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# A Critique of Contemporary Physician Professionalism under the U.S. Healthcare System

By

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B.S., Emory University, 2019

Advisor: Paul Root Wolpe, PhD
Committee Members: Benjamin Stoff, MD, MA; Bruce Greenfield, PhD

An Abstract of
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2024

# Abstract

## A Critique of Contemporary Physician Professionalism under the U.S. Healthcare System

By Logan Kugathasan

The duties and professional responsibilities of physicians have been a subject of debate for as long as the medical profession has existed. As technological and pharmaceutical advancements of the 1900s exponentially grew the scope and capabilities of medicine, conceptions of physicians' obligations to themselves, patients, and society at large – professionalism – were challenged time and time again. Social, political, and economic triumphs and mishaps during this period further re-shaped definitions of professionalism and what the duties of a physician ought to be. This thesis first aims to identify these changes, recognize today's most widely accepted definitions of physician professionalism, and explore what goals and obligations they strive towards. This thesis then documents the rise and establishment of private healthcare institutions in America and identifies their goals and obligations in order to evaluate foundational conflicts that arise between physician and institution. This framework is established to then explore how the goals of American Healthcare as a virtue-oriented profession run antithetical to the realities of American Healthcare as a profit-oriented enterprise. As physicians continue to cede autonomy to consolidated medical entities, they are increasingly compelled to compartmentalize these conflicts in practice. What duty, if any, should physicians have to address the shortcomings of American Healthcare? What are the limits of physician duty and advocacy within such a system? Without confronting the institutional barriers that prevent professionalism's actualization, we risk physicians leaving the tenets of professionalism as abstract concepts to be debated rather than tangible ends to be pursued.

# A Critique of Contemporary Physician Professionalism under the U.S. Healthcare System

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## Section 1: A History of Medical Professionalism

Medical professionalism is a broad and challenging to define idea that underpins the trust the public has in medicine and physicians. Over the centuries, we have come to define, reclaim, and redefine again what professionalism is and what it means to the establishment of trust and cooperative environments by which to heal the sick. Scientific limitations of the 1800s relegated physicians to little more than consolers of the sick and dying. Medicine, as result of such limitations, was rooted in homeopathic remedies that focused on amelioration of symptoms, folk medicine, traditional remedies and letting nature run its course – for better or for worse.[1] Prior to the 1910 Flexner Report, medical schools had no centralized curricula, no standards by which to base medical knowledge, and next to no regulation on whom could acquire a medical license.[2] Yet, there still existed etiquette and codes. In 1803, Thomas Percival published the text Medical Ethics, which would become the groundwork for the AMA's first edition of ethical codes. In this text, Percival wished to establish 'rules of conduct' for practicing doctors. These codes emphasized the *moral obligation* of physicians to serve others and care for the sick.[3] Even before the scientific authority of doctors began consolidating, we see a deliberate attempt to link professionalism and ethics to the duty of a doctor.

Gradual advancements in medicine of the early 1900s, due in part to the reorganization and centralization of medical education in the aftermath of the Flexner Report and growing fascination with the hyper-rational philosophy of German science, propelled the field of medicine into a golden age of development.[2] The first major development came in the form of public hygiene and bacteriology in surgery sterilization.[4; 135] The second came in the form of antitoxins to diphtheria and typhoid – two of the major causes of death at the time. Technological and pharmaceutical advancements would only accelerate in the latter half of the 1900s. The invention of coronary angiography in 1958 revolutionized our understanding of coronary artery disease; further large-scale trials of medications like aspirin, statins, beta-blockers, and ACE inhibitors provided a multitude of new treatment options.[5] The development of recombinant DNA human insulin in 1978 made glycemic control possible for the average patient with diabetes mellitus.[6] Starzl's 1963 report on immunosuppressive cocktails on renal transplants generated an explosive rise in renal graft survival.[7] These developments drastically improved the American life expectancy and built the foundation for scientific rationalism and the reclamation of legitimate authority by medicine.[4;139, 8] However, the concomitant progression of industrialized capitalism marked a sharp increase in the dependence on the skills of others in specialized professions.[4;142] The increasing demand for such skills further bolstered medical authority and made specialized providers more sought-after. This is seen in the substantial increase in physician salaries from $750 - $1500 in 1900 to an average net income of $5,224 in 1928.[4;142]. In a matter of decades, physicians benefited from a drastic rise in income, power, authority, and social approval that would only continue rising.

Medical professionalism of this era was rooted in consolidating and advancing medicine's newfound authority for the benefit of the entire medical community – as was the intention of Flexner in his famous report. The AMA leveraged the significance of Flexner's report to eliminate or discredit professions and schools not aligned with rigorous, systematic medical education.[9] This organization was strongly influential "in linking physician licensure with strict educational standards that (1) restricted entry into the health care marketplace and (2) increased the cost of medical education".[10] Osteopathy, chiropractice, and naturopathy were discredited as forms of alternative medicine. Yet, the consolidation of medical authority was a double-edged sword; while it did lead to a beneficial standardization of education and adherence to the scientific process, it also led to elitism and an artificial shortage of medical professionals.[11] Undeniably, adherence to scientific progress and consolidation of authority yielded astounding and incredible medical advancements as discussed above. Peer-reviewed research and standardized research methods breathed new life into medical progress and continue to hold scientific advancement to a high standard. This professionalism rooted in the retention and advancement of newfound authority cultivated a preferentially analytic *telos* of medicine, fueled by the era's infatuation with scientific discovery and authority. Medicine underwent a social transformation best understood through Starr's theory of social hierarchy as outlined in *The Social Transformation of Medicine in America.* This theory's first assertion, *functionality,* proposes that the functional capacity for medical professionals to actively treat illness made them irreplaceable to the public. This theory's second assertion, *power*, asserts that consolidation of authority and monopolization of resources insulated medical professionals from public retribution.[4;144] As a result, medicine had become more than just healing; it had become a social and economic enterprise.

To early physicians, consolers of the sick and dying, the patient was the subject of care. To physicians in this golden age of medical advancement, the underlying pathology slowly displaced the patient as the subject. The patient became an object that hosted pathology, which de-emphasized interpersonal physician/patient relationships. Bioethicist Edmund Pellegrino lamented on this new goal of medicine, suggesting that physicians were fast becoming "technicians… with patients in the service of science rather than science in the service of patients".[2] Karches' interpretation of Pellegrino's Aristotelian-Thomistic essentialism suggested that, to Pellegrino, the *telos* of medicine and that of human life are fundamentally and irreconcilably different.[12] Treating pain or suffering, the subset of illness more intimately related to the human condition than diagnosis or treatment, could be understood within the *telos* of medicine without physicians understanding how that pain manifests in the mundane realities of life outside treatment of pathology.[12]

One such contribution to this divide between *telos* of medicine and *telos* of human life came from the ‘curtain of silence’ within the medical profession. Self-regulation was extremely limited, and incompetence was rarely recorded and virtually never resulted in disciplinary action.[13, 14] Physicians and medical professionals, up through the late 1980s, were more than reluctant to report instances of incompetence to the authorities. Such an example was seen in the orthopedist Dr. Nork, whose “incompetence, greed, and dishonesty left a trail of dead and permanently disabled patients over the period of several years”.[15; 198] Many social scientists point to flawed regulatory procedures that facilitated many such behaviors.[14] Lack of oversight created an implicit narcissism that insulated physicians from the conditions of their patients.

Another such example of the divide between these two *telos* described by Pellegrino includes the U.S. Public Health Service Syphilis Study (USPHS) at Tuskegee in 1932. In hindsight, the Tuskegee Experiment is considered horrific and inhumane. This recognition of atrocity represents a changing ethos in medicine. However, we must observe and recognize the pattern of thinking within that time to understand how such an experiment was once considered both important and necessary for medicine. Over the course of 40 years, over 400 black men in Macon, Alabama were experimented on and observed under the guise of treatment for to study disease progression and prove how disease progresses differently in Blacks.[11] As Jones suggests, “whether by accident or design, physicians had come dangerously close to depicting the syphilitic Black as the representative black”.[11, 28] Such mental heuristics bolstered a rationale for indifference for treatment of the Black community. Instead of treatment, the committee was focused on collecting data on *how* disease progression differed in Blacks. They were prepared to allow the experiment in the name of scientific achievement – so much so that internal interviews conducted as late as 1969 had directors arguing "a moral obligation" to continue the study.[16] Of note, the AMA's original 1847 code, based on the 1802 text by Percival, was still in effect during the Tuskegee Experiments.[17] These codes obligated physicians "to be ever vigilant for the welfare of the community... [to] be ever ready to give counsel... for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labors for the alleviation of the suffering".[18;105] This represents a clear dissociation between established ethical standards and coordinated actions by a group of medical professionals backed by a United States authority.

When critiquing the development of early medical professionalism, it is important that we differentiate individual physician morality from institutional morality. Most physicians in this era were solo practitioners – a far cry from the consolidated structure seen today. Most individual physicians likely did not seek to abuse the newfound authority that medicine provided or stray from the established AMA code. In fact, patients' confidence in medicine to treat ailments and individual trust in their own physicians were reported to be significantly higher in 1972 than in the late 1900s and early 2000s.[19] Patients reported more respect and more care to their individual conditions by physicians.[19] Narratives that chronicle the humanistic and emotional journeys of medical practitioners, popularized by 20th century authors such as William Carlos Williams, depict a field full of altruistic doctors, residents, nurses, and midwives. This thesis aims to critique the effects of authority and power consolidation on an institutional level.

On a systems level, there are clear examples of disconnect between established medical codes and institutionally supported actions by some medical professionals. It was the failure of our newly established medical authority to properly recognize and reprimand transgressions made in the name of medical authority that constituted a public moral failing. Regardless of what individual physicians' ethics were, institutionally supported acts in the name of medicine reflected on the profession's reputation. As discussed in the text *Bad Blood*, the events in Tuskegee represented an alienation of the marginalized from medicine's promises to treat and sowed a deep distrust that remains today. It facilitated retrospective public health studies that revealed glaring health discrepancies across the board in marginalized populations. As an institution, medicine displayed a callous indifference towards suffering in pursuit of knowledge and further consolidation of authority. There were multiple discussed factors that may have allowed this to happen: the underlying analytic telos of medicine established first by Flexner and later by the AMA, the insulation of medicine from public retribution, and the ever-present drive to further consolidate medical authority. Duffy, in critiquing the aftershocks of the Flexner Report, asks questions in line with Pellegrino's thinking: "Did the Flexner Report overlook the ethos of medicine in its blind passion for science and education?"[2] Perhaps this devotion to authority and prestige played into the gradual erosion in trust and respect that occurred over the past century.[13] Perhaps it was this recognition of institutional failure to reprimand gross transgressions that spurred the modern bioethical redefinition of medical professionalism and what it means to embody professionalism in the wake of the 21st century.

## Section 2A: A Need for New Medical Professionalism

### Introduction

With a clearer understanding of what medicine aspired to in the 20th century, we can come to appreciate how our understanding of medical professionalism has changed. Consider these two modern definitions of professionalism:

*"Professionalism is about accountability and the need for physicians to work in teams and systems that may override physician autonomy for the greater good of the patient or society."*[20]

*"Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served."*[21]

Both definitions of professionalism rely on broad strokes and translating notions of altruism, justice, and overall beneficence to a physician's everyday practice. Notice the stark contrast of ideals presented: accountability and judiciousness of emotions and values. These seem to be a far cry from the 20th century's fixation on rationalism and academic progress. Definition (1) approaches medical professionalism through Stern's core principles of 'excellence, accountability, and altruism' in pursuit of a patient's well-being.[8] Definition (2) approaches medical professionalism through tenets of the ACGME charter which include 'adherence to social justice, patient autonomy, and patient welfare'.[21] While these accounts may differ in the ordering of traits, they aim to converge on a central notion of beneficence towards a patient's well-being. This convergence can best be seen ABIM Foundation's physician charter, which champions the fundamental principles of patient welfare, patient autonomy, and social justice as the basis of medicine's contract with society.[22] Additionally, all three notions of professionalism share a desire to move the definition of professionalism from an ethereal attitude to translational behaviors and actions. But why the shift? What prompted medicine to adopt this newer form of beneficence?

## Legal Pushes

A dominant theory of the rapid development of modern professionalism is rooted in the disillusionment that came with breaches of conduct in the 20th century and outlined in the previous section.[23] Revelations over the events in Tuskegee and widespread malpractice concerning the 'curtain of silence' prompted reform in the 1960s and 1970s.[13] As an institution, medicine had failed to police or reprimand transgressions that came with its newfound authority. The budding field of bioethics, independent of institutional medicine, stepped up to place limits via establishment of patient-centric ethics.[23] Added pressure from this outside regulatory force, a changing social climate, and new legal precedents led patient autonomy and informed consent to become core values of medical training and practice. The notion that physicians always knew what was best for their patients was fast deteriorating. This behavior came to be known as paternalism – the "overriding of a person's actions or decision-making for his/her own good".[21]

This reactionary change spearheaded by bioethics was expedited in part by legal precedents and court cases. It was "legislation, regulation, and litigation… that many issues of abstract, academic concerns to bioethics scholars were quickly transformed into [pragmatic] social policy".[24] The 1957 landmark case *Salgo v. Leland Stanford Jr. University Board of Trustees* and 1972 landmark case *Canterbury v. Spence* both affirmed informed consent as a prerequisite right to any patient seeking medical care.[25, 26] Notions of justice, non-maleficence, and patient autonomy would arise from subsequent legal proceedings.[24]

## Social Changes

With the dethronement of the paternalistic physician and the rise of patient-centric ethics came the humility of hindsight. In the wake of Tuskegee, physicians and officials alike were perplexed by how medical professionals could be complicit in such an experiment despite the implementation of the Nuremburg Code, which established basic rules of engagement for human subjects research after World War II. An investigation appointed by the Secretary of the Department of Health, Education and Welfare (HEW) and led by bioethicist Dr. Jay Katz pushed Congress to pass the 1973 National Research Act.[24] This act established the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, whose sole objectives were "to identify the basic ethical principles which should underlie the conduct of biomedical and behavioral research concerning human subjects" and "develop guidelines which must be followed in such research".[27] Though vague, this was a monumental step in the establishment of fundamental patient and human research subject rights that would serve as a watchdog against future medical atrocities. Social movements to establish patient and human rights also pushed medicine to recognize socioeconomic barriers to healthcare. The 1964 Civil Rights Act, Medicare, Medicaid, and the notion of social justice was welcomed by the medical community. Representatives of the NMA, at the time the dominant group of physician authority, supported these activities in service of opening the health system to all patients regardless of socioeconomic status.[28]

Even with the success of institutional policy drafted to protect vulnerable populations from authoritative medical oversight, medical education was unfortunately slower to change.

Well into the 20th century, virtually every American health institution and medical school was still segregated based on gender and race.[28] Apart from medical schools that served specifically to advance Black excellence (i.e., Howard, Meharry, and Morehouse), Black underrepresentation persisted and continues to persist today. Even then, these schools were systemically excluded from a majority of stewardships and internships post-education.[28]

Alongside civil rights, the 1960s and beyond were also marked by a rise in feminist, disability, and LGBTQ rights discourse. Each of these movements were fundamentally important in shifting the narrative towards the plight of previously ignored subgroups of America and the wanton medicalization of traits. Feminism in the 1960s and beyond was responsible for challenging views on how medicine categorized feminine function as 'reproduction factories' and menopause as endocrine dysfunction that lead to the 'end of femininity'.[29] Disability rights was responsible for challenging views on the medicalization of impairment and stigmatization of the 'sick role'.[30] LGBTQ advocacy challenged deep-seated homophobia both inside and outside the medical community and showed how over-medicalization of identity led to further isolation and worse health outcomes in the LGBTQ community.[31] Social and political changes in the later 19th century gave the medical field cause for reflection. The hyper-rational philosophy of medicine was not immune to social and political influence. Medicine was and continues to be partly responsible for pathologizing human characteristics such as gender, race, and sexual identity. Our definitions of what 'healthy' means is constantly in flux, and the line between adequate medicalization and over-medicalization is intimately tied to subjective ideological discourse.[32] Recognition of this has forced medicine to re-evaluate how disease is defined and treated.

## Medical Futility

Another contributor to a changing professionalism arose from new moral issues profoundly separate from treatment. Two such issues were those of *futility* and *allocation* that accompanied advancing medical technologies.[23] Addressing such moral issues was beyond the scope of a physician's medical prowess.

The first moral issue, medical futility, took the stage in the 1960s and 1970s as technologies like ventilators, feeding tubes, and other forms of life support became more routinely used in hospital care.[23] Life support at the time allowed physicians to keep dying patients alive but rarely helped dying patients recover. The result was a patient in limbo: unable to die without being removed from life support but unable to recover without overcoming large odds. Schneiderman defines an act as medically futile "if (based on empirical data) the desired outcome, although possible, is overwhelmingly improbable".[33] A physician trained in the Flexner-era system was not equipped to handle the social implications of Schneiderman's futility. They required broader contemplation of quality-of-life, suffering, and patients' desires – not just the conflict between physiology and illness.

One such example of medical futility coming to a head was the 1976 case of Karen Ann Quinlan and the right to die. Quinlan, a young woman who had become unconscious and stopped breathing, was put on life support. She fell into a persistent vegetative state. After a few months with no signs of improvement, Quinlan's parents expressed desires to remove her from life support and let her die naturally. Officials and physicians of the New Jersey hospital refused, citing concerns of homicide.[34] This battle found its way to the New Jersey supreme court, which unanimously ruled that hospitals must honor a patient's right to die. The case forced medicine to ask itself questions like: what constituted being alive? What could constitute a death with dignity? And, What the role physicians have in discontinuing life? Evolving medical technologies create unique moral dilemmas that physicians are often the deciding factor on. A more holistic education was needed to prepare a physician for this conflict.

## Distributive Justice

A second moral issue, distributive justice, took the stage with dialysis machines of the 1960s. At the time, dialysis machines were second to none in keeping patients with renal failure alive. However, they were also scarce and absurdly expensive.[23] The sheer lack of resources forced medical professionals to answer previously unanswerable questions: How do we value a life? How do we calculate the worthiness of one's life? Who deserves to live when scarcity necessitates a choice?

The 1962 SAKC (Seattle Artificial Kidney Center) created a panel of physicians, medical professionals, community leaders, and others tasked with answering these very questions to decide who would receive this life-saving dialysis. The panel almost overwhelmingly agreed that social worth, one's contributions and potential contributions to society, would comprise the main criteria of judgement.[35] One's educational background, family, character, moral strength, religious affiliation, and potential contributions to society were meticulously scrutinized and debated.[36] In hindsight, such decisions can be seen as absurdly discriminatory and subjective; bioethicists would later "deride the committee as a 'God Panel'".[35] But, as many argue, what choice was there if abstention was not a choice?

In the wake of these impossible decisions, Congress and Nixon signed legislation that made ESRD (End-Stage Renal Disease) a Medicare supplement.[35] The debate of allocation and distributive justice lives on in physicians' practice through triage protocols and essential medication shortages. Ethical decision-making, as our contemporary definitions of professionalism imply, requires less physician autonomy and more teams, systems, and humility. It requires a multidisciplinary approach with input from experts in issues such as medical futility, triage protocol, resource allocation, etc. to supplement physician treatment plans.

## Section 2B: The Benefits of Evolving Medical Professionalism

The many factors contributing to medicine's changing *telos* had opened Pandora's Box. Healthcare had realized that treating lives was in no way the objective, hyper-rational profession that Flexner had once imagined. From these foundational changes sprung forth entire subclasses of research on health disparities, socioeconomic barriers to health, and patient-centered care. It led to changing notions of what healthcare professionals were to do and what the ideal healthcare professional acted like. It is important to take modern professionalism as it is: a relatively new, evolving field that is both progressive and filled with its own unique flaws. It sets the foundation for self-awareness under accountability. At the same time, it can be resistant to its own self-critical examination and can often clash with its own preformed economic and social institutions. In the end, I argue that widespread adoption of medical professionalism can be argued as inherently *good*. When we come to cover the shortcomings of medical professionalism, I will argue that certain institutional barriers such as private financing and lack of public health infrastructure obstruct medical professionalism from fully embodying what it sets out to become. For now, however, it is vital to recognize the benefits of an evolving medical ethic. In this section, I will discuss the *benefits* that came with evolving medical ethics. In this era, from the late 1990s to present day, we have seen a substantial increase in Black and Hispanic representation within medical education institutions. We have seen a greater focus on research into health disparities, implicit bias, and structural racism that prevent marginalized communities from approaching health. We have seen criticism of the American insurance model and how it alienates patients from healthcare. American physicians have, for the most part, accepted this evolved *telos* as represented by modern definitions of *professionalism*.

## The Benefits of External Regulation

Two important regulators of medical research and practice came in the form of external bodies – IRBs and Bioethics. The legal and social pushes discussed in section 1 eventually led the Commission to draft the Belmont Report in 1979, which outlined the basic principles of (1) Respect for Person, (2) Beneficence, and (3) Justice to regulate all research involving human subjects and vulnerable research subjects.[37] The Department of Health and Human Services (DHHS) implemented regulations on research for federally funded projects adopted by the majority of research institutions and federal agencies, including the FDA, known as The Common Rule. This requires all research involving human subjects to have clear and undeniable informed consent, which includes risks, costs, withdrawal procedures, information transparency, and the number of individuals planned for the study.[38] Most research institutions have Institutional Review Boards (IRBs) to review research submissions and ensure all ethical considerations are met.[38] The rise of Bioethics discussed in section 1 would blossom into an entire academic field from its inception with the 1969 Hastings Center. Other institutions such as the Kennedy Institute would open soon after to share the mantle.[39] From these beginnings spurned new research centers, academic positions, journals, and international conferences.[39] If the end-goal of medicine could not be course-corrected from within, then perhaps external regulatory forces were needed. In this context, perhaps it was inevitable that Bioethics and institutional IRBs would rise to the occasion.

## Evolution of the AMA Code of Ethics

The pushes of the 20th century, along with the newly found authority of Bioethics, helped the medical field make strong changes to its structure. The 1980 revision to the AMA Code of Ethics replaced the principle “A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle” with “A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultations, and use the talents of other health professionals when indicated”.[17] Notice the shift on emphasis between the original and the revision; the focus is shifted from the *individual* to the *group*. The Code of Ethics recognizes the value of shared information between colleagues and patients, rather than the value of the scientific method alone. The 2001 revision adds principles that emphasize “responsibility to the patient” and the support for “access to medical care for all people”.[17] These shifts are more in line with the definitions presented in section 1b provided by (1) Stern and (2) the ACGME charter. These represent a conscious attempt to shift the duty of a physician from technician to a more holistic practitioner.

## Evolution of Disparity Research

Research into health disparities began to take center stage in the late 1980s. Health disparities are differences in health outcomes due to socioeconomic, cultural, behavioral, or environmental factors.[40] The Department of Health and Human Services (DHHS) released the 1985 “Report of the Secretary’s Task Force on Black and Minority Health”, which gave concrete evidence to health disparities affecting America’s minority groups and marginalized populations. The Institute of Medicine (IOM) released the 2003 report “Unequal Treatment: Confronting

Racial and Ethnic Disparities in Health Care".[41] This report further elevated the issue of ethnic disparities in health outcomes when corrected for access and insurance coverage. These two landmark studies engendered efforts to recognize and mitigate health disparities to this day. The Division of Cancer Epidemiology and Genetics (DCEG) program under the National Institutes of Health (NIH) recognizes racial / ethnic populations, populations from socioeconomically disadvantaged backgrounds, rural populations, people with disabilities, and sexual and gender minority populations as those that experience health disparities in the US.[42] The recognition that complex societal factors influence health outcomes, something that will be explored later on in this thesis, may have been a reason healthcare moved to adopt a more holistic and patient-centered approach.

## Contemporary Professionalism: From Technician to Humanitarian

Recall Karches' description of physician akin to that of *technician*. In our current diagnose/treat paradigm, it is impossible for physicians to not be technicians in some form. The knowledge needed to understand our complex biology and reliably treat complex illnesses requires technical skill. However, medicine has slowly been adopting the notion that technical skill is but one aspect of a well-rounded physician. Patient-centered health dismantles the notion that healthcare begins and ends in the hospital setting. We have seen an explosive rise in medical humanities as core components of medical education and training to support this. In 1999, the ACGME adopted core competencies that must be demonstrated by all residents / fellows.[21] Consider the competency requirements listed below:

“Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities”[21]

*Taken from the ACGME core competencies checklist.

Here we see a particular emphasis on not just individual patient health, but on the social factors that may influence patient health that are mirrored in the DCEG statement on health disparities. We also see explicit mentions of ethical principles involving informed consent which can be traced back to DHHS regulations. Through the late 1980s and 1990s, even medical schools were beginning to incorporate formal ethics education into their curricula. A report by DuBois et. al. reported that approximately 79% of US medical schools required a formal ethics course for trainees.[43] Medical school and residency programs have looked increasingly favorably on volunteer work with underserved and vulnerable populations and commitment to addressing health disparity in the past decades.[44]

## Conclusion

The shift in ethos that came with medicine's redefining of professionalism had many beneficial, long-lasting effects. From the recognition of health disparity to the adoption of concrete ethical competencies, medicine had set itself up to alter the way it approached care. However, the cultural shift is only one aspect of healthcare. In the coming sections, we will take an in-depth look at the origins and development of American healthcare's financial structure.

## Section 3A: The Failure of National Health Insurance

Throughout the previous sections, we have come to understand how social and professional development of the medical field has evolved. Furthermore, we now have a small glimpse into how a changing social climate influenced the medical profession to adopt a more humanitarian-focused telos. To further recognize how the modern telos of medicine grinds against pre-formed institutions, we must take a brief dive into the development of America's for-profit insurance model.

### Origins of National Health Insurance Discussion

Physicians of the very early 20th century opposed any form of corporate enterprise in their practices.[4;215] This seems like a far-cry from the private insurance and hospital conglomerate compensation models we see today. But to the early physician and the AMA, as stated in its 1934 code of ethics, it was completely "'unprofessional'… for a physician to permit 'a direct profit' from work".[45] The resistance to organizational care came from a desire to, in line with Starr's notion of power-consolidation of the 20th century, to retain authority in the hands of physicians. Most physicians of the 1900s were independently wealthy; they understood how corporate-oriented structures worked to separate capital from labor. Capital accumulation beyond direct physician compensation meant physicians would have to answer to superiors in charge of capital. The desire for control over their own professional standards initially resisted corporatism.

While national health insurance was consolidated and developed in European countries, America lagged behind. Government had little to do with social policy or welfare. The discussion surrounding national health insurance was certainly taking place in the early 1900s, but its champions were outside organizations rather than political leaders.[4; 243] The AALL (American Association for Labor Legislation), described politically as social progressives, sought socialized healthcare amongst other reforms such as abolishment of child labor and unemployment relief.[4; 244] The rising awareness of the economic burden of illness on working-class families actually caused the AMA to initially switch positions in favor of nationalized healthcare.[46] This was a time where occupational hazards, which disproportionally affected professions such as coal miners, match factory workers, and transportation staff, ran abound.[47] The AALL and AMA's united front pushed national health insurance under the objectives that it would (1) relieve poverty caused by sickness due to rising medical costs and (2) reduce total costs of illness by reducing medical care and create "monetary incentives for disease prevention".[4;247] Both appealed to developing models of national health insurance championed by European countries and, for a while, gained large general support.

## Pushback to National Health Insurance

A major catalyst that derailed this call for national health insurance came from physicians themselves. A minority of physicians pushed back against the AMA's alliance with the AALL.[4;247] Many local and state-wide medical society leaders saw national health policy as an attack on the authority and monetary gains of the mid-20th century. These division leaders worried that compulsory insurance would diminish profit margins by restricting the ability to set their own individual fee-for-service models.[47] Whereas the national AMA House of Delegates supported National health insurance, state medical societies that were run by local physicians did not. These groups gave a platform for the growing number of disgruntled physicians who saw National health insurance as an affront to the authority of their craft.[4;248] The state medical society of Illinois, for example, almost unanimously testified against legislation for compulsory health insurance.[48] Fears of socialism related to the political struggles of World War I only stoked the fire. The state medical society of California called social health insurance "a dangerous device, invented in Germany, announced by the German Emperor… preparing to conquer the world".[4;253] How much of this was genuine fear of the terrors of socialism, rather than the fear of compromised autonomy and burgeoning salaries, is questionable at best. The combination of physicians leaving to serve in WWI and rapidly increasing dissent amongst its vocal minority (mostly consolidated in its upper ranks) caused the AMA to cease interests in social insurance, crippling the AALL's power.[4;272, 48]

Sweeping political reforms amidst the Great Depression saw the introduction of Social Security (1935) under FDR. Intuitively, one would think the Great Depression would have fostered the ideal conditions to push for National health insurance. However, unemployment benefits and care for the elderly took precedence. The CES (Committee on Economic Security) deferred to AMA's now consolidated stance against National health insurance and scrapped the policy entirely.[4;257,48]

In the wake of the economic crisis of the Great Depression, the US was faced with burgeoning costs for medical care. Medical charity care all but vanished under rapidly increasing costs and physicians saw substantial decreases in salary. Starr notes that it "was no easy matter to maintain a common front against government intervention when physicians themselves were in economic difficulty".[4;270] For the first time, it seemed as though most physicians, the American people, and the US government were all in favor of a national health program. However, this was short lived. Though the New Deal had softened the blow of the depression, prominent critics feared it was leading the Democratic Party down the path of socialism .[49; 537] When economic conditions dipped in 1937, conservatism took Congress by storm. By 1938, enough conservative members had been elected to Congress to obstruct new social policies – including healthcare.[50]

## The Final Blow

The final conflict between nationalized and privatized healthcare came to a head during the Truman administration in 1945. Truman, unlike his predecessor FDR, wholeheartedly supported National health insurance. He supported a national payment plan that would "cover the cost of [all] medical expenses and payments to replace lost income as a result of illness or injury".[50] However by this point, fears of socialism, McCarthyism, and the Red Scare were gaining traction in the American populace. In fact, Truman was hesitant to call his landmark proposal 'socialized medicine' at all because of the social fears stoked by the rise of Communism halfway across the world.[50] The AMA, now firmly rooted in its stance against socialized medicine, leveraged that fear. It mobilized physicians and laypeople alike against federal policy and instead gave its support to the growing economic and lobbying power of private insurance organizations.[50] By the end, the AMA's campaign had outspent campaigns in favor of National healthcare by a ratio of 62:1 by allying with private insurance companies, wealthy physicians, and anti-union corporate entities.[4;287] The sheer material advantage displayed by this united front was enough to sway the electorate against public opinion. With the mid-term elections of 1946, conservatives regained the House and Senate and shut down any further notions of national healthcare. Energy and support were instead moved to building up insurance programs for unions, employers, veterans, and other organized groups with economic or political influence.

## Section 3B: The Consolidation of Private Insurance and Hospital Systems

Despite this decades-long back-and-forth on the fate of healthcare financing, insurance companies were already running small-scale operations from the 1910's onwards for farmers, laborers, and other workers under larger commercial employers.[51;364] As medical technology progressed and hospital complexes took root, however, the traditional out-of-pocket funding model for the average American quickly became impossible. Hospitals could rely less and less on individual patients to pay unsubsidized bills without taking loans. To address this, many hospitals formed 'single hospital plans', payment restructurings for entire hospital stays that promoted competition amongst hospitals and served to drive costs down. Over time, these individual single-hospital plans consolidated via the AHA under the name Blue Cross to reduce price competition.[52]

As Blue Cross consolidated into a bureaucratic organization, physicians once again grew wary of an external force influencing healthcare costs. Individual physicians united to create a counter-network called Blue Shield, a physician-controlled policy that served as a pre-paid plan to compensate physician services.[52] It allowed physicians to charge patients the difference between their own costs and the set-price distribution covered by Blue Shield, thus allowing physicians to retain some economic authority. Though the AMA was staunchly against insurance compensation plans, it became clear the average American could no longer afford the ballooning costs of unsubsidized healthcare. It worked with physicians to push Blue Cross in a direction to keep it under physician control.[53] Specifically, it lobbied to have Blue Cross exempted from most regular insurance regulatory bodies to secure domination over the smaller private insurance companies. Private insurance companies of the 1940s, helped in part by the 1938 conservative resurgence, retaliated by adopting the Blues' policies to achieve similar deregulatory statuses.[53]

This ironically freed them from the very constraints Blue Cross sought to leverage against them and set the stage for mass proliferation of corporate-oriented insurance models that would come to dominate American Healthcare after WWII.

As noted in Section 3a, the notion of a National health insurance began to fade further and further from reality soon after Truman. The social conditions post-WWII promoted consolidation of hospital institutions and medical schools within the hospital systems of major cities. This power-consolidation gave bargaining power to the now corporate-oriented hospital complex, serving as the archetype for the 'assembly-line model' of patient care to maximize reimbursements and counter pushback from proliferating private insurance companies.[4;287] With the concomitant rise of profit-oriented biotech and pharmaceutical companies, there formed a complex, multi-directional tug-of-war for profitable practice. Hospital complexes raised prices to offset costs of uncompensated care and raise their bargaining power with insurance companies.[54,55] Insurance companies instituted policies such as institutional billing codes, step therapy, medical necessity, and prior authorization (formerly known as utilization reviews) to obstruct and deny medical actions they felt were unnecessary or too costly.[56] Pharmaceutical and biotech companies, citing heavy expenses incurred in early phases of product development, began charging exorbitant prices to consumers, insurance, and hospitals.[57] The 1980s came to be called the decade of deregulation, with health maintenance organizations dominated by shareholder-driven, for-profit companies focusing on profit-maximization rather than cost-controlling measures.[58] This expanding beast of administrative management demanded a dizzying $812 billion as of 2017, or 34.2% of America's national health expenditure.[58]

Under precedent of Social Security and growing discontent of consumers' isolation from medical care back in the 1960s, America passed Medicare part A, Medicare part B, and

Medicaid. While Medicaid and Medicare were originally supposed to let low-income or unemployed, elderly, disabled, and chronically ill Americans enter the privatized medicine sphere, lack of interest by both federal and state allocation mechanisms crippled its promise. It experienced a brief period of success the 1970s before Regan-era politics slashed Medicaid expenditures more than 18% and the DHHS budget by 25%.[59] Obscure and complicated funding mechanisms behind Medicaid have reduced it to "the purgatory of categorical social welfare systems",[4; 374] with markedly worse outcomes for consumers when compared to those under private plans.[60] Medicare and Medicaid still serve a vital role in America, especially with its revitalization with the ACA, without which we would see millions more uninsured. However, as we will discuss in a later section, the discrepancy between its intent and its reality reveals a dire need for reform.

*"The great illusion of physicians and the hospital industry in the 1970s was that liberal government was causing their troubles"*

This quote by Starr sums up the smoke and mirrors conjured by corporate entities up to and during the Regan years. Whereas physicians, the AMA, and the general public feared that governmental regulation would be the downfall of physician autonomy, they ultimately lost control to corporate. Corporation has integrated into all sides of medical care – through ownership of hospital institutions, insurance corporations, pharmaceutical conglomerates, and biotech companies. The AMA fought against Governmental regulation because it posed a tangible, visible threat to the autonomy of physicians. The slow and creeping corporate restructuring of medicine, however, was much more insidious and existential in nature. It came gradually through 5 steps, as outlined by Starr:

1. *Change in type of ownership and control:* the shift from nonprofit and governmental organizations to for-profit companies in health care.
2. *Horizontal integration*: the decline of freestanding institutions and rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations.
3. *Diversification and corporate restructuring:* the shift from single-unit organizations operating in one market to "polycorporate" and conglomerate enterprises, often organized under holding companies, sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets.
4. *Vertical Integration*: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs.
5. *Industry concentration*: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole.

*Taken from *Starr, Social Transformation of Medicine in America*, page 429.

With the aggressive expansion of profit-oriented corporations came the erosion of physician autonomy and the assimilation into managed hospital systems with complex reimbursement structures. Solo physicians and physician groups were no longer able to set prices for procedures and visits and no longer able to negotiate with smaller-scale insurance companies.

With mounting pressure from consolidated insurance groups, these physicians were compelled to assimilate. While the profession itself continues to advance and cultivate more in-depth understandings of pathophysiology and treatment options, that cultivation is now primarily leveraged as a means for larger institutions' profit.

## Section 3C: Conflicts of Interest Arise

From previous sections, we now have a small glimpse into the professional and financial institutions that played into the development of the modern physician: autonomy-consolidation and corporate restructuring. The 21st century is the century of recognition of the former; modern medicine is seeking to distance itself from its history of oversight and power abuse. As discussed in Section 2, it is making promising steps. However, there comes a point where our reconciliatory movement comes to a head with the corporate ethos (Section 3b) intertwined within it. Medicine refuses to recognize the aftershocks of consolidating itself within the corporate sphere and how such a move limits its development in the professional ethos. How can it? To the physician following contemporary professionalism, finance is a means to an end to patient care. To the corporation the physician finds themself within, patient care is a means to an end for finance. When working within the structure of monetized medical care, how can a physician supersede the means by which he/she is allowed to dispense it?

It is important to recognize where the modern corporate model creates friction against contemporary professionalism. It is here we can begin to tease out the barriers that truly prevent physicians from embodying the modern professionalism that medicine is keen on promoting.

### Access to Care: Damage done by For-Profits

Under the private model of health insurance, health is not a right; it is a privilege. This can be seen by the 2018 Census Report, which documents a total 27.5 million Americans, or 8.5% of the population, that did not have health insurance at any point during that year. Note that this was an increase from 7.9% from 2017.[61] 10.3% did not have any form of insurance in 2019, which dropped to 8.4% in 2022 according to the CDC.[62] Even amongst insured individuals, those with high-deductible health plans (HDHPs) bear significant healthcare costs for checkups, medications, and procedures. Within each disease category analyzed by a 2021 study, patients with HDHPs paid more out-of-pocket than those with low-deductible health plans.[63] The article *Ethical Issues in For-Profit Healthcare* charges for-profit insurance with this problem in two forms. Firstly, for-profits contribute directly to the problem by disallowing care for non-paying individuals. Secondly, for-profits disallow non-profit institutions from engaging in "cross-subsidization", inflating prices of paying customers' care to cover the costs of non-paying customers, via direct market competition.[64] In a semi-regulated marketplace where insurance companies must compete with multiple options, wealthier customers will gravitate towards private companies that do not engage in price inflation. For a multitude of social factors, more affluent individuals are less prone to common conditions like high blood pressure, obesity, heart disease, infections, and mental illness.[65] Private insurance companies are able to recruit wealthier, healthier population subsets with less overall risk and greater payment compliance. This creates small bubbles of self-sustaining insurance structures that only pay for its own better-off investors.

Champions of private health models often make the moral argument that their presence is inherently beneficial to society via taxes, philanthropy, and charity care. They do pay large amounts of taxes, which eventually go on to fund government-sponsored health programs. They do place health centers in underserved areas to reach populations they originally described as 'undesirable'. One such example is the for-profit dialysis company DaVita, which created the Bridge of Life (BOL) kidney care program with the intent to bring life-saving kidney care to people with CKD in underserved areas.[66] Another is Aetna (now part of CVS Health), which engages in multiple philanthropic endeavors through "corporate responsibility" which have unarguably done good.[67] From an ethics perspective, however, we must return the fundamental moral argument at hand – is healthcare a right or a privilege? Taxes paid by insurance companies are not unique to healthcare businesses, making this ethical justification tenuous. Corporate philanthropy and charity care can be disingenuous, which can be seen by applying Slavoj Zizek's concept of charity capitalism outlined in his essay *First as Tragedy, Then as Farce*.[68] DaVita, for instance, leverages federal funding for CKD granted after the Dialysis Crisis of the 1970s, which was intended to afford universal CKD treatment, to generate profit from taxpayer funding. Aetna's insurance model prices out millions of Americans from its policies, contributing to America's large pool of uninsured citizens. In both scenarios, these companies are responsible for creating at-risk populations. They then use a small portion of the profits – gained from the exploitation of at-risk groups – to assist a marginal portion of the at-risk group. This cycle of implication and redemption allows salvation from their initial practice, paving the path to normalize, continue, and even justify said practice.[68]

The remaining population, those who cannot get insurance through work or buy into private insurance networks, are left by the wayside. Medicare and Medicaid are federally funded programs that aim to capture these patient populations and extend some form of care to those who cannot otherwise afford it. While these programs help individuals access standards of care inaccessible to the uninsured, they are by no means on par with private insurance compensation. They restrict access to primary care doctors and specialists, and lead to poorer overall outcomes for the most common health measures.[60] In the next section, disparities between public and private insurance options will illuminate how different standards of care lead to different treatment options against the best interests of the patients in question. The argument that privatized healthcare outperforms single payer will be critiqued in Section 5.

## Privilege vs. Right: The Physician's Dilemma

Given the rugged individualism that has defined much of American exceptionalism, and the discussions in Section 3a/b, the active question of *right* versus *privilege* should not come as a surprise. Excluding times of duress, America has a history of deprioritizing welfare, safety-net programs, and public health programs geared towards the general population. Proponents of for-profit healthcare argue that healthcare should be treated as an elastic good. But, when compared to other developed countries, it is clear that a large schism exists between America's socioeconomic classes. It is also clear that barriers to care have huge, disproportionate consequences on the health of underserved populations.

I argue that, in order to truly embody modern professionalism, physicians must advocate for healthcare as a *right* rather than a *privilege*. While there are well-documented financial reasons that support a single-payer system, this argument is rooted in the moral condition of physicians relative to institution. Under the precondition that a physician should be prioritizing patient welfare, as defined by the ACGME charter, a physician must consider (1) who constitutes patient and (2) the implications of a for-profit system and the end-goals such a system pursues.

Concerning point (1), we must first discuss distinctions between patient and community. If an individual does not seek out care, does this individual fall under the physician's purview? To some, the answer is a resounding *no;* a physician should only be concerned with the patient that has come in to receive care. This parallels the organizational structure that American medicine has traditionally followed, in that medicine is a transactional good with voluntary players. As suggested in Vaughn's text *Bioethics Principles, Issues, And Cases*, not everyone thinks beneficence should be an active process. While the duty not to harm is explicit, the duty to help others is implicit. Thus, we are not obligated to feed the poor nor engage in charity but rather are *encouraged* to by duty.[69] As a society, however, we are beginning to recognize more holistic and fluid evaluations of choice and decision-making. We are beginning to recognize how institutional barriers coerce us into otherwise irrational paths. In other words, the decision to seek out care is complex. What of the individual who denies seeking care out of fear of cost burden or medical bankruptcy? What of the individual who harbors a deep-seated mistrust of physicians due to historical atrocities committed to their predecessors? Of fear they will be mistreated for ethnicity, gender identity, or functional status? These questions have pushed other contemporary concepts of professionalism to incorporate notions of community wellness beyond the walls of the hospital. Barriers to care create widespread and prominent health problems that disproportionately affect specific subpopulations of America. Despite fact that uninsured Americans cannot be *denied* care, the reality is that uninsured Americans are more likely to forgo necessary care, screening tests, and are less likely to report being in good health.[70] Stern's principles, tenets of the ACGME charter, and the ABIM Foundation's Physician Charter – all widely-accepted definitions of professionalism –incorporate society and/or the community at large into the purview of a physician.

The framing of patient as community-member instead of consumer asks the physician to re-frame their profession outside of the trappings of economics. However, financial policy shoehorns physicians into an impossible situation: how does a physician recognize the patient-as-community while adhering to a compensation plan that recognizes patient-as-consumer? It seems paradoxical.

Concerning point (2), we must recognize the effects that different [or absent] insurance policies have on intended plans of care. Referencing several large-population surveys, the NIHS suggests that uninsured adults are less likely to engage in recommended screening tests.[71] The type of insurance and coverage also played roles in determining the extent of screenings [physical exams, blood pressure screening, lipid screening] for cardiovascular disease.[71] Uninsured patients were less likely to receive recommended services for chronic diseases, cardiovascular diseases, diabetes, ESRD, HIV, and severe mental illnesses.[71] Uninsured patients, according to a recent NHANES observational study, are less likely to have blood pressure control in treated hypertension and more likely to have undiagnosed hypertension and hypercholesterolemia.[72] Adjustments "for measures of access to care explained much of these differences".[72] Uninsured patients hospitalized for acute ischemic strokes had "higher levels of neurological impairment" and "24 percent higher risk of mortality compared to privately insured patients".[72] Uninsured patients with cancer are diagnosed "at more advanced stages of disease, have poorer outcomes, and die sooner, even after adjusting for stage of disease."[72] We come to see how preventative care, inpatient care, and holistic wellness are compromised by a patient's lack of insurance. We also come to see how insurance dilemmas spurn from socioeconomic disparity and medical elitism. It becomes clear that the uninsured fare more poorly than insured. But what about stratification within the insured?

Even within the insured populations, disparities exist. Firstly, limitations on coverage and limited benefits dissuade insured individuals from engaging in treatments with high out-of-pocket expenses.[73] Access to mental health care, for example, sees constraints in the forms of increased hidden costs [copayments] and higher deductibles in Medicare/Medicaid healthcare plans versus private ones.[73] Similar statistics can be seen in the fields of substance abuse treatment and oral care. Another study suggests that the Medicare-only population "has fewer physician visits than the privately insured and notably fewer visits than those with joint Medicare and Medicaid coverage".[74] In one university Cardiovascular clinic, systemic hypertension was controlled in 38% of self-pay or Medicare supplement patients, compared to 70% of private or Medicaid subsidization.[75] Secondly, reimbursement levels influence what resources are used by physicians and hospital networks in treatment for the same condition. Delayed and restricted care offered by Medicaid led to higher incidences of AAA ruptures when compared to private insurance coverage.[76] Coronary stent patients with Medicaid were less likely to receive newer DES (Drug-eluting coronary stents) relative to patients on private insurance.[76] These variations in care based on reimbursement rates and restrictions on care actively affect the mortality rates of patients. They also drive medical mistrust amongst poorer populations that are forced to rely on public insurance options.

## The Physician/Patient Relationship

The physician-Patient relationship suffers under the consumer model of healthcare and superficial professionalism – both from the side of physician and from the side of patient. As we will come to see, the power differential vastly favors the medical professional. Under a consumer market, that patient vulnerability is often systematically exploited for monetary benefit. While this relationship *does* benefit both provider and patient, the deontological duties of the physician are nonetheless compromised.

Medicine, as discussed by philosopher Edmund Pellegrino, is a moral enterprise fractured by the transactional nature of market medicine.[77] He suggests that illness reduces capacity and transitions wellness from a peripheral to an overwhelmingly central concern. In that shift, there is a loss of freedom. The patient is often removed from the information necessary to help himself/herself. Thus, they are forced to place trust in an external agent – the physician. The act of trusting, as discussed by moral philosopher Baier, preempts a state of vulnerability.[78; 130], When I place my trust in someone, there is something valuable at stake. If I were to trust a friend with my son, his well-being is at stake. Trust is, most of the time, a voluntary leap-of-faith. In medicine, however, this is not the case. The patient is backed against a wall and, more often than not, forced to confer trust into someone he/she does not know. In order to receive and respect that trust, the physician is expected to (1) carry the requisite knowledge to defend the patient's health and (2) act in the patient's best interest and not his/her own.[77] Thus, the patient-physician relationship is "of its nature an unequal relationship built on vulnerability [and therefore trust]".[77]

The physician is expected to carry and respect the patient's vulnerability as a worthy trustee. This is the duty as outlined by modern professionalism. However, within the confines of transactional medicine, duty (2) – to act in the patient's best interest and not his/her own – is muddied. This deontological duty comes into conflict with the financial drives and goals of the institution he/she represents.

In fee-for-service models, this conflict is made most obvious; overutilization of services leads to greater profit margins for the individual.[64] To Brock and Buchanan, this overutilization can appear via (1) providing medical services [and thus costs] that outweigh benefits, (2) imposing financial costs exceeding benefits, or (3) contributing to higher health care costs for everyone.[64]

In insurance models, this conflict appears via underutilization of services. If base insurance plans like Medicare or Medicaid do not allow for extended-stays, non-essential procedures, or full physical exams, there is an inherent pressure to underutilize resources that would incur a deficit.[64] A denied Prior Authorization – meaning a hospital system will not be reimbursed for a procedure because it was deemed ‘not medically necessary’ even if the physician believes it is – usually means the patient does not receive what is in their best interest or foots an unexpectedly high bill that often cannot be paid. While this is done to support the financial well-being of the institution as a whole, the result is the same: under-supported patients. What is best for the patient [medically necessary care] is not necessarily what is best for the hospital network [compensation for services provided].

Both examples show a manipulation of patient vulnerability. Even an altruistic, good-natured physician who wishes to uphold the tenets of professionalism will find himself/herself at odds with the institutional structures of their hospital. Modern professionalism, in this way, instructs physicians to embody a morality that is incompatible with current structural compensation models. Thus, a modern professionalism that seeks to compromise the duties of a physician within a corporate ethos is a paradox. I argue that this is the reason *why* professionalism has evolved as it has: enforcing a bare minimum while championing individual physicians to aspire to a vague ideal. One can see it in the aforementioned notions of professionalism: *humility*, *compassion, the desire to help one’s community*. What do they even mean? What does a physician acting with compassion look like? We can look to examples of physicians acting compassionately, but they say nothing about what it means to *be* compassionate in practice. And, when compassionate practice interferes with the limits of treatment due to insurance limitations, the concept reveals its own impossibility.

## A Break from the Corporate Ethos

There is a growing voice within the physician population to accept a form of universal healthcare under the name Medicare For All due to this dilemma. The American College of Physicians (ACP) has recently broke from the dominant opinion of the AMA to support Medicare For All, citing current barriers to care, administrative costs, and the unnecessarily complexity that comes with multiple providers.[79] Robert McLean, president of the ACP, stated that American healthcare "costs too much; leaves too many behind without affordable coverage; creates incentives that are misaligned with patients' interests… and fosters barriers to care and discrimination against vulnerable individuals".[80] Each of these concepts have been explored in the previous sections of this thesis. Each of these concepts represent barriers that prevent benevolent physicians from practicing medicine professionally and enable profiteering physicians to game the system at the expense of Americans' health.

## Section 4A: Ethnic Disparities

We have previously discussed some of the discrepancies in care between privately insured, publicly insured, and uninsured individuals. Many of these discrepancies have been linked to (1) the lack public health infrastructure to maintain health, (2) private equity hospital systems and third-party insurance companies engaged in profit-maximization, and (3) lack of an adequate public option for health coverage. We have also come to see how financial structures create powerful barriers against the actualization of contemporary professionalism. As we move from abstract theory to real-world practice, however, it is important to recognize examples of these barriers. While recognizing that there are several barriers to the actualization of professionalism in contemporary healthcare, for the purposes here, this section will outline two prominent and interconnected barriers: ethnic health discrepancies and COVID-19 health discrepancies.

### Ethnic Disparities

The definition of race is a layered concept, which lends itself to different definitions and perspectives. For this thesis, we will be accepting the widely held sociological identification of race as socially constructed categories rather than biologic concept.[81] Race as a social construction is created and enforced by historical policy, political influence, and the resultant social perceptions. These categories are fluid; however, they have had tangible effects on measures of health. As Baciu states in chapter 2 of *Communities in Action*, “racial and ethnic disparities are arguably the most obstinate inequities in health over time, despite the many strides that have been made to improve health in the United States.”[82]

Perhaps one of the most important whistle-blowers in ethnic health disparities was Margaret Heckler. In the 1985 *Report of the Secretary's Task Force on Black & Minority Health*, Heckler detailed the astronomical disparities in health outcomes for Black, Hispanic, and Asian minorities compared to white counterparts.[83] In 2003, the Institute of Medicine (IoM) published a powerful follow-up report called *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*.[84] While this report was generally well-received, there was strong resistance in the medical community to the call-to-action for systemic change. There was skepticism in the medical community that disparities even existed or that health treatments could be influenced by factors such as race and ethnicity.[83] How could well-meaning, educated healthcare professionals create or participate in discriminatory practices?

The IoM's answer mirrors the conclusion made in Section 1 – criticism levied not at individual healthcare professionals, but rather at institutional systems that propagate inequity. The report criticized structural racism embedded within medicine and unconscious implicit bias.[85] While correcting for socioeconomic barriers did diminish disparities, it did not eliminate them. Even when major clinical factors "such as stage of disease presentation, comorbidities, age, and severity of disease are taken into account", disparities persisted across private, teaching, and public hospitals.[85] As discussed in Section 2B, contemporary medicine has made great strides in identifying disparities in health. Contemporary medicine is beginning to understand its own complicity in the propagation of medical disparities through greater disparities research (as will be outlined below). Steps to ameliorate these disparities, however, are often limited by the sheer size and scope of the medical complex and funding structures.

## Discrepancies in care Across Ethnic Groups Today

Ethnic minorities shoulder higher rates of chronic disease and premature death compared to white counterparts.[82] In a review of racial/ethnic disparities in common chronic conditions in American youths, Price claims that racial/ethnic minorities "are 1.5 to 2 times more likely" to have most chronic diseases compared to white counterparts.[86] These rates also follow socioeconomic stratifications mediated by race/ethnicity.[86] Such common treatable diseases as asthma, hypertension, and obesity have markedly higher rates in Hispanic and Black populations.[86] Conversely, many common disorders are under recognized and undertreated in ethnic minority populations, such as mental health and ADHD.[86] In fact, socioeconomic disadvantages have both direct and indirect predictive risks on the development of ADHD.[87] This is compounded by the lack of diagnoses in low socioeconomic groups due to limited mental health coverage. Black and Hispanic individuals are less likely to be insured throughout the course of adulthood vs. White counterparts.[88] These populations show greater instances of socioeconomic characteristics that lead to "greater insurance loss" and "slower insurance gain".[89] This supports the notion that health is intimately tied to socioeconomic conditions. Furthermore, policies that serve as 'safety-nets' associated with insurance loss and public insurance options (i.e. Medicaid) did not mitigate these consequences of socioeconomic disparities. Black individuals are less likely to have health insurance due to socioeconomic conditions and are thus more likely to be in a job that does not offer subsidized private coverage.[89, 90] Social conditions predispose to financial disadvantages which correlate with worse health outcomes for the same health conditions. When combined with the implicit biases discussed above, it can help explain why Black and Hispanic populations often grapple with worse clinical outcomes for common diseases and afflictions.

### Implicit Bias and Professionalism

When returning to the role of contemporary professionalism in recognizing and addressing health disparity, it is important to recognize its benefits and its limits. The components of professionalism outlined in Section 2A (societal good, emphasis on the community being served, recognition of social determinants of health) excel at reflecting on implicit bias. These components challenge medical professionals to recognize historical misgivings and contemplate how our past shaped views on race, gender, and disability. If we accept the premise that disparities continue to exist, then it should be part of the duty of a physician to address them.

The limits of contemporary professionalism reveal themselves when we observe the larger socioeconomic stage that dictates how health plays out. Individual physicians, though aware of health discrepancies across populations rooted in institutional norms, have little power to affect practical course-correction. Whether in a private or an academic setting, physicians are beholden to billing codes, hospital policies, and insurance reimbursements to provide a sustainable model of care. Physicians face a near-infinite demand for services, which creates very little financial incentive for hospital structures to change. As discussed in the section *Conflicts of Interest*, uninsured and underinsured patients simply cannot bear the burden of out-of-pocket expenses. Willner, in the article *Life or Death*, points out that “between 2012 and 2016, the average annual out-of-pocket cost of insulin per T1D [Type 1 Diabetes] patient increased from $2864 to $5705”.[91] A physician attempting to embody professionalism may do well to reflect on biases when treating a patient ensure compassionate, patient-centered care.

What is the role of the physician embodying contemporary professionalism to ensure the patient can afford medication and avoid chronic non-adherence? Hospital, insurance, pharmaceutical, and state-run assistance programs are temporary solutions, but remain chronically underfunded and unable to handle the full load of patients affected by this reality. In addition, what is the role of the professional physician to ensure continued professionalism when the patient is referred to neurology, GI, nephrology, and endocrinology? The segmented care inherent to multisystem diseases increases susceptibility to bias from other providers. In these ways, ethnic disparities are an important part of the conversation surrounding the practical implementation of contemporary professionalism.

## Section 4B: COVID-19 and Public Health Discrepancies

Thus far, our discussion has taken place outside the COVID-19 pandemic. Historical examples of health inequities have been thoroughly discussed. Contemporary examples of health inequities as they relate to ethnic populations and socioeconomic structure have been discussed. However, the COVID-19 pandemic has revealed how a lack of public health infrastructure has further exacerbated disparities, and how themes of commitment to society, community, and social justice (themes inherent to the definition of contemporary professionalism) may be obstructed. In recognizing COVID-19 health discrepancies in relation to public health, we will recognize how the themes of contemporary professionalism require a re-examination of our approach to collective health.

### Understanding the COVID-19 Pandemic

COVID-19 was touted by many in 2020 as the 'Great Equalizer', "a disease that transcended wealth, fame prestige, or age".[92] However, this was not the case. Instead, this pandemic accentuated the health inequities which disproportionately hurt marginalized and vulnerable populations. Low-income groups, for example, are more likely to work in the service sector and thus cannot quarantine and/or work from home.[92] Underserved groups are more likely to use public transportation, less likely to have stable shelter to quarantine in, and live in higher population density areas. Furthermore, underserved groups already have higher incidences of treatable chronic cardiac, renal, respiratory, and endocrine disorders that have been shown to increase exacerbation and mortality from COVID-19.[93]

These factors compound on each other; lack of ability to quarantine, lack of access to healthcare, and lack of access to public health infrastructure isolates vulnerable populations and ignores societal factors that lead to vulnerability. In other words, social determinants of health directly impact contraction and mortality rates. This vulnerability is seen in AMA and CDC data concerning rates of COVID-19 contraction and mortality in different sub-populations in America.

*"In counties where the population was substantially non-white with a median income defined as $60,240, the COVID-19 death rate was more than nine times higher when compared to counties that are substantially white with the same median income. And the infection rate was nearly eight times higher for the more racially and ethnically diverse counties that authors called 'more-poverty areas'".*[94]

Furthermore, when the CDC examined excess deaths in 2020 compared to 2015-2019, it found a 53.6% higher excess death rate in Hispanics and a 34.6% higher excess death rate in African Americans. Compare this to a 11.9% higher death rate in Caucasians in the same study.[95] LA County found that, even within the healthcare worker (HCW) population, there were substantially higher COVID-19 acquisition rates in Latino/Hispanic populations compared to Caucasians.[96]

Race, ethnicity, and poverty are listed as *driving factors* for COVID-19 infection and mortality.[95] This data is representative of structural inequality in accessing healthcare, both within healthcare's own population and the American population at large.

## The Vaccine Rollout, Vaccine Hesitancy, and the Problem with Public Health

The COVID-19 vaccine rollout was a monumental task for both healthcare institutions and the United States government. While successful in mass-vaccinating the public and reducing both contraction and mortality rates from COVID-19, the roll-outdid little to address America's fractured public health programs and the needs of its vulnerable populations.

As discussed in the history and development of private insurance programs, the culture of individualism that defines America's social policy programs worked against the vaccination effort. Though the debate of healthcare as a right or privilege continues, distribution insurance and resource allocation currently places healthcare more squarely in the realm of privilege. Furthermore, there are countless examples of marginalized populations being abused and/or neglected by the medical industrial complex in its pursuit of scientific knowledge and/or profit. The staying power of American public health has thus fragmented under two lenses: individualism and medical distrust.

Health societies, as the AMA Journal of Ethics postulates, needs "both individualism and solidarity".[97] The positive concept of liberty and individualism stresses the importance of inalienable human rights and individual rights. However, individualism is limited when trying to solve complex societal problems. The 'rugged' individualism present in America promotes the notion that individuals are responsible for their own well-being and flourishing. Thus, as the AMA Journal of Ethics further discusses, "ideological divisiveness impedes rational debate... the impediment to guaranteeing universal access to health insurance results more from our diminished capacity for democratic deliberation than from a failure of ethical reasoning".[97] The same can be said about America's fragmented and decentralized public health policies. A mass-vaccination effort for the public good is less likely to be accepted by a population convinced that the public good is secondary to individual health.

Distrust in scientific and medical institutions is deeply imbued within many Americans and has only grown since the onset of the COVID-19 pandemic.[98] This can be due to a multitude of factors, including increased politicization of scientific institutions, experiences relating to financial costs of illness, and historical precedents of oversight. It would be hard to imagine, then, that these same communities would not be wary of a sudden mass-vaccination project championed by medical institutions aimed at the public good. Only 18% of Black Americans in the 2016 National Survey on HIV, for instance, "agreed… that the government usually tells the truth about major health issues".[99] Large-scale events such as the Tuskegee Experiments and the Malaria experiments, as well as transgressions such as monetary barriers, systemic racism, and minimal health engagement have irrevocably damaged trust between the average American and American Healthcare. This in turn led to higher rates of vaccine denial and facemask noncompliance across the board compared to other high-income countries.[100]

## Returning to Professionalism in the Context of Health Discrepancy and Public Health

As we return to the definition of contemporary professionalism as stated by the ACGME charter, we notice shortfalls of what is promised. Professionalism requires adherence 'to social justice, patient autonomy, and patient welfare'. It suggests reflection for 'the benefit of the individual and community being served'. But within the scope of institutional hazards and shortcomings, physicians hit a wall. This is where Baier's notion of *trustworthiness* returns; the explicit duty of professionalism can only encompass base reliability – *not* trustworthiness. Baier's notion requires the physician to transcend core duties (ie to diagnose, treat, and maintain a certain level of respect) to approach these broad ideals outlined in contemporary professionalism.

But how does a physician begin to do this? How can physicians uphold their duty to individual patient welfare if welfare is compromised by financial and racial barriers? How can physicians uphold their duty to the community being served when a fragmented public health infrastructure fails to protect it? Realistically, a physician cannot safeguard their patients from financial ruin nor compel public policy to protect their community. Institutional barriers can severely and/or completely limit the power of the individual physician to act in an idealistically moral way. Sections 4a and 4b serve to highlight several important ideas:

1. Financial barriers to health directly impact individual patient welfare. Cognizant physicians may ameliorate – but not eliminate – financial barriers through charity work and careful knowledge of assistance programs.
2. Racial barriers to health directly impact individual patient welfare. Cognizant physicians may ameliorate – but not eliminate – financial barriers through charity work and careful knowledge of assistance programs.
3. Predominantly private opt-in insurance options reduce the financial incentive to address public / community health concerns. This is at odds with the conclusions drawn from the COVID-19 pandemic – that the line between patient and community member has been blurred.
4. As physicians growingly accept social determinants of health as integral to disease management, they will increasingly be at odds with the current reimbursement model of care.

Regardless of the physician's belief, he/she is held by the financial policy driving the medical institution he/she is a part of. The abstract nature of professionalism, as we will explore in the section 5b, does not yet interrogate these institutional barriers to actualized professionalism. It is imperative that healthcare providers take the next step – to interrogate a system in need of reform.

Now more than ever, we need critical re-examination. COVID-19 has laid bare the failings of racial/ethnic bias and a fragmented public health system. A return to normalcy represents a disregard for the fundamental problems in how America dispenses care. If we are to avoid a return to normalcy, physicians must address institutional barriers to health that lead to the very disparities they hope to overcome. It requires the physician to zoom out. Patient care is important. But so too is framing the patient as a community member and an individual human being. Patient care includes recognizing barriers that prevent the community member, the patient, from achieving standards of health physicians are tasked with maintaining.

## Section 5A: Approaching the Problems of Privatized American Healthcare

### Confronting the COVID-19 Pandemic and the Status Quo

COVID-19 has fundamentally changed how we view healthcare. The United States is not leading the world in COVID-19 cases and deaths because it holds a disproportionate burden of the crisis. It leads the world in COVID-19 cases and deaths because its poor support for public health and decentralized healthcare system alienates the average American from how to control his/her health.  The Covid pandemic has revealed how fragmented and ineffective our system is in treating its more vulnerable populations. Hopkin's data shows that America "has suffered nearly one-fifth of the world's COVID-19 deaths… even as it accounts for just over 4% of the world's population".[101] Furthermore, "23% of the world's recorded COVID-19 cases have occurred among Americans".[101] In the wake of the pandemic, health experts are struggling to understand how America was hit so hard.

As America continues the precarious return towards normalcy, some health policy experts worry that the pandemic will lead to minimal change in public policy and healthcare structure. As Dr. Fuchs mentions on the topic of healthcare policy post-COVID-19, "the pre-pandemic health care system… would be a mistake. The health care system is dysfunctional to many individuals in the US; it is too costly, too unequal, and too uncertain in its eligibility and coverage, with an increasing number of uninsured".[102] Confronting the status quo, however, is no easy task. The economics behind private insurance conglomerates dominate the conversation. As discussed previously with Starr's text, multi-institutional systems operating on profit-margins rather than patient outcomes and/or satisfaction can thrive if medicine is treated as an economic commodity. This raises the question: what does healthcare look like as a distributive service rather than a commodity?

## Comparing American Healthcare to a model of Universal Healthcare as a Status Quo

Here, we will observe an existing model of Universal Healthcare via the Canadian NHI (National Health Insurance) program to understand how Universal Healthcare works. The NHI is a single-payer system financed through general taxes. Because the reimbursement process is conducted exclusively between the 'public insurer' (i.e. the Government) and the HCP (i.e. the Healthcare Provider), the patient pays very little out of pocket other than a negligible co-pay.[103] Operating budgets of hospitals and physician fees are negotiated between the Government and medical associations.[103] The benefits of such a system are visibly apparent – patients who come in to seek care can do so without fear of exuberant medical fees and/or personal financial burden. The lack of third-party negotiation and reimbursement models leads to a significant reduction in administrative cost; a 2017 analysis of government expenditure reports revealed that Canada spent 17.0% of national health expenditures on administrative costs ($551 per capita). Compare this to the U.S. in the same study, which spent 34.2% ($2947 per capita) on administrative costs.[58] It is important to note, however, that Canada still has supplementary mixed public and private insurance coverage for prescription medications, home health care, and long-stay care. In fact, approximately 65% of Canadians have some sort of supplemental private health insurance.[104] Though all Canadians are eligible for public medication reimbursement, coverage is not as absolute and varies considerably across demographics and location.[105] There is a considerable coverage gap for those with mental health conditions, with "21.4% reporting they are unable to afford their medications" according to one cross-sectional survey.[106] Despite this, Canada's overall per-capita spending on healthcare in 2021 comes out to $5,905 – just over the average for OECD (Organization for Economic Co-operation and Development) members.[107]

Compare this to the American Healthcare system, which boasts a staggering per-capita spending of $12,914.[107] This is due to administrative costs from decentralized hospital and insurance policies, price-wars between hospital complexes, insurance companies, and pharmaceutical companies, and greater emphasis on highly specialized diagnostic and therapeutic procedures relative to European and Canadian models.[108] The result of this is higher cost burden on patients. A 2005 cross-sectional observation study found that the proportion of Americans with "difficulty affording healthcare varies by income and health insurance coverage".[109] Nearly one-third of respondents in a national US survey reported avoiding the doctor.[110] Individuals with major health problems and active symptoms are not exempt either; in a recent study, "17% of patients diagnosed with rectal tumors reported… waiting a year or more to seek medical consultation after noticing symptoms", with fear of cost being the major factor.[111] The largest 'traditional barrier to medical care', as found by this study, overwhelmingly stemmed from concerns about health insurance coverage. There is ample evidence to suggest healthcare cost is the main barrier preventing Americans from actively seeking medical care. This barrier is ameliorated in single-payer systems, leading to decreased health disparities and a greater emphasis on non-transmissible chronic diseases (i.e. obesity, diabetes, and cardiovascular diseases).[112] Lower financial barriers leads to higher rates of regular check-ups and emphasis on preventative care "that considers the long-term health and economy of a nation" rather than the immediate profit-seeking alternative.[112] It is understandable, based on healthcare costs, that the COVID-19 crisis has disproportionately affected America's lower SES populations. Financial barriers drive inherent medical mistrust, which could contribute to issues such as lower vaccine uptake rates and facemask compliance.[113] If the goal of medicine is to approach the egalitarian ideal espoused by contemporary professionalism, then the benefits that Universal Insurance cannot be ignored.

Major criticisms of Universal Healthcare, however, must be addressed. The main criticism lodged at Universal Healthcare is that of scarcity. Because there is a limited financial supply afforded by a central distributor, hospitals routinely engage in judicious allocation of resources. When major diagnostic or surgical procedures are deemed clinically necessary, the system must 're-distribute' a finite resource to accommodate them.[103] More specifically, studies have found deficiencies in high-cost medical treatments such as angioplasty, cardiac catheterization, and intensive care. Wait times "Nationwide… for treatment is 13.3 weeks".[103] Using cost as a limiting factor means that Canadians often sacrifice the use of more expensive, cutting-edge treatment options for more equitable care. This is a considerable downside for acute conditions that benefit from immediate care. The timeliness for elective care, non-urgent medical imaging, and non-urgent procedures is considerably higher than other countries.[114] Political figures have cited Canadians travelling to the US to get procedures they would otherwise have to wait months for. Wait times and the prospect of delayed care is a valid and understandable criticism against single-payer healthcare.

The second criticism of Universal Healthcare is implementation in such a diverse country as America. The demographics of Canada are significantly less varied than the demographics of the United States. The US has varying population densities that require different forms of health that cannot be captured in a wide net. Decentralized healthcare allows local hospitals to adapt to the needs of these specific populations that are unique from other countries with homogenous demographics. Indeed, many criticisms levied against the Canadian system concern stark inequities in its own indigenous populations. Members of the First Nations, Inuit, and Métis have experienced greater rates of trauma, chronic disease, infant mortality rates, and suicide.[114] Though these populations are covered under Canada's Medicare plan, many social determinants of health (ie wage gaps, racism, social exclusion) may contribute to this continued inequity.

The third major criticism of a Universal Healthcare system is the effect on research, development, and integration of new drug therapies. Drug companies argue that price control measures on pharmaceuticals risk "stifling innovation", hampering progress, and interfering with a competitive market that currently rewards advancement.[115] Should these claims prove true, it would constitute a valid argument for a profit-oriented system.

Despite the criticisms levied against single-payer healthcare, one overarching statistic must be addressed: Canadians overwhelmingly support their system of healthcare. America's per capita expenditures are high compared to Canadian and European systems, yet "Americans have been consistently less satisfied than residents of other high-income countries with their own nation's health system".[116] Just over half of US respondents to one study showed some degree of satisfaction with the US Healthcare system. Even then, the divide in that group between insured and uninsured Americans was astronomical.[117] An "overwhelming 60% [of American respondents] thought the system needs fundamental changes".[103] Compare this to Canadians, of which "56% of respondents… believed the system requires only minor changes, and only 5% thought the system needs complete rebuilding".[103] This suggests that Canadians prefer the trade-off for waiting time (for non-emergent conditions) that comes with more accessible healthcare. Furthermore, the political claim that Canadians frequently travel to the US to get procedures and circumvent their wait times for emergent conditions was proven mostly false by a 2002 study by Katz using data from the National Population Health Survey, the provincial Ministries of Health, and the Canadian and Health Insurance Association. This report found that this group of

Canadians was “so small as to be barely detectible relative to the use of care by Canadians at home”.[116] Finally, it is important to note how other countries address the issue of pharmaceutical price control. The British NIH, for instance, has a national board that negotiates prices for all pharmaceuticals with industry and independently rewards ‘breakthrough’ innovations while discouraging patenting / monopolization.[118] This practice works to ensure set proportions of profits are distributed to industry with proper oversight.

## Moving to Interrogate Professionalism Within the Context of American Healthcare

Despite the counterpoints levied at single-payer healthcare, the benefits afforded by single-payer systems outweigh their shortcomings. Most relevant to this thesis, such a system allows physicians to best approach the concept of professionalism put forth by multiple medical associations. This system inherently incorporates the patient-as-community because every community member is covered under the same program. This bolstered Canada’s more prolific Public Health programs because cost allocation favors less-costly preventative measures. As we move to the last section of this thesis, it is imperative that we drive home the disconnect between contemporary professionalism and the American Healthcare space. A physician’s commitment to community health and social determinants of health inherently requires a commitment to removing barriers that prevent the community from engaging with healthcare services. As discussed by this section, one of the main barriers to engagement in America is the cost of service. When contrasting American healthcare models with alternative systems, we find that alternative systems are more compatible with what the ACGME, Stern, and ABIM are trying to frame.

## Section 5B: An Abstractive Hazard Looms

Thus far, this paper has focused heavily on historical and technical aspects of healthcare development and delivery. By documenting the rise of both privatized healthcare and contemporary professionalism, we have the adequate context to interrogate the faults inherent in a synthesis of contemporary professionalism in the space of privatized healthcare. This argument rests on my earlier assertion that the *telos* of professionalism and the *telos* of American Healthcare are at fundamental odds. We have outlined how the current financial structure developed to (and continues to) optimize profit, contradicting the stated goals of professionalism – optimizing patient welfare and recovery. We have also contrasted the American system to alternative forms of healthcare that seem to better fit the goals outlined by contemporary professionalism via maximizing access to healthcare resources and public health integration. During this final section, we shall consolidate these ideas into an overarching concept I will call *Abstractive Hazard*.

To recognize the role of *Abstractive Hazard*, it is important to understand the economic reality established by our current healthcare system. About 1 in 8 Americans currently owe $10,000 or more in medical debt.[119] 50% of Americans fear bankruptcy from a medical emergency or major medical event.[120] And despite America spending more money per capita than any other country on Earth, it sees worse outcomes – disproportionately so in minority groups and underinsured populations – than other high-income countries.[121] Safety-net hospitals created to address these concerns are chronically underfunded and unable to provide full measures of care, leading to higher readmission rates and hospital closures.[122] This comes at the same time when insurance companies report record-breaking profit margins. UnitedHealth Group, for instance, reported $5.6 billion first-quarter profits in April 2023.[123] Cigna reported

$1.2 billion fourth-quarter 2022 net income. Private insurance is, first and foremost, profit driven. This fact drives policy, distribution of care, and access. We spend the most money per-capita, yet we continue to rank below 30 countries across multiple public health indicators.[124] This discrepancy comes from issues such as rising overhead in private insurance negotiations[124], administrative costs[125], and drug price gouging driven by politically active pharmaceutical companies.[126, 127] The economic reality established by this thesis is relatively clear – healthcare is a commodity governed by profit maximization rather than patient welfare.

By practicing medicine in America, physicians must tacitly agree to function within a healthcare system that – by design – subverts the responsibilities outlined in contemporary professionalism. Let us return to the discussion of Section 2a – Medical Professionalism Today – and Section 2b – The Theoretical Implication. 2a outlines the overarching definitions of Professionalism as given by Stern, the ACGME, and the ABIM Foundation. Each champion patient welfare, patient well-being, and social justice as a 'necessary component' of the standard of Professionalism. Discussions of the Social Determinants of Health and financial barriers to treatment are commonplace ones in medical education and training, yet we fail to translate these to actionable steps to mitigate them. There are no rules, no translational actions, no defined methods by which to enact notions of patient welfare and/or well-being. These definitions refuse to engage with the non-ideal realities that prevent physicians from acting in respect for patient welfare and/or well-being. 2d outlines Baier and the 'unscripted response'. By leaving Professionalism in the abstract, this essentially shifts the burden of undefined action from our system onto the individual physician. This burden of compassion fatigue and emotional distress are some of the most common causes of physician burnout.[128]

One must ask the question: how does the physician embodying *professionalism* act when set up against these institutional barriers? How does the humanistic physician accept a community member's refusal to seek treatment because of costs? Does a community member who refuses to seek care for fear of costs fail to become a patient? Is the physician thus not obligated to help/treat this individual? Just as we saw in section 3c, there is a fundamental disconnect between the ontological drive established in the ACGME charter and the ontological drive established by American Healthcare. No matter how humanistic the physician is, he/she exists within institutional structures that forcibly reduce patients to financial margins associated with their illness. A sizable minority of physicians self-reported manipulating billing codes or charts to secure coverage for their patients in one randomized sample.[129] For patients who cannot afford the standard of care, provider options include (1) referral to a safety-net provider, (2) apply for charity care, (3) reduce the fee at the physician's expense, or (4) imbue debt.[130] Challenging insurance claim denials requires the physician to expend vast time and effort to navigate first-level appeals, second-level appeals, and independent external appeals[131] that are increasingly being denied as of 2023.[132] These 'band-aid' solutions of charity care, aggressive appeal, and billing manipulation were originally 'exceptions' that have turned into the norm.

Without concrete steps to counter these institutional barriers, we risk leaving a faithful interrogation of our system within the abstract. This is what I call the Abstractive Hazard – the framing of conditions under detached, favorable optics to make them palatable to both the administrator and to the recipient. While contemporary professionalism is a genuinely positive step forwards, it risks falling into a permanent abstraction without targeting the forces that prevent its own actualization. Be it through moral burnout, complacency, or bad faith, we risk physicians accepting our system as-is and molding professionalism to work within its boundaries. Professionalism is a means to critically analyze and improve healthcare practice; it cannot be the end in itself. It risks becoming nothing more than a mission statement that fails to reflect the reality of patient care. After all, the archetype of physician – an unconditional healer that saves lives – is much more digestible than a mediator for a system that extracts value from illness under threat of disability or death. If we accept that physician professionalism itself is ethical, then physicians who champion professionalism without translating it into actionable steps can be, by proxy, ethical without further contemplation. Professionalism must resist abstraction into the transactional nature of contemporary medicine.

## Rejecting the Abstractive Hazard

Rejecting the Abstractive Hazard requires a recognition that maintaining the status quo is (1) incompatible with professionalism and (2) an unsustainable burden on healthcare workers. Rejection of the Abstractive Hazard, above all, requires physicians themselves to develop concrete steps to actualize professionalism.

One such concrete step could be the normalization of advocacy and public policy involvement. Medical professionals have influence, bringing with them "the experience of having directly seen the impact of prior policies both on their own practice environments and on their patients".[133] There are many such narratives of physicians lamenting their impossible situations in navigating care denial and red tape. It is even rooted in the AMA guidelines that physicians should "advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human wellbeing".[134] We should take objective measures of American health inequity, the lamentations of our fellow physicians, and our own personal experiences with healthcare as rallying cries to express righteous indignation of the status quo.

Failure to act and failure to advocate risks a cementing of the status quo and complete corporate domination of the healthcare space. It is not the fault of physicians to find themselves working within unjust conditions; it *ought* to be the duty of physicians, however, to advocate for more just conditions. Normalizing advocacy turns Baier's notion of *unscriptedness* into the scripted.

One catalyst for the normalization of public policy advocacy may be in academic institutions. As Khatana states, "advancement in academic settings largely consists of traditional research with achievement measured in the form of publications… a career focused on public policy therefore often means lack of recognition or promotion at academic medical centers".[135] The opportunity cost of reducing clinical hours to enter public policy de-incentivizes physicians from allocating large amounts of time to public policy. The capital-oriented distribution of medicine prevents physicians from engaging in discourse to critique it. Academic centers should strive to empower voices and create spaces for physicians to engage in public policy work more readily. They should strive to integrate public policy and translational steps in medical schools, residencies, and beyond.

Secondly, pressure can be mounted on professional societies to advocate for change. As discussed in section 3b, professional medical societies such as the AMA wield a considerable amount of power to influence public policy. The AMA does not have a strong track record of supporting Medicare, nor does it currently support a single payer system. However, it did break from its precedent in supporting the ACA. In 2019, a medical student push just barely failed to shift the AMA's stance from 'against' single-payer to 'neutral' on single-payer healthcare.[136] The 'leftward shift' in the AMA's politics, driven by contemporary professionalism, the integration of social determinants of health, and recognition of health inequity, may lead to more significant changes down the road. As stated in 3c, several professional societies such as the American College of Physicians (ACP) has already broken from the AMA to support Medicare for All. A shift in the AMA's stance may not "fundamentally change the equation", according to Dr. Emanuel, co-director of the Healthcare Transformation Institute at the University of Pennsylvania.[136] However, mounting pressure from more politically active practitioners adds to the normalization of discourse surrounding healthcare reform.

## An Uncertain Future

The future of medicine is bright yet uncertain. Medicine has found a powerful tool in redefined professionalism to recognize and critique institutional structures that contribute to well-researched, well-documented health disparities. As the expansion of disparity research and social determinants of health grow, and as the dynamics between the players within the healthcare space are more thoroughly explored, the apparent contradictions between the goals of American Healthcare and of this professionalism will only grow. The *telos* of profit-oriented medicine and the *telos* of benevolent care will remain diametrically opposed no matter how they are dressed up. It is essential, then, that the *telos* of the latter is not encroached upon or incorporated by the former. Medical professionals must recognize their accountability not just to the patient, but to the society that influences patient health. If advocacy is to bring about meaningful change, then this discourse cannot end in the abstract. It requires praxis. No matter how small the action, action must be taken on the part of the physician to advocate and normalize advocacy. In doing so, the *unscripted* becomes *scripted* and a path will be made clear for medical professionals to authentically carry the weight of professionalism. There is proof that our profit-oriented culture continues to damage marginalized populations, everyday Americans, and our community at large. There is proof that alternative medical systems can function more equitably for all. And, by working in tandem with collective advocacy, physicians may make meaningful change in the lives of those they have pledged themselves to heal.

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