PART I

Introduction to Health Care Ethics

Part I provides an overview of the ethical issues facing the U.S. health care system.

© Jannis Tobias Werner/Shutterstock

CHAPTER 1

The Ethics of Health Care

> *"Personal or individual conscience, personal or individual integrity, personal or individual moral autonomy, or any other individualized philosophical values, are not firm foundations upon which to construct a policy regarding professional health care ethics."*
>
> — **Frank H. Knight** (1885–1972), neo-classical economist at the University of Chicago, from *Ethics and Economic Reform* (1935)

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:

1. Explain how to arrive at the desired or intended result when making decisions that are ethical.
2. Understand and evaluate eight decision-making models based on the insights of major philosophers of ethics.
3. Apply decision-making models when making ethical judgments within the health care industry.

KEY TERMS

Affordable Care Act of 2010
Common good
Compensatory justice
Distributive justice
Duties
Ethical
Ethical health care system
Ethical judgment
Exception
Existentialist
Extrinsic value
Fair value
Fairness
Free-riders
Idealist
Inattentional blindness
Intrinsic value
Justice
Justification
Legal rights
Liberty
Marginal utility
Medicaid
Moral rights
Negative moral rights
Pluralism
Pluralistic society
Positive moral rights
Privilege
Risk pool
Shared values
Smell test
Stakeholder society
Stakeholders
Unethical
Utilitarianism
Virtues
Vulnerable populations

ETHICAL OR UNETHICAL DECISION

Individual Health Insurance Mandates

Ethics Issue: *Should everyone share broadly in the risks and costs of poor health? And if so, what decision-making models could help reach this conclusion?*

In Brief: The State of Virginia has asked the federal courts to decide whether individual health insurance mandates should be imposed on its citizens under the **Affordable Care Act of 2010** (ACA), the most comprehensive reform of the U.S. health care system and private health insurance industry in almost a century. Virginia contends that if the individual health insurance mandate is constitutional, then there is no limit to the federal government's power; the government could force people to do almost anything for the common good of the nation. This really is a dispute over how much power Congress has to move Americans from their focus on individualism into a **stakeholder society**, where any legal rights enjoyed are integrally linked to moral responsibilities. In this case, the moral responsibility to maintain one's health and prevent poor health or injury is an essential part of any moral right to access health care. The ethical issue is how much power should be used by the federal government to help create a health care system that works properly for everyone—healthy people and people in poor health.

— *Commonwealth of Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253 (U.S. Court of Appeals for the 4th Circuit 2011), *cert. denied*, 133 S.Ct. 59 (U.S. Supreme Court 2012). (*See Ethical or Unethical Decision* at the end of the chapter for discussion of this ethics issue.)

Introduction

This chapter is designed as an introduction to thinking ethically. Most health care professionals have an image of how they perceive themselves and how they are when they act ethically or are at their best. Almost everyone also has an image of what an **ethical health care system** should be: where medicine's ethical foundations of honesty, competence, and compassion are married to commerce in the delivery of high-quality care and where respect for patient needs has the highest priority. Nearly everyone also has images of what an ethical government and society should be: where every member of society has access to affordable health insurance, and where basic coverage is established through an ethical process. Health care ethics deals with all three of these levels, as illustrated in **FEATURE BOX 1-1**. The goal of this textbook is to embark on a journey to discover the nation's **shared values**, or the accepted ethical principles which constitute justice and fairness in the United States when it comes to health care.

Ethical Decision-Making

How does one make an ethical decision and what is the decision based on? Are there agreed-upon ethical principles or values in the health care industry to guide health care professionals so that they do not simply choose what is most convenient or advantageous

FEATURE BOX 1-1

Three Levels of Health Care Ethics

- Acting ethically as individuals by assuming clear responsibilities for which everyone is held accountable
- Creating ethical health care systems that are sustainable
- Making government and the society it represents become more ethical in the ways it treats every member of society

— Sources: Beauchamp & Childress, 2012; Levine et al., 2007.

rather than what is most ethical? Is there a process one can follow to be sure decisions are made thoughtfully and properly? Fortunately, many philosophers of ethics, from ancient times to the present, have addressed these very questions.

Administrative and judicial decisions throughout this text show how judgments are being made about whether actions and situations are **ethical** or **unethical**, right or wrong, in conformance with accepted ethical principles or not. One indication that an action calls for an ethical decision, as opposed to simply a legal or business decision, is that the action involves an actual or a potential burden or harm to individuals or to the health care system itself (*see, e.g.,* Hamilton, 2009a). Another indication that an action calls for an ethical decision is if it violates what society generally considers ethical behavior or what the law defines as a lawful act. Philosophical models for decision-making can assist in ensuring that the best **ethical judgments** are being made when actions involve an actual or a potential burden or harm to an individual or individuals, or to the health care system itself, or when there is a violation of the law or breach in ethical behavior. Variations between what is considered ethical and unethical, right and wrong, legal and illegal are shaped by **inattentional blindness**, also known as perceptual blindness. Inattentional blindness occurs when the collective thinking of individuals is adapted at different rates (Chabris & Simons, 2010).

A Process for Ethical Decision-Making

There is a recognized process that can facilitate decisions about what should be done. This process contains decision-making models which, when used as part of this larger

ETHICAL DILEMMAS 1-1

1. Ethically speaking, what makes the need for comprehensive reform of the U.S. health care system so difficult to recognize? Clearly, there is inattentional blindness between those who favor a major revamping of the U.S. health care system and those who oppose comprehensive reforms. How can this unwillingness to understand each side's viewpoints be overcome?

FEATURE BOX 1-2

Eight-Step Process for Ethical Decision-Making

- Recognize the ethical issues
- Gather all relevant facts
- Put *all* decision-making models on the table
- Evaluate why the different models are a valid way to decide whether an action or situation is ethical or unethical from various perspectives
- Apply the appropriate models
- Make decisions based on the models
- Monitor the results of those decisions
- Repeat the process again as changes occur

— Sources: Chabris & Simons, 2010; Markkula, 2009; Simons & Chabris, 1999; Wharton, 2005; Wind & Crook, 2006; Freeman, 2001, 2000, and 1995.

decision-making process, can be very helpful in managing health care actions and situations. The steps in this larger process are illustrated in **FEATURE BOX 1-2** and **FIGURE 1-1**.

Models for Ethical Decision-Making

Eight different decision-making models have been identified by leading philosophers of ethics, all of which are listed in **FEATURE BOX 1-3**, and described in full afterward.

In most situations, all eight models are not needed. One or two models can be selected to explain why the action being considered is ethical or unethical. With knowledge of all eight models, the most appropriate ones can be chosen, and the appeals others are making can be identified and countered in situations in which there is no clear ethical choice. It is not necessary to go through each of the eight steps in Feature Box 1-2 for each of the decision-making models presented in this chapter. The process for ethical decision-making is one illustration of how arguments evolve to a decision. As health care reforms are being implemented, the nation is encountering ethical decisions that will be examined throughout this text and are outlined in **FEATURE BOX 1-4**.

The U.S. medical model is based primarily on treating and managing diseases. There is lip service given to prevention, but virtually the entire health care system is based on procedures linked to treating disease as opposed to preventing it. Health insurance plans, including Medicare, direct very few resources to prevention. Medicare itself provides coverage for a comprehensive physical examination only one time, when an individual enters the system. After that, comprehensive physicals have to be paid out of pocket, perhaps aided by Medicare supplemental private insurance. Prevention, in contrast, emphasizes not only early detection of disease that, if ignored, would become serious and expensive, but also behavior interventions to eliminate the potential for disease in the first place or, if disease occurs, to lessen its severity. Health care reforms shift the emphasis on treatment of disease to prevention of disease.

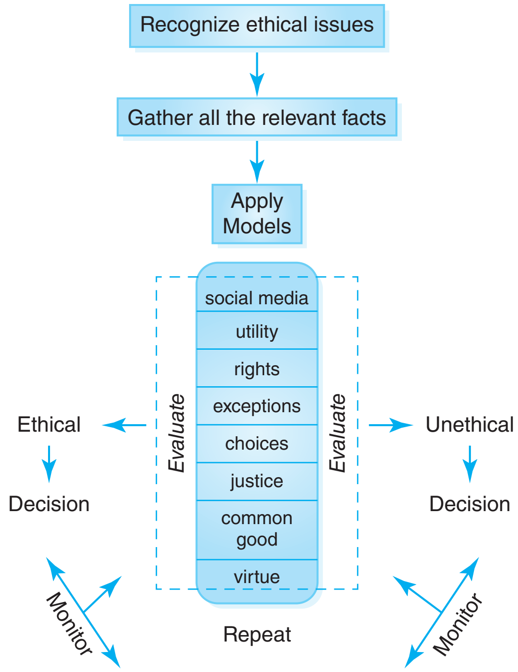


FIGURE 1-1 Process for Ethical Decision-Making

Sources: Markkula, 2009; Wind & Crook, 2006.

Social Media Model

The most common form of decision-making is the Social Media Model. This model was known as the **smell test** (does the situation reek of dishonesty, or is there a whiff of impropriety in the air?) or "the front page [of the newspaper] test" in the days before the social networking phenomenon. Mainly the Social Media Model asks how one would feel having one's actions go viral; if that level of public scrutiny is undesirable, the action is probably unethical. The Social Media Model is where most discussion of ethical issues begins.

Application of the Social Media Model

As illustrated in **FIGURE 1-2**, the Social Media Model entails two steps:

Step 1: Define what the reaction would be, based on popular opinion, if the action or situation being considered was publicized on a social network.

Step 2: Make an ethical decision. Decide whether the situation should continue. To determine why a situation should continue, inquiry must move beyond the Social Media Model to one or more of the seven other decision-making models.

Step 3: Monitor the results of the decision and repeat the process as changes occur.

Would most people be comfortable blogging about the action or situation in question, or letting it continue? Knowing whether most people would find that some actions or situations may be wrong can assist in modifying the actions or situations to help make them more ethical. For instance, states generally require people to manifest the symptoms of Acquired Immune Deficiency Syndrome (AIDS) before providing **Medicaid** insurance

FEATURE BOX 1-3

Eight Decision-Making Models

- *Social Media Model* is based on a combination of philosophies from Kant to Rawls and Dworkin, all introduced further below (Dworkin, 1996/2010 and 2008a-c; Kant, 1781/2009; Rawls, 2005 and 1999). This model has also been informally known as "the smell test" or "the front page test."
- The ideas of Jeremy Bentham (1746–1832), a British jurist and social philosopher; John Stuart Mill (1806–1873), a British social philosopher; and the modern principles of Ronald Dworkin (1931–2013), a New York University scholar of philosophy and constitutional law, combined to develop the philosophy of utilitarianism (Bentham, 1789/2015; Dworkin, 2011/2013, 2013, 2010, 1996/2010, and 1977; Mill, 1863/2011).
- Immanuel Kant (1724–1804), a German philosopher, developed the ethical principles for the *Rights Model* (Kant, 1788/2009 and 1790/2009), which was expanded by F.H. Bradley (1846–1924), a British **idealist** philosopher who believed people need to aspire to goodness and high ethical principles (Bradley, 1988/1927), and Dworkin (2013, et al., 1996/2010, and 1991).
- The *Exceptions Model* is based on the ancient principles developed by Confucius (551 BC-479 BC), a Chinese social philosopher, up to the contemporary ideology of John Rawls (1921–2002), a Harvard professor and social philosopher, and Dworkin (Dobbin, 2008; Dworkin 1998/2013, 1994, and 1985; Rawls, 1971/2005 and 2001; Van Norden, 2001).
- Three classical Greek philosophers: Socrates (469 BC-399 BC) and his student, Plato (427–347 BC), and Plato's student, Aristotle (384–322 BC), laid the foundations for the *Choices Model* (Aristotle, 322 BC/2012; Plato, 380 BC/2007).
- Plato, Aristotle, and Bradley, along with the modern principles of Rawls and Dworkin, who put human dignity at the center of the ethical systems, are the leading proponents of the *Justice Model* (Aristotle, 322 BC/2012; Bradley, 1935, 1927/1988, and 1893/1916; Dworkin, 1998/2010, 2008b, 1986, and 1978; Plato, 380 BC/2007; Rawls, 1971/2005, 2001, 1999, and 1974).
- Writings from Epictetus (55-135), the stoic Greek philosopher, Aristotle, and Plato serve as the basis of the *Common Good Model* (Aristotle, 322 BC/2012; Dobbin, 2008; Plato, 380 BC/2007; Van Norden, 2001).
- The leading philosophers of the *Virtue Model* are Jean-Paul Sartre (1905–1980), a French **existentialist** who believed people must take responsibility for their own actions and shape their own destinies (Sartre, 2000, and 1990/1983), and Dworkin (1996/2010, 2002a, 2002b, and 1978).

— Sources: Beauchamp & Childress, 2012; Markkula, 2009a and 2009b; O'Neill, 2014.

— Note: This list only includes philosophies and works of philosophers that have been recognized and recurrently cited by the U.S. Supreme Court, the U.S. Court of Appeals, and state Supreme Courts since 2010; Rawls is the most cited and Dworkin the second.

FEATURE BOX 1-4

Selected Ethical Decisions to Think About

- Will implementation of the nation's health care reform legislation withstand public scrutiny (*Social Media Model*)?
- Are the benefits of the reform being maximized and the burdens or harms minimized (*Utility Model*)?
- Are legal rights being respected (*Rights Model*)?
- What if everyone were entitled to receive health care (*Exceptions Model*)?
- Are people able to make their own choices (*Choices Model*)?
- Are the benefits and burdens being fairly distributed (*Justice Model*)?
- Are the common benefits of the nation being considered (*Common Benefit Model*)?
- Do the health care reforms improve the best elements of the nation's health care system (*Virtue Model*)?

— Sources: Markkula, 2009; Beauchamp & Childress, 2012.

ETHICAL DILEMMAS 1-2

2. What is holding back decisions on implementing U.S. health care reforms? Ethically speaking, what interests are supporting the focus on medical treatments and thwarting the shift in priorities to prevention of illness and disease?

to purchase the antiretroviral medications (ARVs) that prevent the development of those symptoms (*see, e.g.,* Bolin, 2014; Underhill, 2012). Medicaid is the need-based state-federal health coverage program for those who are poor and financially distressed or who have high out-of-pocket medical expenses. Blogging about this policy may indicate whether this presents an ethical issue but not why this government policy may be unethical. Discussions about indigent Americans facing early deaths from AIDS because of their lack of access to early intervention and care is a quick way of deciding whether this state of affairs is ethical or not.

Strengths and Limitations of the Social Media Model

The strength of the Social Media Model is its focus on public scrutiny and the common consensus on what is ethical. With this model, ethics is as much about what a group thinks as it is about what an individual thinks. The Social Media Model enlists the emotions of

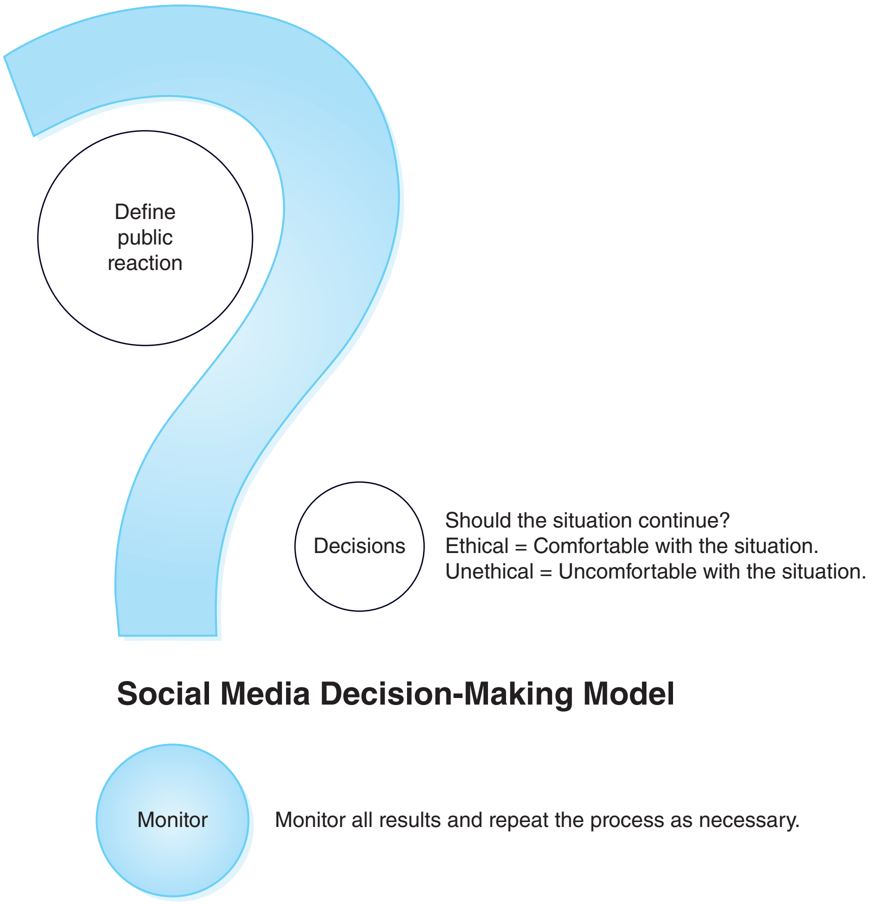


FIGURE 1-2 Social Media Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

personal or organizational shame and embarrassment, two powerful motivators to help ensure that actions are ethical.

The weakness of the Social Media Model is that it only benefits the society or the space in which health care professionals choose to work. Americans are often blind to the ethical dimensions of government policies, or they accept unethical policies as ethical, or the nation is divided on whether policies are ethical or unethical. Living with unethical conduct dulls the ability to notice the wrongfulness of some policies. In this instance, the health care reform's expansion of Medicaid coverage to uninsured Americans who are HIV-positive, who would otherwise not be eligible for Medicaid, has been criticized as being an unnecessary financial burden on states. This demand to consider financial cost is met by pleas to consider the human cost of denying access to ARVs while an uninsured person's immune system is still strong. In this instance, personal ethics cloud sound fiscal judgment. The government pays more to care for someone with full-blown AIDS than they would pay to give the same person ARVs to prevent the onset of AIDS and keep them functioning as a contributing member of society. Early access to Medicaid coverage to purchase ARVs to suppress the HIV retrovirus transforms HIV into a treatable, non-fatal health condition (Purcell, 2010). Ethically speaking, the issue is whether suffering and premature deaths from AIDS need occur, or whether 18,000 Americans should die from HIV/AIDS every year because of unmet medical needs (*see* CDC, 2013).

Utility Model

Utilitarianism, a philosophy of ethics which asserts that the ends justify the means, is a straightforward model for determining ethical courses of action. To discover what should be done in any situation, the various courses of action that could be performed are identified. All of the foreseeable benefits and burdens that could result are then determined. The action that provides the greatest benefit to the most people becomes the most ethical course of action.

For the Utility Model, outcomes or consequences determine what is ethical or unethical. Actions are ethical if they result in the best overall outcome. Outcomes in the health care industry can be measured by such indicators as health versus illness, quality of life, life expectancies, and burdens (current and future costs).

The Utility Model is a valid way to decide which actions are ethical or unethical because everyone counts the same; everyone wants to be healthy or avoid being ill. An ethical decision is based upon what results in healthy lifestyles or the lowest level of unhealthy behaviors, regardless of who is affected. For instance, employers cannot ethically regulate the consequences of weight status for overweight and obese employees unless all employees are sanctioned for their unhealthy behaviors. A policy could monitor the health status of all employees regardless of weight and sanction those with high risk for heart attack, stroke, or diseases such as diabetes. Using the Utility Model, everyone affected by lifestyle discrimination policies has equal standing when a decision is reached.

Balancing Benefits over Burdens

Health care ethics depends on balancing the consequences of conduct. Utilitarianism holds that the right course of action in any situation is the one that produces the greatest balance of benefits over burdens for everyone affected. As long as maximum benefits are produced for everyone, utilitarianism does not focus on how the benefits were created. **Duties** or ethical obligations are justified by reference to the benefits that come from a situation or the burden that is prevented. In this instance, employers are constantly weighing the resulting benefits and burdens of their employees' health care costs.

The principle of utilitarianism can be traced to Jeremy Bentham and John Stuart Mill, eighteenth- and nineteenth-century philosophers who sought an objective basis for determining what laws should be enacted by governments. Bentham and Mill believed that laws that would bring about the greatest net benefits to society once the burdens had been taken into account were the most ethical. Bentham's motto was 'the greatest benefit for the greatest number' (Bentham, 1789/2015). Today, utilitarianism often describes benefits and burdens in purely economic terms (Knight, 2000; *see also* Rawls, 1971/2005).

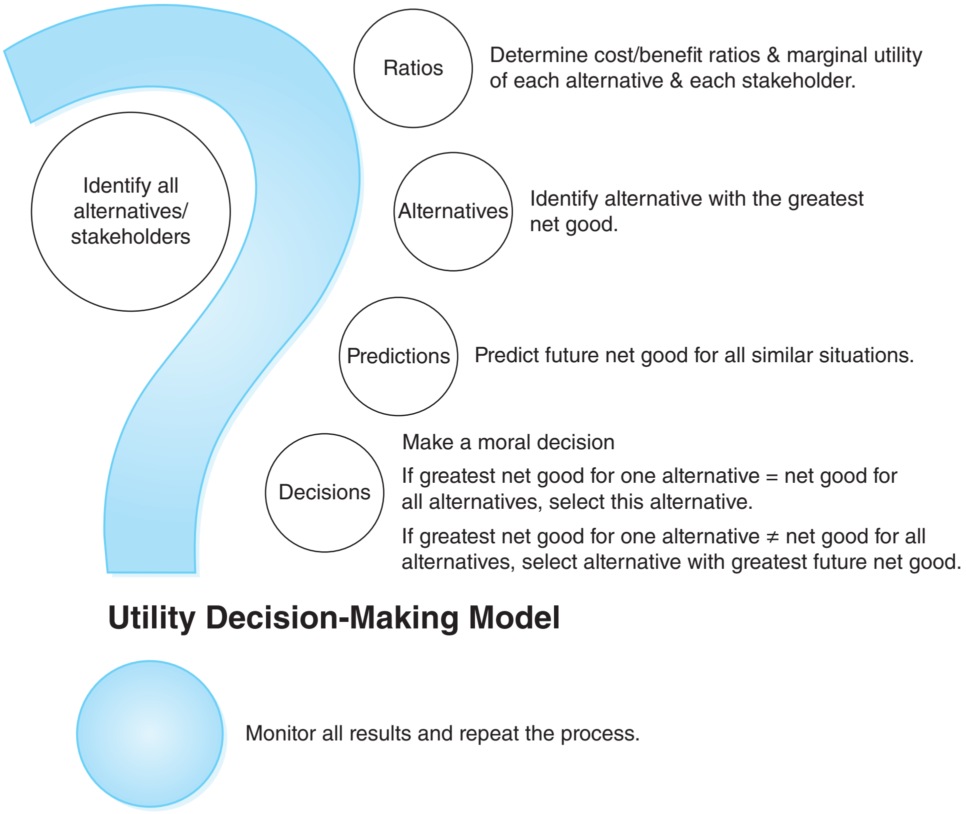
Application of the Utility Model

The Utility Model, as illustrated in **FIGURE 1-3**, involves a six-step framework that focuses on how a decision is made and on outcomes.

Step 1: Identify the alternative actions that are possible and determine who would be affected by any decision. For instance, employers and employees would be the most affected by lifestyle discrimination policies that were enacted to help reduce and fairly allocate health care costs.

Step 2: For each of the alternatives, determine the costs and the benefits for each of the groups affected. This prediction of short-term and long-term outcomes considers the relative value, or **marginal utility**, of the outcomes for different people. In this instance, particular attention could be directed to smoking and the growing prevalence of obesity; that is to say, preventable behaviors and conditions that are both recognized as serious health issues that can no longer be ignored, as well as problems that can often be addressed through environmental interventions.

Step 3: Select the action in the current situation that produces the greatest benefits over burdens for everyone affected. If the burdens outweigh the benefits, the action with the least burden relative to the benefits is the best alternative; this alternative has the greatest net benefits for this one situation.



Determine cost/benefit ratios & marginal utility of each alternative & each stakeholder.

Identify alternative with the greatest net good.

Predict future net good for all similar situations.

Make a moral decision

If greatest net good for one alternative = net good for all alternatives, select this alternative.

If greatest net good for one alternative ≠ net good for all alternatives, select alternative with greatest future net good.

Monitor all results and repeat the process.

FIGURE 1-3 Utility Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

Step 4: Predict the consequences of the action for all similar situations. Because what is done in one situation often becomes a policy for future actions, the best alternative is the one that maximizes benefits for this and all future situations.

Step 5: Make an ethical decision. If the same action is selected in steps three and four, then this is the most ethical action. If different actions are selected, then decide which individual action will produce the greatest long-term benefits and cause the least burden to everyone affected; this is the most ethical action.

Step 6: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Utility Model

The strength of the Utility Model is that outcomes matter in the health care industry. If the outcomes of a particular decision are not good, it is obvious that the ethical principles being used are not good. Therefore, factual data and assessing the probability of potential outcomes are important when deciding what actions are the most ethical. Similarly, the welfare of health care systems must be included in decisions involving the Utility Model; health care systems are affected by individual outcomes. This emphasis on rational calculation and on including everyone that is affected by a decision reinforces the principle that relying upon intuition is often an unreliable method of ethical decision-making.

The weakness of the Utility Model is that it requires accurate probability assessments of likely outcomes. Outcomes may be difficult or impossible to predict because of the complexity of the health care industry and the rapidly changing laws and regulations affecting health care. Moreover, when the U.S. health care system attempts to measure national outcomes on a short-term basis, it becomes nearly impossible to focus on the long-term outcomes of any reform efforts. In addition, while utilitarianism is a popular ethical theory, there are some difficulties in relying on it as a sole method for ethical decision-making. First, utilitarian calculations require that the values assigned to the benefits and burdens resulting from one situation be compared to the benefits and burdens from other situations. But it is often impossible to measure and compare values in health care, as the value of a person's life and respect for human dignity are completely incalculable. Nevertheless, even with this unqualified commitment to respecting life and human dignity, the consequences of actions are often difficult and imprecise to calculate.

One of the greatest difficulties with utilitarianism is its failure to consider principles of justice or whether individuals are treated fairly when decisions are made. If ethical decisions are to take into account considerations of justice and give people their appropriate due or what they are properly owed, then utilitarianism cannot be the sole principle guiding decisions. It can, however, play a role in these decisions. Utilitarianism considers the immediate and the less immediate consequences of actions (*see* Rawls, 1971/2005). Given its insistence on summing the benefits and burdens in any given situation, utilitarianism looks beyond self-interests to consider impartially the interests of everyone affected. The utilitarian standard of ethical conduct is that of everyone affected by the result of a decision (Mill, 1863/2011).

Rights Model

Moral rights are essential to the respect of everyone's human dignity and self-determination. **Legal rights**, in contrast, are human constructs created by society, enforced by governments, and subject to change. **Moral rights** are perennial rights that are not easily subject to change. Everyone possesses moral rights and these moral rights empower people to engage in conduct that does not violate the rights of others, generally as understood and explained by the law (Spiropoulos, 2010).

For instance, under this model, in the United States, **vulnerable populations** that experience health disparities as a result of lack of access to health care and increased exposure to health risks are morally entitled to something from society; they are generally protected by law from actions that benefit society at their expense. Diverse vulnerable groups are most often comprised of minorities, underprivileged people, and people who are marginalized by societal norms, such as sexual orientation or immigrant status (AHRQ, 2012). Vulnerable groups also include high-risk mothers (defined as unmarried, low-income women), children, people with HIV/AIDS, and homeless families. A significant difference in the overall disease incidence, morbidity, mortality, and survival rates among vulnerable populations in the United States exists compared to the health status of the general society (IOM, 2001).

Yet human beings are recognized as valuable in and of themselves (referred to as the **intrinsic value** or the essential parts of a person), regardless of vulnerabilities arising from their health attributes or health insurance status (referred to as the **extrinsic value** or the inessential parts of a person) (*see* Roberts, 2011). Legal rights point to the social conditions required for expression of these values. That is, without access to health care, people cannot live in a way that expresses their intrinsic value.

ETHICS CASE
Disparities in Access to Health Care

Korab, et al. v. Fink, et al.
[Non-Immigrant Resident of the United States v. Governor of Hawaii]
748 F.3d 875 (U.S. Court of Appeals for the 9th Circuit 2014),
cert. denied, 135 S.Ct. 472 (U.S. Supreme Court 2014)

Facts: Tony Korab, a dialysis patient who had been seeking a kidney transplant, sued to stop the reduction of his Medicaid benefits, asserting that it was unconstitutional to deprive him of a kidney transplant. The reduction in his Medicaid benefits occurred because Korab was a foreign citizen who had been granted legal resident status as a non-immigrant (includes people who enter the United States on a temporary basis for business or study). By passing welfare reform, Congress made non-immigrants a category of residents that no longer qualified for federal reimbursement. Consequently, Korab became ineligible for the federal Medicaid subsidy. For the purpose of state Medicaid, Congress created three categories of eligibility: one category is eligible for state benefits; another is denied benefits; and a third may be eligible at the discretion of state governments. Korab fell into the third category. Congress justified its refusal to provide access to health care by insisting that self-sufficiency was always a basic principle of U.S. immigration law; immigrants should not depend on American society to meet their medical needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations.

Legal Analysis: There is considerable debate over immigrants' rights to Medicaid and access to health care. The approaches adopted by different courts diverge significantly based on the different state schemes involved as well as distinct approaches to immigrants.

After federal welfare reform, Hawaii initially continued providing non-immigrant residents with Medicaid. Hawaii did so using state funds and pursuant to the discretion that Congress gave states regarding eligibility for Medicaid. In 2010, following the 2008 economic crisis, Hawaii reduced funding for comprehensive Medicaid benefits because of state budget constraints. Non-immigrant residents were offered less comprehensive Medicaid benefits that did not cover organ and tissue transplants or long-term care services. Korab challenged the constitutionality of this reduction in Medicaid coverage, claiming that it violated the U.S. Constitution by failing to provide him kidney transplant coverage on par with that offered to U.S. citizens.

The court ruled that the state of Hawaii did not violate the U.S. Constitution by offering non-immigrant residents less inclusive Medicaid coverage. Because Congress gave states the authority to decide state-benefit eligibility criteria, the court found that Hawaii's course of action was merely following the direction established by Congress. The court further found that Hawaii had no obligation to fill the gap left by Congress's withdrawal of federal funding for non-immigrant residents.

The U.S. Supreme Court declined to consider the policy and equity issues behind access to Medicaid.

Rule of Law: State budget constraints are a legitimate reason for restricting access to Medicaid.

Ethics Issue: Should foreign citizens who have been granted legal non-immigrant resident status in the United States be eligible to receive access to Medicaid?

Ethics Analysis: This case highlights the disparity in access to health care that arises between non-immigrants, immigrants, and other alien residents in this country. Although undocumented immigrants are unlikely to receive comprehensive health care, disparities in access to health care do not exist only between illegal and legal residents; foreign citizens who have been granted legal resident status in the United States are also subject to disparate determinations for Medicaid coverage.

The situation in this case raises several ethical concerns. Budget constraints always reflect values and, therefore, the matter of ethics must be extended to the process whereby the priorities in state budgets are determined. Because access to Medicaid depends on state budget constraints unrelated to a population's need for access to health care, the right to reduce access highlights the equity concerns that arise when immigrant populations are categorized in the United States. The ethical solution may not be to divest the states of their budgetary power to make autonomous judgments about whether to provide state benefits to immigrant populations; rather, the federal government should issue guidelines to states on how to make fair and equitable decisions in apportioning access to Medicaid. The U.S. Supreme Court's attention to this issue could have been an important step in determining whether, and if so when, disparity in access to health care can be justified, but that opportunity was not realized since it declined to review this case.

Court's Holding and Decision: States may restrict access to Medicaid for foreign citizens who have been granted legal resident status in the United States.

See Cousins, 2014 (discussing this court decision).

Application of the Rights Model

The Rights Model, as illustrated in **FIGURE 1-4**, involves a five-step framework that focuses on respecting life and human dignity.

Step 1: Identify the moral right being upheld or violated and explain why it deserves the status of a legal right. Moral rights are best understood by considering the

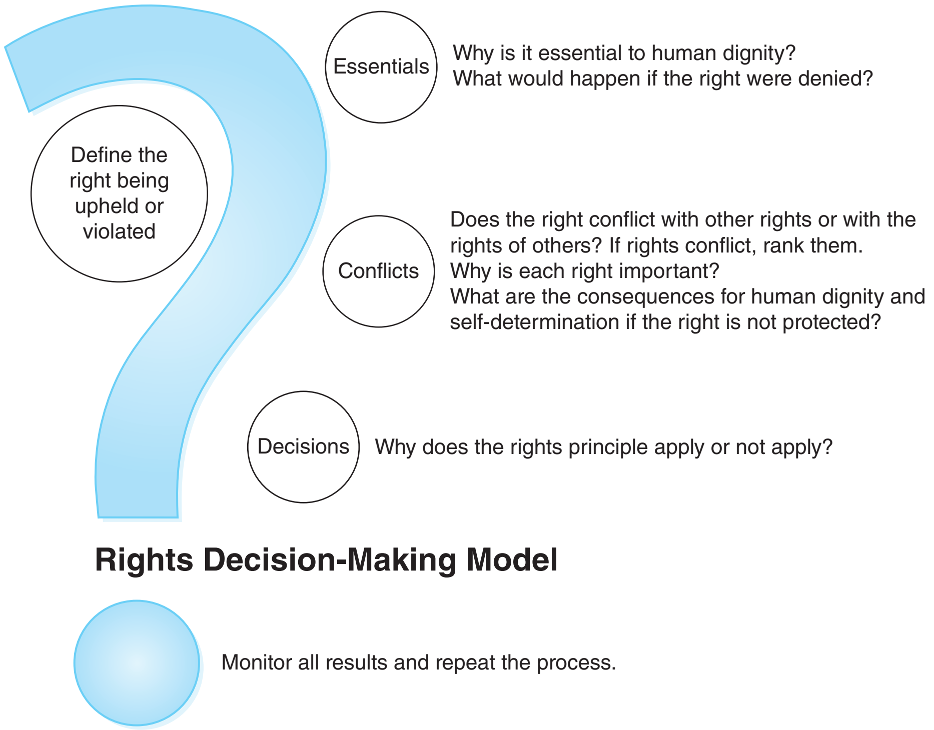


FIGURE 1-4 Rights Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

consequences of people being denied their legal rights. For instance, the health insurance industry is now banned from denying coverage for preexisting health conditions, imposing lifetime caps, or rescinding existing coverage after a person becomes ill. Everyone will now have the benefit of affordable health insurance. Access to health care is no longer a **privilege**, defined as a restricted right or benefit that is not available to everyone. Everyone now has the obligation to purchase health insurance and will have the right to health care.

Step 2: Determine whether the legal right conflicts with the moral rights of others. For instance, does the legal right to affordable health insurance conflict with the nation's ability to assist the least advantaged in purchasing this insurance? Specifically, how will this insurance mandate, along with the entitlement to health care, affect the nation's federal debt? If the federal debt is left unregulated and allowed to freely increase, it will create major financial and fiscal crises in the future, while overburdening U.S. taxpayers tremendously (*see* Wharton, 2010). The moral right to health care is in conflict with the financial cost of care without comprehensive health care reform. In other words, the legal right to affordable coverage conflicts with the tax burden imposed upon everyone, unless patient-centered care and other new forms of health care delivery result in savings as all of the reforms are put into place (CBO, 2011).

Step 3: If the rights conflict, decide which right has precedence. Explain why each right is important and show the consequences for human dignity and self-determination if the right is not protected. People can disagree about which right is more important, as no ranking principle is universally accepted. For instance, the right to have access to affordable health insurance has precedence over the right of the insurance industry to maximize the utility of insurance **risk pools**, which group together individuals with similar health risks to help allocate costs for health care expenses. Because of the intrinsic value of every human being, the well-being of the nation's residents and their right to health care has greater weight than the financial cost of the care for the government subsidies that are required to voluntarily pool dissimilar health risks in order to more evenly share the burden. Likewise, the ability to pay a reasonable cost, or **fair value**, for health care has priority over the assistance provided to access the needed care. *See generally* Rawls, 1971/2005.

Step 4: Make an ethical decision. Decide whether the rights principle does or does not apply and why. If the rights principle applies in this instance, not every U.S. resident will have access to exactly the same health insurance. Although access to basic health insurance will be ensured, there will always be freedom to pursue additional health care based on the ability to pay fair value for that care.

Step 5: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Rights Model

The strength of the Rights Model is that moral rights are a powerful tool for showing respect for life and human dignity. Moral rights have no legal validity, however, unless the intrinsic value in human beings is recognized and enshrined in the law. While most people recognize their own value, not everyone recognizes that others are equal to themselves. Because vulnerable populations have few resources to improve their health care, they are at greater risk for developing health issues and suffering poor health conditions. *See generally* Beauchamp & Childress, 2012. The weakness of the Rights Model is that it is not helpful in most ordinary situations in which people disagree over whether an action is ethical or unethical.

Legal rights, however, sometimes conflict with societal benefits, as well as with other social liberties and privileges. For instance, the absolute natural right of humans to the uninterrupted enjoyment of their health (*see, e.g.*, Blackstone, 1753/2010) sometimes conflicts with the delivery of affordable, high-quality health care, as well as with the **liberty**, or freedom, to pursue one's own dictates in maintaining health insurance coverage. In this case, restrictions on liberty may be ethically justified on the grounds that health insurance coverage is in people's best interests. Solving these conflicts means that some moral rights are sometimes subordinated.

Because there are few universally recognized legal rights (such as the right to access affordable, high-quality health care), people must be vigilant in defending their claims to such rights (*see* Restatement, 1987). Moreover, because of its persuasive power, the Rights Model is regularly applied to situations that are not really serious enough to qualify as a threat to legal rights. *See generally* Beauchamp & Childress, 2012. For instance, while there may be a right to access affordable health insurance for women's reproductive care with mandated coverage for comprehensive prenatal care, should there be a corresponding legal right to mandate access to free contraceptive coverage to prevent unintended pregnancies? A mandate on employers who object to contraception for religious reasons is among the most restrictive means the government could choose to increase access (Rivkin & Whelan, 2012).

Exceptions Model

The Rights Model is often used before the Exceptions Model (Markkula, 2009a). An **exception** claims that in a given situation, an action may be ethical if done by one person but unethical if done by a different person. This is the opposite of claiming that it must be ethical because everyone else is doing it. The Exceptions Model asks what would happen if the individual exception became the ethical principle for everyone.

Application of the Exceptions Model

The Exceptions Model, as illustrated in **FIGURE 1-5**, involves a six-step framework that focuses on how a decision is made.

Step 1: Describe the general and specific ethical issues of the situation. For instance, whether a particular lifesaving treatment protocol would be covered by an insurance plan for a terminally ill patient who has exhausted all other traditional treatment options is a specific ethical issue. Expanded access for patients with a life-threatening or serious disease, but who do not qualify for a clinical trial because of other health problems, age, or other factors, is another specific ethical issue.

Step 2: Determine what would happen if the exception was adopted by others in similar situations. If the exception was adopted by others in similar situations, the exception might become unacceptable for anyone to do because everyone was trying to do it. For instance, current government regulations insist that the public's interest in filtering safe and efficacious medications through clinical trials has a higher priority than the lives of individual patients who are denied access before medications are approved.

Step 3: Decide which exceptions are unacceptable if they became the rule for everyone. For instance, if it is unacceptable to deny investigational medications to patients who have no alternative treatment for life-threatening or serious disease, then

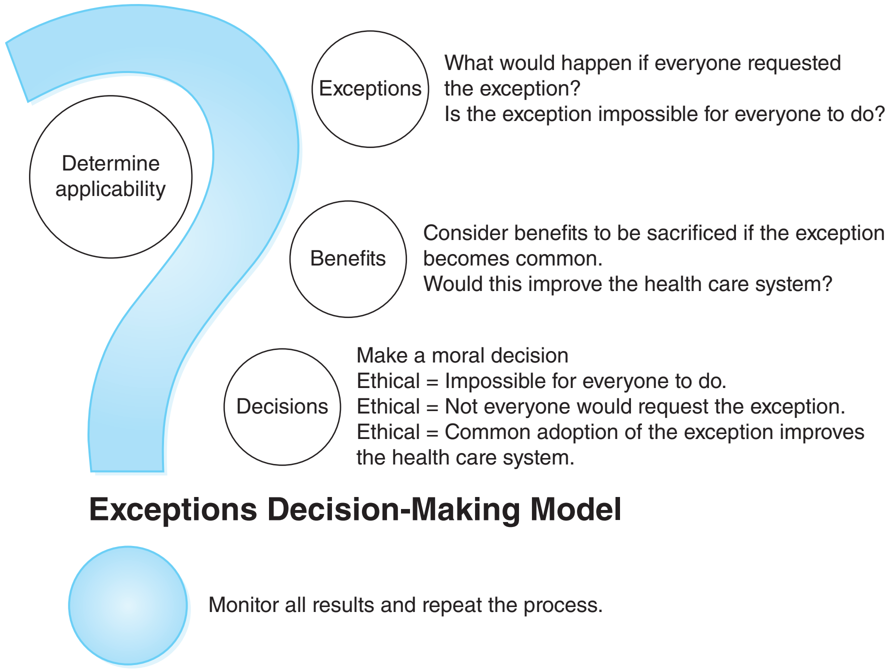


FIGURE 1-5 Exceptions Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

Congress must decide upon a better balance between the risks and benefits of bringing new medications to market.

Step 4: Consider what will have to be sacrificed if the exception becomes common. Determine if this is the kind of health care system that should be created. If this is not the kind of health care system that should be created, in which the exception becomes common, then the exception is not ethical because it is unacceptable for others. For instance, not to follow current government regulations on access to investigational medications would be to make an exception for some patients who do not deserve open access to unapproved medications, since everyone would be considered to have equal access rights. In other words, if access for some patients were allowed before the investigational medications were approved as safe and efficacious, the government would have to allow open access for everyone.

Step 5: Make an ethical decision. If the exception is not practical because everyone would be doing it, then the exception is unethical. Similarly, if common adoption of the exception would create an unacceptable result, then the exception is unethical. The reverse is also true. The exception is ethical if not everyone would be requesting exceptions or if common adoption of the exception is acceptable. For instance, if open access to investigational medications would place unapproved medications in the market that have not been proven to be safe and efficacious, then open access to unapproved medications is unethical. Likewise, if open access to investigational medication would create an unacceptable result, then the exception for patients who have no alternative treatment for life-threatening or serious disease is unethical. On the contrary, to provide investigational medications to patients with no other alternative treatments would be ethical if not everyone would be requesting the unapproved medications.

Step 6: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Exceptions Model

While everyone is equal in regard to certain courses of action, the strength of the Exceptions Model is that it addresses the issue of **free-riders**. Individuals and institutions who take the benefits the ethic of the common good provides, but refuse to do their part to support the common good of their community, are free-riders. The term *free-riders* also refers to the economic problem of people taking advantage of health insurance programs and exploiting the U.S. health care system without due compensation. Certain benefits or exclusions simply cannot be justified for some people, even when no burden is caused, unless the people affected can justify why they deserve to be the exception (Purdy & Siegel, 2012). For instance, why should people over 65 and the disabled be entitled to receive government health insurance if they have the financial resources to purchase affordable private health insurance?

The weakness of the Exceptions Model is that when courses of action are described, ethical issues can be missed, depending on how the situation is being portrayed. Some may portray unacceptable situations differently and give a picture of what may not be the actual situation. For instance, when debating implementation of the individual health insurance mandate (or a requirement that people demonstrate they are covered so they will not be a burden on society if they become seriously ill or injured), the alternative for people who refuse to obtain affordable coverage is for them to choose to die in their own circumstances. In this instance, society lets the uninsured die on their own if they refuse to use their own financial resources to secure affordable coverage and they face a time and situation when and where they choose not to pay for their own health care.

Choices Model

Many controversies center on choosing among moral rights. A moral right flows from human dignity; moral rights are universally accepted by society to be legitimate, and they are near-universal in that they apply to everyone in similar situations. For instance, if society agrees there is a moral right to access health care, then people may be justified in their claim to the right to be provided with affordable health insurance. The **justification** of a claim is dependent on some ethical principle acknowledged and accepted not just by the claimant, but also by society in general. These ethical principles may be as specific as the Universal Declaration of Human Rights (United Nations, 1949) or as general as the legal right to access affordable health insurance. Moral rights are justified by acknowledged ethical principles which are not necessarily clearly codified in law, such as the moral right to access health care.

Negative and Positive Moral Rights

One of the most influential interpretations of moral rights is based on the work of Immanuel Kant, who maintained that everyone has a human dignity that must be respected (Kant, 1781/2009). This human dignity makes it wrong to harm others, such as the denial of health insurance for preexisting health conditions that are outside one's direct control with no modifiable risk factors.

Ethical principles are often used to justify both a moral right to access health care and the privileges related to this right to care. These related privileges are grouped into negative and positive moral rights. A positive moral right is to permit or oblige action; for instance, it is the right to be treated in an emergency situation. A negative moral right is to permit or oblige inaction; for instance, it is the right not to be treated without one's consent.

Negative moral rights, such as the moral right not to be denied access to health care, are moral rights that protect the legal right to choose what health insurance coverage to purchase. These moral rights are called negative rights because such moral rights are claims that impose a negative duty. For instance, the moral right to access health care imposes a duty on the health insurance industry to provide affordable insurance plans. Consumers of health care have a negative right against the health insurance industry in that the health insurance industry is prohibited from acting in a manner that hinders participation in the market.

A moral right to access health care, however, is worthless if people are unable to afford health insurance coverage for their care. A moral right to access health care, then, implies that everyone has a fundamental right to what is necessary to secure a minimum level of health and well-being. **Positive moral rights**, therefore, are rights that provide something that people need to secure their well-being, such as a right to access medical treatments to treat their illnesses. Positive moral rights impose duties on society, such as the ethical obligation to actively assist people to have or to do something. The moral right to access health care, therefore, imposes a social duty to provide people with health insurance to purchase health care. Respecting positive moral rights thus requires more than merely not acting against people's rights or interfering with them. Positive moral rights impose the ethical obligation to assist the welfare of vulnerable populations who are in need of assistance. *See generally* Beauchamp & Childress, 2012.

Conflicts between Moral and Legal Rights

Whenever there is a conflict between moral rights and legal rights, life and human dignity must be respected (Keyes, 2011). Ethical actions must enhance people's basic well-being (Dolan & Peasgood, 2008). How an action might affect legal rights must be considered.

Actions are unethical to the extent that they violate people's moral rights (Peery, 2008). For instance, manipulation of information about implementation of health care reform efforts undermines the moral right to truth and honesty (*see* Wharton, 2010).

When moral and legal rights come into conflict, decisions must be made about which right has priority (Keyes, 2011). While everyone may be entitled to access health care, the moral right to access may have to be balanced against the rights of vulnerable populations and the rights of the nation's taxpayers. How are federal and state governments going to pay for the health care of the uninsured and underinsured? The competing interests at stake have to be examined to answer this question. A judgment should be reached as to whether the interests of society or the interests of vulnerable populations are more vital for ensuring that life and human dignity are respected. For instance, economic costs are mutually exclusive to equality of access to health care (*see* Zamir & Medina, 2008).

Moral rights have a central role in health care ethics. Attention to moral rights ensures that the well-being of vulnerable populations is protected when society threatens that well-being (Rawls, 1971/2005). If vulnerable populations have a moral right, then it is wrong to interfere with that moral right even if society benefits by lower health care costs from such interference.

But moral rights are not the sole consideration in health care ethics. In some situations, the social burdens or the injustices that would result from respecting a moral right are too great to be lawful, and that moral right may have to be limited by the law (*see* Calnan, 2010). Moreover, an emphasis on moral rights is not just a matter of not interfering with others. Relying exclusively on a moral rights model tends to favor vulnerable people at the expense of society.

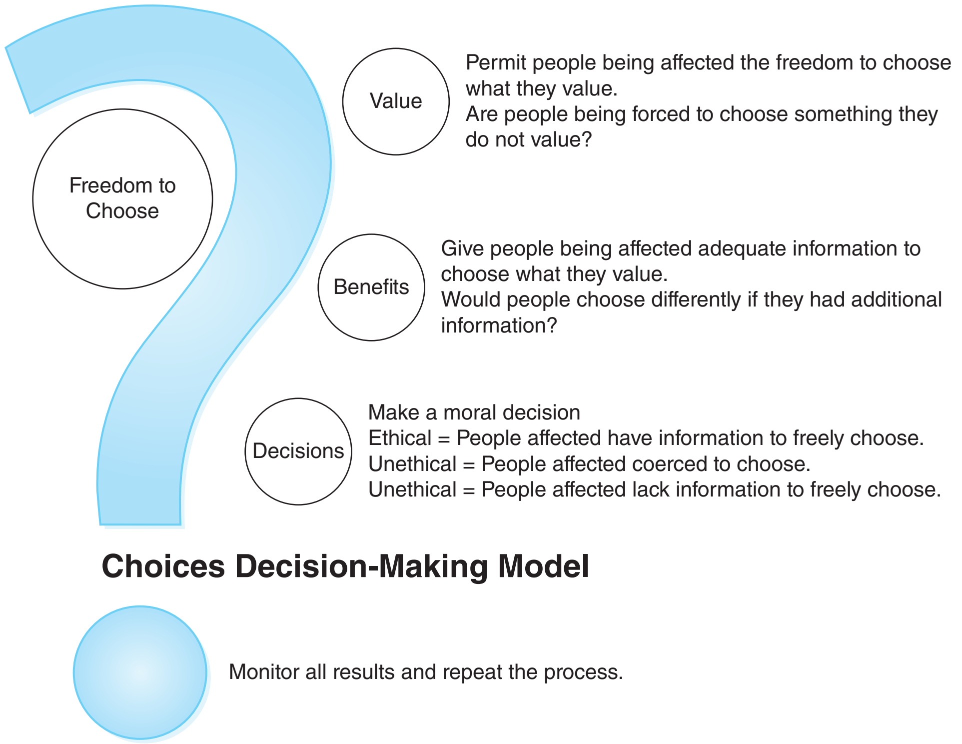
Things have value because people value them. All people deserve equal respect (Keyes, 2011). What one person values has no claim to be more valuable than what others may value (Zamir & Medina, 2008). People must be free; their choices cannot be obstructed when making their own choices based on what they value. Government can only choose for people in special circumstances that are justified (Keyes, 2011), such as when national health care reform is the law or health insurance contracts are forced to provide basic coverage by regulation. Then traditional limitations and business conventions may have to change because of this new set of legal commitments.

Application of the Choices Model

The Choices Model, as illustrated in **FIGURE 1-6**, involves four steps with a focus on how a decision is made. Respect for the individual is a priority when the Choices Model is used.

Step 1: Give everyone the freedom to choose what they value. People are not free to make their own choices if they are being forced to choose something they do not value. For instance, prior choices, such as existing insurance laws and regulations or health insurance contracts, may limit people's freedom to choose what they value most in health care.

Step 2: Give everyone the information necessary to know what they value in the situation being considered. For instance, no longer is the starting point in health care reform about whether to expand coverage of health care services. The debate going forward is how to do it and how to make it affordable. People must have access to all the information necessary to evaluate the ways in which the nation can deliver health care to all U.S. residents. Then they can determine which alternative is most in line with their values. Practical determinations must be made about whether the information is adequate or whether some people would choose differently if they had additional information. *See generally* Wharton, 2010.



Permit people being affected the freedom to choose what they value.
Are people being forced to choose something they do not value?

Give people being affected adequate information to choose what they value.
Would people choose differently if they had additional information?

Make a moral decision
Ethical = People affected have information to freely choose.
Unethical = People affected coerced to choose.
Unethical = People affected lack information to freely choose.

Monitor all results and repeat the process.

FIGURE 1-6 Choices Model for Decision-Making

Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

Step 3: Make an ethical decision. Decide whether the action or situation gives everyone the freedom and the information to choose what they value. For instance, while all U.S. residents have a legal right to purchase basic coverage (public and private), everyone must have the freedom to decide what health risks they are financially willing to assume themselves as well as what level of additional health insurance coverage they wish to purchase to insure that they have access to advanced care or access to highly specialized physicians.

Step 4: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Choices Model

The Choices Model reflects one of the fundamental ways of showing respect for the equality of other humans and respecting everyone's ability to determine the course of their own lives by making choices based on what they think is valuable. Many ethical violations involve denying people information or limiting their freedom to choose. For instance, one of the most controversial aspects of health care reform is the mandate that everyone be required to obtain a basic health insurance plan as defined by the federal government. While there is no uniform definition of what basic coverage should be required, one side views the minimum coverage provision (also known as the individual mandate or the minimum essential coverage requirement) as a denial of the freedom to choose whether to purchase an economic product. The other side claims that the minimum coverage provision is essential to creating effective health insurance markets. The counterargument, however, is that in the absence of a mandate, 33 million people have already made an economic decision to forgo health insurance coverage and attempt to self-insure, which decreases the freedom of choice of society and the insured by forcing them to pay for free-riders, since health care is a service that nearly everyone will utilize at some point in their lifetime, whether or not they are insured, and sometimes whether or not they choose to. Access to health care is a major national problem that requires a national solution, and the solution can work only under conditions in which everyone has health insurance (Baker, 2011).

At the same time, this model can reinforce a simplistic view of decision-making, implying that people are clear about what they value and make rational choices based on those values. In this instance, most people cannot rationally determine their health risks when choosing health insurance coverage, since they cannot accurately predict or calculate their future health care expenses. The concept of freedom is the subject of much disagreement. If someone chooses to obtain health insurance coverage, but cannot afford the comprehensive insurance that they need, their freedom to choose may be limited. Moreover, the line between persuasion and coercion can be difficult to draw. When does a tax for being uninsured become coercive? When does making something look attractive take away from a person's freedom to reject it? For instance, when do government mandates take away the freedom to reject coverage for specified health care services?

Justice Model

No concept has been more consistently linked to health care ethics than the concept of justice. From Plato to Rawls, every major philosopher has held that justice is the core of ethics (Madsen, 2008). Justice means giving people their appropriate due, or what they are properly owed. Although the terms *justice* and *fairness* are closely related and often used interchangeably, they are distinct. **Justice** is used with reference to principles of rightness (Lanshe, 2009); **fairness** refers to objective judgments of the decision-making process that are not specific to particular situations or individuals (Rawls, 1971/2005). For instance, justice mandates that all U.S. residents are entitled to a minimum level of primary health care (including medications) to treat the most common injuries and diseases. This level of care should be universally accessible and affordable to all U.S. residents so they have the unfettered opportunity to achieve and maintain high levels of health which are necessary for a lifetime of well-being and human dignity. Fairness does not, however, entitle everyone to the most technologically advanced care or unfettered access to highly specialized physicians.

Both terms encompass notions of what is morally right or what is expected. When differences arise over what or how benefits and burdens should be distributed, questions of justice inevitably arise. Justice derives its relevance from the conflicts of moral and legal rights that are created when resources are limited and differences exist over who should get what. When such conflicts arise, reasonable principles of ethics are needed so that everyone can accept judgments for determining what people deserve.

Foundations of Justice

The foundations of justice can be traced to the notions of social stability, equality, interdependence, and human dignity (*see* Cohn, 2011). The stability of society depends upon the extent to which the members of that society feel that they are being treated justly (Rawls, 1971/2005). When some members of society are subject to unequal treatment, the foundation has been laid for public unrest, disturbances, and social strife. Members of society are interdependent, and they will retain their voluntary social unity only to the extent that their institutions and their laws are just.

Principles of Justice

The most fundamental principle of justice was defined by Aristotle more than 2,000 years ago: namely, the principle that equals should be treated equally and like things treated alike (Aristotle, 322 BC/2012). For instance, it is necessary to distinguish women from men when addressing health care issues that affect women. While it has been almost 50 years since the U.S. Supreme Court stated that women have the right to access contraception as easily as men have the right to access condoms, many American women, half a century later, still do not have easy or affordable access to birth control. In a just society, the reproductive needs of women would be met and women would have comprehensive access to reproductive care. Principles of justice may require that the root causes of gender health disparities be effectively addressed.

If everyone is equal, that is, has equal value as a human being, then everyone has an equal claim to share the nation's health care resources. By default, equal resources may be distributed to everyone since everyone has equal claims. But, as illustrated in **FEATURE BOX 1-5**, there are circumstances in which everyone does not have an equal claim when resources are limited; a fair distribution in such situations depends on the reasons for their equality or inequality.

FEATURE BOX 1-5

Some Justifiable Reasons for Inequality

- *Accomplishments*: some people simply achieve more than others, so it is just when someone who attains impressive achievements and success is given resources that are not distributed to others who accomplish little; some people can pay for innovative medical products or services that others cannot.
- *Contracts*: prior agreements may exist about how distribution of resources should occur (for instance, tax and welfare legislation), so it is just when the government gives benefits to those who are poor or financially distressed that it does not provide to those at the top of the economic pyramid.
- *Contributions*: some people plainly contribute more to society than others, so it is just when those who make a greater contribution receive more benefits than others.
- *Effort*: some people just work more efficiently or their work products are deemed more valuable by society, so it is just when those who exert more effort receive more benefits.
- *Need*: some vulnerable populations have a justifiable need to receive more resources than others, so it is just when those who have more need for services receive more assistance in securing them.
- *Vulnerability status*: some people may have claims because they are part of a vulnerable population (such as sick children and the disabled), so it is just when they receive more medical products or services than are given to healthy people.
- *Seniority*: some may have applied first for distribution of resources, so it is just when the transplant recipient who is first on the wait list is given first choice over another subsequent patient with a similar level of need when an organ is procured.

— Sources: Beauchamp & Childress, 2012; Markkula, 2009a.

While some criteria justify differential treatment, there are also criteria that are not justifiable grounds for giving people different treatment. For instance, is it fair for adults with preventable health conditions, attributable to smoking and being overweight, to be charged the same health insurance premiums as adults with healthy lifestyles? There are also criteria that do justify treating people differently. For instance, what is a fair level of compensation for patients who are harmed by medical errors, unneeded medical treatments, or defective medical products, versus patients who are harmed because they did not follow their recommended courses of treatment?

Different Kinds of Justice

There are different philosophies of justice. **Distributive justice** refers to the extent to which society's institutions ensure that benefits and burdens are distributed among society's members in ways that are fair and just. When the institutions of a society distribute benefits or burdens in unjust ways, there is a strong presumption that those institutions should be changed. A second kind of justice is compensatory justice. **Compensatory justice** refers to the extent to which people are fairly compensated for their injuries by those who have injured them; just compensation is proportional to the loss inflicted on a person. This is precisely the kind of justice that is at stake in trying to hold gun manufacturers, distributors, and dealers liable for health care burdens arising from crimes involving illegal guns (*see, e.g.*, LCAV, 2011).

Application of the Justice Model

The Justice Model, as illustrated in **FIGURE 1-7**, involves a five-step framework that is used in almost all decisions involving distribution of limited resources.

Step 1: Define the distribution of resources by determining who is getting the benefits and burdens in the situation. Should those who get benefits also share burdens?

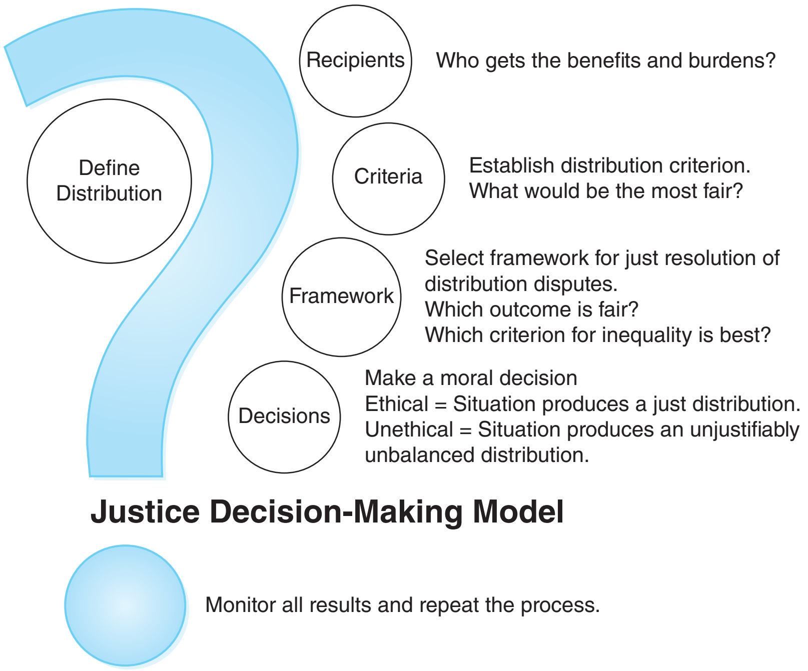


FIGURE 1-7 Justice Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009.

Step 2: Once the distribution is known, establish which criterion for distribution would be the most fair and justify why it would be most fair in the situation.

Step 3: Select a framework to decide what is fair if disagreement persists over which outcome is fair or over which criterion for inequality is best in the situation, then choose a framework to decide what is fair.

Step 4: Make an ethical decision. Decide whether an action will produce a fair distribution and why.

Step 5: Monitor the results of the decision and repeat the process all over again as changes occur.

Strengths and Limitations of the Justice Model

The greatest strength of the Justice Model is its broad focus on the wide-ranging problem of adapting health care decisions to respond to the needs and interests of all **stakeholders** affected. This approach to health care asks everyone affected—government, academics, patients, and the health care industry—to address and balance the multiple claims of shared interests and concerns.

While research shows justice to be one of the most fundamental ethical instincts in humans, the weakness of the model is that there is no single criterion for a fair distribution, so the Justice Model is always open to disagreement among ethically minded people. That is, although the Justice Model provides assurances that its distribution of resources is necessary to protect the human rights of vulnerable populations, at the same time, distributions that are fair can improperly violate the human rights of those upon whom such decisions are imposed (*see* Rawls, 2001).

For instance, when half the pregnancies in the United States are unintended, the nation's policies on reproductive care are not responding to women's needs or the interests of many of the children born in the United States. Because there is no single criterion for defining when human life begins, there is no agreement upon the ethics of contraception. Mandates to provide basic contraception coverage can improperly violate the religious rights of those upon whom such decisions are imposed, even though at the same time, the Justice Model provides that affordable access to contraception is necessary to protect the reproductive rights of women, and arguably those of men as well.

Common Good Model

Being able to live together in society involves common burdens and benefits that are important to the welfare of everyone. For a society to be sustainable, the burdens and benefits must function together to achieve the **common good**. In other words, the common good is achieved when the burdens and benefits of life function together to achieve a sustainable society. In this instance, it includes the things Americans commit to do as a society that benefit everyone.

Although the common good is often associated with the philosophy of utilitarianism, the Utility Model focuses on benefits for the people affected by a decision, whereas the Common Good Model considers more than just those affected. Since everyone has access to the common benefits, society has the ethical obligation to accept the burdens of establishing and maintaining the common benefits.

While the common good has a critical place in current discussions of health care reform, the ethic originated more than 2,500 years ago in the writings of Confucius, Epictetus, Plato, and Aristotle. They defined the *common good* as certain general conditions that exist equally to everyone's advantage. The common good ethic, then, is having a U.S. health care system work in a manner that benefits everyone. Because such a health care system could have a powerful impact on the well-being of all members of American society, it is no surprise that its reform is linked to how well the system functions.

The ethic of the common good in health care does not just happen by coincidence. Establishing and maintaining common benefits and burdens requires the cooperative efforts of many people. But these efforts pay off, for the common resources of the nation are greater than the individual resources of any one provider or health care system. When all members of society have access to health care, no one can be easily excluded.

Societal Obstacles to Acceptance of the Common Good

Although everyone could benefit from the ethic of the common good, not everyone willingly responds to the need to cooperate to establish and maintain common benefits; a number of obstacles hinder American society from successfully doing so.

Pluralism

The very idea of the common good is hard to define in a **pluralistic society** like the United States, where cultural differences are encouraged and political and economic powers are shared by different nationalities and minorities. The inscription on U.S. coins, *e pluribus unum* (out of many, one), reflects the nation's pride in being a melting pot of different nationalities and minorities; the United States has always had an underlying and unifying national consensus about standards of justice and what constitutes right and wrong.

Pluralism, that underlying and unifying national consensus about standards of fairness and justice, has itself, however, come under attack in the recent health care reforms. Different people have different ideas about what is worthwhile in health care or what constitutes the benefits needed. Others disagree about how the burdens should be distributed across society. Given these differences in values and what constitutes right and wrong, it is almost impossible, but not out of the question, to agree on health care system reforms that everyone will support.

Relative Values

Even if everyone agreed upon what was valued, there would be disagreements about the relative values of health care reform. While everyone might agree, for instance, that access to affordable health care should be part of the common benefits, some want to focus on the nation's investment in health information technology, others want to focus on evidence-based medicine, and still others will claim that any major reform is unnecessary. Such disagreements undercut the nation's ability to evoke a sustained and widespread commitment to the ethic of the common good. In the face of such pluralism, efforts to bring about the common good lead to adopting or promoting the views of some, while excluding others, violating the principle of treating people equally. Moreover, any reform efforts force everyone to support some specific notion of the common good, violating the freedom of those who do not share in this ideal.

Free-Riders

Another obstacle encountered by proponents of the ethic of the common good is the free-rider issue. The common benefits are available to everyone, including those who choose not to do their part to maintain the common good. Individuals can become free-riders by taking the benefits the ethic of the common good provides while refusing to do their part to support the common benefits. Government health insurance, for instance, is one of the common benefits to which everyone over age 65 is entitled. Many, however, are reluctant to do their share in managing this consumption of health care. When up to one-half of the medical treatments received are not evidence-based and do not improve health (*see, e.g.*, IOM, 2009), the free-riders are destroying the common good, including that of patients and the health care providers and health insurers who pay for the treatments (*see* Purdy & Siegel, 2012; Todd, 2011). The national reluctance to support efforts to control government health insurance costs has helped lead to the system's near collapse.

Individualism

Attempts to promote the ethic of the common good are affected by individualism (Berman, 2011). Historical traditions place a high value on individual freedom, on personal rights, and on allowing people to act independently (*see* Mariner, 2009). American culture views society as comprised of separate independent individuals who are free to pursue their own individual goals and interests without interference from others. In this individualistic culture it is difficult to convince people that they should sacrifice some of their freedom and some of their self-interest for the sake of the common good.

Unequal Sharing of Burdens

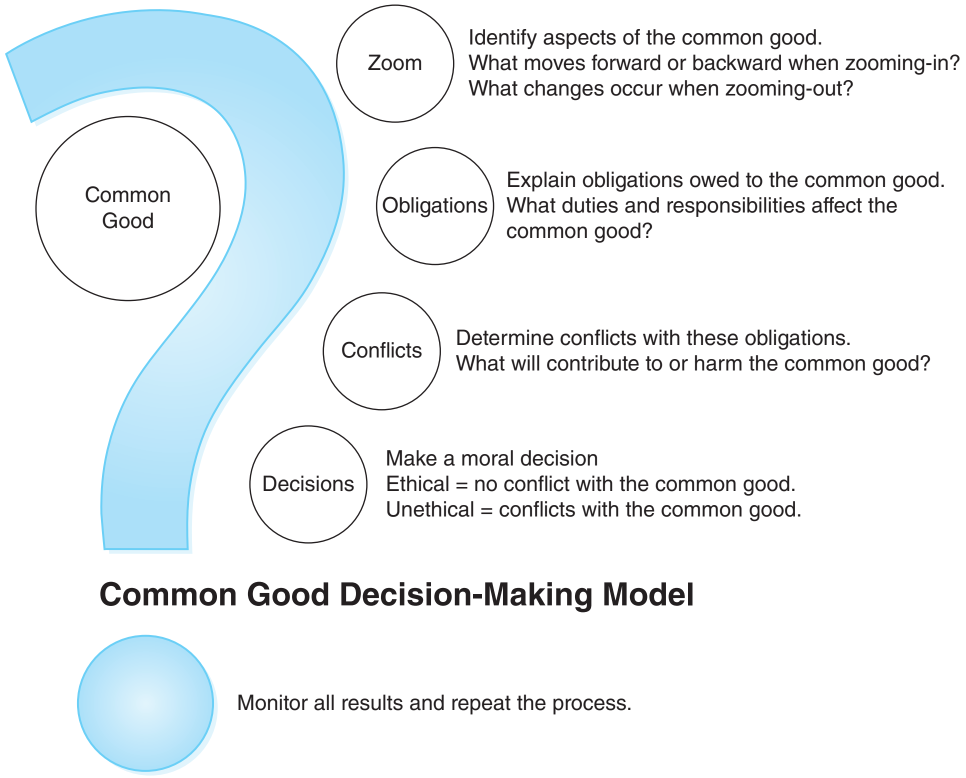
Appeals to the ethic of the common good confront the problem of an unequal sharing of burdens. Maintaining the common good often requires that some people bear burdens that are much greater than those borne by others. For instance, making the health care system more affordable and equitable may require mandating that everyone purchase health insurance. The health insurance industry may be forced to change its approach to doing business from one of mitigating risk to that of attempting to eliminate risk. It may be unjust to force people and whole industries to carry unequal burdens for the sake of the ethic of the common good. The prospect of having to carry unequal burdens leads some individuals and industries to resist any attempts to secure the common good.

Application of the Common Good Model

Whereas the Utility Model focuses on the total benefits and burdens produced, the Common Good Model focuses on whether the action or situation contributes to or burdens a particular aspect of the common good. The Common Good Model, as illustrated in **FIGURE 1-8**, involves six steps with a focus on how decisions benefit everyone. Whether applied to a defined group or applied in general, society is the priority when the Common Good Model is used.

Step 1: Identify what specific aspects of the common good are involved by zooming in and then zooming out. For instance, it is important for the biotechnology industry to zoom in on the details underlying its core medical technologies. The industry also needs to zoom out, to define how society will pay for the advanced medical technologies that biotechnology is developing.

Step 2: Define which specific parts of the common good that depend on the current situation for their functioning could move forward or backward by a change. Some actions will strengthen the common good and others will weaken it. In this instance, the common benefits serve among other things, the biotechnology industry, the health care delivery systems and providers who use the products of biotechnology, the legal and the regulatory systems that are necessary for



Identify aspects of the common good.
What moves forward or backward when zooming-in?
What changes occur when zooming-out?

Explain obligations owed to the common good.
What duties and responsibilities affect the common good?

Determine conflicts with these obligations.
What will contribute to or harm the common good?

Make a moral decision
Ethical = no conflict with the common good.
Unethical = conflicts with the common good.

Common Good Decision-Making Model

Monitor all results and repeat the process.

FIGURE 1-8 Common Good Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009.

the production and marketing of biotech products, as well as the technology that makes all these activities possible. The common benefits ethic also includes the ideologies used to maintain different aspects of the common good.

Step 3: Explain the ethical obligation to promote and protect particular aspects of the common good. For instance, define the ethical obligations that the biotechnology industry or parts of it have to maintain because they benefit from them. In this case, if the biotechnology industry benefits from its commercial models and regulatory framework, there is an ethical obligation to promote these particular aspects of the common benefits or at least not to burden them. The best elements of the U.S. biotechnology industry should be protected, especially its scientifically advanced institutions with their elaborate systems of specialized knowledge, advanced technologies, and rules of conduct.

Step 4: Determine whether the proposed action or situation conflicts with this ethical obligation. Laws and regulations must strengthen the common benefits and protect aspects of them from risks. For instance, biotechnology executives might recognize that even though they may charge hundreds of thousands of dollars for their patented products, maintaining trust in the biotechnology industry may require that they modify their pricing structure. Maximizing the effects of the law means that lobbying for their interest group has to be more restrained; or that maintaining the courts as an efficient problem resolution mechanism requires that, even though the deep pockets of biotechnology companies enable them to litigate patent lawsuits indefinitely, they should not do so.

Step 5: Make an ethical decision. Determine whether the action or situation conflicts with the ethical obligation to contribute to the common good.

Step 6: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Common Good Model

The Common Good Model provides an important reality check. No matter how much someone contributes to their own success, the model reminds them that society also contributes and that existing institutions and ideologies enable them to carry on their activities. The ethic of the common good is a challenge for all Americans to view themselves as members of the same society, while respecting and valuing their individual right to choose the type of health care they want.

There is a great deal of disagreement over what constitutes the common good and over relative values when ideals conflict. Moreover, the Common Good Model runs contrary to a long-standing American tradition of individualism and the pursuit of self-interest, so it may stir up immediate resistance that could distract from the ethical issues to be resolved. Obstacles to the ethic of the common good highlight the broader question concerning the kind of health care system the nation wants and how this can be best achieved.

Virtue Model

The kind of person health care professionals choose to be and the kind of health care system they decide to work for are as important as their actions on the job. Character and work culture are represented and influenced both by how health care professionals act and by what they aspire to be. To focus only, as the other decision-making models do, on how to judge whether actions and situations are ethical or unethical overlooks an important aspect of health care ethics. Most people in the health care industry aspire to have **virtues**, or habits of acting in certain ways that correspond to their core values. Compassion, courage, diligence, education, fairness, generosity, honesty, integrity, self-control, and tolerance are virtues that health care professionals, and the health care industry in general, aspire to acquire. If someone knows who they are and who they aspire to be, they can decide how to act by considering whether an action is something that would be done by the kind of person they want to be. People's futures are often shaped by their actions. The same can be said for organizations. *See generally* Beauchamp & Childress, 2012; Markkula, 2009a.

Application of the Virtue Model

The Virtue Model, as illustrated in **FIGURE 1-9**, is comprised of a five-step framework that focuses primarily on the kind of person someone aspires to be and secondarily on judging their individual actions.

Step 1: Determine whether the situation helps you to or hinders you from becoming the type of professional you most want to be.

Step 2: Establish whether the situation corresponds to the industry's reputation or vision of what it would like to be. This image is explained in health care providers' mission and vision statements, the core values, and the ethics code.

Step 3: Ascertain whether the situation improves the delivery of high-quality, equitable health care.

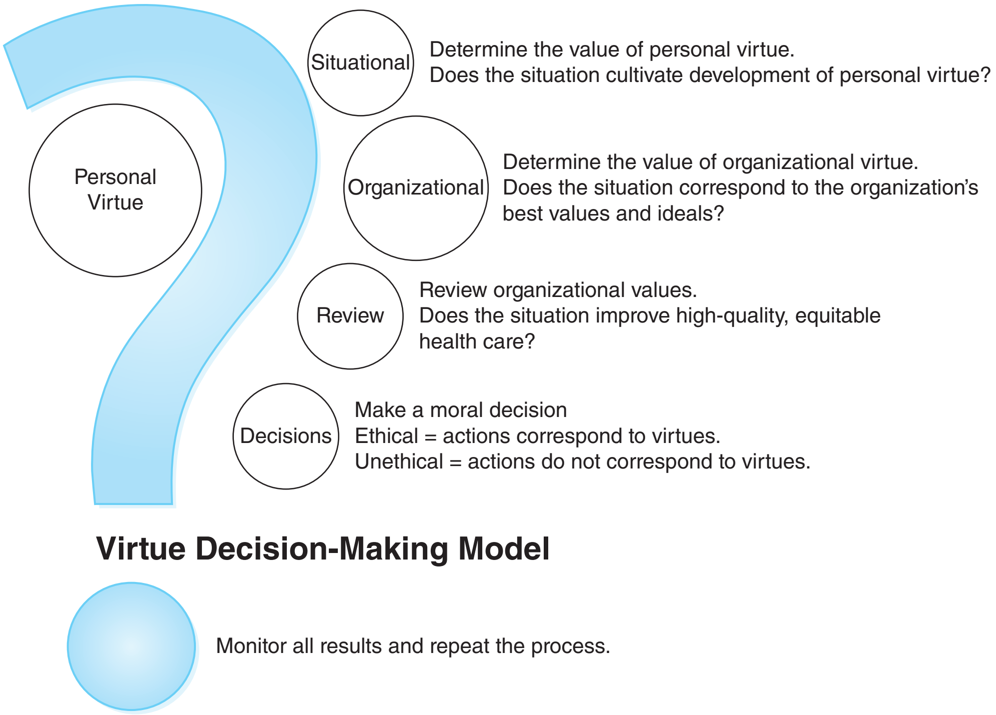


FIGURE 1-9 Virtue Decision-Making Model

Sources: Beauchamp & Childress, 2012; Markkula, 2009.

Step 4: Make an ethical decision. Actions that correspond to the virtues most people in the health care industry want to be associated with are ethical.

Step 5: Monitor the results of the decision and repeat the process as changes occur.

Strengths and Limitations of the Virtue Model

The Virtue Model focuses not only on individual actions but also on the larger questions of what kind of health care professional it is beneficial to be and on the role that one's environment plays in setting ideals. The Virtue Model emphasizes that being an ethical person is not just a matter of following ethical principles, but also involves developing habits of acting in ways that society thinks people should act. Most people do not act in a consistent manner across different situations (*see* Mitchell, 2006). This does not mean that people do not have dispositions to act a certain way; rather, it suggests that consistent virtue may be very hard to develop because situational factors greatly affect people's decisions and conduct. *See generally* Moffit, 2002.

Comparing Conclusions from the Different Decision-Making Models

The immense complexity of the U.S. health care system requires that portfolios of decision-making models be available for making ethical decisions. Use of multiple models increases the level of confidence in the rightness of decisions, especially when a situation is complicated, or a decision makes a significant difference to people or an organization.

In health care ethics, it is important to be confident but never certain. Using several models increases the chance of generating new insights into why some actions are unethical or wrong. Having different perspectives on why something is wrong can be helpful in designing alternatives that produce the benefits that made the action attractive in the first place but without the qualities that made it wrong (Beauchamp & Childress, 2012).

Balancing Options Using Several Decision-Making Models

Different models highlight the limitations of other decision-making models, as illustrated in **FEATURE BOX 1-6**. Often, the use of multiple models in making controversial or complicated decisions balances their strengths against their limitations.

Resolving Conflicts in Judgment

For most situations involving ethical issues, the decision-making models yield the same judgment (*see, e.g.*, Hamilton, 2009); the only difference is their rationale as to why certain actions are unethical. In some situations, however, the models result in different ethical judgments. As illustrated in **FEATURE BOX 1-7**, when this happens and the conflicts cannot be resolved, one might ask what the correct course of action is.

FEATURE BOX 1-6

Contrast of Different Models for Decision-Making

- *Social Media Model* helps determine whether the application of any other models is necessary.
- *Choices* and *Rights Models* focus attention on the importance of respect for the human dignity of individual patients and health care professionals, whereas the *Exceptions* and *Utility Models* focus more on outcomes.
- *Exceptions* and *Choices Models* focus on how decisions are made, whereas the *Utility Model* is concerned with results as opposed to the conditions or rules the action can meet.
- *Virtue Model* focuses primarily on the kind of health care professional someone aspires to be and secondarily on judging individual actions.
- *Utility Model* focuses on the benefits or total net effects for the people affected by a decision, whereas the *Common Good Model* considers more than just those affected.

— Sources: Beauchamp & Childress, 2012; Hamilton, 2009.

FEATURE BOX 1-7

When Ethical Conflicts Cannot Be Resolved

- If the actions being considered are ethical according to some of the decision-making models and unethical according to others, a judgment must be made. The best course of action should minimize ethical conflicts; in other words, it should pass the challenge that the Social Media Model presents.
- Health care professionals sometimes disagree about the ethical thing to do. These disagreements can be expected. At least, however, the ethics of the actions or situation are being questioned and pondered so as to determine how best to act and to ensure that a particular course of action is not entirely unethical.
- Balancing the various decision-making models is part of developing the practical management skills health care professionals need to cultivate. Sometimes, however, a judgment must simply be made. Maintaining the common good may require moderating or even foregoing the exceptions, choices, rights, justice, or virtue claims. Alternatively, strong considerations that are raised by the Exceptions, Choices, Rights, Justice, Utility, or Virtue Models may override the claims of the Common Good Model.

— Source: Beauchamp & Childress, 2012.

Conflicts in ethical judgments are at the apex of a steep and slippery slope in health care ethics. When making these controversial decisions, intuition does not always guarantee that the judgments reached are the most ethical. Judgments often become clouded in these situations. To overcome this limitation, discussions should be held until consensus is reached about the best balance among the models for the situation.

Problematic Moral Clarity—Universal Values and Principles

This text seeks moral clarity on universal values and principles as they pertain to the *American ethic of health care*. Decisions should not and cannot be divorced from values. This aim will not result in a definitive statement, but rather, a question: What actions will best reflect the universal values and principles that have served America so well for the past two centuries? Above all, everyone must become more fully aware of what they say they believe in and put a priority not on projecting their values and principles, but upon reflecting them more deeply, accurately, and consistently.

ETHICAL OR UNETHICAL DECISION

Individual Health Insurance Mandate

Ethics Issues: *Should everyone share broadly in the risks and costs of poor health? And if so, what decision-making models could help reach this conclusion?*

Ethics Analysis: Yes, everyone has an ethical obligation to share in the risks and costs of poor health under the Rights and Justice Models. Everyone should be required to participate in and become a member of one of the nation's risk pools, where the risks and costs of poor health are pooled broadly and where access to care is provided on the basis of medical need. People may be required to contribute toward financing the nation's health care costs based on their ability to pay. Everyone may freely select which risk pool to participate in to cover their risks of poor health by entering into a contract relationship with a health insurer; public insurance plans (Medicaid) and individual subsidies will be available for anyone unable to pay for private insurance.

Ethics Analysis: No, people should not be required to share the risks and costs of poor health under the Common Good Model. Health insurance is not like social insurance; society has no ethical obligation to cover everyone's risks of poor health. People should not be required to engage in economic activity by being required to enter into a contract relationship with a health insurer. Congress should not require people, who are not doing anything to help finance the nation's health care costs, to do something. Access to health care should be tied to the ability to pay.

Court's Holding and Decision: Case dismissed. While Virginia claimed that Congress lacked authority to enact the minimum coverage provision to maintain health insurance, the federal court of appeals held that Virginia lacked standing to litigate this issue. Virginia lacked the sovereign authority to nullify federal law. Virginia could not litigate in federal court to protect its citizens from operation of the nation's health care reform.

— *Commonwealth of Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253 (U.S. Court of Appeals for the 4th Circuit 2011), *cert. denied*, 133 S.Ct. 59 (U.S. Supreme Court 2012). *See* Adler & Cannon, 2013; Ben-Asher, 2012; Howard, 2012; Huberfeld, 2011; Kapp, 2012; Leonard, 2012; McCullough, 2013; Morgan & Hale, 2012; Record, 2012; Sachs, 2012; Siegel, 2012; Somin, 2012; Thomson, 2012; Willis & Chung, 2012 (discussing this court decision). *See also Mead v. Holder*, 766 F.Supp.2d 16 (U.S. District Court for the District of Columbia 2011), *affirmed*, *Seven-Sky v. Holder*, 661 F.3d 1 (U.S. Court of Appeals for the D.C. Circuit 2011), *cert. denied*, 133 S.Ct. 63 (U.S. Supreme Court 2012); *Florida, et al. v. U.S. Department of Health and Human Services*, 648 F.3d 1235 (U.S. Court of Appeals for the 11th Circuit 2011), *affirmed in part and reversed in part*, 132 S.Ct. 2566 (U.S. Supreme Court 2012); *Liberty University, et al. v. Geithner, et al.*, 671 F.3d 391 (U.S. Court of Appeals for the 4th Circuit 2011), *cert. denied*, 133 S.Ct. 60 (U.S. Supreme Court 2012); *Thomas More Law Center v. Obama*, 651 F.3d 529 (U.S. Court of Appeals for the 6th Circuit 2011), *cert. denied*, 133 S.Ct. 61 (U.S. Supreme Court 2012).

CHAPTER SUMMARY

- The health care industry is seeking firm foundations, reasoned principles of ethics, and helpful guidelines to assist it in making ethical decisions.
- Ethical decision-making generally uses an eight-step framework: recognize the ethical issues; gather all the relevant facts; survey decision-making models; evaluate the relevance of each model for the situation; apply the appropriate model(s) to the situation; make decisions based on the model(s); monitor the results of those decisions; monitor progress and repeat the process as changes occur.
- The Social Media Model holds that a decision is ethical if it withstands public scrutiny.
- The Utility Model indicates that a decision is ethical when it maximizes good and minimizes harm to the greatest number.
- The Rights Model states that a decision is ethical if it respects and guarantees the human rights of the people affected.
- The Exceptions Model asserts that a decision is ethical when a benefit given to one person can become a normative standard of conduct toward all people.
- The Choices Model requires that people make their own free and independent choices.
- The Justice Model maintains that a decision is ethical when the various benefits and burdens associated with the decision are fairly distributed.
- The Common Good Model finds that a decision is ethical when the common benefits and burdens are balanced with the common good.
- The Virtue Model deems that a decision is ethical if it manifests essential human virtues and thereby enables health care professionals and providers to be noble and humane.
- Use of multiple models increases the level of confidence in the rightness of decisions by balancing the models' strengths against their limitations.

REFERENCES

Adler, J. H., & Cannon, M. F. (2013). Taxation without representation: The illegal IRS rule to expand tax credits under the PPACA. *Health Matrix: The Journal of Law-Medicine, 23*, 119–195.

AHRQ (Agency for Health Research and Quality). (2012). *National health care disparities*. Rockville, MD: AHRQ.

Aristotle. (2012). *Ethics*. London, England: Pearson's Penguin Classics (originally published before 322 BC).

Baker, A. J. R. (2011). Fundamental mismatch: The improper integration of individual liberty rights into commerce clause analysis of the Patient Protection and Affordable Care Act. *University of Miami Law Review, 66*, 259–312.

Beauchamp, T. L., & Childress, J. F. (2012). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.

Ben-Asher, N. (2012). Obligatory health. *Yale Human Rights and Development Law Journal, 15*, 1–18.

Bentham, J. (2015). *Introduction to principles of morals and legislation*. Rochester, NY: The Scholar's Choice (originally published 1789).

Berman, M. L. (2011). A public health perspective on health care reform. *Health Matrix: The Journal of Law-Medicine, 21*, 353–383.

Blackstone, W. (2010). *Commentaries on the laws of England*. Renton, WA: Forgotten Books (originally published 1753).

Bolin, M. (2014). The Affordable Care Act and people living with HIV/AIDS: A roadmap to better health outcomes. *Annals of Health Law, 23*, 28–60.

Bradley, F. H. (1988). *Ethical studies*. Oxford, England: Clarendon Press (originally published 1927).

___. (1935). *Collected essays*. Vols. 1-2. Oxford, England: Clarendon Press.

___. (1916). *Appearance and reality*. New York, NY: Macmillan (originally published 1893).

Calnan, A. (2010). The instrumental justice of private law. *University of Missouri-Kansas City Law Review, 78*, 559–615.

CBO (Congressional Budget Office). (2011, February 18). Letter from D. L. Elmendorf, Director of the CBO to P. Ryan, Chairman, House Committee on the Budget, U.S. House of Representatives, Washington DC.

CDC (Centers for Disease Control and Prevention). (2013). *HIV surveillance report: Diagnoses of HIV infection and AIDS in the United States and dependent areas*. Atlanta, GA: CDC.

Chabris, C. F., & Simons, D. (2010). *The invisible gorilla: And other ways our intuitions deceive us*. New York, NY: Crown Publishing Group.

Cohn, M. (2011). Form, formula and constitutional ethos: The political question and justiciability doctrine in three common law systems. *American Journal of Comparative Law, 59*, 675–713.

Cousins, M. (2014). Equal protection: Immigrants' access to healthcare and welfare benefits. *Hastings Race and Poverty Law Journal, 12*(1), 21–56.

Dobbin, R. (2008). *Discourses and selected writings*. London, England: Pearson's Penguin Classics (original work of Epictetus published 108 AD).

Dolan, P., & Peasgood, T. (2008). Measuring well-being for public policy: Preferences or experiences? *Journal of Legal Studies, 37,* 5–26.

Dworkin, R. M. (2013). *Justice for hedgehogs*. Cambridge, MA: Belknap Press (originally published 2011).

___. (2013). *Religion without god*. Cambridge, MA: Harvard University Press.

___. (2013). *Taking rights seriously (Bloomsbury revelations)*. New York, NY: Bloomsbury Academic (originally published 1996).

___. (2010). *Freedom's law: The moral reading of the American Constitution*. Cambridge, MA: Harvard University Press (originally published 1996).

___. (2008a). *Democracy possible here? Principles for a new political debate*. Princeton, NJ: Princeton University Press.

___. (2008b). *Justice in robes*. Cambridge, MA: Belknap Press.

___. (2008c). *The Supreme Court phalanx: The Court's new right-wing bloc*. New York, NY: New York Review Books.

___. (2002a). *A badly flawed election: Debating* Bush v. Gore*, the Supreme Court, and American democracy*. New York, NY: New Press.

___. (2002b). *Sovereign virtue: The theory and practice of equality*. Cambridge, MA: Harvard University Press.

___. (1994). *Life's dominion: An argument about abortion, euthanasia, and individual freedom*. New York, NY: Vintage/Random House.

___. (1991). *Bill of rights for Britain: Why British liberty needs protection*. London, England: Chatto & Windus of Random House.

___. (1986). *Law's empire*. Cambridge, MA: Belknap Press.

___. (1985). *A matter of principle*. Cambridge, MA: Harvard University Press.

___. (1978). *Taking rights seriously*. (5th Edition). Cambridge, MA: Harvard University Press.

___. (Ed.). (1977). *The philosophy of law (Oxford readings in philosophy)*. New York, NY: Oxford University Press.

___. (2013). *Taryn Simon: An American index of the hidden and unfamiliar*. Ostfildern, Germany: Hatje Cantz (originally published 2008).

Freeman, W. (2001). *How brains make up their minds*. New York, NY: Columbia University Press.

___. (2000). *Neurodynamics: An exploration in mesoscopic brain dynamics (perspectives in neural computing)*. Philadelphia, PA: Springer (overview of Freeman's published works).

___. (1995). *Societies of brains. A study in the neuroscience of love and hate (The International Neural Networks Society)*. New York, NY: Lawrence Erlbaum/Taylor & Francis Group.

Hamilton, III, J. B., at Markkula Center for Applied Ethics. (2009). *Identify ethical issues*. Santa Clara, CA: Santa Clara University.

___. (2009a). *How to compare conclusions from the different tests*. Markkula Center for Applied Ethics. Santa Clara, CA: Santa Clara University.

Howard, A. E. D. (2012). The Constitution and the role of government. *Charleston Law Review, 6*, 449–510.

Huberfeld, N. (2011). Federalizing Medicaid. *University of Pennsylvania Journal of Constitutional Law, 14*, 431–484.

IOM (Institute of Medicine). (2009). *Initial national priorities for comparative effectiveness research*. Washington, DC: National Academies of Sciences.

___. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

Kaiser Family Foundation. (2014). *The global HIV/AIDS epidemic*. Washington, DC & Menlo Park, CA: Kaiser.

Kant, I. (2009). *The critique of pure reason*. London, England: Pearson's Penguin Classics (originally published 1781 and also referred to as Kant's "First Critique").

___. (2009). *The critique of practical reason*. London, England: Pearson's Penguin Classics (originally published 1788 and also referred to as Kant's "Second Critique").

____. (2009). *The critique of judgment.* London, England: Pearson's Penguin Classics (originally published 1790 and also referred to as Kant's "Third Critique").

Kapp, M. B. (2012). If we can force people to purchase health insurance, then let's force them to be treated too. *American Journal of Law and Medicine, 38*, 397–409.

Keyes, E. (2011). The just society and the liberal state: Classical and contemporary liberalism and the problem of consent. *Georgetown Journal of Law and Public Policy, 9*, 1–65.

Knight, F. H. (2000). *Selected essays by Frank H. Knight*. Vol. 1-2 (ed. by Ross B. Emmett). Chicago, IL: University of Chicago Press.

____. (1935). *Ethics and economic reform.* Edison, NJ: Transaction Publishers.

Lanshe, J. (2009). Morality and the rule of law in American jurisprudence. *Rutgers Journal of Law and Religion, 11*, 1–60.

LCAV (Legal Community Against Violence). (2011). *Gun violence statistics*. San Francisco, CA.

Leonard, E. W. (2012). Affordable Care Act litigation: The standing paradox. *American Journal of Law and Medicine, 38*, 410–444.

Levine, M. A., et al. for the American Medical Association Ethical Force Program. (2007). Improving access to health care: A consensus ethical framework to guide proposals for reform. *Hastings Center Report, 37*(5), 14–19.

Madsen, P. (2008). Professionals, business practitioners, and prudential justice. *McGeorge Law Review, 39*, 835–849.

Mariner, W. K. (2009). Toward an architecture of health law. *American Journal of Law and Medicine, 35*, 67–87.

Markkula Center for Applied Ethics. (2009). *Making an ethical decision*. Santa Clara, CA: Santa Clara University.

____. (2009a). *A framework for thinking ethically*. Santa Clara, CA: Santa Clara University.

____. (2009b). *Ethics operationalized: Effective ethics for the workplace*. Santa Clara, CA: Santa Clara University.

McCullough, R. L. (2013). What is all the fuss about?: The United States Congress may impose a tax (it's called the "individual mandate"). *Southern California Interdisciplinary Law Journal, 22*, 729-780.

Mill, J. S. (2011). *Utilitarianism, liberty, and representative government*. Toronto, Canada: University of Toronto Libraries (originally published 1863).

Mitchell, J. B. (2006). My father, John Locke, and assisted suicide: The real constitutional right. *Indiana Law Review, 3*, 43–101.

Moffit, R. E. (2002). The economic and ethical dimensions of health policy. *Journal of Contemporary Health Law and Policy, 18*, 663–672.

Morgan, E., & Hale, S. T. (2012). Health care access: Access after health care reform. *The Georgetown Journal of Gender and the Law, 13*, 307–332.

O'Neill, O. (2014). *Acting on principle: An essay on Kantian ethics.* (2nd ed.). New York, NY: Cambridge University Press.

Peery, Jr., N. S. (2008). Corporate social performance: Ethics and corporate culture. *McGeorge Law Review, 39*, 813–834.

Plato. (2007). *The republic*. London, England: Pearson's Penguin Classics (originally published 380 BC).

Purcell, J. (2010). Adverse clinical and public health consequences of limited anti-retroviral licensing. *Berkeley Technology Law Journal, 25*, 103–134.

Purdy, J., & Siegel, N. S. (2012). The liberty of free riders: The minimum coverage provision, Mill's "harm principle," and American social morality. *American Journal of Law and Medicine, 38*, 374–396.

Rawls, J. (2005). *A theory of justice*. Boston, MA: Belknap Press (originally published 1971).

____. (2005). *Political liberalism.* New York, NY: Columbia University Press.

____. (2001). *Justice as fairness: A restatement*. Cambridge, MA: Harvard University Press.

____. (1999). *Collected papers.* S. Freeman (Ed.). Cambridge, MA: Harvard University Press.

____. (1974). The independence of moral theory. *Proceedings and Addresses of the American Philosophical Association, 48*, 5–22.

Record, K. L. (2012). Litigating the ACA: Securing the right to health within a framework of negative rights. *American Journal of Law and Medicine, 38*, 537–547.

Restatement (Third) of Foreign Relations Law of the United States. (1987). Philadelphia, PA: American Law Institute.

Rivkin, Jr., D. B., & Whelan, E. (2012, February 15). Birth-control mandate: Unconstitutional and illegal. *Wall Street Journal*, p. A13.

Roberts, J. R. (2011). The Genetic Information Nondiscrimination Act as an antidiscrimination law. *Notre Dame Law Review, 86*, 597–648.

Sachs, S. E. (2012). The constitutionality of the Affordable Care Act: Ideas from the academy: The uneasy case for the Affordable Care Act. *Law and Contemporary Problems, 75*, 17–27.

Sartre, J.-P. (2000). *Existentialism and human emotions*. New York, NY: Citadel.

____. (1990). *Notebooks for an ethics [cahiers pour une morale].* Chicago, IL: University of Chicago Press (originally published 1983).

Siegel, N. S. (2012). The constitutionality of the Affordable Care Act: Ideas from the academy: Free riding on benevolence: Collective action federalism and the minimum coverage provision. *Law and Contemporary Problems, 75*, 29–74.

Simons, D. J., & Chabris, C. F. (1999). Gorillas in our midst: Sustained inattentional blindness for dynamic events. *Perception, 28*, 1059–1074.

Somin, I. (2012). The constitutionality of the Affordable Care Act: Ideas from the academy: A mandate for mandates: Is the individual health insurance case a slippery slope? *Law and Contemporary Problems, 75*, 75–106.

Spiropoulos, A. C. (2010). Rights done right: A critique of libertarian originalism. *University of Missouri-Kansas City Law Review, 78*, 661–704.

Thomson, K. (2012). State-run insurance exchanges in federal healthcare reform: A case study in dysfunctional federalism. *American Journal of Law and Medicine, 38*, 548–569.

Todd, A. E. (2011). No need for more regulation: Payors and their role in balancing the cost and safety considerations of off-label prescriptions. *American Journal of Law and Medicine, 37*, 422–443.

Underhill, K. (2012). Paying for prevention: Challenges to health insurance coverage for biomedical HIV prevention in the United States. *American Journal of Law and Medicine, 38*, 607–666.

United Nations. (1949). *Universal declaration of human rights*. New York, NY: UN.

Van Norden, B. W. (Ed.). (2001). *Confucius and the analects: New essays*. New York, NY: Oxford University Press.

Wharton School at the University of Pennsylvania. (2010). Health care reform: Not ready to be discharged yet. *Knowledge@Wharton*.

____. (2005). What's behind the 4-minute mile, Starbucks and the moon landing? The power of impossible thinking. *Knowledge@Wharton*.

Willis, S. J., & Chung, N. (2012). No healthcare penalty? No problem: No due process. *American Journal of Law and Medicine, 38*, 516–536.

Wind, J., & Crook, C. (2006). *The power of impossible thinking. Transform the business of your life and the life of your business*. Philadelphia, PA: Wharton School Publishing.

Zamir, E., & Medina, B. (2008). Law, morality, and economics: Integrating moral constraints with economic analysis of law. *California Law Review, 96*, 323–391.