclusions based on Arrow's investigation than he did. While Arrow advocates prudence in treating health care as a commodity, he does ultimately view health care and the patient–health care provider relationship as commodities. In part because of this, Arrow's article is often cited as the beginning of the commercialization of medicine and the commodification of health.[7] Unlike Arrow, I will argue that the circumstances of the patient and the uncertainty faced by the patient are what lead to the necessity of the health care provider to act as a fiduciary.

In Chapter Three, I address the contemporary view of the commodification of health care by reviewing four papers, two of which defend and encourage viewing health care under the free market, while two others present (somewhat limited) criticisms of the ability of the free market to encompass health care. The first paper I review approaches the issue of the commodification of health care from the perspective of "stakeholder capitalism,"[8] while the second paper I address argues that advancement in medicine and health care can only be maximized if health care is pushed fully into the free market.[9] I argue against both works and their implications that the patient–health care provider relationship would function more efficiently if it were treated solely as a business interaction. After presenting both of these works and my objections, I address two works that object, although in circumscribed ways, to the commodification of the patient–health care provider relationship. The third paper presents the claim that the moral norms of society dictate how that society distributes necessary human goods, including health care.[10] The fourth and final paper claims that the patient-provider relationship is essential to health care, and that the relationship should be the pivotal point to any investigation of how health care is provided to society as a whole.[11] The third and fourth paper support my argument that the patient–health care provider relationship is not, and should

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[7] Relman. *Op Cit.* note 4.
[8] Gilmartin, Mattia J. and R. Edward Freeman. "Business Ethics and Health Care: A Stakeholder Perspective." *Health Care Management Review*. Volume 27 (2), April 2002. 52 – 65.
[9] Capaldi, Nicholas. "The Ethics and Economics of Health Care." *Journal of Medicine and Philosophy*. Volume 30 (6), 2005. 571 – 578.
[10] Wildes, Kevin Wm. "More Questions than Answers: The Commodification of Health Care." *Journal of Medicine and Philosophy*. Volume 24 (3), 1999. 307 – 311.
[11] Andereck, William. "From Patient to Consumer in the Medical Marketplace." *Cambridge Quarterly of Healthcare Ethics*. Volume 16 (1), January 2007. 109-113.

not, be viewed as, a business interaction. I conclude the third chapter by outlining where the third and fourth papers leave off, and how I will then present my own position in the fourth and fifth chapters of my dissertation.

The essential component of Chapter Four is my illustration of why the patient–health care provider relationship cannot be viewed as a business relationship. I do this by first presenting both the historical account of the free market in addition to contemporary notions of the free market, including ‘stakeholder capitalism.’ I argue that regardless of one’s basis for understanding the free market, the consumer is an autonomous agent seeking his/her own conception of the good, while the business person is primarily motivated by maximizing profit. Neither the consumer nor the merchant are directly attempting to benefit the other party. In fact, both are attempting to maximize their end of the transaction.

While some business ethicists and economists argue that modern interpretations of the free market, including ‘stakeholder capitalism,’ are able to properly incorporate health care to the benefit of patients, health care providers, and society as whole, I counter that even ‘stakeholder capitalism’ relies on profit motivation on the part of the merchant, and that this motivation is unacceptable for health care providers who act as fiduciaries for their patients. In order to support the above claim, I discuss four significant problems with the position that ‘stakeholder capitalism’ can morally incorporate the patient–health care provider relationship. First, the underlying argument made by those who propose using ‘stakeholder capitalism’ as a model for health care is invalid. Second, the primary motivation is what is of importance when comparing business interactions with patient-provider interactions. Therefore the claim that there are similar outcomes in business interaction and the patient–health care provider relationship is irrelevant. Third, patients ought to be allowed to act upon their values in their interactions with health care providers, and it is not always possible for consumers to do so. Fourth, ‘stakeholder capitalism’ does not address Arrow’s ultimate concerns of uncertainty on the part of the patient.[12]

After criticizing the view that health care can and should be viewed as a subset of ‘stakeholder capitalism,’ I provide an overview of the patient–health care provider relationship, demonstrating the components of the relationship which makes said relationship unique: (1) the uncertainty of the patient, and (2) the expert knowledge of the provider. Because of these elements, the health care provider necessarily acts as a fiduciary; patients enter into a relationship with their providers trusting that the provider will work solely for benefit of the

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[12] Arrow. *Op. Cit.* note 2. For an overview of Arrow’s work, see Chapter Two.

patient rather than for profit, fame, legacy, etcetera. If this trust breaks down, the relationship suffers significantly. I conclude this presentation of the patient-provider relationship by showing that willfully ignoring the circumstances of the singular interaction of the patient–health care provider is tantamount to moral failure as a health care provider.

The final section of Chapter Four addresses a counter-argument to my position. The counter-argument contests that a health care relationship is comparable to a business relationship, and, in fact, sometimes business relationships are superior to the patient-provider relationships. Proponents of this position present examples of merchants who treat their customers with the respect, dignity, care, and generosity that some health care professionals lack. I respond that there are two reasons this argument fails: 1) it misinterprets the primary aim of the merchant, and 2) it confuses acts done out of friendship with standard business interactions. The similarities upon which the counter-argument focuses are actually superficial. The fiduciary nature of the patient–health care provider relationship is not replicated in even the most caring, considerate business interaction. The factor that is essential to the health care relationship is beneficence, and this is missing from even exemplary business relationships.

In Chapter Five I address the way to properly understand the characteristics of the patient–health care provider relationship I present in Chapter Four. Chapter Five begins with a review Aristotle's work, Nicomachean Ethics.[13] Aristotle argues that only when one achieves the fully virtuous life will one act appropriately in any given situation. This means that one will feel the right emotions, in the right amount, at the right time, and act in the right way. I additionally will discuss a contemporary interpretation of the theory. My outline of the theory is followed by a presentation of two recent applications of virtue theory – one to relationships and one to a profession. The first utilizes virtue theory in order to understand humans' responsibilities based on their relationship with the environment. The second applies virtue theory to the profession of law enforcement. These two works will provide a framework for understanding how to one can apply virtue theory to modern issues and professions, a framework I employ in applying virtue theory to the patient–health care provider relationship in section four of the fifth chapter.

In section four of Chapter Five, I argue that the particular virtue of character required of health care providers is beneficence. While this virtuous character trait is required for all individuals who are attempting to achieve the fully virtuous life, it is of particular importance

[13] Aristotle. Nicomachean Ethics. Second Edition. Translator: Terence Irwin. Hackett Publishing Company: Indianapolis, Indiana. 1999.

for those working within the field of health care. This is because beneficence is required of those acting as fiduciaries. While this may seem to create a tense interface between patient autonomy and the role of fiduciary, I point out that leaving behind paternalism and embracing patient autonomy cannot truly occur unless the health care provider acts as a fiduciary and utilizes the virtue of beneficence. Health care providers must act for the best interest of their patients. Respecting patient autonomy only further mandates that health care providers act with beneficence in their interactions with patients. To change the patient–health care provider relationship to a business interaction, or to insist that health care providers *should* treat the patient–health care provider relationship as a business interaction, is to demand that health care providers act viciously.

The conclusion of Chapter Five addresses a counter-argument brought to the forefront by the television show *House, M.D.* This counter-argument claims that the virtues required of a health care provider are actually vices in every day life. I responded to this objection in two ways: first, being a virtuous person means knowing how to properly apply the virtues in specific circumstances, and second, the virtues of character and virtues of intellect do not vary from person to person, or from professional life to personal life. Thus, the counter-argument that a virtuous health care provider has character traits that commonly are viewed as vices is not sound.

The final chapter, six, will present a case study for illustrating the ramifications of my understanding of the patient–health care provider relationship. This case study highlights the fragility of the patient-provider relationship and the implications of utilizing the virtue of beneficence for the health care provider. This application will also further support my ultimate argument that the patient–health care provider relationship is not a business relationship. The health care provider is morally required to treat his/her patient in a beneficent manner, which is not a part of a business interaction.

## Chapter Two: Arrow, Uncertainty, and Patients' Desires in Decision Making

### *I. Introduction*

The first published work that analyzed health care as a market was presented in 1963 by Kenneth J. Arrow who wrote an article reviewing the ability of the free market to account for and predict behavior within health care.[14] As previously mentioned, Arrow's comprehensive piece continues to be drawn upon by contemporary writers from numerous fields, ranging from those who would treat health care as a simple commodity to those who share my position, specifically that the patient–health care provider relationship ought not be treated as a business interaction. Therefore, in order to understand the current controversy regarding the commodification of the patient-provider relationship, it is important first to review Arrow's work.

In this chapter, I review Arrow's main position, focusing on the four elements of health care he feels make health care a unique commodity:

1. The demand of health care is erratic compared to consumption of other goods.
2. The behavior of the health care provider is not dictated by free market norms.
3. The knowledge of the required health care treatment for any given illness is significantly unequal between the patient and the provider.
4. Entry into the field of health care is heavily restricted.

These four points, Arrow argues, supports his claim that health care is a unique commodity, and that the patient–health care provider relationship, while not a standard business interaction, is still a type of commodity. This 'commodity' is part of what patients purchase when they seek out health care, particularly acute health care.

Subsequent to presenting Arrow's argument, I examine how contemporary patients view the patient–health care provider relationship. Recent studies on this issue highlight patients' desire to partner with their health care providers in making health care decisions. Patients seldom wish for their health care providers to take full control of patient care, but patients do rely heavily on their health care providers to present treatment options, the risks and benefits of those treatment options, and the providers' expert opinion on the best treatment available. From this literature, one can deduce that while patients do seek out health care providers due largely to the types of uncertainty Arrow explicates in his article, patients do not view their interactions with their providers as a business interaction, contrary to Arrow's

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[14] Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." *The American Economic Review*. Volume 53 (5), December 1963. 941 – 973.

conclusion. Patients generally do not seek out the 'commodity' of health care, or the 'commodity' of the patient-provider relationship. Patients commonly view their relationship with their providers as a partnership, one in which all participants are focused on achieving the best health outcome for the patient.

My presentation and review of Arrow's work and the contemporary notions of patients about the nature of the patient-provider relationship is then followed in the next chapter with a review of four contemporary articles that address, in varying ways, Arrow's position that the free market is able to encompass health care. Because these contemporary works rely heavily on a shared notion of health care as a human good and the possibility that this good is a commodity, it is first necessary to review the work that began this particular strand of argumentation.

*II. Economic Theory and Health Care: Arrow*

As mentioned above, one of the first comprehensive investigations into the compatibility of the free market and health care was published by Kenneth J. Arrow in 1963.[15] In his work, Arrow outlines four[16] issues that distinguish health care from other commodities.

1) The demand for health care is erratic.
2) The behavior of the health care provider is not dictated by free market norms.
3) Knowledge is significantly unequal between the patient and the provider.
4) Entry into the field of health care is restricted.[17]

I will address these four points in turn in the following paragraphs.

*A. Arrow's Four Main Points*

*1) The demand of health care is erratic compared to predictable consumption of other goods.*

Arrow, addressing the issue of health care consumption from the perspective of the individual consumer, argues that the consumption of health care is erratic. Arrow notes that there are there are three types of health care: preventative, chronic, and acute. He claims that while preventative and chronic care are both somewhat predictable, acute health care is not. Arrow points out that acute health care is needed only when there is a "departure from the normal state of affairs."[18] This is what positions acute health care in a unique subset of

[15] Arrow. *Op. Cit.* note 14.
[16] Arrow included a fifth area of concern in his work (pricing) that is now outdated.
[17] Arrow. *Op. Cit.* note 14. 948.
[18] Ibid. 948.

commodities. Unlike clothing or food,[19] there is no way to completely prevent or predict the need for health care. Acute health care is more closely associated with other commodities needed on an emergency basis, such as damage repair after a natural disaster. While it is not uncertain when one needs a gallon of milk, it is uncertain when one will need acute health care services, much like it is uncertain when one needs to call a plumber for a clogged drain.

However, unlike other commodities sought out on an emergency basis, such as fixing a broken pipe, there are additional concerns at stake when one seeks out health care for acute illness. Particularly, as Arrow notes, when acute health care is required, the patient's personal integrity is compromised. In serious cases of illness, one's personal integrity, including one's physical, mental, and emotional well-being, is weakened. The patient's life may even be at risk. Often the patient's capacity to work is limited, and the health care the patient seeks is required in order to avoid further loss of work. For Arrow, this last point is big a concern, as is the unpredictability of the call for health care; not only is the need for acute health care unpredictable and unavoidable, there is a risk that the individual will no longer be able to provide for him/herself. If the patient's integrity is not sufficiently restored, it is possible that the patient will not be able to regain his/her social autonomy.[20]

*2) The behavior of the health care provider is not dictated by the standard free market norms.*

Arrow explains that the health care 'commodity' can be both a physical product and an activity on the part of the provider. This is not unique to health care. Child-care, for instance, is similar in that one is purchasing a service from the person who is providing that service. However, it is important to keep in mind that the activity of the health care provider is part and parcel to the 'commodity' of health care. Arrow explicates a number of ethical demands placed on the health care provider which directly affect the type of 'good' that the patient then purchases. The most important of these ethical demands is that the health care provider is morally obligated to act in the best interests of the patient.

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[19] These are the standard goods Arrow uses for comparison. I address these types of goods, which are often referred to as 'austere goods,' in comparison to health care in later sections.

[20] Arrow. *Op. Cit.* note 14. 949.

The assaults on personal integrity that Arrow finds most concerning include 1) a risk of impairment, and 2) a risk of death. I address Arrow's worry about personal integrity in the third section of this chapter.

Social autonomy, for Arrow, means that the individual is able to provide for him/herself by earning an income. If one becomes so ill that one is unable to return to work, then one no longer has social autonomy. This possibility that the individual will not be able to reenter the workforce is yet another piece of uncertainty.

Arrow illustrates in his work that the provider is expected to act in the best interests of his/her patient: "[The provider's] behavior is supposed to be governed by a concern for the customer's welfare which would not be expected of a sales[person]."[21] There is a great deal of trust placed in the health care provider, much more so than most other providers of services. Arrow provides examples of practical behaviors within the field of health care that illustrate the unique nature of health care: advice giving by the provider is devoid of self-interest; the patient's treatment is dictated by an objective understanding of the health of the patient; the health care provider is viewed as a health expert not only by the individual patient, but also by the community at large; and patients generally prefer to be treated by the same providers over a long period of time.

Overall, the health care provider acts as a fiduciary[22]. The provider's actions are guided by the well-being of the patient, not the provider's self-interest. The patient acts based on his/her trust in his/her provider. This certainly does not imply nor require the patient to merely submit to the dictates of his/her provider. Being a fiduciary does not demand that a provider act with paternalism toward his/her patient.[23] The patient can and should be treated as an autonomous, rational being, capable of making his/her own choices. However, Arrow correctly points out that in order to make those choices, the patient relies heavily on his/her provider and trusts that his/her provider is motivated and governed solely by the best-interest of the patient.[24]

3) *The knowledge of the required health care treatment for any given illness is significantly unequal between the patient and the provider.*

As briefly mentioned above, it is the skilled care of the health care provider that the patient is actually 'purchasing.' Arrow explains that, standardly, consumers rely on previous experience or word-of-mouth to make informed choices about goods and services, and they are even able to do research on the products of their choice if they so desire. However, this is not the case in health care. The health care provider is expected to have special knowledge that is

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[21] Ibid. 949.
[22] 'Fiduciary' here is used in the health care sense; it does not imply a business fiduciary relationship. The term, in the sense of a proper patient-provider relationship, implies that the patient trusts that the provider will act in the patient's best interest. The full nature of the fiduciary relationship between the patient and the health care provider is addressed further in both Chapter Four and Chapter Five.
[23] In Chapter Five, I further argue that the interaction between the fiduciary nature of the health care provider and the call for patient autonomy can be resolved without the health care provider acting with paternalism toward his/her patient. In fact, paternalism is immoral on the part of the health care provider.
[24] Arrow. *Op. Cit.* note 14. 949. In Chapter Four I briefly review what patients expect of their health care providers in regard to providing information and advice.

not available to the patient, and it is this information that is at least a part of the 'commodity' being sought. The patient seeks out the care of a health care provider because the provider has special training and information, and the provider is therefore able to diagnose and treat the patient's illness.

One might argue that this has changed significantly since Arrow published his article; it is possible now to do research on one's illness and treatment options via the internet just as one might investigate different car manufacturers or insurance companies. For example, one can 'diagnose' one's illness using the internet.[25] Then, one can go on to review treatment options, including success rates, side effects, and cost of care. Given this glut of information, it may seem that Arrow's concern is outdated.

I respond that while one may be able to do a preliminary investigation regarding one's illness, doing this is not enough. Just as was the case when Arrow wrote in 1963, one must still seek a formal diagnosis from a health care provider, especially if treatment for the condition is by prescription. While an on-line diagnostic page may lead me to suspect that I have rheumatoid arthritis (I have pain in my ankles that comes and goes, and it was not caused by injury), I still must see a health care professional to confirm my suspicions and get the treatment I need. While the gulf of knowledge between patient and provider may have shrunk in the past forty years, I maintain that health care providers are still sought out for their training and expertise. This claim is supported by the studies I review in the next section of this chapter; patients rely heavily upon their health care providers for expert information regarding illness and treatment. As the studies I review show, Arrow's point is still correct: the information that a patient has is significantly less than that of the health care provider, and this is acknowledged by both the patient and the provider at the outset.

4) *Entry into the field of health care is heavily restricted.*

In most cases, the supply of a product is not formally regulated. Further, there are no legal restrictions on who can enter into a field or sell a particular good. Only when the quality of the good is a great enough concern, or when specific education is required in order to supply the good, is entry into the field limited. Because health care is a 'product' of concern and because it requires a great deal of education to become a health care provider, entry into a health

[25] http://familydoctor.org, for example, offers a 'search by symptom' option on its homepage.
Of course not all sources of information on illness and diagnosis are reliable. As I mention in the following paragraph, one website indicates that I might have rheumatoid arthritis, from which I do not in fact suffer.

care education program is limited and costly, and entry into the health care professions is regulated by licensing.[26] This, of course, is true of other professions as well, including the legal profession. Likewise, licensing is required for many construction related jobs, such as plumbing, roofing, and electrical work. Much like the legal profession, health care education is lengthy and costly. However, licensing for other fields, such as plumbing, is not nearly so costly, although it is as lengthy as other types of professional education.[27] What is similar in all professions is that education and some type of licensure is required. Further, there is often a requirement of continuing education. This is true of health care professionals as well, and this departure from the norm of the free market raises questions regarding how 'free' the market in question actually is. It is precisely this question that Arrow notes in his work.

*B. Summary and Review of Arrow's Argument*

Arrow's ultimate conclusion is that health care is a unique market essentially due to uncertainty. Uncertainty, according to Arrow, arises in many forms in health care, but it always results in the inability of market norms to predict the use and precise nature of acute health care. Arrow's broadly defined uncertainty includes: uncertainty regarding when/if one becomes ill, uncertainty on the part of the patient regarding the required treatment for various illnesses, and even uncertainty regarding the recovery time after being treated.[28] Arrow concludes his work with an in-depth discussion of possible types of insurance individuals might want, given the high level of uncertainty regarding health and a note regarding the special nature of the patient-provider relationship. He prophetically notes that chronic illness and maternity are special circumstances even within the problematic economic market of health care. Chronic illness and maternity require costly health care for which individuals will certainly wish to insure themselves. However, individuals who already exhibit symptoms of chronic illness or are already pregnant will find it next impossible to get heath insurance to cover those particular health care needs.[29] His elaboration on the patient-provider relationship notes that trust and delegation are required. Patients simply are unable to know what type of treatment is required, and they must trust that their providers will be acting in their best interest. Further, Arrow

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[26] Arrow. *Op. Cit.* note 14. 951.
[27] In Minnesota, there are exams for the various levels of plumbing licensure, and a four year apprenticeship is required for starting in the plumbing profession. See: http://www.doli.state.mn.us.
[28] Arrow. *Op. Cit.* note 14. 959.
[29] Ibid. 963.

claims physicians' *social* obligation to provide the best practice available is "part of the commodity the physicians sells."[30]

Arrow's work clearly presents health care as a unique market (if a market at all). His work is thorough in the sense that it presents a number of caveats that even medical ethicists do not always recognize. First, he notes in his introduction that 'health' is not the commodity he is investigating, but rather that he is focusing on 'health care,' since health has a number of factors as important as health care, including poverty, nutrition, shelter, and sanitation.[31] Second, he clearly states that public health is integral to understanding health of individuals, and that it is possibly more important to understanding and maintaining health than acute health care for individuals.[32] More significantly than the above, Arrow illustrates the specific issues in health care which separates it from other markets. His tone is cautionary regarding the possibility of providing different types of health insurance, and how those types of health care insurance can and can not be implemented.

Unfortunately, even while Arrow is thorough and cautionary, he ultimately views not only health care provided to patients but also the relationships established between patients and providers as commodities. Arrow describes patients as 'purchasing' health care from informed providers, and providers 'selling' a social obligation to individuals and the community as a whole. Arrow's article has been cited as the beginning of the era of commercialization of medicine and the commodification of health.[33] While this may or may not have been his intention, his work did pave the way for other economists and business theorists to take seriously the possibility that health care could be bought and sold on the free market, and that part of the commodity purchased was the patient-provider relationship. It is his commodification of the patient–health care provider relationship and the social obligations of providers that I find especially disconcerting. This trend of commodification of the patient–health care provider relationship continues to be presented seriously in contemporary articles that review health care, and many offer arguments encouraging society to continue to shift health care into the free market. It precisely this commodification of the patient–health care provider relationship against which I argue. In order to support my position that it is immoral to

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[30] Ibid. 965. It is unclear why Arrow deemed this social obligation a commodity (or even part of a commodity) instead of an ethical obligation that was outside the realm of commodification.
[31] Ibid. 941.
[32] Ibid. 954.
[33] Relman, Arnold S. "The Health of Nations: Medicine and the Free Market." *The New Republic*. March 7, 2005. 23 – 30.

commodify the patient-provider relationship, I provide information regarding what patients actually desire in their interactions with providers in the following section.

*III. Patient Uncertainty and Health Care Decision-Making*

One of the important issues Arrow's work highlights is that patients face much uncertainty when they are acutely ill. The three forms of uncertainty which I find factor most heavily into the patient–health care provider relationship are: 1) patients have a basic level of uncertainty regarding when they might need to use health care or visit a health care provider; 2) patients face uncertainty regarding what services they need, what their illness is, and how it should be treated; 3) patients have uncertainty regarding the likelihood that they will recover, the time it will take to fully recover, and even if a full recovery is possible. Thus, patients lack knowledge in their relationships with health care providers, and patients have some (varying) level of vulnerability due to their illness. All of this uncertainty leads to a relationship in which the balance of power is drastically unequal. The patient lacks expert, medical knowledge and relies on the provider to share this information and act in the patient's best interest in the process of diagnosing the illness, providing treatment options, aiding in making treatment decisions, and treating the patient.

Arrow's point that patients are a vulnerable population is an important aspect that weighs heavily on the patient–health care provider relationship as well. In fact, Arrow claims that the very nature of illness may debilitate the patient's ability to fully reason and make choices which are in the patient's best interests. This can be due to the nature of the patient's particular illness (e.g., the classic case of an illness causing coma), but it can also be due to pain and suffering on the part of the patient (e.g., the significant pain and physical suffering which comes with passing a kidney stone), and even fear and insecurity on the part of the patient (e.g., the fear and insecurity that arises when one is diagnosed with a life-threatening form of cancer). The uncertainty of the patient, the degree to which the patient's reasoning is debilitated, and the vulnerability of the patient varies greatly depending on the life experiences of the patient (e.g., if the patient has been diagnosed and treated for this particular ailment previously) and the particular illness from which the patient is suffering. For instance, there is little physical suffering and emotional stress when a patient is ailing from a low-grade bladder infection while there is great pain, suffering, and emotional stress when the patient is diagnosed with multiple sclerosis.

While this uncertainty, vulnerability, and lack of expertise on the part of the patient does not necessitate that the health care provider act in a paternalistic manner toward the patient, these factors are all central to the relationship between the patient and the provider. One patient may want his/her health care provider to present detailed information regarding the patient's illness and treatment options, while another patient may wish to have little information. Patient A may wish to make the final choice regarding treatment, while patient B may rely more heavily on his/her provider for advice and even allow the health care provider to make the finial treatment decision. None of this indicates that a patient should not provide informed consent to the treatment. However, it does raise questions about the type of interactions patients actually desire in the realm of health care.

The issues Arrow notes in his seminal work in conjunction with a shift to patient-centered care and patient autonomy begs a number of questions: how do patients view their relationships with their health care providers, and how do patients wish to interact with their providers? Fortunately, there have been many studies done on patients' preferences regarding their relationships with their providers, including how much information patients wish to have regarding their illness, the available treatment options, and how patients prefer to make ultimate decisions regarding treatment for their diseases. In the following paragraphs, I address a few of the issues raised by Arrow's position on the nature of the patient–health care provider relationship, and how contemporary patients view these concerns and the patient-provider relationship itself.

*A. "The Activated Patient: Dogma, Dream, or Desideratum?"*

In 1987, Steele *et al.* published a review of studies conducted in the late 1970s and early 1980s regarding the issue of 'the activated patient.'[34] Their paper, "The Activated Patient: Dogma, Dream, or Desideratum," discusses the then contemporary goal of patient-physician relationships. This was what the authors term 'the activated patient.'[35] An activated patient is one who does not passively interact with his/her health care provider. The patient instead asks questions in order to receive full explanations, clearly states his/her preferences in treatments and outcomes, and generally wishes to be fully informed and make the ultimate choices about his/her health care. This view of the patient places a great deal of emphasis on involving the patient in his/her health care with the ultimate goal of ensuring patient satisfaction and

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[34] Steele, David J., Barry Blackwell, Mary C. Gutmann, and Thomas C. Jackson. "The Activated Patient: Dogma, Dream, or Desideratum?" *Patient Education and Counseling*. Volume 10, 1987 (1). 3 – 23.
[35] Ibid. 4.

adherence to treatments. Steele *et al.*, however, view this as an ideological view of the patient-provider relationship, and they articulate in their paper that the research done provides little support for this idealized view of the patient-provider relationship. They claim that this lack of support on the part of the researchers proposing the activated patient model is due to poorly designed studies of the patient-provider relationship, which often are not rigorous, are "conceptually weak,"[36] and have flaws in methodology. The goal of their work is to place this new view of 'the activated patient' in a broader historical context in addition to reviewing the research done to support this view of the patient-provider relationship.[37]

Steele *et al.* compile a list of six ultimate conclusions from their review of the research done on the patient-provider relationship.

1. Patients in general want to be informed about their illnesses and the treatment options available to them.
2. Information that permits patients to anticipate and prepare for an experience can be a potent resource for coping with the distress and discomfort of illness and treatment.
3. Information interacts with patients' preferences and personality traits in producing outcomes. More information is not always better than less.
4. While there is evidence that some patients desire an active role in decision making and may benefit from such a role, there is little evidence that this is sought by most patients in most situations.
5. The links between patient autonomy and clinical outcomes tend to be weak, ambiguous, or mediated by unexamined variables.
6. Clinicians are often poor judges of patients' information needs and participation preferences.[38]

The authors further claim that the existing evidence does not support a broad application of 'the activated patient' model of patient care and the subsequent required changes to the patient-provider relationship. The evidence the authors do review shows not only that the desires of the patients vary from patient to patient, but also that the desires of particular patients vary over time. For instance, patient A might wish for greater control over his/her health care when he/she is seeking preventative care, but if patient A becomes acutely ill with a life-threatening disease, patient A might desire for the health care provider to share the diagnosis, treatment options, and the provider's opinion regarding the best available treatment protocol, but this patient, who had historically made his/her own choice about health care, might wish to simply

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[36] Ibid. 4.
[37] Ibid. 4.
[38] Ibid. 19.

cede the decision in this case to his/her provider. Knowing that this is possible (and might even be likely to happen), Steele *et al.* state that:

> [c]linicians should therefore actively elicit and strive to understand their patients' perspectives and formulate approaches to treatment that are congruent with these perspectives. Clinicians must also recognize that patients' situations are not static. Needs and preferences change and these changes should be assessed and incorporated into individualized treatment programs.[39]

Steele *et al.*'s work published in 1987 laid the ground for further research to be done on patient-provider interaction in the following two decades, some of which I review in the following paragraphs.

*B. "Decision Making During Serious Illness: What Role Do Patients Really Want to Play?"*

Lesley Degner and Jeffery Sloan published a study on patient preferences in making decisions regarding critical illness in 1992.[40] They surveyed 436 recently diagnosed cancer patients and 482 members of the general population regarding treatment decisions for life-threatening disease. They compare results of what generally healthy patients predicted their desired roles in treatment decision making would be with the desired roles of patients who have been recently diagnosed with cancer.[41] Degner and Sloan divide the possible interactions with health care providers regarding treatment decisions in the following five areas:

> A. I prefer to make the final selection about which treatment I will receive.
> B. I prefer to make the final selection of my treatment after seriously considering my doctor's opinion.
> C. I prefer that my doctor and I share responsibility for deciding which treatment is best for me.
> D. I prefer that my doctor makes the final decision about which treatment will be used, but seriously considers my opinion.
> E. I prefer to leave all decisions regarding my treatment to my doctor.[42]

(A) and (B) are considered to be "active roles" (on the part of the patient) by the authors. (C) is termed a "collaborative role," while (D) and (E) are said to be "passive roles."[43]

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[39] Ibid. 20.
[40] Degner, Lesley F. and Jeffery A. Sloan. "Decision Making During Serious Illness: What Role Do Patients Really Want to Play?" *Journal of Clinical Epidemiology*. Volume 45 (9), 1992. 941 – 950.
[41] Ibid. 941.
[42] Ibid. 943.
[43] Ibid. 943.

Of the cancer patients, only 12% of respondents preferred an active role in decision making regarding treatment; 29% opted for a collaborate role, and 59% chose a passive role. Members of the general population, on the other hand, leaned toward active roles in decision making; 64% preferred an active role, 27% wanted a collaborative role, and only 9% opted for a passive role. The authors also investigated how both cancer patients and the general population wished for treatment decisions to be made on their behalf if they were incapacitated.[44] Of the cancer patients, 10% wished for their family members to have "dominant" role in decision making; 51% of cancer patients wished for family members and the physician to share the role in making treatment decisions, and 39% chose for the physician to have "dominant control of treatment decisions." The general population chose for family to have control over treatment decisions 40% of the time; 46% stated that they wished for shared control, and 9% wished for their physician to have dominate role in decision making.[45] Degner and Sloan found that age, education, and gender were all related to preferences regarding making treatment decisions, while age was the "most important predictor of preferences."[46]

The authors noted in their discussion that the findings of their study they found most striking were 1) the high percentage of cancer patients who wished to play a passive role in treatment decision making, and 2) that this high percentage was not replicated in the general public's predication of their own preference in a life-threatening situation. Degner and Sloan noted that their findings were in contrast to other previous studies done on this particular issue. Degner and Sloan had a higher percentage of cancer patients opt for a passive role than two previous studies. Degner and Sloan explained that part of the discrepancy between their work and previous surveys might be due to the options made available to the respondents. Degner and Sloan provided five options on their surveys regarding treatment decision making where as other previous studies only provided two options: "I prefer to participate in decisions about my medical care and treatment" and "I prefer to leave decisions about my medical care and treatment up to my doctor."[47] Two other possibilities for the differences in finding between Degner and Sloan's work compared to the other two works include 1) difference in time between the diagnosis of cancer, and 2) cultural differences – Degner and Sloan conducted their

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[44] Tia Powell discusses decision making for cognitively impaired patients in "Voice: Cognitive Impairment and Medical Decision Making." Her narrative and overview of studies done on this issue is of importance for those who wish to seek further information on this issue. Powell, Tia. "Voice: Cognitive Impairment and Medical Decision Making." *The Journal of Clinical Ethics*. Volume 16 (4), Winter 2005. 303 – 313.
[45] Degner and Sloan. *Op. Cit.* note 40. 945.
[46] Ibid. 947.
[47] Ibid. 948.

survey in Canada while the other previous studies were conducted in the United States. The difference between healthy respondents and cancer patients in preferences of control over treatment decisions was consistent with previous studies.[48]

The results of the Degner and Sloan study are notable both in themselves and in reference to Steele *et al.*'s work on 'the activated patient.' While the general population often indicates that they would wish to retain control in treatment decision making in the face of life-threatening illness, this is not found to be the case in populations of recently diagnosed cancer patients. As Degner and Sloan state in their discussion, "patients newly diagnosed with a serious illness such as cancer are unlikely to seek an active role in selecting their medical treatment."[49] Degner and Sloan claim that making individual assessments in preferences is essential for proper division of control over treatment decision making.[50] This clearly needs to be reassessed even by providers treating patients over a long period of time given that preferences seem likely to change when a life-threatening illness is diagnosed.

*C. "What Role Do Patients Wish to Play in Treatment Decision Making?"*

A study asking similar general questions to those posed by the Degner-Sloan research was published by Raisa Deber, Nancy Kraetschmer, and Jane Irvine in 1996.[51] Deber *et al.* formulated their research, however, by piecing out decisions about particular problems and decisions about ultimate outcomes, which are often based on personal values. The authors claim that while patients do wish for their health care providers to take control over particular problem solving tasks, patients desire to remain involved (and even have ultimate control over) decision making.[52] Problem solving tasks, according to this study, include when or whether to perform particular diagnostic tests, determining possible treatment options, assessing possible risks and benefits of treatments options, and the likely outcomes from the available treatments. Decision making included determining which risks and benefits were acceptable to the particular patient and ultimately deciding which treatment should be pursued (e.g., what should

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[48] Ibid. 949.
[49] Ibid. 949.
[50] Ibid. 949.
[51] Deber, Raisa B., Nancy Kraetschmer, and Jane Irvine. "What Role Do Patients Wish to Play in Treatment Decision Making?" *Archives of Internal Medicine*. Volume 156 (13), July 8, 1996. 1414 – 1420.
[52] Ibid. 1414.

be done for this particular patient).[53] The control over either problem solving or decision making was divided into five possible responses:

1. Doctor Alone
2. Mostly the Doctor
3. Doctor and You Equally
4. Mostly You
5. You Alone[54]

The authors then divided these five responses into three categories. Responses (1) and (2) were situations in which patients "Hand Over" control to their providers. Response (3) was "Shared" decision making, whereas (4) and (5) "Retain" control.[55]

Deber *et al.* found that among 300 patients they surveyed, patients preferred for the health care provider to retain control over problem solving issues at a rate of 78.3%. 20.1% wished for control over problem solving to be shared with their health care provider, and 1.6% opted to retain control over problem solving. When questioned about decision making, only 22.3% would hand over control to their health care provider, 47.7% wanted to share control over decision making with their provider, and 30.0% wanted to retain control over decision making.

The authors point out in their discussion that merely studying 'patient participation' (in regard to participation in the patient-provider relationship) is misleading and even creates further confusion in understanding patient preferences. According to Deber *et al.*, patients do wish to rely heavily on their providers regarding problem solving due to the sheer body of knowledge that the providers have and patients lack. This does not indicate, however, that patients similarly wish for their health care providers to make ultimate decisions regarding treatments.[56] Deber *et al* emphasize that the patient–health care provider relationship should focus on the values of the patient, and that it should base informed consent on the patient's education level and understanding of situation at hand. The provider's expertise is highly valued by the patient, and proper communication between the patient and the health care provider will ensure that the patient's needs and values will be respected throughout the tenure of the patient-provider relationship.[57] Deber and Kraetschmer investigate their findings in this study further in an article they co-wrote with Sara Urowitz and Natasha Sharpe in 2007. I discuss this work later.

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[53] Ibid. 1418.
[54] Ibid. 1417.
[55] Ibid. 1420.
[56] Ibid. 1418.
[57] Ibid. 1420.

*D. "Patient Preferences for Medical Decision Making: Who Really Wants to Participate?"*

In 2000, Neeraj Arora and Colleen McHorney published a study utilizing a four-year observational study of over 2,000 patients, each of whom suffered from one of the following chronic diseases: hypertension, diabetes, myocardial infarction, congestive heart failure, and depression.[58] The observational study posed the following statement: "I prefer to leave decisions about my medical care up to my doctor," and allowed patients to respond on a five point scale:

(1) strongly agree
(2) agree
(3) uncertain
(4) disagree
(5) strongly disagree[59]

Those patients who chose (1) or (2) were termed by the authors as "passive" in decision making. Patients who selected (4) or (5) were termed "active." Any patient who selected (3) was excluded from the study.[60]

Arora and McHorney found that 69% of their patient population preferred a passive role in decision making, but that the patients varied greatly regarding their wish to participate depending on their characteristics. For example, younger patients, patients with higher education, and patients with less severe illnesses all were more likely to prefer to be active in decision making. The authors also found that those patients who more highly valued their health preferred a passive role in decision making. Arora and McHorney noted that their results were supported by a number of previous studies done on patient participation in decision making.

The limitations of the study highlighted by the authors was that their researched utilized only one question regarding the desires of the patient to participate in decision making, and that the survey from which the authors extracted their data was a single survey, and thus would not track patients' preferences over time. They also note that health care providers are likely to be inaccurate in their predictions of patients' desires regarding decision making.[61]

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[58] Arora, Neeraj K. and Colleen A. McHorney. "Patient Preferences for Medical Decision Making: Who Really Wants to Participate?" *Medical Care*. Volume 38 (3), March 2000. 335 – 341.
[59] Ibid. 336.
[60] Ibid. 336.
[61] Ibid. 339. For research and discussion of patients' accuracy when self-describing participation in decision making, see: Arora, Neeraj K., John Z. Ayanian, and Edward Guadagnoli. "Examining the

*E. "Do People Want To Be Autonomous Patients? Preferred Roles in Treatment Decision-Making in Several Patient Populations"*

The final study I discuss is one I previously mentioned. It was conducted by Raisa Deber, Nancy Kraetschmer, Sara Urowitz, and Natasha Sharpe.[62] This study was set up in much the same way Deber and Kraetschmer organized their previous study; the focus was the role patients wish to have in treatment decision making (as opposed to problem solving). The authors surveyed 12 populations of patients. The patients were being treated for: breast cancer, prostate disease, fractures, continence, orthopaedics (sic), rheumatology, multiple sclerosis, HIV/AIDS, infertility, benign prostatic hyperplasia, or cardiac disease. In addition, 50 healthy nursing students were also surveyed. The respondents were posed two different vignettes, one posing chest pain and one utilizing the respondents' current health status.[63]

Deber *et al.* found that only 1.0% of their study population wished for a totally autonomous role in treatment decision making.[64] The highest percentage preferring to make treatment decisions totally autonomously in both the current health status scenario (5.0%)[65] and the chest pain scenario (2.0%)[66] was found in the patients being treated for prostate disease. Similarly, few respondents preferred a totally passive role in treatment decision making. 20.4% of the study population opted for totally passivity in the current health scenario, while 33.9% opted for passivity in the chest pain scenario. In both scenarios, breast cancer patients had the highest rate of preferring a passive role in decision making: 35.5%[67] in the current health situation and 55.8%[68] in the case of chest pain. The highest rate of preference in both vignettes was a shared role in treatment decision making. In the current health status vignette, 78.1% of the respondents chose this response,[69] while 65.2% of respondents chose to share treatment

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Relationship of Patients' Attitudes and Beliefs with Self-Reported Level of Participation in Medical Decision-Making." *Medical Care*. Volume 43 (9), September 2005. 865 – 872.

[62] Deber, Raisa B., Nancy Kraetschmer, Sara Urowitz, and Natasha Sharpe. "Do People Want To Be Autonomous Patients? Preferred Roles in Treatment Decision-Making in Several Patient Populations." *Health Expectations*. Volume 10 (3), September 2007. 248 – 258. These authors conducted another interesting survey prior to this which studied the nomenclature patients' preferred. See: Deber, Raisa B., Nancy Kraetschmer, Sara Urowitz, and Natasha Sharpe. "Patient, Consumer, Client, or Customer: What Do People Want To Be Called?" *Health Expectations*. Volume 8 (4), December 2005. 345 – 351.

[63] Deber, Kraetschmer, Urowitz, and Sharpe. *Op. Cit.* note 62. 248.

[64] Ibid. 253.

[65] Ibid. 254.

[66] Ibid. 255.

[67] Ibid. 254.

[68] Ibid. 255.

[69] Ibid. 254.

decision making in the chest pain vignette.[70] In the current health status vignette, the highest percentage preferring shared decision making were patients with multiple sclerosis (90.5%).[71] In the chest pain scenario, the nursing students had the highest rate of preferring shared decision making at a rate of 96.0%.[72]

The main conclusion of this article was: "Despite consumerist rhetoric among some bioethicists, very few respondents wish an autonomous role. Most wish to share [treatment decision making] with their providers."[73] The authors note that patients wish to leave problem solving tasks to their health care providers (e.g., selecting diagnostic tests, providing a list of possible treatment options, explaining the risks and benefits of each treatment option) while the patients desire to retain a say in the treatment decision making (e.g., weighing the risks and benefits of each possible treatment, making the final selection of which treatment to pursue).

> These results are not what one would expect in a health-care environment that is strongly influenced by advocates of health-care consumerism; however, they are consistent with a growing body of literature that suggests that shared model of the doctor-patient relationship is desirable.[74]

What the authors argue their findings illustrate is that patients desire to be informed by their health care providers about the nature of their illness, the choices of treatments available to them, and the risks and benefits of those treatments. Patients also want to participate in making final decisions regarding their treatment, but they wish to do this in conjunction with their health care providers.[75]

*IV. Conclusion*

Two of Arrow's main points are that the health care providers' actions are not dictated by standard free market norms, and that the knowledge required for health care is vastly unequal between the patient and the health care provider. Arrow goes on to argue that these issues in conjunction with the uncertainty the patient faces create a unique 'commodity' which is purchased by the patient. While Arrow notes that this 'commodity' is certainly different from other types of commodities sold on the free market, he ultimately claims that acute health care sought by patients is indeed a 'commodity,' and part of this 'commodity' is the relationship

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[70] Ibid. 255.
[71] Ibid. 254.
[72] Ibid. 255.
[73] Ibid. 248.
[74] Ibid. 256.
[75] Ibid. 256.

between the patient and the health care provider. It is his presentation of health care as a 'commodity' that has been taken up by contemporary authors in support of their positions that health care ought to be pushed further into the realm of free market in which autonomous customers seek out the products they view as optimal for their needs. However, I argue in chapters four and five that this understanding of the patient–health care provider relationship as a 'commodity' is inaccurate, and those who advocate for this position are encouraging health care providers to act immorally.

Arrow's two points mentioned above are part of the reason I argue that the patient–health care provider relationship is not a 'commodity' to be bought and sold on the free market. First, as Arrow's paper makes clear, health care providers are expected to act in the best interests of their patients. Patients trust that their health care providers are not motivated by self-interest in their interactions with patients. This view of what patients desire of the health care providers is echoed in the studies I reviewed above. Patients wish and expect their health care providers to act as partners with them in making treatment decisions, and both partners in this relationship have the goal of achieving the best outcome possible for the patient. This is not what is expected in a business interaction when two self-interested parties interact. The merchant in a business interaction is not a fiduciary, whereas a health care provider is a fiduciary – one who acts in the best-interests of the patient and enables the patient to make the best health care choices possible. While it is not clear from the studies that patients' integrity is actually at stake, as Arrow claims it is when patients are acutely ill, the studies do support Arrow's underlying position: a patient desires and expects that his/her health care provider will act solely for the best interest of the patient, and that in doing so, the patient and the provider will work together to the patient's benefit.

Second, and inextricably linked to the first point, health care providers have significantly more information than patients. Patients seek out health care providers because patients need this information, information necessary to the diagnosis and treatment of the patients' ailments. This unequal knowledge is cited in the studies I reviewed on the patient-provider relationship above. Patients desire that their providers utilize their expert training in order to select the proper diagnostic tests, provide the patients with a list of possible treatment options, and then explain to the patients the risks and benefits of each treatment option. One of the reasons this is so closely tied to the previous point is that patients must trust that their health care providers do all of the above while acting in the patients' best-interests. Whereas a business person is expected to sell a product in order to maximize profit, this is not how the

provider is expected to act. The health care provider uses his/her education and training in order to help the patient rather than to maximize the provider's own profit.

I disagree with Arrow's position that patients purchase a 'social obligation' from health care providers, and that part of this 'commodity' purchased is the relationship with the health care provider. Providers are fiduciaries to their patients, not merchants, and yet Arrow argues that health care can be bought and sold on the free market, and that part of this purchase is the patient-provider relationship. Arrow makes this argument even while pointing out that patients face many types of uncertainty when they are acutely ill. This uncertainty includes 1) when patients need to use health care, 2) patients lack of knowledge regarding what type of treatment they need, and 3) patients are unsure how long their recovery will last (or even if recovery is possible). While Arrow claims that this type of uncertainty could be taken into account in the free market via health insurance, I contend that the knowledge and power the patients lack and the patients' vulnerability necessitates that the health care provider act as a fiduciary. The patient lacks medical knowledge, relies on the provider to share this information, and depends on the provider to act in the patient's best interest.

The studies I reviewed on patient preferences in decision making over the past 20 years support this view of patients' expectations and desires. Patients prefer to participate with their health care providers in making weighty health care decisions. Patients continue to rely heavily on their health care providers for expert knowledge – knowledge of which diagnostic tests to run, knowledge of how to interpret those tests and make the correct diagnosis, knowledge of what treatments are available and likely to work for the patient's particular illness, and knowledge of the possible risks of those procedures. Similarly, when the stakes are high, when the patient's life is at risk, patients again are likely to rely more heavily upon their providers for guidance in treatment decision making. While patients prefer their providers to share decision making regarding major health care choices, they do so while taking into serious consideration their health care providers' suggestions and concerns. As Deber *et al.* noted in their 2007 paper, patients dealing with severe illness do not seem to act like consumers in the open market; patients desire to partner with knowledgeable, supportive health care providers in order to make health care treatment decisions.

Even though patients do not desire to act as consumers, nor do they seem to act as consumers, many business ethicists, economists, and health care providers have followed the

trend Arrow started. As I show in the following chapter, current business ethicists and economists make arguments similar to Arrow's. Many have advocated for viewing health care as a 'commodity' and placing all of health care in the free market. This shift would include changing the patient–health care provider relationship into a business interaction. In response to these positions, arguments against viewing health care as a commodity have been made, citing the difficulty of using a business interaction as a model for receiving health care. These contemporary arguments have taken some ethical concerns seriously, namely that health care providers are sought because they are experts, and that providers cannot be viewed as business agents because health care providers are interested in something other than making a profit. In the following chapter, I review arguments in favor of placing health care, and the patient-provider relationship, under the free market, as well as arguments which question the morality of this shift.

## Chapter Three: Contemporary Positions Regarding Placing Health Care In the Free Market

### *I. Introduction*

As I mentioned in the previous chapter, contemporary authors have taken seriously Arrow's argument in favor of placing health care and the patient–health care provider relationship in the free market. There have been discussions regarding the positive ramifications of operating health care as if it were a commodity as well as concerns presented about this possibility as well. In this chapter, I will address four contemporary works, two of which argue in favor of placing health care and the patient-provider relationship in the free market, taking Arrow's ultimate position further than he did four decades ago. The second set of articles address potential problems with shifting health care into the free market, questioning the implications of this shift. In presenting these four articles, I am not endorsing any of the ultimate claims of the works. Rather, I review these papers in order to show that this question, raised originally by Arrow in 1963, is still very much in debate today. Further, even though there are those who argue that viewing health care and the patient-provider relationship as a commodity is problematic, these authors have not taken seriously what is missing from the patient-provider relationship when it is considered a business interaction or a commodity. In other words, my argument that treating the patient-provider relationship as a business relationship is immoral is not currently present in the literature.

In this chapter, I will first review two articles which defend and encourage viewing health care as a free market, one authored by Mattia J. Gilmartin and R. Edward Freeman, the other by Nicholas Capaldi. Gilmartin and Freeman approach the issue of the commodification of health care from the perspective of a revised view of business ethics, while Capaldi's article considers the issue from a philosophical view of science and the history of science. Both of these works support Arrow's claim that health care would function more efficiently under the free market, and that treating health care as a commodity does not harm the patient–health care provider relationship. After I have presented the opposition's view, I will support my own argument by reviewing two contemporary works that object to Gilmartin, Freeman, and Capaldi. Kevin Wm. Wildes writes that the moral norms of society dictate how that society distributes necessary human goods, including health care, while William Andereck argues that the patient-provider relationship is essential to health care and ought to be the pivotal point to any investigation of how health care is provided at large. While both Wildes and Andereck are hesitant to agree with Gilmartin, Freeman, and Capaldi, neither Wildes nor Andereck argue that

it is immoral to reformulate the patient–health care provider relationship as a business interaction.

While all four of these contemporary works address the fundamental nature of health care and how heath care is accessed, none of them address what I consider to be an essential element of the discussion of the commodification of health care – that the patient-provider relationship cannot be treated as a standard business relationship. After reviewing these four works in this chapter, I will present my argument on this matter in chapters four and five.

*II. Stakeholder Capitalism: Gilmartin and Freeman*

Current business ethicists and economic theorists argue that health care can be adequately represented by a modern interpretation of capitalism, particularly 'stakeholder capitalism.' Gilmartin and Freeman claim that much of the criticism of market-based health care is predicated on a misrepresentation of capitalism, which they term "cowboy capitalism."[76] "Cowboy capitalism" is defined by Gilmartin and Freeman as allowing for the separation of business decisions and ethical considerations. According to cowboy capitalism, a business is allowed to deliberate solely on what will maximize profit without regard for any external, or ethical, concerns. Gilmartin and Freeman argue that this is a misunderstanding of how modern businesses and consumers actually act. They argue that stakeholder capitalism is a better representation of the free market, and that stakeholder capitalism is based on the "responsibility thesis."[77] The "responsibility thesis" states that most people (and, presumably, businesses) do take responsibility (including moral responsibility) for their actions, including the repercussions their actions may have on other individuals. From this standpoint, businesses take seriously the ethical ramifications for their decisions. Gilmartin and Freeman claim that arguments currently made against allowing health care to operate under the capitalist model are actually arguments against "cowboy capitalism," and, as such, those arguments against capitalism miss the point at best, or are deliberately made to misconstrue how the business world operates at worst.[78]

Gilmartin and Freeman present stakeholder capitalism as able to consider the values of all participants, including "entrepreneurs, managers, customers, suppliers, financiers, and communities."[79] Each participant is essential to the market, and, because of this, only when all of these groups are satisfied is the market able to flourish. Under this model of capitalism,

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[76] Gilmartin, Mattia J. and R. Edward Freeman. "Business Ethics and Health Care: A Stakeholder Perspective." *Health Care Management Review*. Volume 27 (2), April 2002. 52 – 65.
[77] Ibid.
[78] Ibid.
[79] Ibid.

cooperation from all stakeholders is essential for any business to succeed. Human beings, according to Gilmartin and Freeman, make choices based on complex relationships and values. People are not simply profit-maximizers. Certainly there are cases in which individuals act selfishly, but Gilmartin and Freeman argue that this need not be the basis for understanding the market and how individuals operate within it. For example, Gilmartin and Freeman point out that many individuals participate in certain businesses in order to perform meaningful work that benefits the community as a whole. Because stakeholder capitalism is able to take actions such as these into account, stakeholder capitalism presents an all-encompassing understanding of human interaction and value rather than the muted version presented by cowboy capitalism. Stakeholder capitalism recognizes the values people act upon in their dealings with the free market. Gilmartin and Freeman further claim that the free market continuously creates new *sources* of value. They argue that this creation is a productive, not destructive, force inherent to capitalism. Gilmartin and Freeman present stakeholder theory not only as an alternative for understanding how health care can be viewed as a market, but also as a grounding from which we may reform health care in the United States.[80]

While Gilmartin and Freeman do present a charitable interpretation of the market and rightfully point out that capitalism is often misunderstood and misconstrued in academic literature, the authors make assumptions about health care that are as unfair as those who present "cowboy capitalism" as the framework for the free market. First, Gilmartin and Freeman argue that the values viewed as inherent in health care are not limited to that particular field. They claim that "empathy, civility, integrity, and generosity" are all valued within businesses just as these traits are valued in health care providers. In fact, the authors argue that those traits are essential to "exemplary customer service" in business practices.[81] Certainly Gilmartin and Freeman are correct in claiming that some businesses do treat their customers with the same attention and care that health care providers show their patients, but that does not necessarily lead to the conclusion that patients ought to be considered customers. The claim – because proper patient care includes the same qualities as exemplary customer care, patient care can be viewed as a form of customer care – falls short; Gilmartin and Freeman do not show that patients *should* be viewed as customer at all.[82] Furthermore, even under the stakeholder view of

[80] Ibid.
[81] Ibid.
[82] I address a version of this argument made by Gilmartin and Freeman further in Chapter Four, as well as my counter-argument which explains that their position is invalid.

capitalism, customers are presumed as acting as fully autonomous, informed individuals. However, this is simply not the case in a patient-provider relationship. Providers are expected to act as fiduciaries for their patients in addition to exhibiting the virtues listed by Gilmartin and Freeman. It is the fiduciary nature of the patient-provider relationship that cannot be properly represented under any form of capitalism.[83]

Second, Gilmartin and Freeman extol the free market for its ability to promote "invention, innovation, and entrepreneurship"[84] in both the broad view of health care as an industry and in the interpersonal relationships between the stakeholders.[85] The position that capitalism is essential to health care because of the market's ability to foster invention and innovation, which is essential to health care, is not unique to Gilmartin and Freeman; many economists, politicians, and business ethicists make this claim.[86] However, those who make this argument fail to take seriously the contrary position. While the free market does promote, and is, in fact, based on innovation, it is not the case that the free market is the only way to achieve such innovation. For example, academia is a place where new ideas, theories, arguments, and even products are continuously produced and promoted. Research and publication of original work are expected from most professors and graduate students. While it is true that universities do have a monetary stake in such research and publication, many individuals enter into academics for love of their field, a desire to increase depth of understanding in their field, and to broaden the knowledge base for all.[87] As Gilmartin and Freeman make so pointedly obvious, humans operate from complex motivations and values, only one of which is making a profit. In assuming that invention, innovation, and entrepreneurship can only, or best, arise from the free market ignores the other various reasons people have for achieving those goals.[88]

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[83] As mentioned above, by 'fiduciary' I do not mean that providers make decisions for their patients. Patients do make their own health care choices, but they cannot do so without the information and care first provided by their health care providers. For a further discussion of what is entailed in a fiduciary relationship, see chapters four and five.
[84] Gilmartin and Freeman. *Op. Cit.* note 76.
[85] Ibid.
[86] See also: Capaldi, Nicholas. "The Ethics and Economics of Health Care." *Journal of Medicine and Philosophy*. Volume 30 (6), 2005. 571 – 578. Capaldi makes this specific argument. Pauly, Mark V. "Taxation, Health Insurance, and Market Failure in the Medical Economy." *Journal of Economic Literature*. Volume 24 (2), June 1986. 629 – 675. Petratos, Pythagoras. "Does the Private Finance Initiative Promote Innovation in Health Care? The Case of the British National Health Service." *Journal of Medicine and Philosophy*. Volume 30 (6), 2005. 627 – 642. Petratos argues that the Private Finance Initiative has increased innovation in British health care.
[87] I discuss the complex issue of the interaction between industry and academia in my discussion on the Bayh-Dole Act in the next section.
[88] Gilmartin and Freeman. *Op. Cit.* note 76.

*III. Medical Innovation in a Free Market: Capaldi*

In addition to Gilmartin and Freeman's argument that the free market is capable of comprehending and accurately predicting health care and is useful in properly administering health care, other authors argue that viewing health care as a free market is essential to the continual progress of medical invention and innovation. As Gilmartin and Freemen mentioned, the free market is often considered to be the best possible means for furthering technology. Nicholas Capaldi takes this position in his paper "The Ethics and Economics of Health Care."[89] Capaldi argues that "medical innovation proceeds most efficiently and effectively within a free market."[90] Capaldi motivates this argument using Adam Smith's view of the free market[91] and Capaldi's own description of what he terms the "technological project," defined as the scientific drive to understand and manipulate the natural world. Capaldi explains that the technological project arose with the works of Bacon, Descartes, and Locke in the seventeenth century, and that it has only escalated since that time. Capaldi claims that, within the field of medicine, the technological project has shifted the primary focus of the field from 'do no harm' to 'enhance the mind and body of patients.' According to Capaldi, most physicians no longer attempt to restore the body to its natural state (e.g., treat illness), and those physicians who do pose such a goal for themselves are operating under a model of medicine that is not appropriate for the modern world.[92]

*A. Capaldi's Argument*

Capaldi's main argument is that medical innovation is most efficient when it operates under a free market.[93] He predicates this argument on two claims: one, the technological project is a historical fact that the modern world cannot deny nor reverse; and two, the technological project has been a success in that humans have achieved "remarkable technological advances"[94] which have been shared around the globe. Capaldi maintains that the technological project's advances have altered the fundamental function of medicine to the point that it now aims to improve lives via "the conquest of nature,"[95] which he sees as including everything from vaccinations to preventing disease to providing cosmetic surgery to alter one's appearance.

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[89] Capaldi, Nicholas. "The Ethics and Economics of Health Care." *Journal of Medicine and Philosophy*. Volume 30 (6), 2005. 571 – 578.
[90] Ibid. 571.
[91] I review Adam Smith's work in some detail in Chapter Four.
[92] Capaldi. *Op. Cit*. note 89. 572.
[93] Ibid. 573.
[94] Ibid. 572.
[95] Ibid. 573.

After positing these background points, Capaldi then argues that medical innovation should be conducted in a free market because the market provides two advantages: 1) it promotes competition, and 2) it encourages innovation.

Firstly, according to Capaldi, the free market promotes competition because under a free market resources are held by private individuals or companies. These individuals or companies are rewarded under a market system for creating advances in technology because such advances result in new and cheaper products, and those people with the best ideas are then rewarded by the market by selling their services to the highest bidder. Thus, the competition inherent in the free market motivates and rewards innovation.[96]

Secondly, the framework of the free market allows for innovation to happen at a higher rate than any other framework. Capaldi utilizes Adam Smith's position that the free market allows for division of labor, specialization, and increased productivity, all of which help innovation to flourish, to support his claim. "Because it is the best vehicle for innovation, the free market economy is the best form of economic system for engaging in the technological project."[97] Thus, the characteristics of the free market foster innovation.

*B. My Objections*

Capaldi's work, however, is far from thorough, and I object to his paper on three major points and two minor points. These are as follows:

1) Capaldi is incorrect when he claims that the technological project has fundamentally altered the central aim of medicine.

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[96] Ibid. 573. Capalidi's claim that the free market increases innovation and decreases prices for consumers is a topic of great debate when taken into the realm of medical advancement, including pharmaceutical research and development and medical technological advancement. Merrill Goozner argues in his book, The $800 Million Pill: The Truth Behind the Cost of New Drugs, that major drug companies have not actually felt the sting of competition. While there are now more drugs than ever competing, the introduction of 'me too' drugs (drugs which treat the same illness, often with similar rates of effectiveness, side-effects, and even based on the same molecule) has not decreased prices of these drugs. See: Goozner, Merrill. The $800 Million Pill: The Truth Behind the Cost of New Drugs. University of California Press: Berkeley, California. 2004. "Chapter 8: Me Too!" See also: Amoresano, Guy V. "Branded Drug Reformulation: The Next Brand vs. Generic Antitrust Battleground." *Food and Drug Law Journal*. Volume 62 (1), 2007. 249 – 256.

Additionally, major pharmaceutical companies are not motivated to innovate and develop drugs for neglected diseases or orphan diseases. For more on this issue, see: Stirner, Beatrice. "Stimulating Research and Development of Pharmaceutical Products for Neglected Diseases." *European Journal of Health Law*. Volume 15 (4), December 2008. 391 – 409. See also: Trouiller, Patrice, Piero Olliaro, James Orbinski, Richard Laing, and Nathan Ford. "Drug Development for Neglected Diseases: A Deficient Market and a Public-Health Policy Failure." *The Lancet*. Volume 359 (9324), June 22, 2002. 2188 – 2194.

[97] Capaldi. *Op. Cit*. note 89. 574.

2) Capaldi wrongly assumes that competition resulting from the free market is the preferable method to achieve innovation in medicine.
3) His argument that fostering innovation in a central, or regulated, economy is impossible is flawed.

My two final, lesser criticisms are with his presentation of centralized economies and their impact on society. I address these five issues in order.

*1) The Technology Project Has Not Altered the Aims of Health Care*

Capaldi's primary claim that the technological project has fundamentally altered the object of medicine is not the fact he presents it as. Capaldi attempts to silence his critics by stating that those physicians and health care providers who still view medicine's main goal as 'do no harm' are operating on an outdated model of medicine. However, he provides neither reasons nor arguments to support this claim. Indeed, contemporary bioethics literature seems to soundly support the thesis of 'do no harm,' while there is little to no support for Capaldi's claim that the modern view of medicine is to 'enhance lives' (nor does Capaldi offer any evidence or literature to support his view).

Capaldi seems to use his two claims, one, that the technological project is a historical fact, and two, that the technological project has been a success, to support his view that medicine's objectives are not what they once were. While these two claims cannot be denied, they are broad, sweeping claims about technology in general (Capaldi includes cell phones and computers as examples of achievements of the technological project). He only vaguely attempts to include health care examples in his brief overview of the extensive scope of the technological project. The few examples he does include regarding health care are the dramatic increase in life expectancy in the past century and the advent of 'new cures' for old diseases, both of which he attributes to "medical technology."[98] He also mentions that most of the winners of the Nobel Prize for medicine are from the United States and Britain, countries that Capaldi notes are committed to the free market.[99] This is scanty evidence for his claim that health care has transitioned from 'do no harm' to 'do good' or 'enhance lives.' Neither does he provide much support for the claim that the free market is the best method for achieving medical innovation.

The position that medicine no longer attempts merely to cure but also to enhance has been reviewed by other authors in contemporary bioethics literature. It is a central theme in

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[98] Ibid. 574.
[99] Ibid. 574.

Carl Elliott's work Better Than Well.[100] Elliott claims that medical enhancements are not simply presented as ways to become bigger, better, faster, more attractive, etcetera. 'Enhancements' are also presented as 'cures' or 'treatments' for illnesses. "Most of what are commonly called enhancement technologies today can also be described as treatments. Viagra can enhance sexuality or treat impotence; plastic surgery can enhance the body or treat disfigurements."[101] Elliott argues that this is no coincidence. For an 'enhancement' to become accepted by health care professionals, it must not be merely an 'enhancement,' but it must, and primarily, be viewed also as a 'treatment.'

> As much as American medicine has changed in recent decades, most doctors still feel as if they are in the business of curing human illnesses rather than making people feel better about themselves. Thus, if the industry wants to sell an enhancement technology to a doctor (rather than a consumer) the technology must be transformed into a treatment.[102]

Elliott argues that 'enhancements' are only understood, accepted, and utilized by health care professionals when they are presented as 'treatments' for recognizable illnesses. While this is manipulated often by those who advocate for new enhancements (often enhancements are consciously presented as 'treatments' rather than 'enhancements'), this is done precisely because health care professionals are hesitant to provide enhancements rather than treatments. This contrasts sharply with the presentation of 'enhancement' Capaldi provides. It does not seem to be clearly accepted by medical professionals that medicine's aim is 'enhancement' rather than 'cure' as Capaldi would have his audience believe.

Other contemporary bioethics work, such as Nancy King's article[103] on medical research, attempts to refocus medical professionals on the point that health care is provided in order to treat ill patients, and often, those treatments are not successful. "Medicine fails people. Research fails people. […] [O]ur faith in medical progress is profound. Much of the lure of breakthrough medical technology lies in the hope that this time, the fix will really and truly work."[104] King's paper illustrates the frustration health care professionals have at their inability to effectively treat patients; this concern only highlights the limitations of health care understood as 'treatment.' King claims that health care does not always result in successful

[100] Elliott, Carl. Better Than Well: American Medicine Meets the American Dream. New York, W. W. Norton and Company: New York City, New York. 2003.
[101] Ibid. 107.
[102] Ibid. 120.
[103] King, Nancy M. P., JD. "The Healthy-Patient Paradox in Clinical Trials." *Atrium: The Report of the Northwestern Medical Humanities and Bioethics Program.* Issue 5, Spring 2008. 9 – 11, 22.
[104] Ibid. 9.

treatment of illness. It is not the case, in her opinion, that medicine has achieved that goal and is ready to move on. While it is possible that 'enhancement' can be a goal at the same time as 'treatment,' it certainly is not the case that the whole of medical care has "transformed" from 'do no harm' to 'produce good.' Medical providers still seek ways to make ill patients well. Capaldi needs to present overwhelming evidence in order to prove that the desire of health care providers has shifted to 'enhancing lives' rather than restoring patients to health.

*2) The Free Market Is Not the Preferable Method To Achieve Innovation in Medicine*

Capaldi, like Gilmartin and Freeman, makes the assumption that competition resulting from the free market is the foremost method for achieving innovation. He claims that under a free market economy owners are able to experiment with their resources at will, and that those who do experiment will be rewarded for successful attempts. Due to this, the innovation inherent in a free market should be utilized by placing medical technology fully in the realm of capitalism.[105] But Capaldi does not investigate, or even mention, other possible motivations for experimentation or innovation. For Capaldi, the only reason one might attempt to produce new treatments, drugs, or techniques is because it would result in increasing profit. This ignores the complex reasons people have for attempting original work, and it does not recognize the other venues, even in the United States and Britain, in which such research is done. In fact, the only time Capaldi mentions work done within academia is when he explains that private industry was able to use research done in universities, teaching hospitals, national laboratories, and non-profits after the passage of the Bayh-Dole Act in 1980.

*a. The Bayh-Dole Act*

In December of 1980, what is commonly known as The Bayh-Dole Act was passed. [106] Officially termed the "Bayh-Dole University and Small Business Patent Procedures Act," this act was encoded in 35 U.S. codes Chapter 18, as "Patent Rights in Inventions Made with Federal Assistance." This law allowed for those who have federal funding to patent inventions made with use of those funds. The Bayh-Dole Act explicitly included universities receiving federal funding for research. Thus, inventions made by university researchers who are receiving federal funding could be patented by the researcher, and further, the royalties from the commercial production of those inventions would go to the researcher who holds the patent.

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[105] Capaldi. *Op. Cit.* note 89. 573.
[106] The act is codified in 35 U.S.C. § 200-212, and implemented by 37 C.F.R. 401.

There are limitations to the patent rights available to those who receive patents under this law. For example, there are requirements for manufacturing of said inventions to occur in the United States.

Overall, this was a push by the federal government to foster cooperation between universities (and their researchers) and commercial industry. Instead of federally funded research sitting on the shelf, unused by industry (and therefore the public), researchers would be encouraged to patent their work and facilitate its production and implementation by working with industry. Universities and researchers would have a fiscal incentive to conduct innovative research, and, more importantly to the advocates of the act, to push those inventions into market.

Since its implementation, and subsequent revisions, many have applauded the Bayh-Dole Act. On its 25th anniversary, members of the House of Representatives passed a resolution saluting the act on various points. A few of the commended effects of this act include: it eliminated 26 different Federal agency policies regarding patenting federally funded developments, it generated "millions of dollars in annual licensing royalties for universities and nonprofit institutions," and the act provided incentives to encourage "the exchange of technology and research" between researchers, universities, small businesses, and larger industries.[107]

*b. Problems with the Bayh-Dole Act*

However, not everyone has been impressed with this particular bit of legislation. One question posed regarding this act is presented by Jennifer Washburn in her book University Inc.[108] "What share of the university-based inventions generated since 1980 were commercialized *because* of the institutions created under Bayh-Dole, and what share *would have been commercialized anyway*?"[109] There is very little data available regarding finical success that can be attributed primarily to the act, and the information that is available is

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[107] United States. Cong. House. 109th Congress, 1st Session. House. Con. Resolution 319, Expressing the Sense of the Congress Regarding the Successful and Substantial Contribution of the Amendments to the Patent and Trademark Laws that were Enacted in 1980, on the Occasion of the 25th Anniversary of its Enactment. [Introduced in the House of Representatives; December 16, 2005.] 109th Congress, 1st Session, GPO Access. Web. February 8, 2009. < http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_reports&docid=f:hr409.109.pdf>

[108] Washburn, Jennifer. University Inc. The Corporate Corruption of American Higher Education. Basic Books: New York City, New York. 2005.

[109] Ibid. 143. Emphasis in original.

provided by the Association of University Technology Managers, a biased organization.[110] What Washburn was able to discern in conducting her research is that many researchers are concerned about

> the possibility that in placing such a premium on patenting and licensing, Bayh-Dole may actually disrupt many of [the] older, nonproprietary methods of bringing knowledge into practical use, with unknown consequences for the health and vitality of the broader innovation system.[111]

The "older, nonproprietary methods" Washburn mentions include: publications, conferences, and consulting, all of which she terms "open pathways." "Open pathways" are still utilized by researchers at large in order to benefit from the research of others within their field. These methods are more difficult to track, but those who have done studies on this find that "open pathways" are still the primary method for exchanging ideas, information, and motivating new innovation.[112]

What is more alarming than some of the issues presented above by Washburn is the manipulation of the Bayh-Dole act by industries. As intended by the act, close relationships were developed between university research centers and corporations. For example, in the early 1980s, Du Pont gave $6 million dollars to Harvard for genetic research, Hoechst provided $50 million to Massachusetts General Hospital for medical research, and Monsanto gave $2.3 million to Washington University for biomedical research.[113] The amount of money exchanged alone should raise ethical eyebrows – what exactly is the industry funding? How many strings are attached to these grants? And, more importantly, how are these relationships, which raise conflict-of-interest worries, affecting the research done at universities? When this type of money is being thrown around, there are dangers of researchers losing control of designing, conducting, and publishing research on their work.

A local example of this type of conflict-of-interest in action is the case of Dr. Leo Furcht, chairman of lab medicine and pathology at the Univeristy of Minnesota Medical School. In the late 1990s, Furcht's colleague, Dr. Catherine Verfaillie, made a patent-worthy discovery in stem-cell research. When the Univeristy of Minnesota declined to patent Verfaillie's work, Furcht created a company MCL, and patented Verfaillie's findings in conjunction with her and another researcher. In July 2000, Furcht, in his position as chairman of lab medicine and

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[110] Ibid. 142.
[111] Ibid. 145.
[112] Ibid. 145.
[113] Ibid. 71.

pathology, guided a $501,000 grant from Baxter Healthcare to Verfaillie's research (conducted at the Univeristy of Minnesota Medical School), and paid the grant directly to MCL. Furcht did not disclose any of this to the University of Minnesota. Only when Verfaillie notified the dean that she had not been paid was an investigation conducted. The investigation found that Furcht had committed a serious violation of the Univeristy of Minnesota's conflict-of-interest policy. He was reprimanded and banned from any business-sponsored research for three years, but he retained his chairmanship of lab medicine and pathology. In fact, the same dean who reprimanded him in 2005 made him a co-chair of an ad-hoc committee created to rewrite the Univeristy of Minnesota Medical School's conflict-of-interest policies in 2008.[114]

When industry and universities work closely, when industry funds university research, and when the research done at universities is designed by industry, it becomes easy for such transgressions such as those perpetrated by Dr. Furcht to happen. While the Bayh-Dole Act may have many positive implications for university research, it has also created a system in which industry can design, run, and interpret research done at universities. The ethical guidelines intended to provide boundaries for such research have taken years to create, and, unfortunately, those guidelines are still lacking in scope. What is clear is that research done by academics based on scientific inquiry and done for the benefit of society at large has been greatly diminished.

Economists, such as Capaldi, praise the Bayh-Dole Act for encouraging intertwining of academia and industry, but the oversight for such relationships is severely lacking, and as such, manipulation is rampant, especially in medical research (often funded by pharmaceutical and medical device industry giants). What is driving the research funded by industry is the market? Companies want to find new ways to cure old diseases, create new patents on old drugs, and they use highly recognized academic names to sign on to their work in order to give it more pull in the medical community. While Capaldi and others who echo his arguments claim that the market is the best environment for medical advancement to flourish, there is little evidence that the Bayh-Dole Act, the main piece of federal legislation encouraging universities to utilize the market as a driving force for research, has had the effect Capaldi claims. In fact, the negative

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[114] Lerner, Maura, Josephine Marcotty, and Janet Moore. "U Doctor on Ethics Panel was Disciplined." Star Tribune. December 21, 2008. Accessed February 8, 2009. <http://www.startribune.com/lifestyle/health/36500989.html>

ethical ramifications of the act are still being investigated and should be a major concern for all health care professionals.[115]

*3) Flawed Argument: Fostering Innovation in a Central Economy* ***Is*** *Possible*

Capaldi states that attempting to foster innovation in a central, or even highly regulated, economy is a contradiction in terms: economies are too complex for any person or computer to predict on a basic supply/demand level, let alone show when and where to place money and resources in order to achieve innovation. This, for Capaldi, is the contradiction – a centralized economy cannot plan innovation because innovation, by definition, is unplanned. Certainly Capaldi makes a humorous point here, but it is hardly a legitimate argument against the possibility for innovation to occur in a centralized or regulated economy. A centralized or regulated economy is able to fund research of those whose work promises advancements. For example, the United States' government has funded research and innovation for years via the National Institute of Health and the National Science Foundation in an analogous manner; those who have previously conducted successful research and who have provided outlines of new ideas are given grants to fund the development of their innovative research. In this manner, funding originating from the government, a centralized source (i.e., not based on forces emanating from the free market), is able to aid research and innovation. One need not know with certainty when and where innovation will occur to attempt, even successfully, to achieve it.

Ironically, Capaldi cites Pfizer's Discovery Technology Center as an example of how a business operating in the free market is better able to produce innovation compared to federal funding. Capaldi explains that the Discovery Technology Center has been modeled, at least in part, on the basic style of a university research center. Pfizer's goal was to use the funding and data available to the large corporation in combination with the 'atmosphere' of a research laboratory to create a 'brainstorm center.' A profit-motivated entity is thus able to achieve innovation in a manner that centralized funding cannot, according to Capaldi's claim.[116] However, I see the Discovery Technology Center as an example of a business utilizing the model of innovation driven by federal funding. It seems that Pfizer's Center is an example of an international organization 'planning' innovation in the same manner in which governments, including the United States, 'plan' innovation utilizing federal funding. Capaldi's claim that innovation cannot arise successfully from a centralized governmental source does not hold

[115] For more information regarding the corruption of university research by industry, see Carl Elliott's forth-coming book.
[116] Capaldi. *Op. Cit.* note 89. 576.

water. Further, Capaldi's position dismisses a great deal of immoral implications which arise when industry is the sole, or central, source of funds for innovation, research, and implementation of new treatments and procedures.[117]

*4) Other Criticisms*

My fourth and fifth complaints are made with regard to Capaldi's presentation of both central and highly regulated economies. I take issue with Capaldi's disregard for the theory behind centralized economics. He presents the Soviet Union as the prime example of a planned economy, and blames the *economy* of the USSR for the loss of "upwards of several hundred million lives."[118] This is hardly a fair representation of socialism, and yet Capaldi cites its failure as *overwhelming* evidence that centralized economies cannot work and further uses this 'evidence' as proof that centralized economies cannot and should not be relied upon for technological innovation.[119] Moreover, he dismisses the ability of a highly regulated economy to work in part because there is "good reason to *oppose limiting profits*."[120] Capaldi claims that even within a highly regulated economy "there is no consensus or economic meaning to the idea of what constitutes a 'just' profit."[121] This is simply an appeal to ignorance, a common logical fallacy (one which every professor of moral theory has encountered). Simply because there is no agreement about what a 'just' profit might be does not necessarily lead to the conclusion that a 'just' profit does not exist.

Capaldi's work does highlight some of the more frequent arguments made on the behalf of the effort to place medical care and medical research solely under the banner of free market. However, his reasoning is flawed, and he misrepresents the positions against which he is arguing. He may be correct in claiming that the free market is able to enhance medical innovation, but he does not even attempt to address other methods, nor does he acknowledge the moral repercussions of shifting medicine, even in part, into unregulated trade.

Both Gilmartin and Freeman's work and Capaldi's article present two cases for pushing health care into the realm of free markets. However, as mentioned above, both of these papers require much deeper, more thorough investigation than the authors have presented. In

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[117] For a discussion of the complicated issues which arise when industry drives medical research, see Carl Elliott's forthcoming book.
[118] Capaldi. *Op. Cit.* note 89. 575.
[119] At least Capaldi didn't cite Hitler's version of social democracy.
[120] Capaldi. *Op. Cit.* note 89. 576. Emphasis in original.
[121] Ibid. 576.

reviewing their claims here, I, of course, am not endorsing their conclusions. Rather, my reasoning for including them in this chapter was simply this: it is important to note that in the past five years there have been serious, published works advocating for the position against which I argue. Many economists, business ethicists, politicians, and even some health care providers and bioethicists strongly hold that medical care will only function and achieve success at an optimal rate if it is treated as a product in the free market. Some authors, such as Gilmartin and Freeman, do attempt to take into account the possible moral ramifications of such a shift, but those attempts are shortsighted and circular. What should be debated before and above all else is this: is it morally acceptable to allow health care to become a commodity? Ought we allow the patient-provider relationship to de/evolve into a business transaction?

Other authors have taken the above questions seriously, devoting arguments and publications to the ethical dilemma I describe above. These works range from those who refuse to budge from the waffling middle ground to arguments asserting that the free market and health care are incompatible. Discussed below are two works that have attempted to address the morality of heath care and the free market. Kevin Wildes's work highlights some of the critical points of the discussion that many others have overlooked, but his original bias toward the market clearly colors his ultimate recommendations. William Andereck's article attempts to outline the true nature of the patient–health care provider relationship, noting that only when both the patient and the provider operate with respect for persons, rather than patients presenting themselves as autonomous consumers, is health care able to achieve the ends which both parties seek. Andereck, much like Wildes, is not advocating the complete withdrawal of health care from capitalism, but he does present some cautions and specific limitations regarding how health care can operate as a marketplace. I review each work and its limitations in turn.

*IV. Health as a Social Construction: Wildes*

Kevin Wildes's presentation of the questions essential to the issue of the commodification of health care brings to light three essential points.[122] First, Wildes points out that health, health care, medicine, and markets are all social constructions.[123] By understanding

[122] Wildes, Kevin Wm. "More Questions than Answers: The Commodification of Health Care." *Journal of Medicine and Philosophy*. Volume 24 (3), 1999. 307 – 311.
[123] Social constructions are, loosely defined, things, ideas, institutions, etcetera, which could not exist if society had not created, named, recognized them. Social constructions are usually contrasted with

that these institutions are our own creations, he proposes redefining all of them in order to achieve a medical market place that is ethically acceptable. He notes that other basic human goods are distributed through the free market, such as clothing, while society provides a base level of other basic human goods, e.g., education.[124] The process by which society allocates these other goods could be the model for the medical market place.

Second, Wildes notes that how a society distributes basic human goods, what society prioritizes, and how society decides to allocate limited resources is based on the moral commitments of that society. For instance, some moral theories indicate that an ethical society ought to provide or ensure access to basic human goods for all its citizens. Indeed, a society may deem itself morally bound to provide a fundamental base of health care for all its citizens while allowing the free market to allocate health care above this lower bar.[125]

Third, an individual's view of the good life, or the moral life, will have a direct effect on how that individual appraises and values the importance of his/her health care. "A free, open market allows those who *can* enter it choice about the type of health care they would like in accord with their views of their lives."[126] Wildes sees allowing individuals to make their own decisions about their health care as essential in order to allow those individuals the ability to achieve their version of the good life. He claims that free interaction in the market place is necessary in order for those with radically different views of the good life, including their valuation of health, to achieve their individual ends.[127]

While Wildes's paper presents some essential concepts, such as the reflection of social values in the manner in which a society allocates basic human goods, he clearly is operating from the bias that the free market should be used to allocate health care, at least to some degree. It is due to this bias that I disagree with Wildes on two particular points. First, Wildes argues that the market allows individuals to create and fulfill their own goals. While this may be the case for some, the concern of many bioethicists is for those who are left out of the free market. As Wildes notes, the free market allows for the exchange of goods and services *for those who are capable of entering into the market*. Individuals and families of lower socio-economic

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naturally existing objects (e.g., rocks, trees, land formations), things which humans and human social interaction had no hand in creating. For a further discussion of social constructions, see: Boghossian, Paul A. "What is Social Construction?" Times Literary Supplement. February 23, 2001. 6 – 8.

[124] Wildes. *Op. Cit.* note 122. 310.

[125] Ibid. 310-311.

[126] Ibid. 310. Emphasis added.

[127] Ibid. 310.

status are the ones who suffer the most from operating health care as a market place. As David Blumenthal notes, setting health care up as a free market will certainly benefit some "consumers," while it will leave others out of the loop entirely. Blumenthal explains that markets have a tendency to accentuate preexisting inequalities.[128] For instance, those with low income who are currently unable to purchase health insurance will likely not be benefited by pushing health insurance, and health care in general, further in the direction of a free market.

Second, Wildes acknowledges that health care is considered by many to be a basic human good, but he does not investigate the nature of that particular good. He does not address the relationships necessary to health care, namely the patient–health care provider relationship. He conflates health care with austere goods, such as clothing. He may be correct in claiming that a moral society should provide basic subsistence and that it is acceptable to allow the market to take over beyond that point when it comes to food, shelter, and clothing. It is true that our society does provide a minimal level of many basic human goods (e.g., food stamps and subsidized housing). Likewise, government-funded hospitals are required to provide emergency health care to all. This is an example of a lower-bar which Wildes mentions; all members of society have access to some basic health care, but beyond that level, individuals may choose if and how they access health care. The problem with viewing health care in this manner, however, is that this overlooks, or loses all together, the essential character traits of health care, including the uncertainty the patient faces and the necessity of a relationship with a health care provider.

As mentioned in the second chapter, Arrow notes that acute health care is unpredictable because it is sought out on an emergency basis (my example of another good sought on an emergency basis was damage repair after a natural disaster). What sets acute health care apart from even these other examples of goods bought on an emergency basis is that there are additional concerns at stake when one seeks out health care for acute illness. Particularly, as Arrow notes, when acute care is required, patients face multiple types of uncertainty. The knowledge and skills required to aid the patient are held by health care professionals. Thus, the patient–health care provider relationship is necessary and essential to resolve the patient's illness. These factors must be taken into account when addressing what type of good (or basic human good) health care is, and how, therefore, to allocate this particular good.

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[128] Blumenthal, David. "Effects of Market Reforms on Doctors and Their Patients." *Health Affairs*. Volume 15 (2), Summer 1996. 170 – 184.

*V. Respect for Persons versus the Autonomous Consumer: Andereck*

William Andereck's article, "From Patient to Consumer in the Medical Marketplace," addresses the special relationship between the patient and the provider.[129] He argues against completely placing health care under the free market, citing problems inherent in viewing the patient–health care provider relationship as one between two autonomous equals. Patients may be able to do cursory research in the age of internet, but the provider is ultimately the health care expert. Further, illness can debilitate a patient's reasoning, especially in cases of chronic or severe illness. For these reasons, Andereck maintains that the patient-provider relationship ought to be based on "respect for persons,"[130] which, as he defines the phrase, highlights the fiduciary nature of the patient-provider relationship. What Andereck finds essential to the "respect for persons" model is that the needs, desires, and values of the patient are central to the goals of both the patient and the provider; the provider is ethically bound to deliver treatment to the patient that matches the patient's demands as nearly as possible.[131]

Andereck contrasts the "respect for persons" model with the "autonomous patient"[132] model of health care. The "autonomous patient" became increasingly popular in the mid to late 1990s, and with it the concepts of patient rights and complete patient control over all aspects of his/her health care. Whereas "respect for persons" demands that providers tailor treatment to the needs and values of the patients, the "autonomous patient" model is based more on the business model of consumption. Much like the buyer-seller relationship, under the "autonomous patient" model, patients are allowed the positive right to demand certain treatments, medications, and therapies, some of which are inappropriate, while others may even be hazardous to the patient. Andereck notes that the recent change in marketing has only buoyed the "autonomous patient" model of health care, i.e., instead of advertising to medical professionals, medical devices and therapies are being marketed directly to patients/consumers

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[129] Andereck, William. "From Patient to Consumer in the Medical Marketplace." *Cambridge Quarterly of Healthcare Ethics*. Volume 16 (1), January 2007. 109-113.
[130] Ibid. 110.
[131] Ibid. 110. Of course there may be limits to this, which Andereck does not discuss in depth. For instance, health care providers might not be morally required to provide futile treatment to patients even when patients and patients' surrogate decision makers demand such treatment. For a discussion on this point, see: Jecker, Nancy S. and Lawrence J. Schneiderman. "When Families Request 'Everything Possible' Be Done." *Journal of Medicine and Philosophy*. Volume 20 (2), 1995. 145 – 163.
[132] Andereck. *Op. Cit.* note 129. 111. Andereck does not use this specific term, as he does "respect for persons." Rather he simply discusses patients who view themselves as autonomous consumers with positive rights.

who then go to their providers and ask for devices and therapies which may be inappropriate or harmful.[133]

The "autonomous patient" model has, for reasons noted above, furthered the advance of medicine into the realm of the free market, and Andereck highlights the negative effects this change has had on health care. For example, under the "autonomous patient" model, so-called empowered patients are the ones making the majority of the decisions regarding their health care, not always to the benefit of their health. In contrast, under the "respect for persons" model that Andereck advocates, patient's needs, desires, well-being, and values are inherent in the decision procedure, but the health care provider is the one making the ultimate treatment decisions. Andereck argues for this model based on the premise that it is actually in the best interest of the patient, and that it meets the demands of the Aristotelian notion of virtue. According to Andereck, the virtue of respect for persons demands that the physician treat the patient neither as a mere object nor as a dictator demanding care. It is the mean between these two vices[134] that Andereck advises; the health care provider should see the patient as a whole being, one with concerns, wishes, a past, a future, personal relationships, and values. The provider should work for the well-being of his/her patient while considering all of these factors.[135]

Andereck's article clearly calls for limiting the commercialization of medicine, especially the patient–health care provider relationship. For Andereck, the patient-provider relationship is fiduciary relationship, not one of two equally-powered beings interacting, nor is it a business relationship where the consumer is able to make specific demands of the provider as if he/she were purchasing a commodity. Andereck illustrates that the model we use for health care has a great impact on how patients see their health care, how health care is marketed, how providers are expected to act, the attitudes of health insurance companies, etcetera. Andereck's paper highlights the problematic conditions brought to the table by the claim of total patient autonomy. While those who make calls for patient autonomy might not, *prima facie*, seem to advocate for viewing health care as a free market, Andereck argues that the way patient autonomy has been implemented over that past years has led to commodification of medical care, especially the patient-provider relationship.

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[133] Ibid. 111.
[134] For further discussion of Aristotelian virtue, vice, and *eudemonia* (the best of all possible lives), see Chapter Five.
[135] Andereck. *Op. Cit.* note 129. 112.

While Andereck explicates some serious concerns that all health care providers, bioethicists, and economists should address, his short work leaves room for further clarification on one issue in particular. Andereck obviously is reluctant to hop on the "autonomous patient" bandwagon for unmistakable reasons (e.g., his argument that patients do not have the right to demand treatment). However, his criticism of viewing the patient as a self-directed individual seems to overcompensate for the issue at hand. It should be noted that the argument against the commodification of the patient–health care provider relationship does not necessitate the stripping of patient rights. Rather, many bioethicists have argued against the commodification of the patient-provider relationship utilizing patient rights as an essential premise. What all advocates of the vital nature of the fiduciary patient-provider relationship accept, and indeed demand, is that the patient's needs and welfare should come first and foremost. The provider is to check all concern for his/her own desires at the office door. From this perspective, it is reasonable to make positive rights claims for the patient, as Andereck alludes to in his work. What is unacceptable is the demand that patients should, or need to, make specific stipulations about the details of their health care. Certainly Andereck is not arguing against informed consent to treatment, but he does argue that the model of health care that envisions patients making diagnoses, choosing their treatments without advice, or receiving prescriptions upon command is unacceptable. Any model of health care that allows for such is one that views the patient as a completely informed, autonomous consumer, with the health care provider regulated to the status of a merchant plying his/her goods at the lowest cost to the selective customer. I concur with Andereck's position that this is one of the ills which falls out of the commodification of health care.

*VI. Conclusion*

What is needed, and what I provide in the following two chapters, is an understanding of a healthy patient–health care provider relationship: one that elucidates the demands of this unique and fragile connection. In Chapter Four, I lay out both an idealized version of a business relationship as well as a patient–health care provider relationship. In doing so, I show that even a view of stakeholder capitalism, which includes Gilmartin and Freeman's responsibility thesis, is unable to fully encompass what is necessary for a healthy patient-provider relationship, namely the virtue of a fiduciary, beneficence. In the fifth chapter, I discuss virtue theory and show how it is able to fully explicate what is required of a health care provider since virtue theory demands first and foremost an understanding of how to achieve and incorporate the

virtues properly in one's life. Both chapters four and five present my argument that the patient-provider relationship is not reducible to a business relationship because acting as a business person does not include the necessary virtue of beneficence, which is morally required of health care providers.

**Chapter Four: Business Models vs. Health Care Relationships**

*I. Introduction*

The argument presented by economists, bioethicists, and even some health care providers that a patient–health care provider relationship can and should be viewed as a business relationship hinges on a particular view of how capitalism directs business interactions. However, various interpretations of capitalism have been presented over the past two centuries. Adam Smith's seminal work, The Wealth of Nations, outlines the free market in stark terms, focusing on the invisible hand of competition.[136] Smith argues that capitalism need not be restrained by any legal or moral bindings; in fact, capitalism is most efficient for all (merchants and consumers alike) when left alone.[137] Modern interpretations of capitalism, such as that provided by Gilmartin and Freeman, on the other hand, aim to expand Smith's original presentation by explaining how moral values are indirectly taken into account on all levels of business interactions. The view that health care relationships should be treated as business relationships has arisen from both views of capitalism. In this chapter, I argue against viewing the patient–health care provider relationship as a business interaction regardless of one's interpretation of capitalism.

In the second section of this chapter, I outline the two types of capitalism mentioned above. I explicate the traditional view of capitalism first presented by Adam Smith, then contrast this type of capitalism with the contemporary stakeholder view, for which Gilmartin and Freeman advocate. In the third section, I present four arguments against placing health care within a stakeholder version of capitalism. These arguments are as follows: 1) the necessary components of stakeholder capitalism are not identical to the necessary components of a health care relationship. Thus, the argument presented that the two are interchangeable is invalid. 2) Regardless of similarities in outcomes, there are moral differences between a business interaction and a health care relationship. Therefore, claiming that the two are fundamentally similar based on an evaluation of the results of both interactions begs the question. 3) Stakeholder capitalism contains constraints, many of which are ignored by advocates of stakeholder capitalism, which are unacceptable in a patient–health care provider relationship. And, 4) as Arrow discussed in 1963, health care is not an austere commodity because of uncertainty. For all of these reasons, the patient-health care provider cannot be viewed simply as a type of business interaction.

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[136] Smith, Adam. The Wealth of Nations. Bantam Dell: New York City, New York. March, 2003.
[137] Ibid. 572.

The fourth section of this chapter is a presentation of the essential elements of a patient–health care provider relationship. This explanation of how to properly view health care relationships expands on the arguments offered in the third section. I offer a positive view of the vital virtue which a health care provider necessarily must exhibit in order for the patient-provider relationship to be a healthy, successful interaction. The fifth and final section of this chapter offers a counter-argument to my outline of patient–health care provider relationship and a reply to this counter-argument. Some might argue against me that, in fact, exemplary customer care provided by a merchant is often better than the care provided by a health care provider. Thus, my view of a patient-provider relationship is idealized, and not what actually happens, and further that I am too harsh in my objection to business interactions. I reply to this objection by pointing out that exemplary customer care is either done out of self-interest (on the part of the merchant) or friendship. Thus, the claim that exemplary customer care is actually better than the care provided by a health care provider is based on a misinterpretation of the motivation of the merchant providing the exemplary service. Additionally, health care providers operate on different virtues when compared to the virtues displayed by the outstanding merchant. The virtue of a health care provider is the virtue displayed by a fiduciary (beneficence), whereas beneficence is not required of a business person in an exchange on the free market.

*II. The Standard Version of the Free Market versus 'Stakeholder Capitalism'*

The most basic form of a business relationship in a capitalist, free market is that of a consumer interacting with a merchant. The consumer is standardly assumed to be an autonomous individual seeking a product to fulfill his/her specific need(s). The consumer is expected to act in his/her self-interest by 'shopping around,' i.e., seeking out the best quality product at the lowest available cost. The merchant's ultimate goal is to provide a product for which there is a great demand, while simultaneously maximizing his/her share of the market for that product. This is often done by innovation either relating to the product (creating a bigger, better product), or relating to the manufacturing of the product (producing the product at a lower cost). This type of interaction within the free market is considered just because both the consumer and the merchant enter into the transaction freely and are able to make their decisions autonomously. So long as neither side is forced by coercion (e.g., the merchant does not lie about the product), the purchase of the product is said to be fair.

"[The merchant] intends only his own security; and by directing that industry in such a manner as its produce may be of the greatest value, he intends only his gain, and he is in this, as in many other cases, led by an invisible hand [...]."[138] Both the merchant and the consumer are said to be inadvertently aiding the economy of the community by acting in their own self-interests. When the consumer and the merchant do exchange money for the product, both are assumed to be attempting to maximize their end of the transaction; neither is working to benefit the other party. However, the consumer, by purchasing the best product available at the lowest cost, is encouraging merchants to vie for the consumer's business. Likewise, the merchants, in attempting to out-do others in their particular market, are constantly providing new products at lower costs for the community. While neither is overtly attempting to aid anyone else, the market flourishes due to the resulting competition. It is this interaction that is encouraged by Adam Smith. Smith argues that when all work for their own best-interest, the interests of society at large are, unintentionally, also met. "By pursuing his own interest he frequently promotes that of the society more effectually than when he really intends to promote it."[139]

The typical product example used to illustrate the free market is the mousetrap. Suppose the Rat-Killer company invents, manufactures, and markets a new method of trapping and killing mouse invaders. The company manufactures their product and sells it to members of the public who are attempting to eliminate pesky mice intruders. Since Rat-Killer's new product is more effective than the other mousetraps on the market, Rat-Killer is able to sell its product at a slightly higher price, thus making a higher profit than the other companies. Other mousetrap companies with less effective mousetraps lose some of their share of the market because of competition with Rat-Killer's new product. The consumers are happy because their hard-earned dollars are being spent in a more effective manner. Under this conventional understanding of the free market, Rat-Killer's primary concern is making money; while their new product has made their customers happier, that was not the company's ultimate goal. Insofar as a happy customer is a repeat customer, Rat-Killer has a strong interest in ensuring customer satisfaction, but this does not change the primary concern of the company. Rat-Killer is interested in a profit. If making their customers happy increases the likelihood that the company will be profitable, then Rat-Killer will attempt to make their customers happy. Merely attempting to make their customers happy does not mean that the company is exhibiting

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[138] Ibid. 572.
[139] Ibid. 572.

beneficence. Rat-Killer is only acting as any responsible business would to ensure the financial security of the company.

Some contemporary economists bristle at this presentation of a business interaction. As presented in Chapter Three, Gilmartin and Freeman[140] argue that the above understanding of capitalism is a misrepresentation of what actually occurs. For instance, the company Rat-Killer is not a single entity. It incorporates owners, employees, researchers, developers, etcetera. Likewise, customers ought not to be lumped into one category. Each individual consumer has his/her own interests and considerations to take into account, and Gilmartin and Freeman argue that those considerations cannot be reduced merely to purchasing the most effective and reasonably priced mousetrap. It is likely, Gilmartin and Freeman contend, that both the employees of Rat-Killer and Rat-Killer's customers are worried about the environmental impact of the product, the influence of the corporation on the community, and perhaps even the welfare of the creatures being captured. Gilmartin and Freeman term this understanding of the free market 'stakeholder capitalism.'[141]

Stakeholder capitalism might replace the previous mousetrap presentation of capitalism with the following. At the same time that Rat-Killer releases its new mousetrap, another mousetrap-making company, Mousy-Rescue, markets a new no-kill mousetrap. Additionally, Mousy-Rescue spends a great deal of time and money informing the public that their company does not pollute the environment, that they pay a living wage to all employees, and that the company donates some of their profits to local schools. The employees of Mousy-Rescue are excited to work for a 'green,' socially responsible company, and the employees tell their friends and neighbors about Mousy-Rescue and its superb products. Now, consumers with pest problems are able to choose between two new products (one marketed by Rat-Killer and one marketed by Mousy-Rescue). Both are equally effective, and the cost is approximately the same as well. Stakeholder capitalism claims that conscientious consumers will likely opt for the product that is made by the socially responsible company. Whether it is because the product does not kill mice or rats, the company pays all of its employees a reasonable wage, Mousy-Rescue does not harm the environment, the company donates money to the community, or all of the above, consumers will opt for the product made by a company they respect and wish to support. Neither businesses nor consumers are merely driven by a cost-benefit analysis.

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[140] Gilmartin and Freeman. *Op. Cit.* note 76.
[141] Ibid. For more discussion of 'stakeholder capitalism' see Chapter Three.

According to stakeholder capitalism, humans make business decisions based on numerous factors (some of which are listed above), and it is very rare for either a business or a customer to make a product choice based only on price and effectiveness. Thus, according to stakeholder capitalism, Mousy-Rescue will outsell Rat-Killer, grab a larger portion of the mousetrap market, and generally be a healthier, larger company than Rat-Killer. Because Mousy-Rescue takes seriously the complex relationships and values of its employees and its customers, it will be a thriving business. Ultimately, the main point made by proponents of stakeholder capitalism is that my example of Mousy-Rescue is a more accurate representation of how capitalism actually works.

Both Rat-Killer and Mousy-Rescue are companies attempting to maximize profit. This is what it means to participate in business. However, the two companies go about maximizing profit in different ways. Rat-Killer focuses on providing a cheep, yet effective, product for their customers. Mousy-Rescue, on the other hand, has additional motivations at stake. The company wants to make a profit, but it also wants to do so in a manner that shows concern for its employees, the community, the environment, and even the pests themselves. Mousy-Rescue, however, is not acting altruistic in its actions. Mousy-Rescue is as concerned with its bottom line as Rat-Killer; if Mousy-Rescue can no longer make a profit, then the rest of its seemingly 'altruistic' efforts are irrelevant. What is, and must be, the predominate motivation for Mousy-Rescue, and any company, is profit. While Mousy-Rescue attempts to make its profit while being socially responsible, even acting in this manner enables them to capture a particular portion of the market that perhaps Rat-Killer has neglected. By demonstrating its concern for its employees, the community, the environment, and mice, Mousy-Rescue is able to appeal to concerns of customers that Rat-Killer has neglected.

If stakeholder capitalism is an accurate presentation of how companies and consumers actually operate, then businesses that realize that consumers have concerns beyond cost-effectiveness of products will only be acting fiscally responsible by appealing to those other concerns of the public. Mousy-Rescue is able to maximize profit by exhibiting concern for more than the cost-effectiveness of its product. When viewed from this light, the difference between Rat-Killer and Mousy-Rescue becomes less vivid. Both companies are ultimately concerned with profit and both go about maximizing profit. The only difference is the manner in which the companies attempt to maximize profit. Cowboy capitalism and stakeholder

capitalism differ only in their understanding of how to ultimately achieve profit; profit, in both understandings of capitalism, is what is of fundamental importance to businesses.

According to Gilmartin and Freeman, as well as other contemporary economists and business ethicists, 'stakeholder capitalism' takes into account relationships and values of all of the 'stakeholders' (e.g., entrepreneurs, managers, customers, suppliers, financiers, and communities). People do not care only about their bank accounts, and they do make value-judgments when they shop. That is why, according to those who present this form of the free market, capitalism is not only able to incorporate health care and the relationships inherent in health care, but they further argue that stakeholder capitalism is the groundwork from which we should operate when we work to improve or reform health care. Health care providers, much like the Mousy-Rescue employees, feel that they are providing the community with an essential 'product,' and they take pride in doing their work well. 'Consumers' of health care make value judgments about the health care they purchase. Health care 'customers' take into account whether their health care providers are personable and compassionate, interested in giving back to the community at large, and if the employees are treated well in addition to evaluating the health care they receive (i.e., if their health care provider was able to correctly diagnose and treat their ailments).

Regardless of whether one uses stakeholder capitalism or a more traditional version of the capitalism to assert that the free market can, and should, be applied to health care, the resulting argument is the following: an excellent merchant/business will not offer poorly made wares, will care about the happiness of his/her customers, will take into account how their business impacts the environment and the community, will pay living-wages, and will provide health insurance to their employees. On the other side of the equation, consumers are drawn toward companies that exhibit the above-mentioned traits, and they will avoid products offered by companies that do not go above-and-beyond. Eventually, companies that do not treat their customers with respect, care, and generosity, and who refuse to treat the environment and the community in a responsible manner, will be put out of business.

This is no less true for health care than any other business, so the argument goes. Health care providers who do not treat their patients with respect, care, and generosity will soon find themselves without patients, and thus without a 'business.' Just as businesses must take into account their relationships with their consumers and the community at large, so must health care providers be concerned about their relationships with their patients and their communities.

The free market is as capable of adjusting for healthy business relationships as it is shoddy products and poor craftsmanship. Advocates of the free market and stakeholder capitalism alike claim that there is no need to employ a different evaluation system when assessing health care providers and health care relationships. Instead, we should increasingly push health care further into the realm of the free market.

I respond that this argument is invalid, and further that this interpretation and subsequent application of capitalism to health care is neither accurate nor morally acceptable. In the following section, I outline four objections to the above claims, including an analysis of the argument, an outline of why this understanding of capitalism is faulty, and finally what would happen to health care if we embraced this argument.

*III. Four Arguments Against Health Care as a Part of 'Stakeholder Capitalism'*

There are four significant problems with the argument presented above. First, the argument made by those who propose using stakeholder capitalism as a model for health care make an invalid argument when they conclude that business relationships and health care relationships are interchangeable. Second, the primary motivation is what is of importance when comparing business interactions with patient-health care provider interactions. So, any argument that concludes that outcomes are essentially the same in business relationships and patient–health care provider relationships is irrelevant. Third, it is not always possible, as proponents of stakeholder capitalism claim, for consumers to act upon their values, whereas it is morally required of a health care provider to allow his/her patient to act upon the patient's values. Fourth, proponents of stakeholder capitalism do not address Arrow's concerns of uncertainty, and it was uncertainty in particular that let Arrow to conclude that health care was not a standard commodity.[142]

*A. Reply One: Argument is Invalid*

The above argument is unable to validly conclude that it is possible to treat the patient–health care provider relationship as any other stakeholder business interaction. The invalid argument presented by stakeholder capitalism proponents can be reconstructed as follows:

**P1)** All stakeholder business relationships necessarily include "positive interactions" between all stakeholders.

[142] Arrow. *Op. Cit.* note 14. For an overview of Arrow's work, see Chapter Two.

**P2)** "Positive interaction" is defined as including empathy, civility, integrity, generosity, and all stakeholders must be satisfied by the interaction.

**P3)** Patient-provider health care relationships necessarily include empathy, civility, generosity, and result in the satisfaction of both the patient and the health care provider.

**P4)** From **P2** and **P3**, patient-provider relationships necessarily include "positive interactions".

**P5)** Stakeholder business relationships and patient-provider relationships share one necessary condition.

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**C)** Patient-provider relationships are the same as stakeholder business relationships (or, the two types or relationships can be treated as interchangeable).

The conclusion does not necessarily follow from the premises presented. The only way for this type of argument to work is to claim that "positive interactions" are sufficient to stakeholder business interactions as well as patient–health care provider relationships, but this is also clearly false. What is sufficient to a stakeholder business relationship seems to be some sort of commodity exchange, and this is precisely what I argue does not occur in a patient-provider relationship interaction. This difference becomes more apparent as I address the following three responses to the stakeholder business interaction argument.

*B. Reply Two: Similarity of Outcomes is Irrelevant*

Even if we allow that it is the case that businesses and health care providers both act with the empathy, civility, generosity, and ensure that the consumer/patient is satisfied with the interaction, it does not follow that the two interactions are significantly morally similar. This is because I hold that one's primary motivation does make a difference when morally evaluating one's actions.[143] To illustrate this point take, for example, Nicadeamus and his uncle Io. Nicadeamus visits his ailing mother in the hospital because Nicadeamus cares about his mother's health and overall well-being, and he knows that by being there, he will support her during her recovery. Io, on the other hand, visits his sister because he thinks it is possible that

[143] This position, of course, favors an ethical theory which can account for motivations of agents as virtue theory is able to do. I will not attempt to prove that virtue theory is, in fact, the best moral theory (or a complete moral theory). However, I do feel that an important part of moral evaluations of individuals and actions includes an assessment of the agent's motivations (as problematic as making that assessment can be). In the following example I provide (the comparison of Io and Nicadeamus), I attempt to show that our moral intuitions support this view.

she has included him in her will, and he knows that by visiting his sister in the hospital, it is likely that she will increase the portion of her estate that she will leave to him in her will. Certainly we would say that Nicadeamus has done something morally good, and that it is likely that Nicadeamus is a good person. Io, however, has done something immoral; he has acted only out of self-interest in a situation in which we would argue his primary concern and regard should be for his ailing sister.

If Io makes it clear to his sister that he is only visiting in order to ensure his future inheritance, he at least is not deceiving her. However, if Io does hoodwink his sister into thinking that he really wanted to be there simply because he loves her, his action seems even worse. Io's visit will seem significantly similar to Nicadeamus's, and the patient would likely have the same reaction to both Io's and Nicadeamus's visit. However, her (incorrect) interpretation is not the central aspect in the moral evaluation of Io's and Nicadeamus's actions. Even if the patient thinks/claims that both Io and Nicadeamus have acted morally, we who are in the know would disagree with the patient's claim. This example illustrates that we have a moral intuition that the primary motivation of the agent, not merely outward appearances nor end results, matter when evaluating both the agent's action as well as the agent's character traits.

This is essential to keep in mind when comparing a business interaction to the patient–health care provider relationship. Even if the business interaction includes 'positive interaction' (according to the stakeholder model of the free market, there is empathy, civility, integrity, generosity, and all stakeholders achieve satisfaction from the interaction), what drives the empathy, civility, integrity, generosity, and satisfaction in a business interaction is profit. At the end of the day, what matters in business interactions is the bottom line of the account's ledger. It is quite likely that focusing on 'positive interactions' is a productive method in achieving business growth and profitability, and this is the reason for ensuring that a business is set up according to the model of stakeholder capitalism. Compare this to the patient–health care provider relationship. The patient-provider relationship includes empathy, civility, integrity, generosity, and satisfaction on the behalf of both the patient and the provider not because it maximizes profit, but rather because that is the best way to achieve health on the behalf of the patient and to ensure a long-lasting, trusting patient-provider relationship. The motivations of the patient-provider interaction plainly should not be similar to the stakeholder business interaction.

One might retort that simply because the stakeholders in a business interaction care about profit and/or a commodity, that does not entail that the interaction is immoral. There is no reason, this response would claim, to assume that merely having profit/commodity as the ultimate end is not a sufficient reason to deem the entire business interaction immoral. I agree with this position completely. However, I claim that taking this position one step further is unacceptable. While it is not immoral for profit to be the end goal for a 'positive' stakeholder business interaction, it is immoral if profit is the end toward which the provider or the patient directed their actions in the patient–health care provider relationship.

*C. Reply Three: Acting on Values*

The claim made by 'stakeholder' economists that the consumer will be able to act on his/her values is not always true in business interactions. Very often customers are forced to buy products, and thereby support companies, against their wishes. For example, Dakota is a single mother who cannot afford a car. She is on a tight budget and is severely restricted as to where she is able to shop. When she does shop, she is only able to go to the few stores in her neighborhood. Once there, she must select from the products those merchants offer. So, if Dakota is looking for an effective mousetrap, she may or may not have Mousy-Rescue as an option. Further, if it is in stock at her local store, it might be out of her price range. Due to her budget constraints, she may only be able to afford a less-effective and less-expensive mousetrap, even though she wishes she could support the Mousy-Rescue company. Dakota, like most single parents, faces constraints that drastically limit her abilities to shop according to her values, as economists claim all (or even most) customers can and do. In practicality, consumers are limited by time (e.g., the time to go to a store of his/her choice), transportation (e.g., the ability to drive, bike, walk, or take the bus to a store of his/her choice), and budget (e.g., the ability to purchase the product of his/her choice). Dakota may be forced to purchase a mousetrap that was manufactured by a company of which she does not approve in a store that she feels has immoral business practices. Her ability to act as a conscientious consumer is nullified by other restrictions.

It might seem that these limitations would affect her ability to select her health care in a similar manner, and, to some extent, this is true. Her primary provider choices might be limited by transportation factors, just as her clinic and hospital preferences will be checked by her health insurance (if she is lucky enough to have any). However, I argue that the relationship she does have with her health care provider ought not to be one of the factors outside of her control.

Her relationship with her provider is not one of lesser quality simply because of her inability to truly have her druthers regarding her choice of health care provider. The patient–health care provider relationship must meet her standards of quality health care. Her provider, whomever she sees, should still treat her with respect, integrity, honesty, and goodwill. This is because the profession of health care has a radically different goal than any business interaction. The first and foremost aim of any health care provider is to ensure the health of his/her patient, and the health of the patient cannot be ensured unless the health care provider allows the patient to bring his/her values to medical appointments.

Health care providers often act upon respect for their patients' values, sometimes without even realizing it. For example, Dakota visits her health care provider complaining of fatigue, shortness of breath, insomnia, and dizziness. Her health care provider diagnoses her as having severe anemia caused by low red blood cell production, and they discuss possible treatments. Dakota's health care provider encourages Dakota to eat iron-rich foods, such as clams, mussels, oysters, and liver (beef, chicken, or human). Dakota informs her provider that eating those foods is not an option; she is a vegetarian (and not a cannibal). So, the two discuss other treatment possibilities. This is a simple example of a patient's values coming into context during treatment. Regardless of where or from whom Dakota seeks medical attention, she *is* able to act upon her values in a way that she is often not as a business consumer.

*D. Reply Four: Arrow's Concern of Uncertainty*

Current economists and business ethicists have neglected to address Arrow's primary concern regarding the difference between health care and other austere commodities (such as mousetraps): uncertainty. As mentioned in Chapter Two, Arrow claims that uncertainty in health care includes uncertainty regarding when or if one will become ill, the uncertainty of the patient regarding what the illness actually is and how it is to be treated, and finally, the uncertainty of the patient (and sometimes even the health care provider) regarding recovery time.[144] None of these forms of uncertainty apply to most other goods. It is not uncertain when or if one will need food or clothing. Nor is it unknown how to resolve the problem of a hungry tummy or cold toes. And, of course, it is not a mystery how long it will take for the tummy to become un-hungry after eating, or how long the toes will need to warm up. Arrow said that austere goods, such as food, clothing, shelter, water, etcetera, have almost no uncertainty related

[144] Arrow. *Op. Cit.* note 14.

to them. Other goods, such as mousetraps, have very little uncertainty associated with them, but such uncertainty is negligible when comparing it to the uncertainty coupled with health care.

Arrow's main concern regarding uncertainty was that uncertainty would be the focal point of any patient–health care provider relationship. The patient seeks out the health care provider precisely because the patient does not know what is wrong or how to treat his/her illness. The health care provider is asked for expert advice in order to help the patient resolve the illness. This type of relationship is known in medicine as a fiduciary relationship; the patient trusts the health care provider to act in the patient's best interest in diagnosing the illness and advising and prescribing treatment. The patient seeks out an expert who will act as a fiduciary precisely because of the patient's uncertainty. The trust imbued in the health care professional is essential to the relationship and to the health of the patient.

This type of fiduciary relationship is clearly not similar to any business interaction, whether it is a 'stakeholder' business interaction or no. There are similarities, true. As mentioned in my first reply, both 'stakeholder' business relationships and patient–health care provider relationships include empathy, civility, generosity, and result in the satisfaction of all parties. However, as mentioned above in my second objection, the motivation for the inclusion of these qualities varies greatly between a business interaction and a patient-provider relationship. Even the most honest, successful business interaction is built on the desire to maximize profit. If there is trust in any of the members of a business interaction, it is that he/she will conduct his/her end of the business transaction/relationship in an honest manner. This does not mean that the honest business associate is trusted to act in the best interest of any other member of the transaction, but that is exactly the type of trust the patient must have in his/her health care provider. This lack of trust is not an issue in a healthy business interaction because the members of the transaction, including the consumer, do not have the uncertainty a patient has. The consumer is not at a loss regarding what product is needed, the cost of the product, how to obtain it, etcetera. There is no need for a fiduciary in a business interaction because uncertainty is not at stake. This is the essential difference between even the most healthy, prosperous business relationship and a patient–health care provider relationship.

In the next section, I lay out a standard patient–health care provider relationship. This illustrates the necessary components of such a relationship, which in turn aids in clarifying the difference between a health care relationship and a business interaction and provide support to my argument that the patient–health care provider relationship cannot be reduced to a business

interaction. To turn the patient-provider relationship into a business interaction is to force the health care provider to ignore his/her fiduciary responsibilities to the patient.

*IV. The Patient–Health Care Provider Relationship*

As mentioned above, the patient–health care provider relationship does not resemble a business interaction due to uncertainty. This uncertainty can be broken down into three main points: 1) there is an uneven balance of knowledge regarding the services being prescribed and/or utilized, 2) the patient has some (varying) level of vulnerability, and 3) there is never any certainty regarding use of health care/visiting a health care provider. These three factors, taken in conjunction with the motivation of the health care provider, result in a unique relationship. The health care provider, the expert in the situation who is relied upon for this expert knowledge, is trusted by the patient to make the correct diagnosis and to provide viable treatment options. However, the patient retains ultimate control over the relationship, its boundaries, and the ultimate health care decisions made. Further, the aim of the health care provider in this relationship is to aid the patient; the provider's motivation is to provide support, experience, and expertise to the patient. I will explicate this delicate balance in this section.

*A. Overview of the Patient–Health Care Provider Relationship*

In the stereotypical situation, a patient feels ill and he/she seeks out a health care provider. The reason for the visit to the health care provider is twofold: diagnosis and treatment. Usually, the patient either has only a vague idea of the cause of the illness or no idea at all. He/she has a list of symptoms, a mere description of the affliction to offer the health care provider. It is then the health care provider's obligation to take the patient's description and turn that into a diagnosis. This generally includes asking pertinent questions, performing a physical examination, ordering necessary tests, and perhaps even consulting other health care providers and diagnostic aids. Once the diagnosis is made, the health care provider is then expected to offer a treatment plan to the patient. If the patient finds the treatment plan amenable, he/she agrees and proceeds as directed. Of course this is the bare bones outline of what can be a long, arduous process. For instance, it may take weeks to get test results, there may be more than one diagnosis to rule out, and referrals might be required. Regardless of the intermittent steps or the time required to complete them, the ultimate goal and general procedure remains the same.

The essential elements to this interaction are (1) the uncertainty of the patient, (2) the expert knowledge of the provider, and (3) that both the patient and the health care provider have the same goal – achieving the best outcome possible for the patient. These three elements are intricate to the trusting relationship; the patient must trust (to some degree) the health care provider's ability to resolve the patient's illness in one manner or another, and that the health care provider will do this without ulterior motives. The patient trusts that the provider is working solely for the best interest of the patient, not for the gain of the health care provider. This trust arises out of this unique set of circumstances: the unequal amount of knowledge, the possible vulnerability of patient, and the health care provider's role as a fiduciary. The patient enters into the relationship trusting that his/her fiduciary will work solely for benefit of the patient, not for profit, fame, or legacy. If the fiduciary nature of this relationship breaks down, if the provider no longer acts with the patient's interests as his/her primary motivation, the relationship suffers. If the patient no longer trusts his/her provider, the patient will seek out another health care provider in order to have a proper fiduciary. Often, this is exactly what happens in the case of getting a second opinion. The patient lacks trust in his/her health care provider's abilities and/or motivations.

*B. The Health Care Provider as a Fiduciary and the Patient's Vulnerability*

Much has been made in contemporary bioethics literature regarding viewing the health care provider as a fiduciary. Some claim that this is not the proper way to understand the patient–health care provider relationship because it mitigates (in their view) the focus on the patient's voice and rights. However, I argue that this worry, while not totally unfounded (medicine has a nasty history of not working primarily for the patient's best interest), should not be taken to the extreme. The patient does have control over certain aspects of the relationship and the health care provided. For example, as noted above, the patient is able to act upon his/her values when deciding upon a treatment regime. The patient is also able to accept or decline testing, examinations, and referrals. The patient does retain ultimate control of the parameters of the relationship and the health care provided. However, this does not alter the fact that the health care provider is the expert and is providing this expert care to the patient. More importantly, this is exactly what the patient trusts that his/her provider will do. This is the essential nature of a fiduciary relationship.[145]

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[145] I discuss this position in greater detail in Chapter Five. Chapter Five includes a few historical examples of health care that was not focused on the best-interest of the patient, the response to these

What is also important to take into consideration is that the patient not only lacks expert medical knowledge, but also that the patient often is suffering from some level of vulnerability. Of course the level varies according to many factors, including (but not limited to) the patient's understanding of the field of medicine, the patient's previous health history, the patient's relationship with his/her particular health care provider, and the illness in question. A patient complaining of an ingrown toenail will likely not suffer from much vulnerability. However, a patient receiving treatment for cancer will be very vulnerable. This is because the patient is frightened, may be in severe pain, worried about family and friend's reactions to his/her illness, dealing with long-term and short-term life plans, and a myriad of other factors. One should not discount the significance of extreme emotional distress and pain when considering the ability of the patient to think rationally. This is not to imply that the patient's decisions and demands should be ignored (except in extreme cases, such as when a durable power of attorney for health care decision-maker is legally named). The patient still has, and ought to have, ultimate control over his/her health care. However, the patient is likely going to rely more heavily upon his/her health care provider and the health care provider's expertise as the patient's integrity wanes. In cases of serious illness, the trust in the patient's fiduciary is heightened, as is the reliance on the health care provider's expertise. This cannot be overlooked by either health care professionals or bioethicists.[146]

A patient–health care provider relationship is unlike almost any other. Even other professional relationships have significant differences when compared to that of the patient-provider, and clearly the health care interaction is not reducible or interchangeable with a business relationship. There is much more at stake in a health care relationship than even the most complex business model can incorporate. Further, what is lost when one attempts to reduce a patient–health care provider relationship to a business interaction is the analysis of the uncertainty which makes the relationship unique, and, more importantly, the primary motivation of the health care provider. Thus, if one were to reply to my interpretation of the patient-provider relationship that one accepts that there is uncertainty unique to the relationship and that it cannot be taken into account if one were to attempt to redraw the patient-provider relationship as a business interaction, but that one feels that the business version is preferable (for whatever reason), one is prescribing a patient-provider relationship that is actually immoral. A health

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examples of abuse of paternalism in medicine, and a further explanation of why a focus on patient autonomy does not negate the fiduciary nature of the patient–health care provider relationship.

[146] For a more thorough discussion of the type of interaction and decision-making patients actually desire in both standard patient-provider interactions as well as when the patient has been recently diagnosed with a severe illness, see my review of studies done on patients' desires in Chapter Two.

care provider cannot morally treat the relationship he/she has with his/her patient as a business relationship. Willfully ignoring the circumstances of the singular interaction of the patient-health care provider is tantamount to moral failure as a health care provider (or prescribing moral failure to the health care provider if the one making the argument is not him/herself a health care provider).[147]

*V. Counter-Argument and Reply*

*A. Overview*

A common reply to my position is that I am taking a conventional business interaction as my standard for a business relationship, and that just as there are outstanding health care providers, there are outstanding business persons who seem to act as fiduciaries to their customers. While I agree wholeheartedly that there are outstanding business owners who truly do go above and beyond what I have described previously, I reply that this counter-argument fails for one of two reasons. In this section, I present the counter-argument and my two responses to its position.

*B. Counter-Argument*

Some might retort that my presentation of a patient–health care provider relationship *does* resemble an exemplary business relationship, despite my claims that the twain never shall meet. Auto mechanics, for example, are sought by customers who are experiencing uncertainty similar to that of an ill patient. As stated above, the three types of uncertainty a patient exhibits are as follows: 1) there is an uneven balance of knowledge regarding the services being prescribed and/or utilized, 2) the patient has some (varying) level of vulnerability, and 3) there is never any certainty regarding use of health care/visiting a health care provider. The counter-argument claims that the first and third form of uncertainty apply in many cases of business interactions, as in the auto mechanic example. The auto mechanic customer lacks expert knowledge and seeks out the auto mechanic when his/her car is unexpectedly ailing. Further, the customer trusts that the mechanic will use his/her expert knowledge to ensure that the car is repaired properly and safely. The customer retains the ultimate power in the relationship because he/she can decline some or all of the services the mechanic prescribes. If the customer

[147] I explain the moral failing of a health care provider who treats his/her patients as mere customers in Chapter Five.

does assent to the mechanic's expert advice, the customer trusts the mechanic just as a patient trusts the health care provider with his/her care.

What makes this comparison even more compelling is the testimony of customers who have exceptional relationships with their mechanics. Some mechanics do treat their customers with the respect, dignity, care, and generosity that some health care professionals lack. Mechanics have stayed open late in order for their repeat customers to pick up their wheels. Others will not charge when their repairs are done to compensate for previous errors. I have even had mechanics refuse payment for labor in making estimates when my car was ultimately deemed unsalvageable. This type of exceptional customer care rivals that of many health care providers. If one has more trust and faith in his/her auto mechanic, it seems reasonable for one to claim that this type of customer-merchant relationship is similar to, or even superior to, a patient–health care provider relationship.

*C. Response One*

There are two reasons this argument via comparison fails: 1) it misconstrues the ultimate motivation of the business owner, and 2) it conflates acts done out of friendship with business interactions. First, as previously mentioned, the ultimate aim of any business, according to any formulation of the free market, is to make a profit. Regardless of if a business is analyzed using 'cowboy capitalism' or 'stakeholder capitalism,'[148] the main purpose of the business is to maximize revenue. Certainly the method of doing this changes drastically depending on the business model used, but the goal is unaffected by the methodology.[149] An auto mechanic who takes seriously his/her reputation, customer satisfaction, and repeat business

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[148] Gilmartin and Freeman. *Op. Cit.* note 76.

[149] This is not to say that a business owner will do anything to maximize his/her profit. Certainly business folk might place constraints on their actions for moral reasons, and rightly so. However, acting with integrity, encouraging sound moral character, etcetera is not exhibited of the business person qua business person, but rather business person qua moral human being (or good citizen, respectful individual, etcetera). There are, of course, business people who take seriously their moral code, but they do not do so based on their business obligations. What is of concern here is the argument that business people act as fiduciaries as part and parcel of their standing as a business person. This, I respond, is not the case.

It is also true that some business owners will not compromise some principles in how they run their businesses. For example, a business committed to providing only vegan, cruelty-free wares will likely not start offering leather purses simply because doing so would increase the business' profitability. However, these types of businesses are unusual; they are marginalized and fringe businesses, not what are commonly thought of when thinking of examples of businesses operating in the free market. Further, while these types of businesses will not alter their fundamental position on the types of goods they offer, they are still businesses. If they did not make a profit, they would go out of business. If they truly were not interested in making a profit, they would be non-profit organizations. While these businesses do operate only in adherence with the owners' moral values, they are still businesses and also only operate if they produce a profit.

will likely act with courteousness, respect, and honesty when dealing with his/her clientele. The mechanic will patiently explain problems and possible repairs, charge reasonable rates for those repairs accepted by the customer, and even extend extra courtesies to repeat and devoted clients. The ultimate reason for doing this, however, is to ensure future profitability. By maximizing customer satisfaction, the mechanic is truly showing concern for his/her bottom line. Again, this is perfectly morally acceptable; the merchant is expected to act in his/her own best interest in conducting business affairs. It just so happens that acting in the best interest of the business entails operating an honest, conscientious company. Taking responsibility for errors made by staff, offering extended hours, and even refusing payment for perfunctory duties all fall reasonably into the category of operating a successful business by ensuring customer satisfaction.

Health care providers, on the other hand, act as fiduciaries not to ensure that their patients bring their "business" back to the clinic in the future. Health care providers act with care, courteousness, respect, and honesty because this is what is morally required of the fiduciary relationship. The provider's motivation is to aid the patient. This is not the provider's motivation because aiding the patient results in profitability. This is the provider's motivation because acting on the best-interests of the patient is how to achieve the best health outcomes, heal (as much as possible) the patient, and mostly to ensure that the patient achieves his/her health goals. Patients trust that their health care providers are acting with beneficence rather than with profit-motivation. While the customer of the auto mechanic who has excellent customer satisfaction will undoubtedly be an impressed, repeat customer, said customer does not question the motivations of the auto mechanic. The customer knows that the mechanic is attempting to run a successful, profitable business. The patient of a courteous, respectful, honest health care provider likewise does not question the motivation of the provider; the patient trusts that the provider is not attempting to run a successful, profitable business, but rather that the provider is solely acting in the best-interest of the patient.

*D. Response Two*

The outstanding examples of customer care are sometimes done not in order to ensure future profitability on the part of the auto mechanic's business, but rather these are instances of the mechanic acting out of friendship.[150] This means that the auto mechanic sets aside his/her

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[150] I use the term 'friendship' here loosely; it includes friendship between two individuals, family, romantic partners, and other significant emotional relationships.

hat as a business owner, and puts on his/her hat as friend, family member, significant other, etcetera. The auto mechanic in these situations is not acting qua auto mechanic. For example, if Katrina's car breaks down, and is towed, assessed, and fixed at only cost of the parts by her cousin's auto garage, this is done out of familial courtesy rather than as method to ensure future business with the customer. Katrina is certainly being paid an extraordinary level of customer treatment, but this is not because Katrina is a repeat customer, a client who is likely to refer her friends, or even because she is hot. Katrina's cousin is acting out of concern for her as a member of his/her family rather than acting as a dutiful auto mechanic. While we can applaud Katrina's cousin's actions as morally laudable on the grounds that other cousins might not act likewise in similar circumstances, we certainly do not evaluate her cousin's actions based on any model of capitalism. This is because the mechanic is not acting out of his capacity as business owner in this circumstance. In this case, the mechanic is acting as a concerned, courteous family member. The fact that the mechanic is a business owner is irrelevant in this circumstance; there is no business motivation in this case. Thus, this is not a counter-argument to my presentation of the difference between business interactions and the patient–health care provider relationship because this is not an example of a business interaction.

Actions done in order to maximize the company's future and actions done out of friendship (or some other intimate relationship) clearly are not akin to the actions done in accord with the patient–health care provider relationship. The similarities upon which the counter-argument focuses are actually only similar to the patient–health care provider relationship in a superficial manner. The fiduciary nature of the patient–health care provider relationship is not replicated in even the most caring, considerate business interaction. The factor that is essential to the health care relationship is beneficence, and this is missing from business transactions. In the following chapter, I explain the nature of the patient-health care relationship utilizing virtue theory in order to illustrate further how it varies from business interactions which occur in capitalism in a morally significant manner.

**Chapter Five: Virtue Theory and Its Applications**

*I. Introduction:*

In the previous chapter, I outlined the basics of a patient–health care provider relationship. I argued that a proper understanding of this type of interaction necessarily includes that the health care provider exhibit the virtue of a fiduciary, namely beneficence. This virtue, which is not utilized in a business interaction, is essential for the patient–health care provider relationship to meet basic moral standards. In this chapter, I outline virtue theory and present some contemporary applications of the moral theory. After sketching this moral theory, I argue that beneficence is necessary on the part of the health care provider for an ethically sound patient–health care provider relationship, and that beneficence on the part of the health care provider is what causes the patient–health care provider relationship to look radically different than a business relationship. This application of virtue theory to the patient–health care provider relationship further supports my argument that this relationship is separate from capitalism and business interactions in general.

In order to clarify why virtue theory is able to accommodate health care interactions, I will first present an overview of virtue theory. This section will include a description of Aristotle's original view of virtue theory as he presented it in Nicomachean Ethics. I will also present a modern interpretation, provided by Rosalind Hursthouse, of Aristotle's theory – one way in which a contemporary author has attempted to shore-up virtue theory from objections and worries. Hursthouse's work provides a clear-cut manner by which one can evaluate the morality of actions in addition to the morality of individuals. This will be of use when I address what is morally required of health care providers in a later section.

Section three of this chapter offers examples of how two contemporary authors have applied virtue theory to particular moral questions and modern professions. The first work I will address, a paper written by Susan Foster, illustrates that a virtuous person will necessarily take into account the goodness of others (which she notes includes non-humans). The second work, by David Coady, focuses on a particular profession, and he explains that certain professions require the professionals to exhibit particular character traits as part of their work. These two articles will provide a framework for understanding how virtue theory, a moral theory approximately two millennia old, can successfully offer moral guidelines for contemporary society. They do so by focusing on very different aspects of virtue theory, both of which I call upon in section four.

Section four, in which I apply virtue theory to the patient–health care provider relationship, shows that the health care provider must act upon a certain virtue of character in order for the patient–health care provider relationship to function properly and for the health care provider to act virtuously. To make this argument clearer I will draw upon the works of Hursthouse, Foster, and Coady: Hursthouse's explanation of how virtue theory is capable of morally evaluating actions, Foster's work on the virtuous person's ability to account for the goodness of others in particular relationships, and Coady's claim that particular virtues have more importance in particular professions.

The fifth and final section of Chapter Five addresses a counter-argument to my presentation of the virtuous health care provider. The counter-argument claims that a truly virtuous health care provider cannot actually be a virtuous person in his/her day-to-day life. The counter-argument contends that the virtues that make a health care provider excel at his/her profession are character traits that we often dislike in people in general. I will present this counter-argument further in the final section, and then reply that this counter-argument misrepresents what virtue theory actually requires of a health care provider.

### *II. Virtue Theory: Ancient and Contemporary Versions*

The primary author of virtue theory, still cited in contemporary literature, is Aristotle. His work Nicomachean Ethics[151] laid the groundwork for medieval (e.g., Saint Thomas Aquinas) and contemporary (e.g., Philippa Foot) interpretations of virtue theory. In this section, I will outline Aristotle's ancient version of virtue theory and a contemporary, neo-Aristotelian version of the theory as well. The neo-Aristotelian version of virtue theory I will provide comes from Rosalind Hursthouse's book, On Virtue Ethics.[152]

#### *A. Aristotle's Virtue Theory*

Virtue, to Aristotle, takes two different forms: virtue of the intellect and virtue of character.[153] Both are necessary to achieve a virtuous life, and only the virtuous life leads to *eudaimonia*, the highest form of happiness.[154] For Aristotle, virtue is human activity of the soul in its perfect or highest form. Virtues of intellect include rational thinking, which can be taught,

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[151] Aristotle. Nicomachean Ethics. Second Edition. Translator: Terence Irwin. Hackett Publishing Company: Indianapolis, Indiana. 1999.
[152] Hursthouse, Rosalind. On Virtue Ethics. Oxford University Press: New York City, New York. 1999.
[153] Aristotle. *Op. Cit.* note 151. 1103a5-10.
[154] Ibid. 1098a16-19.

and practical wisdom, which must be acquired through living.[155] Virtues of character are what we commonly think of as virtues: courage, proper pride, honesty, etcetera. Aristotle's Nicomachean Ethics focuses on how to achieve both the virtues of character and virtues of intellect, and how acquiring both types of virtues lead to living the best possible life.

Aristotle deems that virtues of character must be character traits because they can not be capacities nor feelings.[156] One is neither lauded nor condemned for being able to feel an emotion.[157] Likewise, one is not applauded nor chastised for feeling an emotion.[158] What is at stake in moral evaluations is if one feels the correct emotion, in the correct amount, at the proper time and place, and further how one responds to the emotion. This is what makes Aristotle's moral theory agent-centered, or character-based. Moral evaluations apply primarily to a person, and only subsequently to the person's actions. To be virtuous is to be habituated so as to have the correct responses to particular events. It is to feel the right emotions, at the right times, in the right amounts, toward the right objects, and to thus act/respond in the right way.[159] Aristotle acknowledges that this understanding of being virtuous and doing the virtuous action means that both are incredibly difficult. There is only one correct way to act/be, but there are various ways to err.[160]

Each virtuous character trait lies between two extremes, both of which are vices according to Aristotle.[161] Courage, Aristotle's primary example, is the mean between rashness and cowardliness. To have too little courage is to be a coward, while having it in excess is to act rashly.[162] The virtuous person has the correct amount of courage and exhibits courage in the correct situations, such as when defending one's home. Further, the courageous person will call upon his/her[163] courage at the correct time with no deliberation necessary. The virtues Aristotle

[155] Ibid. 1103a5-10.
[156] Ibid. 1106a12-13.
[157] Ibid. 1106a8-10.
[158] Ibid. 1105b30-32.
[159] Ibid. 1106b21-24.
[160] Ibid. 1106b30-35.
[161] Ibid. 1107a1-3.
[162] Ibid. 1107b1-4.
[163] Aristotle does not think that women are capable of achieving virtue since he views them as inherently irrational beings. However, I hold that modern interpretations of virtue theory need not take Aristotle at his word here. Having said this, I do acknowledge that there is contemporary debate among feminists as to if Aristotle's work can be salvaged from his misogyny. See: Green, Judith M. "Aristotle on Necessary Verticality, Body Heat, and Gendered Proper Places in the Polis: A Feminist Critique." *Hypatia*. Volume 7 (1), Winter 1992. 70 – 96. This article argues that Aristotle's view of women, slaves, and other "non-rational" beings is inherent in all of his works, and that it is impossible to eliminate these views from his position successfully. For another review of the work done on this area, see: Mulgan,

describes in Nicomachean Ethics include: courage, temperance, liberality (regarding small amounts of money), magnificence (regarding large sums of money), magnanimity (regarding great honor), proper ambition and pride (regarding lesser honors and goals), good temper, truthfulness, wittiness, friendliness, modesty, and righteous indignation.[164]

One is only virtuous when one is habituated to respond (both internally and externally) properly to any situation.[165] If one must reflect upon the situation before one knows which response is virtuous, then the person is not fully virtuous. Further, if one must force oneself to act according to virtue, then one is not virtuous, but rather continent.[166] For example, I know that the virtuous act is not to 'rubber-neck' when passing an auto accident while driving. However, I must remind myself not to look at the accident, to focus on the road, and to continue to drive at the appropriate speed. While my action might appear to be virtuous to the outside observer, I have not fully habituated myself to act without deliberation and effort in these situations. Therefore, I am not fully virtuous; I am merely continent.

According to Aristotle, one must also have all of the virtues of character and the virtues of intellect in order to be virtuous.[167] It is not possible to have only some of the virtues and be fully virtuous. If I possess courage, but do not possess proper pride, I am not virtuous.[168] I might act with courage in the correct situations, but then I will likely boast about my actions at inappropriate times. Only when I possess all of the virtues of character, virtues of intellect, and use them in conjunction with one another will I be fully virtuous.[169]

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Richard. "Aristotle and the Political Role of Women." *History of Political Thought*. Volume 15 (2), Summer 1994. 179 – 202.

I will not address this debate, but my work does assume that Aristotle's work is recoupable.

[164] Aristotle. *Op. Cit.* note 151. 1107b1-1108b10.

It is unclear whether Aristotle intends to present a complete list of the necessary virtues, or if the list he provides is not meant to be exhaustive. I take this list to be of necessary virtues, but not sufficient virtues to be truly virtuous. Notably, I claim that beneficence is a necessary virtue, not only for health care providers but for all individuals. I address this claim further in section four of this chapter.

[165] Aristotle. *Op. Cit.* note 151. 1105a26-29.

[166] Ibid. 1151b33-1152a5.

[167] Ibid. 1144b30-1145a2.

[168] There is debate regarding whether one can fully attain one particular virtue prior to achieving all of the virtues (e.g., can one have the virtue of courage without the virtue of proper pride?). For a review of one argument in favor of the unity of the virtues, see: Gottlieb, Paula. "Aristotle on Dividing the Soul and Uniting the Virtues." *Phronesis*. Volume 39 (3), 1994. 275 – 290.

I leave this debate for another time, but I do assume that one can habituate oneself to the various virtuous character traits at different rates, and therefore that it is possible for one to have varying levels of different virtuous character traits. This does not imply neither (a) that one can fully achieve one virtuous character trait prior to achieving all of them, nor does it imply (b) that this is impossible.

[169] Those who argue that Aristotle's moral theory allows for immoral actions when one is not fully virtuous (e.g., one does not have all of the virtuous character traits, but one does have some of them) have misinterpreted Nicomachean Ethics. The common counter-example is of the courageous Nazi solider

When one does achieve the fully virtuous life, then one will always act appropriately in any given situation. One will, by definition, feel the right emotions, in the right amount, at the right time, and respond in the right way. One will not only do the virtuous act, but one will enjoy doing the virtuous act because it is virtuous (rather than for any other possible gain). Because one loves the virtuous response and holds his/her virtue in the highest regard, one will have achieved the best possible life, *eudaimonia*. It is only by being virtuous that one is capable of living this life, and one would rather sacrifice one's life than to do the vicious act.

*B. Rosalind Hursthouse on Virtue Theory*

Rosalind Hursthouse's article book On Virtue Ethics outlines her contemporary interpretation of virtue theory, explains and responds to a number of objections to the theory, and delves into how virtue theory provides a method for choosing the morally correct action and morally evaluating the actions of others.[170] She goes to great lengths to explain how virtue theory differs fundamentally from both utilitarianism and deontology, and, in the process, explains that virtue theory is as capable as the other two forms of ethical theories of addressing the question of "How should I act?" in addition to the question "What kind of person should I be?"

Hursthouse addresses the underlying accounts for right action according to utilitarianism, deontology, and virtue theory in her first chapter. Her outline of how virtue theory defines right actions is as follows:

> (1) An action is right [if and only if] it is what a virtuous agent would characteristically do in the circumstances.[171]
> (2) A virtuous agent is one who has, and exercises, certain character traits, namely, the virtues.
> (3) A virtue is a character trait that…[172]

This outline of how virtue theory defines morally correct action provides a clear response to those who claim that virtue theory has nothing to say about what the right action is in a particular situation. The counter argument posits that virtue theory addresses only the question

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who fights fiercely for a horrible cause. However, Aristotle's work clearly indicates that while this Nazi solider might have the character trait of courage (or a close approximation of courage), the solider is not actually virtuous, and is therefore acting viciously in this circumstance. Therefore the Nazi solider is not a counter example to Aristotle's virtue theory.

The only way the Nazi solider might be considered a counter example to Aristotle's virtue theory is if one does not hold the position that the unity of virtues is a necessary part of virtue theory.

[170] Hursthouse. *Op. Cit.* note 152.
[171] Ibid. 28.
[172] Ibid. 29.

of “Who should I be?”, and does not (or cannot) respond to the question “What should I do?”, or “How should I decide what to do?” In fact, as Hursthouse points out, virtue theory allows one to deduce moral ‘rules’ similar to those rules provided in deontology (e.g., Do not lie.). These rules, which Hursthouse terms rules of virtue ethics (or “v-rules”),[173] are derived from virtues and vices. For example, “[a]ccording to virtue ethics, I must not tell this lie because it would be dishonest to do so, and dishonesty is a vice.”[174]

Another major criticism of virtue theory addressed by Hursthouse is that virtue theory does not provide a decision procedure, a method by which anyone who knows the rules of virtue theory, or v-rules, can input the details of the situation at hand and come to the morally required action without using moral wisdom.[175] She acknowledges that applying the virtue and vice concepts in particular circumstances is often difficult – knowing which virtues are applicable, how those virtues ought to be weighed in conjunction with each other, and what specific action the virtues call for in the circumstance – takes great practical and intellectual wisdom. For instance, an intelligent adolescent might not be able to correctly utilize the moral theory when thinking through a complex situation.[176] A clever adolescent will not be able to simply “crank through” the rules of the theory and come to the virtuous action. But this is not a plausible counter-argument to virtue theory. Virtue theory acknowledges that understanding morality and becoming fully virtuous is a difficult, lengthy process. The counter-argument that this demands too much of those who would look to a moral theory for guidance, is, according to Hursthouse, ill-founded.[177]

A third criticism of virtue theory to which Hursthouse responds to a third criticism and further clarifies the foundations of the theory, offering a sound response to a serious argument against the theory. This concern Hursthouse addresses involves what she terms “resolvable dilemmas.”[178] In these cases, agents are faced with a situation in which there are two (or possible more) actions under consideration, however, none of these options are actions one relishes doing. All the available actions would result in some feeling of guilt, remorse, or emotional pain, which Hursthouse terms “moral remainder” or “moral residue.”[179] For example, assume Ozz promised two friends he would move in with them (into separate homes).

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[173] Ibid. 37.
[174] Ibid. 39.
[175] Ibid. 56.
[176] Ibid. 59.
[177] Ibid. 61.
[178] Ibid. 46.
[179] Ibid. 44.

Both friends act upon Ozz's promise, find homes, sign leases, arrange to move into the new location under the assumption that Ozz will fulfill his pledge. Ozz is then left with the choice of keeping his promise to one of his two friends and breaking his promise to the other friend. Ozz knows that breaking his promise to either friend will cause economic hardship (he has, after all, promised to pay half the rent at both locations), but it will also cause hard feelings and will possibly jeopardize his friendship with whomever he now informs he is breaking his promise.

Hursthouse would call Ozz's dilemma a resolvable dilemma. He is able to make a choice here, even though making this choice is difficult and will likely cause Ozz to feel pangs of regret, remorse, and other forms of moral residue. If one of Ozz's two friends is in greater need of a roommate (for fiscal, emotional, or other reasons), clearly the 'right' action for Ozz is to move in with the friend who needs him more. This is the action deemed optimal by virtue theory by using the rules of virtue theory, but, as Hursthouse points out, this does not mean that Ozz should not feel bad about his action. According to virtue theory, Ozz ought to feel remorse and regret for his action in this case, and more fundamentally, for erring when he made the promises to two friends in the first place. Ozz has "through previous wrongdoing, landed [himself] in a situation in which [he] is forced to choose between two evils."[180] It is his lot to feel regret and guilt, and virtue theory not only provides him with a method for deducing the proper course of action in this unenviable situation but also explicates why Ozz is a vicious person for getting himself into this situation. "Resolvable dilemmas which no virtuous agent would ever be faced with will also be resolvable by a morally right decision, but what is done will not be assessed as morally right."[181] Ozz should have moral residue in this circumstance because he was not acting virtuously when he made two promises knowing that he could not keep both. His action in keeping one promise but not the other is not morally right, even though it is the best choice available to him in this situation.

The last point of Hursthouse's which I discuss is an issue similar to the predicament presented above. Hursthouse moves from dealing with "resolvable dilemmas" to addressing so-called "irresolvable, tragic dilemmas."[182] The objection to virtue theory brought in by the concept of irresolvable, tragic dilemmas is summarized by Hursthouse as follows:

> [The virtuous agent] acts, for she must act, and whatever she does is wrong, impermissible; she can only emerge from the

[180] Ibid. 50.
[181] Ibid. 51.
[182] Ibid. 72.

> situation with dirty hands. But then, how can we call her virtuous without contradiction?[183]

Hursthouse claims that this objection is not actually problematic to virtue theory because virtue theory, unlike deontology and utilitarianism, does not primarily define right action. What is fundamental to virtue theory is that the virtuous agent is the agent who possesses virtues of character and virtues of intellect. With this in mind, Hursthouse restates the above irresolvable, tragic dilemma as follows:

> Tragic dilemmas, situations from which, perforce, the agent emerges with dirty hands, are situations in which the supposedly charitable, honest, just … agent is forced to act callously, dishonestly, unjustly … But if someone acts callously, dishonestly, unjustly …, she cannot be charitable or honest …; that would be a contradiction. So, if there are tragic dilemmas then no one can really be charitable or honest …; no one can really have those character traits. There cannot be such a thing as a virtuous agent.[184]

When phrased in this manner, it becomes clear that such an "irresolvable, tragic dilemma" never actually occurs, according to Hursthouse. There will never be a time when a virtuous agent will not be able to act upon his/her virtues. While the situation might be such that the virtuous agent feels remorse and pain[185] when choosing the best available action, this certainly does not indicate that he/she is not acting upon the virtues of character and virtues of intellect. What it does mean, as Hursthouse correctly points out, is that even the virtuous life can be marred by being forced to do an act simply due to circumstances, an act that the characteristically vicious person would do and the virtuous person would never do (if he/she had his/her druthers).[186] Operating from this understanding of irresolvable, tragic dilemmas, Hursthouse argues that while these situations certainly are tragic, they are not, as some claim, irresolvable. There is a virtuous course of action in these cases, and while the virtuous agent will not be able to make the ideal choice due to circumstances, and will likely have moral residue of pain and remorse, these cases are not irresolvable.[187]

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[183] Ibid. 72.
[184] Ibid. 73.
[185] Hursthouse does further argue that while the virtuous agent will likely feel remorse and pain, he/she ought not feel regret, since feeling regret indicates that he/she should have made a different choice, and in such circumstances, there was no other choice to make. Ibid. 76.
[186] Ibid. 74.
[187] Ibid. 75.

Overall, Hursthouse's work addresses how virtue theory can provide moral guidance in particular situations and presents a way to find the morally correct action using this character-based theory. In doing this, Hursthouse also shores up virtue theory from not only common and misconceived criticisms of the theory, but also illustrates that what are often considered the failings of this theory are, in fact, its strong points. Her book is one example of how contemporary authors have taken seriously the current applications of this ancient moral theory, and her responses to various objections to the theory force opponents of virtue theory to once again take Aristotle's work seriously. Her application of the theory to the various moral problems, including both resolvable dilemmas and irresolvable, tragic dilemmas, provides more groundwork for other contemporary virtue theorists to likewise utilize the theory, applying it to other moral problems, and, more importantly, to my work, to various professions and relationships. In particular, her illustration of how to start from a moral theory which dictates particular virtues of character and virtues of intellect and end up with a method for prescribing action is of importance when I address what virtue theory demands of the health care provider in section four. Before moving to this application of virtue theory, however, I outline other applications of the theory in contemporary literature in the following section.

*III. Examples of Applications of Virtue Theory*

In recent years, there have been numerous applications of virtue theory to moral problems, professional roles, as well as various relationships. Philippa Foot's notable work "Euthanasia"[188] was an application of virtue theory to that particular moral problem, and Rosalind Hursthouse's "Virtue Theory and Abortion"[189] is also often cited as a prime example of an application of the theory to a contemporary moral issue. In this section, I review Susanne Foster's work on virtue theory and the environment. Foster's explication of how virtue theory allows one to see and act upon the goodness in others is be beneficial in my discussion of the patient–health care provider relationship in section four. I then review David Coady's article "Stanley Milgram and Police Ethics," which provides a discussion of how the virtues ought to be considered in police ethics. Coady's primary goal is to illustrate the virtues necessary for police officers to act appropriately when faced with orders to use excessive force, and in doing this, he shows that particular virtues are of greater importance in particular professions. Again,

[188] Foot, Philippa. "Euthanasia." *Philosophy and Public Affairs.* Volume 6 (2), Winter 1977. 85 – 112.
[189] Hursthouse, Rosalind. "Virtue Theory and Abortion." *Philosophy and Public Affairs*. Volume 20 (3), Summer 1991. 223 – 246.

this major point of Coady's is essential in my discussion of the profession of health care in section four.

*A. Virtue Theory and Environmental Ethics*

Susanne Foster argues in "Aristotle and the Environment" that virtue theory, unlike deontology, utilitarianism, and feminist ethics, is uniquely able to account for humans' obligations to particular entities in nature, as well as why humans should act as stewards for the environment in general.[190] Foster presents three major elements of Aristotle's biological and teleological theory in order to provide answers to the questions 'Why should I be moral?' and 'Why should I care about the welfare of others?' Her presentation of Aristotle's work allows her to provide answers to both questions.[191]

The first essential element of Aristotle's work that Foster presents is that all natural bodies, including humans, are substances. Further, all substances are things that have natures. She arrives at this interpretation utilizing both Aristotle's Physics[192] and On the Parts of Animals.[193] Aristotle means by "substances have natures" that all substances have a specific body (or body shape/structure) and characteristic traits that are carried out by that specific body. The characteristic traits will, of course, vary from substance to substance. The characteristic traits of a plant, according to Foster's interpretation of Aristotle, are "resistance to corruption, growth, reproduction, and taking in nutrients."[194] The body of the plant is structured so that these traits can flourish. Humans have these same traits, but these traits are not characteristic of humans because humans have other capacities which plants do not have.

Second, Aristotle claims that it is in the interest of all natural, living bodies to "realize their natures."[195] Foster argues that one of Aristotle's main premises is that to be (to exist) is to be good; existence in and of itself is a good.[196] The more a substance is able to fully exist, the more good that substance has achieved. Therefore, by realizing its nature, a living body has achieved its full measure of good. While Foster does acknowledge that achieving one's end looks different across different species, and that using the language of 'desiring one's end'

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[190] Foster, Susanne E. "Aristotle and the Environment." *Environmental Ethics*. Volume 24 (4), Winter 2002. 409 – 428.
[191] Foster provides two answers to these two questions, but I will address only one answer in this overview of her work.
[192] Aristotle. Physics. Oxford University Press: New York City, New York. 2008.
[193] Aristotle. On the Parts of Animals. Harvard University Press: Cambridge. 1968.
[194] Foster. *Op. Cit.* note 190. 412.
[195] Ibid. 415.
[196] Ibid. 415.

seems awkward when applied to so-called lower life forms, this does not imply that Aristotle's argument is invalid. Certainly animals do have ends, and it is not absurd to think that they feel pleasure in achieving those ends.[197] Likewise, it is not odd to think that a plant that is healthy, reproducing, and flourishing has more fully achieved its nature than a plant that is suffering from malnourishment or is unable to reproduce. Therefore, as Foster notes, we can understand what Aristotle means when he claims that a living substance has actualized its nature when it has successfully carried out or fulfilled its character traits.[198]

Foster notes, when she presents Aristotle's third main element, that this element brings in notions of ethics along side notions of teleology. According to Aristotle's presentation of biology, living things are hierarchically ordered. This notion is used primarily by Aristotle to illustrate why it is that humans are superior to other living substances; humans, in that we have the characteristic of reason, are superior to other life forms.[199] Reason is key to living a virtuous life because both virtues of character and virtues of intellect require the use of rationality. While there are other prerequisites for living a virtuous life (e.g., health), these other prerequisites are neither virtues of character nor virtues of intellect. These prerequisites are essential to the flourishing of all living substances, albeit in different forms; these traits are not particular to humans and therefore are not critical to humans flourishing in particular.[200]

Foster's presentation of these three elements of Aristotle's teleological and ethical theories provide a groundwork for her to provide answers to the questions 'Why should I be moral?' and 'Why should I care for the wellbeing of others?' Foster begins explaining her answers by reminding us that a fully virtuous person will have 'complete' friends. These friends are others whom one values almost as extensions of oneself. The friendship one has with 'complete' friends is viewed of as a good in itself. As such, one will care greatly about one's friends and their wellbeing because the friendship itself is a good to the individual.[201] If I am a virtuous agent, I will work to maintain that relationship and act, when appropriate, as a steward with respect to my friend.

Foster argues that this type activity is applied beyond relationships of complete friends. Since all living substances have some inherent goodness in that they exist, and further have the potential to flourish, a virtuous individual will work to promote that excellence in all living substances (not just in humans, but in other species as well). This type of stewardship is

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[197] Ibid. 416.
[198] Ibid. 417.
[199] Ibid. 418.
[200] Ibid. 419.
[201] Ibid. 421.

inherent in being a virtuous person. Being virtuous entails acting in the proper manner toward all classifications of substances. One treats complete friends with a high level of respect and care, but one also treats all substances with some level of respect and stewardship because all substances have some level of goodness.[202]

Further, respecting the goodness in others is noble. A virtuous person does the noble act not for any particular reward, although the reward for being virtuous is the best possible life. The virtuous person does the noble act because it is noble. This is why it is virtuous to consider not only the possible benefits for oneself when determining which course of action to take, but rather in taking seriously the possible good achieved for others in doing the noble act. Therefore, if, as mentioned above, one recognizes good in all of its forms – sentient and non-sentient, living and non-living, young and old, etcetera – one will do the noble act because all of the persons and things affected by that action will be valued appropriately and their inherent goodness will be respected.

It is in this manner that Foster explains that the virtuous person will necessarily care for the environment, both its components and in its entirety. "Seeing the goodness of being and the beauty and complexity of the natural world is [a] cognitive component in the development of complete virtue."[203] The biosphere, ecosystems, species, and particular substances all have some level of goodness. For instance, the survival and flourishing of the biosphere is essential for ecosystems, species, and particular individuals. Not only does the biosphere have its own level of goodness, which is more than the mere sum of the goodness of its parts, but it also is a primary good in that its existence is a necessary condition for the flourishing of other substances. Given this, a virtuous person will care deeply about the preservation of the biosphere. The virtuous human will not care about the biosphere simply because his/her existence hinges on the existence of the biosphere, but because the biosphere possesses goodness.

The upshot, for Foster, is that virtue theory provides two essential components when dealing with the environment. Primarily, it explains what contains goodness and why. Only when one properly understands what is good and why is one able to properly identify objects of moral concern and consideration. For example, if one does not truly understand how the environment is good in and of itself (rather than, for instance, any instrumental good it provides to humans), one will not view the environment as an object with a moral claim on humans.

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[202] Ibid. 423.
[203] Ibid. 424.

Secondarily, Aristotle's theory provides a hierarchy of goodness of various substances and objects. Virtue theory can explain why it is virtuous to save one's own child rather than a house plant in a fire.[204] Further it also dictates that ecosystems ought to be preserved, in certain circumstances, at the cost of particular species and at the cost of human enjoyment (in the case of parks ruining ecosystems due to human visitors) and human expediency (in the case of building a highway through an ecosystem).

Foster's work explains in detail how virtue theory can be properly applied to environmental ethics without the addition of virtues specific to the environment. She argues that starting from a proper understanding of Aristotle's work, one is able to morally evaluate one's position with regard to the environment. Being truly virtuous means that one has a proper understanding of the good of the natural world and all of its components, not merely humans. While Foster utilizes this portion of Aristotle's work in order to found her argument that humans are morally required to care for the environment, her argument that all beings contain goodness and that the virtuous person will respect the goodness in others highlights an essential point in virtue theory which provides support for how the virtuous person acts toward others in general and in specific situations. In particular, it supports my claim that a virtuous health care provider, in acting beneficently toward his/her patient, will show concern for the patient as an individual who has inherent goodness. In the patient–health care provider relationship, the respect for the patient's inherent good, the patient's ultimate goals and life plans, and the patient's current needs come first and foremost to the health care provider. Foster's work aids in illustrating why this is the case, and further is one example of a contemporary ethicist applying Aristotle's virtue theory to a modern moral problem.

*B. Virtue Theory and Police Ethics*

David Coady addresses how particular virtues factor into professional attitudes, specifically professional police work, in his article "Stanley Milgram and Police Ethics."[205] Coady argues that since particular character traits, most notably moral courage (which leads to police officers refusing to obey orders to exact excessive violence), are desirable, testing police officers for this particular virtue ought to be a part of ethics testing in police forces. He likens this to the entrapment testing done to evaluate which individuals are likely to take bribes.

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[204] Ibid. 428.

[205] Coady, David. "Stanley Milgram and Police Ethics." *Australian Journal of Professional and Applied Ethics*. Volume 3 (2), November, 2001. 16 – 28.

Coady motivates this argument by discussing Stanley Milgram's 'Obedience Experiments,'[206] and the seven major implications these experiments have for police ethics, all of which I address below.

Stanley Milgram's 'Obedience Experiments' were set up along the following general guidelines: volunteers were told that they were participating in an experiment that was designed to test the effects of pain on learning capacity. The volunteers, under the 'supervision' of an 'experimenter' (a "stern looking man dressed in a grey technician's coat"),[207] were to shock the 'learner' when the 'learner' gave a wrong answer. The 'learner' was merely an actor who was pretending to get the electrical shocks administered by the volunteer.[208] The investigation was actually testing the obedience of the volunteer to authority even when the volunteer was clearly causing the 'learner' physical harm.[209] A volunteer was deemed "compliant" when the volunteer continued to administer shocks that were above the "DANGER – SEVERE SHOCK 375 volts" mark on the 'electrocuting machine,' at which point the 'learner' would go silent (as if unconscious). Volunteers were informed at this point that if there was no response from the 'learner,' the volunteer should regard that as an incorrect response and continue to administer 'shocks.'[210] If, at any point, the volunteer refused to continue to give shocks, the volunteer was termed "defiant" in this scenario.[211]

Milgram's findings were rather, if you pardon the pun, shocking. When the volunteer was unable to see or hear the 'learner,' but could hear "thumping noises," the defiance rate was only 34%. The defiance rate was 37.5% when the volunteer was able to hear all of the 'learner's' responses, but was still unable to see the 'learner.' When the volunteer was in the same room as the 'learner' (only a few feet away), the defiance rate was 60%. Finally, when the volunteer was required to place the unwilling 'learner's' hand on the 'electrocution pad,' defiance jumped to 70%.[212]

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[206] Milgram, Stanley. "Behavioral Study of Obedience." *Journal of Abnormal and Social Psychology*. Volume 67 (4), 1963. 371 – 378. For a more in depth discussion of his experiments, see: Milgram, Stanley. "Some Conditions of Obedience and Disobedience to Authority." *Human Relations*. Volume 18 (1), February 1965. 57 – 75.
[207] Milgram, Stanley. "Behavioral Study of Obedience." *Journal of Abnormal and Social Psychology*. Volume 67 (4), 1963. 373.
[208] Ibid. 372.
[209] Ibid. 372.
[210] Ibid. 374.
[211] Ibid. 374.
[212] Milgram, Stanley. "Some Conditions of Obedience and Disobedience to Authority." *Human Relations*. Volume 18 (1), February 1965. 57 – 75. 62.

Coady presents seven implications of this experiment for police ethics after presenting an overview of the 'Obedience Experiments.' One, we tend to overestimate how much our moral beliefs affect our behavior. What we should be more focused on, rather than moral beliefs, is our moral character.[213] This means, according to Coady, that ethical education for police should shift its concentration from changing moral beliefs to habituating moral character.[214]

Two, the experiments show that often the motivation and rationalization for the use of unjustified violence and force is one's sense of duty to the organization and to immediate superiors.[215] While conventional wisdom indicates that people who use excessive force and unjustified violence do so because they are particularly brutal and/or sadistic, Milgram's experiments indicate this is incorrect. The volunteers did not enjoy 'shocking' the 'learners,' but they continued to do so out of what they said was a sense of duty to the experiment and to the 'experimenter,' who was supposedly overseeing their work.[216]

Three, it seems that a sense of responsibility for one's violent actions is mitigated when one is informed that one must follow orders. Coady explains that when someone is instructed that his/her 'job' does not include making ethical judgments and rather that he/she must simply to follow orders, this impacts how he/she psychologically reacts to causing harm.

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[213] There has been philosophical work done utilizing Milgram's experiments as a premise to show that, in fact, people do not have character traits at all, but rather that people merely react to situations based on the particulars with which they are presented. This position, termed 'situationism' has been presented by Gilbert Harman and John Doris. For Harman's position, see: Harman, Gilbert. "Moral Philosophy Meets Social Psychology: Virtue Ethics and the Fundamental Attribution Error." *Proceedings of the Aristotelian Society*. Volume 99, 1999. 315 – 331. For another version of 'situationism,' see: Doris, John. Lack of Character: Personality and Moral Behavior. Cambridge University Press: New York City, New York. 2002.

This position has dire consequences for virtue theory, since the moral theory would be moot if character traits did not exist. However, Harman's and Doris's positions have been thoroughly discredited by those who point out that merely because one does not always correctly predict one's behavior in certain circumstances, this does not necessarily mean that character traits do not exist. For more on the responses to situationism, see: Kamtekar, Rachana. "Situationism and Virtue Ethics on the Content of Our Character." *Ethics*. Volume 114 (3), April 2004. 458 – 491. See also: Sabini, John and Maury Silver. "Lack of Character: Situationism Critiqued." *Ethics*. Volume 115 (3), April 2005. 535 – 562.

I would like to thank my colleague Ian Stoner for his help in locating this material and clarifying situationism for me.

[214] Coady. *Op. Cit.* note 205. 20.

[215] Ibid. 20.

[216] Ibid. 19.

Responsibility for the harm is more easily shifted to one's superiors when one thinks it is not one's job to make those ethical calls.[217]

Four, there is usually a feedback loop regarding devaluing the victims of unjustified violence and using that excessive force when interacting with those devalued individuals.[218] Coady notes: "It is not uncommon for two things to each contribute to the explanation of the other, in the sense that they mutually reinforce each other, e.g., stock market crashes and investors' panic, terrorism and retaliation to terrorism, black anger and white fear."[219] Police should be cautious regarding making and acting upon rhetoric which singles out certain groups or categories of the public as 'deserving' of heavy-handed police tactics.

Five, the physical distance between two individuals matters when considering the potential for excessive force and violence. The volunteers in Milgram's experiments were least likely to be compliant when they were actually touching the 'learners.' This proximity greatly reduced the volunteers' willingness to cause physical harm to another. Coady argues that this indicates that police should use short-range weapons (e.g., batons and nightsticks) rather than long-range weapons (e.g., firearms and tear gas). "It is also a consideration against using horses for crowd control."[220]

Six, while Milgram's experiments did not find any strong correlations between particular backgrounds and resistance to compliance, there was an indication that individuals with higher levels of education, and moral education in particular, were slightly more likely to be defiant. Coady points out that the current shift of encouraging police officers to continue their education should be furthered. Coady also argues that this correlation indicates that on-the-job ethical education that includes a discussion of Milgram's experiments is clearly justified.[221]

Seven, the 'Obedience Experiments' illustrated that conformity has a much larger impact on one's actions than originally thought. When in the presence of other defiant individuals, one is much more likely to refuse to cooperate with calls for exacting physical harm. Likewise, when acting alongside those who are complying, one is more prone to comply as well. Coady argues that encouraging conformity among police forces might only exacerbate this particular issue. Strict uniform codes, hair cut regulations, and the like should be

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[217] Ibid. 20.
[218] Ibid. 20.
[219] Ibid. 21.
[220] Ibid. 21.
[221] Ibid. 21.

reevaluated since encouraging one's actions on what the group does hinders the individual from making the choice he/she feels is best.[222]

In response to these findings, Coady offers two proposals for achieving the goal of reduced excessively violent police action. His modest proposal is to test individual police officers using Adorno's 'F scale,' a scale which evaluates tendencies toward fascism.[223] These test results should factor into decisions of hiring, firing, promotion, and demotion.[224] Coady's bolder proposal is to use 'Obedience Experiments' similar to Milgram's either on officers whom are suspected of using excessive violence, or on all police force members.[225] Both proposals operate on the same premise: police officers should be tested (in one form or another) for vices that are "particularly common amongst police officers and particularly contrary to their role morality."[226]

Currently, police officers are tested for the vice greed by setting up entrapment situations in which individual police officers are offered a bribe by undercover police agents. Those officers who take the 'bribe' are punished or fired. Coady claims that a similar test should be done in order to test for the vices identified with the: "propensity to attribute responsibility for one's actions to someone else, and the propensity to use unjustified violence."[227] Coady focuses on vices and virtues because of Milgram's findings; one's character states have a much larger impact on one's actions than do either self-predictions of behavior or self-described moral beliefs. What actually counts is how one *will actually respond* to particular orders and situations, and this is determined by one's character – whether one is habituated to respond in the morally (and legally) correct way to requests of excessive force and violence. While offering moral education and discussions of disobeying immoral orders is a good start, what is more essential is understanding the character of members of the police force and developing the proper virtues of character in said individuals.

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[222] Ibid. 22.
[223] Alan Elms's work indicates that there is a relationship between scores on the 'F scale' and compliance in obedience experiments. For more information on the 'F scale,' see: Adorno, T., E. Frenkel-Brunswik, D. J. Levinson, and R. N. Sanford. The Authoritarian Personality. Harper: New York City, New York. 1950. For information regarding how the 'F scale' relates to obedience, see: Elms, Alan C. Social Psychology and Social Relevance. Little and Brown: Boston, Massachusetts. 1972.
[224] Coady. *Op. Cit.* note 205. 22.
[225] Ibid. 22.
[226] Ibid. 26.
[227] Ibid. 26.

Unlike Foster, Coady does not start his discussion of applied ethics with an overview of virtue theory. While he does cite Aristotle's work, his focus is much more on psychological and sociological studies done on understanding character and how character influences action. While Coady's approach differs greatly from Foster, the underlying theme is the same in both articles: Aristotle's virtue theory can be applied to particular problems, relationships, and even professions in order to resolve moral dilemmas. Understanding virtues of character, virtues of intellect, and the ultimately virtuous life is tremendously useful when addressing ethical concerns. In particular, as shown by both Foster's and Coady's articles, Aristotle's theory can be successfully applied to show that a virtuous person will take seriously obligations to care for others (which includes humans, animals, and the environment), and that specific virtues are of more importance for individuals in specific professions. These two points are addressed in the following section where I show how to properly apply virtue theory to the patient–health care provider relationship. Health care providers, like all people, should have the virtue of beneficence. However, given the nature of their profession, health care providers are required to act upon this virtue daily in a way that perhaps others are not. I explain how this plays out in the patient–health care provider relationship in the next section.

### *IV. Applying Virtue Theory to the Patient–Health Care Provider Relationship*

In the previous two sections, I outlined virtue theory and how contemporary versions of this moral theory can be successfully applied to ethical issues. One of the merits of this theory is that it not only addresses how to act in specific situations, but that it does this by highlighting the essential characteristics of the individual acting. For instance, Foster's work on environmental ethics illustrates that one ought to care about the wellbeing of others (including non-human animals and the environment). Thus, if one is virtuous, one will necessarily care about the well-being of others and act nobly toward others. This is because a virtuous person will necessarily do the noble act because it is the noble act; the virtuous person acts virtuously out of love for virtue and nobility.[228] Likewise, Coady's work on police ethics focuses on the virtues necessary for police to act virtuously in their profession. Specifically, Coady argues that police officers need the virtues, or character traits, of taking responsibility when appropriate and using proportional response to aggression.[229] When police officers have said virtues, they will not act with undue aggression, nor will they follow immoral commands from their superiors.

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[228] Foster. *Op. Cit.* note 190. 423.
[229] Coady. *Op. Cit.* note 205. 26.

Both Foster's and Cody's papers illustrate that in order for actions to be virtuous, the agent must first habituate his/herself to successfully integrate the virtues of character and virtues of intellect into his/her personality. When evaluating actions or relationships using virtue theory, it is therefore essential to understand the underlying virtues of character and virtues of intellect that are at stake in those actions and relationships.

Virtue theory is a character-based moral theory; what is essential to the theory is that the individual obtain the virtues, both virtues of character and virtues of intellect, in order to live the best possible life. It is this focus on virtue that allows one to apply this theory to relationships and professions in order to understand how those relationships and professions ought to look. In this section, I apply virtue theory to the patient–health care provider relationship. This application will highlight the virtue a health care provider must have in order to achieve a successful relationship with his/her patient, namely beneficence. As mentioned in previous chapters, this is a virtue that is not necessary to a business relationship. By drawing out the implications of utilizing this virtue, I provide further support for my argument that a patient–health care provider relationship is fundamentally different from a business interaction.

*A. Beneficence: The Key Virtue of the Health Care Provider*

Compiling an exhaustive list of virtuous character traits necessary to being virtuous is an activity surrounded by much debate. It is, in my opinion, the ultimate weakness of virtue theory that this list seems notoriously elusive. In the first section of this chapter, I outlined the list of virtues that Aristotle provided in Nicomachean Ethics.[230] While it is not clear whether Aristotle attempts to provide a comprehensive list, many contemporary virtue theorists have taken his list as a starting point rather than the final word. My work follows this vein of reasoning. If the virtues of character are those virtues that allow one to act nobly and relish his/her nobility, I claim that beneficence certainly is necessary.

Beneficence is essential not only for individuals working within the field of health care, but for all individuals. For instance, it seems that beneficence is required in order for a person to be truly charitable to both strangers and loved ones. Certainly, always being beneficent would not lead to a noble, virtuous life (e.g., one cannot donate all of one's money to charity, leaving no funds to pay for one's rent, food, clothing, etcetera), but of course this is not what is required of a virtuous individual. A virtuous person is one who has all of the virtues and acts upon those virtues at the right time, with regard to the right people, in the right amount, for the

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[230] Aristotle. *Op. Cit.* note 151.

right reasons, and while feeling the right emotions. Thus, virtue theory does not demand of a virtuous person that he/she always act beneficently (or courageously, or with magnanimity, or with proper pride, etcetera), but that the virtuous person act with beneficence when appropriate.

As mentioned in the previous section, this means that the virtuous person will draw upon different virtues at different times, in different situations, and with regard to different relationships. While all virtuous agents will have the same virtues, virtuous agents will not use all of these virtues in every situation. For instance, a virtuous person who is also a business owner will not act utilizing the virtue of beneficence in his/her business dealings. A virtuous health care provider, on the other hand, will incorporate the virtue of beneficence in his/her dealings with patients. With all this in mind, I discuss in this section the meaning and import of the virtue of beneficence for the health care provider, and why it is essential for health care providers to always act upon this virtue when they interact with patients.

Beneficence, loosely defined, is having the trait of doing (or producing) good for another person. This includes acting with charity and kindness toward others, acting to produce good for another individual, and even acting selflessly (when the situation requires acting as such). Because of this, beneficence is an essential character trait for health care providers when they are interacting with patients. It is a crucial component because a health care provider acts as a fiduciary. The good that health care in particular attempts to provide is, of course, good health for the patient, both physical health and mental health. This good is provided to the patient by the health care provider without thought for the health care provider's own desires or wishes. While utilizing the virtue of beneficence does not always call for selflessness on the part of the virtuous agent, this selflessness is exhibited as a part of beneficence in the patient–health care provider relationship. Selflessness, sympathy, caring, and concern are all demonstrated by the health care provider when said provider is employing the virtue of beneficence in his/her interactions with patients. The ultimate aim of providing health care is ensuring the health of the patient; this end cannot be ensured without the health care provider utilizing the character trait of beneficence.

The claim that beneficence is an essential character trait when providing health care is not new. It is inherent in the moral positions held the many professional organizations associated with health care that providers must first and foremost "do no harm." Additionally, the argument that virtue theory is in the position to explain the ethical ramifications of utilizing these virtues when acting as a health care provider has been presented previously. In the mid-

1980s, virtue theory found new footholds among medical ethicists. While health care ethics had previously primarily focused on principalism, and still does to a large extent, the usefulness of virtue theory for understanding the moral requirements in the realm of providing health care was being investigated. For instance, Earl Shelp edited a book of essays focusing on this very issue. Virtue and Medicine: Explorations in the Character of Medicine included papers on historical origins of virtue theory, investigations of how character impacts both how the patient and the health care provider view and respond to health care, and objections to the use of virtue theory in this field.[231] Edmund D. Pellegrino and David C. Thomasma co-authored the book The Virtues in Medical Practice, which likewise discussed how virtue theory can be properly applied to health care. Their work discussed not only the theory itself and how it could be integrated with bioethics principalism, but also delved into particular virtues of character and virtues of wisdom health care providers ought to attain.[232] These, of course, are just two examples of books published on this particular area of study. In addition, there are a number of articles published in the last 25 years regarding why and how virtue theory is helpful in thinking about bioethics.[233]

While my application of virtue theory to the profession of health care is obviously not original, my main issue here *is* innovative: the character trait of beneficence on the part of the health care provider is essential to a morally acceptable patient–health care provider relationship, and it is the utilization of this character trait on the part of the health care provider that differentiates the patient–health care provider relationship from a business relationship. A virtuous health care provider will act as a fiduciary for his/her patient; that is, the health care

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[231] Shelp, Earl E., ed. Virtue and Medicine: Explorations in the Character of Medicine. D. Reidel Publishing Company: Boston, Massachusetts. 1985.

[232] Pellegrino, Edmund D. and David C. Thomasma. The Virtues in Medical Practice. Oxford University Press: New York City, New York. 1993.

[233] For examples of a variety of discussions of applications of virtue theory and a variety of character traits required of health care professionals, see: Erde, Edmund L. "The Inadequacy of Role Models for Educating Medical Students in Ethics with some Reflections on Virtue Theory." Theoretical Medicine. Volume 18 (1-2), March – June 1997. 31 – 45. This article discusses the different between teaching ethics, including virtue theory, versus merely utilizing medical professionals as role models for medical students. Forsberg, Ralph P. "Teaching Virtue Theory Using a Model from Nursing." *Teaching Philosophy*. Volume 24 (2), June 2001. 155 – 166. Forsberg provides a discussion of how it is useful to utilize nurses as examples when teaching virtue theory. Glannon, W. and L. F. Ross. "Are doctors altruistic?" *Journal of Medical Ethics*. Volume 28 (2), April 1, 2002. 68 – 69. This paper discusses the difference between the characteristics of altruism and beneficence in morally evaluating health care providers. McKay, A. C. "Heroes – Or Just Doing Their Job? Supererogation and the Profession of Medicine." *Journal of Medical Ethics*. Volume 28 (2), April 2002. 70 – 73. This is an investigation of the moral requirements of health care providers during times of pandemics, including a discussion of the difference between what is morally obligatory and what is supererogatory.

provider will work for the best interest of the patient without concern for the health care provider's own ends. The health care provider is sought out by the patient for the health care provider's expertise and aid. In order to properly provide this expertise and aid, it is critical that health care provider act as a fiduciary, not as a business person.

*B. The Role of the Health Care Provider: Patient Autonomy Versus Paternalism*

My emphasis of the fiduciary nature of the health care provider's role will likely strike many medical ethicists and health care providers as unacceptable. At the same time that virtue theory was beginning to be taken seriously in bioethics, the importance of patient autonomy was likewise coming to the forefront of health care ethics, and for good reason. Medicine has an ugly history of acting with paternalism toward patients and the public as a whole. Lying to patients in order to 'shield' them from an unpleasant diagnosis was commonplace. While done with the intent to aid the patient, it clearly did not allow patients to make informed decisions regarding their health care, nor did these treat patients as autonomous individuals with their own set of goals and priorities.[234] This is one of the more benign examples of paternalism in health care (and one that sadly still occurs today).

A far more extreme example of paternalism can be found in the case of Donald "Dax" Cowart.[235] In 1973, Cowart was severely burned in a propane explosion. He had third degree burns over approximately 65% of his body. He was treated against his will for 14 months, first at Parkland Hospital in Dallas, Texas, and then at Texas Institute of Rehabilitation and Research in Houston, Texas. From the beginning, Cowart vocally and violently refused treatment, repeatedly begging medical staff to cease treatments and allow him to die. He underwent excruciating treatments, most of which are no longer used. Even though Cowart was legally an adult (in fact, he was just released from active duty as a pilot for the Army Air Force Reserves), his mother and his attorney made most of his medical decisions and consented to Cowart's treatment on his behalf. After his recovery, Cowart spoke out against being treated without consent, and he continues to maintain that even though he did fully recover, the treatment he received was unacceptable. He should have been released as he requested. His case highlights some of the disturbing trends in paternalism in medical care. While Cowart's health care team knew that he was in excruciating pain and that he wished to go home, they also felt obliged to

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[234] For a discussion of truth-telling in health care, see Chapter Five in Rosamond Rhodes, Leslie P. Francis, and Anita Silvers. (Eds.) The Blackwell Guide to Medical Ethics. Blackwell Publishing: Malden, Massachusetts. 2006.
[235] "Dax's Case." Directed and Produced by Donald Pasquella. Videocassette. Unicorn Media Inc., 1984.

do what they felt was in his best-interest, even if that meant treating him against his will. Cowart's case was one starting place for a much needed discussion on informed-consent in health care. This example highlights what the paternalistic-centered form of health care allowed in the United States.

In part as a reaction to such unethical behaviors (even if said unethical behaviors were well-intended) on the part of health care professionals, medical ethicists and health care professionals began discussing and implementing forms of informed consent – a way to ensure that patients were advised of their medical condition and were advised of the treatment options available for their condition. Patient empowerment became central to health care. Patients were to be given the specialized information the health care provider had regarding the patient's illness and treatment possibilities, and the patient was then to make an informed decision about which treatment should be pursued (or to refuse treatment altogether). It obviously was for good reason that this shift from paternalism to respect for patient autonomy occurred. One of the indirect consequences of this shift, however, was distaste for viewing health care providers as fiduciaries. The reasonable concern for ensuring patients' abilities to make their own health care decisions resulted in a downplaying of the role of health care advisor played by health care professionals. Often, the health care professional was advised to act as a repository of medical information, passing that knowledge along to the patient so that the patient then could make his/her choice regarding treatment. Paternalism was to be avoided at all costs; informed consent became the goal.

I agree that this shift from paternalism to respect for autonomy was necessary and long overdue. However, it should not eclipse the importance of the role of advisor played by the health care provider. Health care providers are sought out precisely because they have expertise and experience dealing with illness. They have knowledge patients lack, and they have access to diagnostic tools and treatments patients need. Even a patient well-versed in health care seeks out medical care precisely because he/she needs a professional opinion. There is an imbalance in knowledge in the patient–health care provider relationship, as mentioned in previous sections, and even the most contentious attempts at ensuring patient autonomy does not eradicate this imbalance. The combination of acting as a fiduciary while ensuring proper informed consent is a delicate act, one that requires health care providers utilize their technical knowledge in addition to their ability to treat patients with the respect, concern, and dignity they deserve. This is where an understanding of the implications of acting with beneficence becomes

essential. Health care providers will be better able to deal with the interaction of patient-autonomy and the fiduciary nature of health care if the health care providers have virtues of intellect and virtues of character, including the virtue of beneficence.

Health care providers must act virtuously in their interactions with patients; they must utilize their scientific knowledge and skills, their practical wisdom, and their virtuous character traits in order to fulfill their moral obligations to their patients. Beneficence is an essential character trait in this mix because it focuses the health care provider's attention on the needs and the goals of the patient while eliminating the health care provider's own needs and desires from the interaction. To provide for the patient, the health care provider must be able to utilize beneficence in order to fully address the patient's concerns with empathy, compassion, and self-effacement. This is essential because patients lack both knowledge and power in the patient–health care provider relationship. Such an uneven distribution of power and knowledge necessitates vigilance on the part of the agent who has the upper-hand; health care providers must always keep the patients' interests in mind because patients are in a vulnerable position both with regard to the relationship and due to the fact that the patient is dealing with some sort of illness.

The issue of patient-empowerment, however, only provides further support for my argument that the patient–health care provider relationship is not a business relationship. Patients are not consumers; patients do not seek out health care in the way they seek out other goods.[236] Likewise, health care providers are not selling a product. Providers ought to act out of the best interest of their patients rather than ensuring their own fiscal security. In order to do this, health care professionals must act upon the character trait beneficence. The needs, concerns, and wishes of the patient always come first. This is why the health care professionals are fiduciaries rather than sales persons. The patient–health care provider relationship is not and should not be treated as a business relationship. If the health care provider did treat the patient–health care provider relationship as a business relationship, the health care provider would not be acting virtuously. To insist that health care professionals treat the patient–health care provider relationship as a business interaction would be to insist that health care professionals act viciously. When one understands virtue theory and what it morally requires of

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[236] This is not to say that patients do not, sometimes, act as if they are consumers. In fact, many aspects of medical care today encourage patients to treat health care as a commodity, health care providers as vendors, and the relationship as a standard customer-retailer interaction. My argument is that while this *does* occur, it *ought not* occur, and further that the health care provider is morally required to treat his/her relationship with his/her patient as something fundamentally different from a business relationship.

health care professionals, as presented in this chapter, it becomes clear why my argument is not radical. My conclusion, that the patient–health care provider relationship is not a business relationship, nor ought it be changed to this type of relationship, follows simply from a proper understanding of health care and virtue theory. I review my argument in its entirety in the next and final chapter. Prior to doing this, I first discuss one final possible objection to the claim that virtue theory is essential to understanding the patient-health care professional relationship.

*V. House M.D.*

The recent television show, House M.D., has created much stir regarding the patient–health care provider relationship.[237] The main character, Dr. Gregory House, is a brilliant physician, renowned for his diagnostic abilities. His bedside manner, however, leaves much to be desired. He is cold, callous, irreverent, and can even be downright rude to his patients, staff, and co-workers. While his manners are reprehensible, his patients applaud him for his help in their cases. It seems that each week Dr. House is able to correctly diagnose and treat some horrible illness that has been misdiagnosed or undetected for days, months, even years. Many who love the show have told me repeatedly that if they were dealing with a catastrophic illness, they would chose Dr. House as their physician over a caring, considerate, but less knowledgeable physician any day of the week and twice on Sundays.[238]

What I find most disturbing about the response to this show is the false dichotomy it presents in many peoples' minds. 'I would choose a physician whom I felt was clearly competent to treat me over a physician with a better bedside manner but in whom I had less confidence.' Why do so many assume that they must pick between the two? Why does there seem to be the assumption that if a health care provider has an encyclopedic knowledge of disease and treatment, that health care provider is allowed, or (worse yet) expected, to have little compassion or empathy? In fact, I was presented with the following counter-argument to my

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[237] *House M.D.* Fox. KMSP, Minneapolis, MN. 2004 – Present.

[238] There have been studies done on precisely this point. For information regarding patient preferences, see the following literature: Bendapudi, Neeli M., Leonard L. Berry, Keith A. Frey, Janet Turner Parish, and William L. Rayburn. "Patients' Perspectives on Ideal Physician Behaviors." *Mayo Clinic Proceedings*. Volume 81 (3), March 2006. 338 – 344. Britto, Maria T., Robert F. DeVellis, Richard W. Hornung, Gordon H. DeFriese, Harry D. Atherton, and Gail B. Slap. "Health Care Preferences and Priorities of Adolescents with Chronic Illnesses." *Pediatrics*. Volume 114 (5), November 5, 2004. 1272 – 1280. Delgado, A., L. Andrés López-Fernández, J. de Dios Luna, N. Gil, M. Jiménez, and A. Puga. "Patient Expectations Are Not Always the Same." *Journal of Epidemiology and Community Health*. Volume 62 (5), May 2008. 427 – 434. Wensing, Michel, Hans Peter Jung, Jan Mainz, Frede Olesen, and Richard Groli. "A Systematic Review of the Literature on Patient Priorities for General Practice Care. Part I: Description of the Research Domain." *Social Science and Medicine*. Volume 47 (10), 1998. 1573 – 1588.

claim that health care providers should exhibit the virtue of beneficence: a truly virtuous health care provider cannot actually be a virtuous person. The counter-argument, further described below, contends that the virtues that make a health care provider excellent at his/her trade are character traits that we often dislike in people in general. I present this counter-argument further in the next section, and then reply to that this counter-argument, much like the television show House M.D., misrepresents what virtue theory actually requires of a health care provider.

*A. Objection: Being a Virtuous Health Care Provider Precludes Being a Virtuous Person*

One of the counter-arguments to my position that virtue theory gives guidance to health care providers, and that it should be used to delineate the patient–health care provider relationship from a business relationship, is that virtue theory actually demands that health care providers be vicious in their everyday lives.[239] For instance, the counter-argument goes, a surgeon needs to be able to dehumanize his/her patient in order to focus on the surgery completely and operate successfully. The surgeon might cover his/her patient's face, or refer to the patient in terms of the surgery site (e.g., 'I will operate on this leg.' instead of saying 'I will operate on this patient's leg.'). The surgeon, to be the best surgeon he/she can be, actually needs to cultivate the character trait callousness; in order to perform necessary, even life-saving, surgeries, the surgeon must have a certain degree of distance from the patient. Empathy would be detrimental for the successful surgeon, hindering his/her ability to perform in the operating room. Empathizing with each and every patient would be far too draining for the surgeon. Surgeons would burn-out if they were morally required to fully feel compassion for each patient. Successful surgeons will need to have some character traits that will shield them from feeling too much for any particular patient.

In order to make health care one's profession, one must maintain a certain level of distance, callousness, and even acerbity. Further, while these character traits must be cultivated in order for one be a good health care provider, these character traits are clearly not valued in all people in our everyday interactions. Parents, for example, ought not have these character traits. Thus, to be a good health care provider, one must have character traits which make one a bad person in his/her everyday life. In other words, a virtuous health care provider is not necessarily a virtuous person.

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[239] This counter-argument was articulated to me by Mark Herr, my friend and colleague. I appreciate his help in providing me with this objection.

*B. Two Responses*

I argue against this position in two ways. First, while a virtuous person must act on particular virtues at different times, being virtuous means that one knows when it is appropriate to utilize the different virtues given the circumstances. Second, the claim that a virtuous health care provider must maintain distance, callousness, and acerbity in order to be a virtuous health care provider is false. A virtuous health care provider certainly will have the virtue of beneficence, which necessitates acting with empathy, sympathy, and respect toward patients. Certainly this requires a great deal of mental and emotional fortitude on the part of the health care provider, but to act otherwise is to act as a vicious health care provider.

*1) A Virtuous Agent Properly Utilizes the Virtues*

As I mentioned when I presented virtue theory at the beginning of this chapter, Aristotle maintains that the virtuous person is one who knows when to act upon the appropriate virtues. The virtuous person will respond by utilizing the correct virtues for the given situation. He/she will respond at the right time, in the right manner, for the right reasons, in the right way, toward the right people, while feeling the right emotions, etcetera.[240] For example, when a virtuous person is faced with the difficult situation of responding to a friend who is suffering from depression, the virtuous person will act with beneficence, honesty, and friendliness (to name a few virtues at stake). He/she will offer help to his/her friend, be willing to listen to his/her friend's concerns, and encourage his/her friend to seek out a health care professional. The virtuous person will do this while feeling empathy, sympathy, love, etcetera, and he/she will be motivated to act because his/her friend is in need. Overall, the virtuous person will employ the pertinent virtues in order to provide the type of assistance his/her friend needs in this particular situation. Part of what it means to be virtuous is to have this ability to know how to properly respond given the circumstances at hand.

A virtuous health care provider, then, will be able to act upon the correct virtues in his/her professional life. Further, if this person is truly virtuous, he/she will also act upon the correct virtues in other situations as well. The virtuous health care provider will act with beneficence when dealing with patients just as he/she will do when interacting with his/her children, friends, loved ones, etcetera. The virtuous health care provider will be able to apply that particular virtue in the different situations as is necessary. For example, more empathy might be necessary when interacting with one's children, while sympathy might be required in

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[240] Aristotle. *Op. Cit.* note 151. 1106b21-24.

dealing with one's patients. The virtuous person will know how to properly respond to both situations, how to properly make use of the virtue beneficence. Thus, the objection that a virtuous health care provider has virtues that make him/her a 'vicious' individual in his/her everyday life is a misinterpretation of virtue theory.

*2) Virtues Do Not Change*

As I mentioned in Chapter Five and again above, the virtues of character and virtues of intellect do not vary from person to person, nor from profession to profession. A virtuous person does not have a different set of virtuous character traits and virtues of intellect when compared to virtuous health care provider. The virtues of character and intellect allow one to act appropriately in any given situation, so while a virtuous person might utilize different virtues in different circumstances, the virtues themselves are the same for all.

While the counter-argument claims that there are character traits that health care providers might need in their profession which would otherwise be considered vices, I respond that this is again a misunderstanding of virtue theory and a mischaracterization of health care. The virtues necessary, while elusive as a concrete list, do not fluctuate. There are not character traits that are considered virtues at times and vices at other times. The counter-argument points to callousness as an example of a character trait considered a virtue for health care professionals, but a vice in the majority of people. I respond that callousness is, in fact, a vice wherever it is found. If callousness refers to a cold disposition toward patients, a disregard for minimal pain or slight discomfort, or even a tendency to overlook the lesser preferences of patients, I would deem this character trait a vice rather than a virtue.

While I understand that a level of callousness might serve a health care provider as a mental or emotional shield from the constant pain and suffering the health care provider is required to deal with daily, the possible practical implications of using this character trait does not mean that it is a virtue of character. If a health care professional is required to cause some level of pain or discomfort (e.g., give a shot, operate on a patient), the character trait that should be utilized in these situations is not callousness. The health care provider ought to utilize beneficence when causing pain and when taking consideration for the slight preferences of his/her patients, because this is what is required of the virtuous health care provider. While the counter-argument does bring up the indubitable mental and emotional strain placed on a health care provider in the line of his/her work, the claim of the counter-argument that distance and callousness are legitimate responses to this emotional and mental strain is false.

Acting virtuous is incredibly difficult, and part of this is due to the fact that the virtues of character are not character traits which lead to mental and emotional ease. However, these character traits are virtues because they allow the individual to act nobly and, when employed by the health care provider, to treat patients with the dignity, care, and respect the patients deserve. While some emotional distance might be required in the operating room, for example, true callousness is not what is required to achieve this distance. In fact, callousness might lead the health care provider to treat his/her patient as a mere object, cause the patient undue pain and indignity, and result in overall poor patient care. I argue that it is possible for the health care provider to achieve the necessary emotional distance without utilizing the vice of callousness. Callousness is a vice precisely because it does not allow the agent to act nobly toward others nor does it allow the agent to flourish. Callousness requires treating others without concern for their wellbeing. This necessarily conflicts with the virtues at stake in a patient–health care provider relationship, especially beneficence. Because callousness is a vice, utilization of callousness would have negative ramifications for the health care provider, the patient, and the patient–health care provider relationship.

Virtue theory illustrates why beneficence is an essential character trait for the health care provider, and provides further support for my argument that the patient–health care provider relationship is not a business interaction. I review my argument in its entirety in the next and final chapter. Prior to doing this, I present a pressing ethical dilemma for health care providers in South Dakota, and I illustrate how my presentation of the patient-health care professional relationship aids the health care professional in addressing this particular ethical issue.

**Chapter Six: Conclusion**

*I. Application to Case: South Dakota Law (§ 34-23A-10.1 2006.)*

*A. Presentation of Law*

In 2006, the South Dakota legislature passed a law regarding the informed consent process in obtaining an abortion in non-emergency circumstances. One portion of the bill outlines, quite specifically, the 'facts' which must, legally, be presented to people seeking abortions. The following is a portion of this bill:

> A consent to an abortion is not voluntary and informed, unless, in addition to any other information that must be disclosed under the common law doctrine, the physician provides that pregnant woman with the following information:
>
> (1) A statement in writing providing the following information:
> (a) The name of the physician who will perform the abortion;
> (b) That the abortion will terminate the life of a whole, separate, unique, living human being;
> (c) That the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota;
> (d) That by having an abortion, her existing relationship and her existing constitutional rights with regard to that relationship will be terminated;
> (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including:
> (i) Depression and related psychological distress;
> (ii) Increased risk of suicide ideation and suicide;
> (iii) A statement setting forth an accurate rate of deaths due to abortions, including all deaths in which the abortion procedure was a substantial contributing factor;
> (iv) All other known medical risks to the physical health of the woman, including the risk of infection, hemorrhage, danger to subsequent pregnancies, and infertility;
> (f) The probable gestational age of the unborn child at the time the abortion is to be performed, and a scientifically accurate statement describing the development of the unborn child at that age; and
> (g) The statistically significant medical risks associated with carrying her child to term compared to undergoing an

induced abortion.[241]

The South Dakota law outlines a 'script' to which health care providers must legally adhere in order to avoid committing a crime when they discuss abortion with patients. I argue in the following paragraphs that because this script includes incorrect scientific data, misleading legal information, and value-laden terminology, health care providers are minimally morally required to "contextualize the script."[242] Health care providers are additionally morally allowed to contentiously object to participating in this form of 'informed consent,' and that providers are likewise morally allowed to advocate reversing this legislation.

In the following paragraphs, I outline, first, one portion of incorrect scientific data the South Dakota legislature demands health care providers tell to women seeking abortions. Second, I will illustrate that there is little evidence for the South Dakota legislature's claim that the woman and the unborn human have a relationship which is protected by the United States Constitution. Third, I will point out some of the value-laden terminology written in to the South Dakota 'script.' After reviewing these three issues with this law, I will explain that, with these items in mind, health care providers are morally bound to tread lightly around this particular bit of legislation because of the beneficence required of the health care professional.

*B. Factual and Moral Problems with South Dakota's Legislation*

This law has been criticized for many reasons. First, §1.e.ii states that women who have abortions are at an increased risk for "suicide ideation and suicide." However, the scientific studies done on this issue have not proven this point to be true. Charles *et al.* conducted a comprehensive review of studies conducted between January 1, 1989 through August 1, 2008 which evaluated the effect of abortion on long-term mental health.[243] The authors found that the higher the quality of the study, the less likely the study was to indicate that women had long-term mental health repercussions after their first abortion.[244] The lower-quality studies were the only ones which indicated that women who underwent their first

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[241] Public Health and Safety: Performance Of Abortions - Voluntary and informed consent required-- Medical emergency exception-- Information provided. South Dakota Codified Laws § 34-23A-10.1. 2006.

[242] Minkoff, Howard and Mary Faith Marshall. "Government Scripted Consents: When Medical Ethics and Laws Collide." Working Paper. Received March 25, 2009. Many thanks to Minkoff and Marshall for sharing the draft of their paper with me.

[243] Charles, Vignetta E., Chelsea B. Polisa, Srinivas K. Sridharab, and Robert W. Bluma. "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence." *Contraception*. Volume 78 (6), December 2008. 436 – 450.

[244] Ibid. 448 – 449.

abortion had negative mental health outcomes.[245] Their results corroborated what other authors and professional societies have previously claimed: there is no clear data indicating that women who undergo elective abortion suffer negative mental health repercussions as a result of the abortion.[246]

Second, §1.c indicates that the woman and the fetus have an "existing relationship" which "enjoys protection under the United States Constitution." While the law is not clear as to where in the constitution this relationship is protected, one might look to how the United States Supreme Court has interpreted the constitution in recent years regarding the relationship between the woman and the fetus. In its ruling on Roe v. Wade, the Supreme Court clearly stated that what was essential to the legality of abortion was the privacy and safety of the woman; the embryo/fetus does not have legal status. In the majority opinion, Justice Blackmun wrote that the term 'person' applied only to post-partum infants, not to fetuses. While the court did allow for states to regulate abortion after the first trimester, the emphasis in allowing for proscription of abortion was on the increased risk to the woman in later-term abortions.[247]

The main principles of Roe v. Wade were affirmed in the 1992 Supreme Court Case Planned Parenthood of Southeastern Pennsylvania v. Casey. In its ruling on this case, Justices O'Connor, Kennedy, and Souter wrote that the three main parts of Roe v. Wade still stood. First, women have a right to opt for abortion prior to viability of the fetus. Second, states have the right to prohibit abortion after viability of the fetus unless the pregnancy endangers the life or health of the woman. Third, the state has a legitimate interest in protecting the health of the woman and the life of the fetus.[248] While the court decision upheld the Roe v. Wade decision, it is important to note that this ruing was not a majority ruling, but rather a mere plurality, and thus is not binding in the strictest sense. Finally, in 2007, the Supreme Court upheld the Partial-Birth Abortion Act of 2003. In its majority ruling, the court wrote that the Act was neither vague nor that it placed undue burden on women.[249]

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[245] Ibid. 449.

[246] For further information on this issue, see: Bradshaw, Z. and P. Slade. "The effects of induced abortion on emotional experiences and relationships: a critical review of the literature." *Clinical Psychological Review*. Volume 23 (7), December 2003. 929 – 958. See also: Lie, Mabel L. S., Stephen C. Robson, and Carl R. May. "Experiences of Abortion: A Narrative Review of Qualitative Studies." *BMC Health Services Research*. Volume 8 (150), July 17, 2008.

[247] Roe v. Wade. 410 United States 113. United States Supreme Court 1973.

[248] Planned Parenthood of Southeastern Pennsylvania v. Casey. 505 United States 883. United States Supreme Court 1992.

[249] Gonzales, Attorney General v. Carhart. 550 United States 124. United States Supreme Court 2007.

What can be gleaned from these three essential Supreme Court cases is that the United States Supreme Court has dictated that women have the right to have an abortion which is protected by the court's interpretation of the 14th Amendment (which has been interpreted to include a right to privacy). While this right to an abortion was never without limitations, the existence of this right has been reaffirmed in two subsequent court cases to the pivotal Roe v. Wade decision, which first indicated that a woman's choice to have an abortion is included under the Court's interpretation of a right to privacy. Women are able to have an abortion, and the state is not allowed place undue burden on women who seek out abortion. The state does have "an interest" in protecting the life of the fetus, but this interest stands as significant in relation to the woman's rights to privacy and a woman's right to an abortion *only* when the fetus is medically viable after birth.

The Supreme Court, in these three rulings, did not indicate that the woman has an "existing relationship with that unborn human being" which "enjoys protection under the United States Constitution," as stated by the law of South Dakota. The state might act upon its perceived duty to protect the life of the fetus, but this sense of duty was one of the state, not one the woman, was said to have. In fact, it is unclear upon what South Dakota bases its understanding of the relationship it claims a woman has with her unborn fetus, and what federal legislation or federal court decisions South Dakota would cite as a support for claiming that this relationship between the woman the fetus "enjoys protection under the United States Constitution."

Third, the South Dakota legislation presents the idea of abortion in a skewed light. For example, the 'script' dictates that the health care provider tells his/her patient that the abortion will "terminate the life of a whole, separate, unique, living human being." While many people may believe this to be true, there are others who would find this statement not only false, but inflammatory. Minkoff and Marshall present an alternate version of the 'script' to highlight how such value-laden terminology can impact the patient-provider interaction:

> [B]efore being offered a termination of pregnancy [women] would be informed that the fetus they are carrying is not a human being; the latter assertion being no less credible than the converse, which is currently contained in the South Dakota script.[250]

[250] Minkoff and Marshall. *Op. Cit.* note 242.

Whether or not the fetus is a living human being is a subject of much debate. To present women the 'facts' of their pregnancy in these terms does not elucidate the situation and the options available to women. Rather, it obviously supports one interpretation of pregnancy, the metaphysical status of the fetus, and implies moral and legal responsibilities toward the fetus in light of those terms.

> Whether the fetus is a "human being" is thus understood by all sides to the abortion controversy to be an essentially contested moral proposition. For South Dakota to require a physician to "inform" his patient that she will be terminating the life of a "human being" is consequently not innocent. It deliberately and provocatively incorporates the language of ideological controversy and forces physicians to affirm the side of those who oppose abortion.[251]

As presented above, the legally prescribed list of contents for the patient consent form contains (1) scientific 'facts' which are not supported by the current research, (2) federal legal references which are likewise not clearly supported by the Supreme Court's interpretation of the United States Constitution, and (3) value-laden terminology which (a) force the health care providers to present themselves as 'anti-abortion,' or 'pro-life,' and (b) presents the option for abortion to women in a negative moral light. Given that the legislature of South Dakota mandates that health care providers adhere to this 'script,' health care providers are placed in an uncomfortable position. Health care providers must legally adhere to this 'script' (failure to comply might result in a class 2 misdemeanor charge against the health care provider), yet complying with this state statute violates the ethical standards for ensuring informed consent on the part of the patient. What the South Dakota legislature has done is to mandate what occurs in the patient–health care provider relationship regarding discussions of abortion. Health care providers are not able to fully act as fiduciaries because of this law; what I argue is morally required of health care providers is not attainable because of the legal constraints placed upon them by the state.

In the following paragraphs, I utilize my presentation of the ideal patient–health care provider relationship (discussed in the preceding chapters) to review this current issue for health care providers. This discussion explains why following South Dakota's 'script' would result in the health care providers not securing proper informed consent because their ability to

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[251] Post, Robert. "Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech." *University of Illinois Law Review*. Volume 2007 (3), 2007. 939 – 990. 956.

act beneficently is hindered, and what health care providers morally should do in response to this conundrum.

*C. Why Informed Consent Is at Risk & The Moral Response for Health Care Providers*

My argument presented in the above chapters concludes that the key virtue for health care providers is lost when the patient–health care provider relationship is changed into a business interaction. This virtue is beneficence. One of the reasons that this virtue is essential to the patient–health care provider relationship is because of the uncertainty on the part of the patient. The patient does not have the knowledge set available to health care professionals; patients seek out health care professionals precisely because the patients lack information regarding their conditions and how to properly treat those conditions. The health care professionals, as part of their role of fiduciary, provide this information to patients in order to ensure that the patients can make informed choices about their health care. Health care providers ought not dictate treatment; paternalism in health care, as noted in Chapter Five, has, for good reason, been left behind and in its place is respect for patients' autonomy. While health care providers should use their expertise to offer sound medical information for their patients, they must do so with the goal of arming their patients with the necessary knowledge to make their own health care decisions.

One of the reasons that the 2006 South Dakota law outlined at the beginning of this section is problematic (to say the least) is because it directly interferes with this portion of the patient–health care provider relationship. Health care providers discussing the option of abortion with their patients are legally obligated to provide inaccurate information to their patients, and they further must refer to the pregnancy in loaded terms (at least once and in writing). These two issues alone create major problems for the health care providers. First, the health care provider, instead of providing the medical knowledge generally accepted by the health care community, is mandated to tell patients misinformation or risk losing his/her license and being charged with a misdemeanor. Second, the health care provider is required to possibly offend both the health care provider's and the patient's principles by presenting the pregnancy in the terms dictated by the South Dakota legislature.

*1. How the South Dakota Statute Violates Informed Consent*

There are two essential elements to informed consent. First, the health care provider must provide his/her patient with the technical information the patient lacks in order for the

patient to be fully informed regarding his/her options. This is the 'informed' portion of 'informed consent.' The 'consent' portion of 'informed consent' can only be said to actually occur when patients are not coerced by their health care providers in making health care decisions. This second element of informed consent mandates that health care providers not attempt to sway their patients based on values, ideals, or metaphysical notions the health care provider has with which the patient may not agree. The values which should be at the table during the informed consent process include the health care provider's commitment to beneficence and the patient's personal values and personal metaphysical ideals.[252] As I will illustrate in the following paragraphs, the South Dakota 'script' violates informed consent in that it does not allow for either of these two essential elements.

The foundation for informed consent is truth-telling; health care providers are expected to provide patients with accurate information regarding their illness, possible treatment options, and the risks involved with those treatment options. For example, The American College of Obstetricians Gynecologists Committee on Ethics stated that the accuracy of the disclosure provided in the informed consent process is judged by criteria which may include: "1. The common practice of the profession; 2. The reasonable needs and expectations of the ordinary individual who might be making a particular decision; and/or 3. The unique needs of an individual patient faced with a given choice."[253] In order for patients to make informed choices, those patients must first be provided with accurate, pertinent information. As I showed in the previous section, the South Dakota 'script' demands that health care providers present inaccurate scientific information to patients.

The second essential element in achieving informed consent is ensuring that health care providers do not unduly influence their patients ultimate health care decisions. Health care providers will be asked for their professional opinion regarding which treatment option is optimal, what the patient is likely to expect from certain treatments, and even which treatment seems to the health care provider to be the best choice for this particular patient. These are not unreasonable questions for a patient to have, and the health care provider should respond honestly and openly to these matters because this is what beneficence demands of the health care professional. However, it is unethical for health care providers to attempt to sway their patients during the informed consent process if the basis for this emphasis is the health care providers' personal values. This is unethical under the standard view of informed consent in

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[252] Minkoff and Marshall. *Op. Cit.* note 242.

[253] Committee on Ethics of the American College of Obstetricians and Gynecologists. "Ethical Dimensions of Informed Consent." ACOG Committee Opinion 108, May 1992. Revised 2004.

that biasing one's patient does not allow that patient to make his/her own health care decisions. This type of influence is what health care providers tossed out when they shifted from paternalism to focusing on patient autonomy. Further, presenting options in a prejudice manner is immoral under my presentation of the patient–health care provider relationship because it does not allow for true beneficence. If health care providers are more concerned about their own values and personal judgments than they are their patients' well-being, health care providers are not acting on the essential virtue of beneficence.

The South Dakota legislation demands that health care providers present the option of abortion in value-laden terms, as I explained in the previous section. In that health care providers are the ones who are legally bound to present this information, it might seem to the patient that the health care provider morally approves of this partial view of abortion. Even if the health care provider makes it clear to his/her patient that this script originated not with the particular health care provider, but rather from the South Dakota legislature, the patient is still being presented biased information and is told that this biased information is how the state of South Dakota views the issue of abortion. This is still a form of coercion, although originating from the state rather than the health care provider, and it still might unduly influence the ultimate decision of the patient. Regardless of where the bias originates, it ultimately mitigates the ability of the patient to make an informed decision of his/her own.

### *2. Moral Obligations of South Dakota Health Care Providers*

There are a number of responses to the issues central to the South Dakota legislation that can be deduced from my presentation of a proper patient–health care provider relationship. One, health care providers are forced to pay even closer attention to the already delicate relationship with their individual patients who are seeking information about abortions. It might very well be possible to present the information legally required while remaining attuned to the specific needs of the patient. However, this will require extra delicacy and forethought. Two, contentious objection to this particular law (or similar laws) would be morally acceptable; refusing to participate in this type of legally altered informed consent process is morally acceptable, and should be supported by the larger health care professional community. Three, health care providers are morally allowed (and possibly obligated) to lobby against this particular law, as they would be for any law which mandates that they provide inaccurate information to their patients and undermines their ability to act as fiduciaries. These are just a

few options available to the virtuous health care provider faced with this legal and moral conundrum, and I explain each of these three responses in the following paragraphs.

One, health care providers discussing the option of abortion with patients morally must tread a very thin line if they wish to avoid prosecution. As Minkoff and Marshall point out, health care professionals "can, when called upon to counsel a patient, contextualize the script, separating medical fact from legislative conjecture."[254] Health care professionals are the ones in conversation with patients, and while they are legally bound to provide the information presented in the South Dakota bill, health care providers are not limited to presenting only that information. Additionally, providers are allowed to explain to their patients where this information originated and that there is currently sound medical and legal reason to see the information in the South Dakota script in a dim light. "In essence, it is the [health care provider's] burden to rehabilitate a counseling process that has been debauched by the South Dakota legislature."[255]

At the very least, health care providers placed in this situation are morally bound to explain not only the standard information presented when patients make informed health care decisions, but are now also to present the South Dakota 'script' in a manner that allows patients to make uncoerced consent (or, as uncoerced as possible, given the circumstances). In order for health care providers to act truly beneficently in this circumstance, that is, in order to work primarily for the best interest for their patients, health care providers are morally obligated to share this 'script' with their patients in a manner in which the patients are still able to make the best health care choices. This means that health care providers must point out the misinformation, legally murky underpinnings, and value-laden language in the 'script.'

Two, given the misinformation, the legally murky underpinnings, and value-laden language in the South Dakota law, health care providers have the moral right to contentiously object to this law. Since this law mandates that health care providers act immorally and unprofessionally (given that many professional societies outline what is professionally required in the informed consent process, as shown in the ACOG example above), providers might ethically choose to refuse to participate in this state-sanctioned hijacking of the informed consent process and the patient–health care provider relationship. Health care providers might

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[254] Minkoff and Marshall. *Op. Cit.* note 242.
[255] Ibid.

also choose this path because their first amendment rights have been infringed upon by the state.[256] If health care providers take this route, it seems plausible that they could find support in doing so in their respective professional organizations.

Three, health care providers also have the ethical latitude to lobby against this law, support its repeal, and prevent other states from making similar laws. Given that health care providers are morally required to act with beneficence toward their patients, health care providers certainly have the option to oppose the type of legislation under which the South Dakota law falls since this law limits providers' ability to act with beneficence toward their patients. If state or federal governments attempt to circumvent, alter, or do away with proper informed consent and the health care provider's ability to act with beneficence toward his/her patient, health care providers are morally allowed to speak against such attempts. Given that these laws, such as the law in South Dakota, do not allow for ethically healthy patient-provider interactions, health care providers are certainly within their moral bounds to stand against such laws, encourage their repeal, write papers and letters to this effect, and prevent passage of similar laws.[257]

*D. Conclusion*

As I have explained in the above pages, the South Dakota legislation containing the 'script' for health providers to present in informed consent conversations regarding abortion is problematic for three reasons, and in violating the premises of informed consent, the law interferes with the patient–health care provider relationship by mitigating the provider's ability to act as a fiduciary. The law does this firstly by in that it mandates that health care providers present misinformation regarding the risks of voluntary abortion, e.g., that there is an increased likelihood of suicide ideation and suicide after abortion when the scientific evidence does not support such claims. Secondly, it refers to federal protection for the 'relationship' the woman has with the 'unborn human,' which supposedly can be found in the United States Constitution. However, the Constitutional support for this claim is vague at best. Thirdly, the South Dakota

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[256] For an argument explaining this position, see: Curfman, Gregory D., Stephen Morrissey, Michael F. Greene, and Jeffrey M. Drazen. "Physicians and the First Amendment." Editorial. *New England Journal of Medicine*. Volume 359 (23), December 4, 2008. 2484 – 2485. See also: Post, Robert. "Informed Consent to Abortion: A First Amendment analysis of Compelled Physician Speech." *University of Illinois Law Review*. Volume 2007 (3), 2007. 939 – 990.

[257] It seems that there could be a stronger argument made here – that, in fact, health care providers are morally *obligated* to lobby against such legislation. I will not address this possibility here, but will focus on it in further research.

law presents the option of abortion in value-laden terms which present abortion in a negative light. Given that the South Dakota law suffers from these three issues, informed consent is difficult, if not impossible, to achieve when health care providers present this legislated material. This is because the misinformation does not allow for proper education of patients (the 'informed' portion of 'informed consent'), and that either the state or the health care provider (or both) attempt to coerce the patient in making her ultimate health care decision (the 'consent' portion of 'informed consent').

Given that health care providers are placed in the position of being legally forced to manipulate the informed consent process, health care providers have at least three moral responses. First, health care providers are morally bound to explain where this 'script' originated, that it contains misinformation, that it misconstrues the federal standing of women and 'unborn humans,' that it presents abortion in a light with which the patient and/or the health care provider might not agree, and finally that the there is more information necessary for the patient to consider when making a decision regarding voluntarily terminating pregnancy. Since health care providers are morally obligated to act utilizing the virtue of beneficence, health care providers must contextualize this 'script' in order to allow their patients to make the best possible health care decisions. Second, health care providers are morally allowed to refuse to participate in this state mandated form of informed consent. Since the South Dakota legislature has violated both essential elements of informed consent, health care providers are ethically allowed to refuse to present the 'script' dictated by state law. Third, health care providers are morally allowed to lobby against this law, advocate its repeal, and urge that other states not follow suit. This is just one example of how health care providers can utilize the virtue of beneficence in order to deal with a morally and legally problematic infringement on the patient–health care provider relationship.

*II. Argument Summary*

My dissertation has presented two arguments. First, I argued that the claim that a patient–health care provider relationship is a business relationship is false. Second, I argued that the assertion that a patient–health care provider relationship can be successfully altered in order to be a business relationship is also false.

In order to support these two arguments, I first reviewed the one of the main origins of the commodification of health care in Chapter Two. I presented Kenneth Arrow's (an economist) paper in the December 1963 *The American Economic Review,* which has been viewed as the primary work on the interface of health care and the free market.[258] Arrow concludes that health care is a unique market because of the uncertainty unique to health care, which includes uncertainty as to when/if one becomes ill, uncertainty of the patient regarding treatment, and even uncertainty regarding the recovery time after being treated.[259] In order to provide contemporary support for Arrow's claim that patient's face a variety of uncertainty and that this uncertainty is key regarding how patients wish to interact with their health care providers, I reviewed a number of studies done on what patients desire of their interactions with their health care providers. These studies provide evidence for Arrow's interpretation of the patient–health care provider relationship, as well as support my claim that patients rely heavily upon their health care providers when seeking health care. Patients view their health care providers as partners, and they trust that their providers will act as fiduciaries when interacting with patients.

While Arrow is cautionary in his investigation of health care as a commodity, he ultimately views health care and the patient–health care provider relationship as commodities. In part because of this, Arrow's article has been cited as the beginning of the commercialization of medicine and the commodification of health.[260] I addressed this trend of commodification of health care by reviewing two more recent works, both of which defend and encourage viewing health care under the free market, in Chapter Three. Gilmartin and Freeman approach the issue of the commodification of health care from the perspective of "stakeholder capitalism,"[261] while Capaldi argues that advancement in medicine and health care can only be maximized if health care is pushed fully into the free market.[262] I argued against both works, first by illustrating the shortcomings of stakeholder capitalism (a topic I revisited in chapter four), and then by

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[258] Arrow. *Op. Cit.* note 14.
[259] Ibid. 959.
[260] Relman. *Op Cit.* note 33.
[261] Gilmartin and Freeman. *Op. Cit.* note 76.
[262] Capaldi. *Op. Cit.* note 89.

providing examples of innovation that occurs outside the free market. After presenting both of these works and my objections, I addressed two works that object to Gilmartin, Freeman, and Capaldi, and support, to varying degrees, my own arguments. Wildes argues that the moral norms of society dictate how that society distributes necessary human goods, including health care.[263] Andereck claims that the patient-provider relationship, which is essential to health care, ought to be the pivotal point to any investigation of how health care is provided at large.[264] Both Wildes's and Andereck's positions support my argument that the patient–health care provider relationship is not, and should not, be viewed as a business interaction, and my presentations of their work, where it leaves off, and how I take it as a springboard for my own argument is the conclusion of Chapter Three.

In Chapter Four, I addressed the reasons why the patient–health care provider relationship cannot be viewed as a business relationship. To do this, I first presented the standard understanding of business under the free market, and then I contrasted this view with the modern understanding of how businesses operate, called stakeholder capitalism. According to historical accounts of the free market, as presented, for instance, by Adam Smith, the consumer is standardly assumed to be an autonomous individual seeking a product. Further, the consumer is expected to act solely in his/her self-interest. The merchant's goal is to provide a product for which there is a great demand, while, simultaneously, maximizing his/her share of the market for that product. When the consumer and the merchant interact, both are assumed to be attempting to maximize their end of the transaction; neither is working to benefit the other party.

In contrast to this view of the free market, I set forth the business model that Gilmartin and Freeman claim is more accurate, and which I mentioned in Chapter Three. Gilmartin and Freeman, and many other contemporary economists and business ethicists, argue that the free market is more accurately described by 'stakeholder capitalism,' which takes into account relationships and values of all of the 'stakeholders.' These stakeholders include entrepreneurs, managers, customers, suppliers, financiers, and communities. Unlike the historical account of the free market, stakeholders do not care only about their self-interest; they make value-judgments when they shop. Thus, the argument contends, stakeholder capitalism is not only able to incorporate health care and the relationships inherent in health care, but they further argue that 'stakeholder capitalism' is the groundwork from which we should operate when we

[263] Wildes. *Op. Cit.* note 122.
[264] Andereck. *Op. Cit.* note 129.

work to improve or reform health care. ‘Consumers’ of health care make value judgments about the health care they purchase, just as they do in all other realms of their consumption.

In response to Gilmartin and Freeman’s claim that health care can be and ought to be viewed as an instantiation of stakeholder capitalism, I presented four significant problems with their argument. First, the argument made by those who propose using stakeholder capitalism as a model for health care is invalid. Second, because the primary motivation is what is of importance when comparing business interactions with patient-health care provider interactions, the argument that the outcomes are the same in business and health care is irrelevant. Third, it is not always possible for consumers to act upon their values, while it is morally required of a health care provider to allow his/her patient to act upon the patient’s values. Fourth, proponents of stakeholder capitalism do not address Arrow’s concerns of uncertainty.[265]

After criticizing the view that health care can and should be viewed as a subset of stakeholder capitalism, I presented a proper understanding of the patient–health care provider relationship and what makes said relationship unique. The two essential elements to this relationship are (1) the uncertainty of the patient, and (2) the expert knowledge of the provider. Because of these elements, the health care provider necessarily acts as a fiduciary. The patient enters into the relationship trusting that his/her fiduciary will work solely for benefit of the patient, not for profit, fame, legacy, etcetera. If this trust breaks down, the relationship suffers significantly. It is because of this that a patient–health care provider relationship is unlike almost any other, even professional, relationships. There is much more at stake in a health care relationship than even the most complex business model can incorporate. I concluded that willfully ignoring the circumstances of the singular interaction of the patient and the health care provider is tantamount to moral failure on the part of a health care provider.

The final section of Chapter Four addresses a counter-argument to my claim that a health care relationship is not comparable to a business relationship. The counter-argument claims that my presentation of a patient–health care provider relationship *does* resemble an exemplary business relationship. Central to this counter-argument are examples of merchants who treat their customers with the respect, dignity, care, and generosity that some health care professionals lack. It seems, according to this objection to my argument, that there is little difference between stellar customer care and health care. I responded that there are two reasons this argument fails: 1) it misconstrues the primary aim of the merchant, and 2) it conflates acts done out of friendship with business interactions. Actions done in order to maximize the

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[265] Arrow. *Op. Cit.* note 14.

company's future and actions done out of some intimate relationship clearly do not have the same motivation found in the patient–health care provider relationship. The similarities upon which the counter-argument focuses are actually superficial. The fiduciary nature of the patient–health care provider relationship is not replicated in even the most caring, considerate business interaction. The factor that is essential to the health care relationship is beneficence, and this is missing from even exemplary business relationships.

Following my presentation of the central characteristics of the patient–health care provider relationship in Chapter Four, I addressed the way to properly understand these characteristics in Chapter Five. Chapter Five began with an overview of virtue theory. I reviewed Aristotle's work, Nicomachean Ethics.[266] Aristotle argues that only when one achieves the fully virtuous life will one act appropriately in any given situation. This means that one will feel the right emotions, in the right amount, at the right time, and respond in the right way. One will do the virtuous act and will enjoy doing the virtuous act because it is virtuous. When one achieves the virtuous life, one will be living the best possible life, *eudaimonia.* Only by being virtuous is one capable of living this life. After discussing the historical origins of virtue theory, I addressed a modern interpretation of the theory as presented by Rosalind Hursthouse, which provides a contemporary application of virtue theory and also responds to a number of modern objections to virtue theory.[267]

Following my presentation of virtue theory, both an historical and a contemporary version, I shifted to recent applications of virtue theory. First, I presented Susanne Foster's work "Aristotle and the Environment," which explains how virtue theory can be applied to environmental ethics.[268] She argues that being truly virtuous means that one has a proper understanding of the good of the natural world and all of its components, not merely humans. Second, I addressed David Coady's article "Stanley Milgram and Police Ethics."[269] Coady argues that since moral courage is desirable, testing police officers for this particular virtue ought to be a part of ethics testing in police forces, just as entrapment testing is currently done to evaluate propensity to take bribes.

In section four of Chapter Five, I undertook the task of applying virtue theory to the patient–health care provider relationship just as Foster and Coady applied the theory to their areas of work. First, I addressed the particular virtue of character beneficence, which I argued

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[266] Aristotle. *Op. Cit.* note 151.
[267] Hursthouse. *Op. Cit.* note 152.
[268] Foster. *Op. Cit.* note 190.
[269] Coady. *Op. Cit.* note 205.

was the key virtue of health care providers. Since virtues of character are virtues that are required in order to lead a flourishing life, I claimed that beneficence is necessary. This trait is essential not only for individuals working within the field of health care, but for all individuals. After describing this key virtue, I noted that my application of virtue theory to the profession of health care was not original. However, as I pointed out, my argument is new. Beneficence is an essential characteristic for any health care provider entering into a patient–health care provider relationship. Further, it is the utilization of beneficence that differentiates the patient–health care provider relationship from a business relationship. A virtuous health care provider is a fiduciary for his/her patient. The health care provider works for the best interest of the patient without concern for the health care provider's own ends.

After arguing that the health care provider was a fiduciary in the patient–health care provider relationship, I addressed the tense interface of patient autonomy with the role of fiduciary. I noted that, historically, there was excellent reason for health care providers to leave behind paternalism and to turn toward respect for patient autonomy. But, as I also pointed out, one of the consequences of this shift was growing mistrust for viewing health care providers as fiduciaries. Concern for ensuring patients' abilities to make their own health care decisions resulted in a downplaying of the role of 'advisor' played by health care professionals. I argued, though, that leaving behind paternalism and embracing patient autonomy actually supports my own position. Patients are not consumers, and they do not seek out health care in the way they seek out other goods. Health care providers cannot act as if they are selling a product; providers cannot care solely, or even primarily, about their own ends. Health care providers must act for the best interest of their patients. Respecting patient autonomy only further mandates that health care providers act with beneficence in their interactions with patients. To change the patient-health care professional relationship to a business interaction, or to insist that health care professionals *should* treat the patient–health care provider relationship as a business interaction, is to demand that health care professionals act viciously.

I concluded Chapter Five with a discussion of the counter-argument brought to the forefront by the television show "House, M.D." This counter-argument claims that the virtues required of a virtuous health care provider are actually vices in every day life. I responded to this objection in two ways. First, I pointed out that being a virtuous person means that the agent knows how to properly apply the virtues in specific circumstances. Second, I illustrated that the virtues of character and virtues of intellect do not vary from person to person, or from professional life to personal life. Beneficence is a virtue in health care providers just as it is in

parents, friends, professors, etcetera. Thus, the counter-argument that a virtuous health care provider has character traits that commonly are viewed as vices is unsound.

In this manner, I argued that the patient–health care provider relationship is not a business relationship. The health care provider is morally required to treat his/her patient in a beneficent manner, which is not a part of a business interaction. Even the most exemplarily business interactions are still based on both participants attempting to achieve their own self-interest, which includes the business person attempting to maximize profit. This motivation is immoral for a health care provider. Because health care providers are treating patients who lack expert knowledge, training, are vulnerable, and facing multiple types of uncertainty, providers are morally obligated to act as fiduciaries. Health care providers must have the patients' values, needs, concerns, and, of course, health, in mind, and providers may not act with selfish motivations. When health care providers utilize selfish motivations, they provide sub-par health care, disrespect their patients, and are acting viciously to boot. Further, when the patient–health care provider relationship faces interference from an outside source, as is the case in South Dakota, health care providers are forced to further ensure that their patients' well-being is ensured, that proper informed consent occurs, and that the relationship does not further suffer.

In future work, I would like to investigate the additional moral responsibilities that fall out of the health care provider's moral obligation to act with beneficence toward his/her patients. It seems that advocating for patient welfare in legislation, working toward a comprehensive public health platform, and even advocating for international health reform might be required of health care professionals due to their obligation to act with beneficence toward patients. However, the interface between health care professionals' moral obligation to act beneficently while still achieving their own personal life-plans needs elucidation. Additionally, while I have shown what is morally required of health care providers in individual situations with individual patients, it is unclear where or if this responsibility changes when shifting from individual patients to working for public health (local, state, national, or international).

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