The American Journal of Bioethics

ISSN: 1526-5161 (Print) 1536-0075 (Online) Journal homepage: https://www.tandfonline.com/loi/uajb20

Addressing Dual Agency: Getting Specific About the Expectations of Professionalism

Jon C. Tilburt

To cite this article: Jon C. Tilburt (2014) Addressing Dual Agency: Getting Specific About the Expectations of Professionalism, The American Journal of Bioethics, 14:9, 29-36, DOI: 10.1080/15265161.2014.935878

To link to this article: https://doi.org/10.1080/15265161.2014.935878

Published online: 15 Aug 2014.

Submit your article to this journal

Article views: 440

View related articles

View Crossmark data

Citing articles: 25 View citing articles

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=uajb20

The American Journal of Bioethics, 14(9): 29–36, 2014
Copyright © Taylor & Francis Group, LLC
ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265161.2014.935878

Target Article

Addressing Dual Agency: Getting Specific About the Expectations of Professionalism

Jon C. Tilburt, Mayo Clinic

Professionalism requires that physicians uphold the best interests of patients while simultaneously insuring just use of health care resources. Current articulations of these obligations like the American Board of Internal Medicine (ABIM) Foundation's Physician Charter do not reconcile how these obligations fit together when they conflict. This is the problem of dual agency. The most common ways of dealing with dual agency: "bunkering"—physicians act as though societal cost issues are not their problem; "bailing"—physicians assume that they are merely agents of society and deliver care typically based on a strongly consequentialist public health ethic; or "balancing"—a vaguely specified attempt to uphold both patient welfare and societal need for judicious resource use simultaneously—all fail. Here I propose how the problem of dual agency might begin to be addressed with rigor and consistency. Without dealing with the dual agency problem and getting more specific about how to reconcile its norms when they conflict, the expectations of professionalism risk being written off as cute, nonbinding aphorisms from the medical profession.

Keywords: professionalism, role morality, dual agency, professional ethics, physicians, health care

In the Physician Charter on Professionalism written by the American Board of Internal Medicine (ABIM) Foundation, and European Federation of Internal Medicine, we are told that physicians must uphold the best interests of patients while simultaneously insuring that health care resources are distributed justly in society. In the absence of more specifics, these expectations represent a conundrum: Physicians cannot uphold these two core tenets of professionalism (ABIM Foundation 2004; Snyder 2012) all the time. They demand something physicians cannot deliver in our current U.S. health care system. Frequently, the best interests of individual patients stand in conflict with societal interests in just distribution of health care resources, and physicians find themselves betwixt and between. Yet both remain part of medicine's modern-day professionalism pipe dream. Despite their popular appeal, these dual expectations of professionalism require physicians to live their professional life with a divided heart—a problem referred to as "dual agency."

> Dr. Smith is precepting in the resident clinic where Ms. S is seen. Ms. S is a 43-year-old mother of three with morbid obesity (body mass index [BMI] of 53), sleep apnea, chronic pain, dilated cardiomyopathy (ejection fraction 35%), and chronic renal insufficiency (creatinine 1.4). She was abused as a child and suffers from posttraumatic stress disorder (PTSD). Her obesity makes it difficult to care for her children or hold down a job. She is on public assistance. Ten years ago she took "phen-fen" for weight loss and was left with permanent heart valve damage and congestive heart failure. She currently receives Medicaid for her health care coverage. The state legislature recently decided to opt out of Medicaid expansion under the Affordable Care Act and is contemplating additional potential cuts to services for children and the elderly in the coming years (due to declining income tax revenue and an 9% unemployment rate) unless their entitlement program expenses can be constrained. Aware of the Medicaid crisis and Ms. S's need, the physicians wonder what their responsibilities are to Ms. S as well as their responsibility to help support the solvency of the state Medicaid program. They want to do what is best for the patient and Medicaid, which they view as an important social justice initiative. Should they recommend gastric bypass surgery to Ms. S?

Cases like this illustrate the challenge of dual agency. Should the physician seek the individual good of the patient even if doing so further jeopardizes an important societal mechanism for achieving justice for populations? Should society's interests in just distribution of health care ever trump the patient's need in the day-to-day care of patients? If the preceding expectations of professionalism are binding and not just aspirational platitudes, taking them seriously requires that the profession own up to the challenges those expections create, examine the options that exist for reconciling them, and take any needed steps to embody them in the contemporary practice of medicine.

Address correspondence to Jon C. Tilburt, Mayo Clinic, Division of General Internal Medicine, 200 1st Street SW, Rochester, MN 55905, USA. E-mail: tilburt.jon@mayo.edu

In the following I argue that (1) the stated expectations of professionalism require potentially irreconcilable competing commitments; (2) these competing commitments create the problem of dual agency; (3) the main strategies to deal with the problem fail; and (4) further conceptual work is needed to delineate how physicians can reconcile these competing commitments. My primary objective is to fully acknowledge and appreciate the seriousness of the dual agency problem. I illustrate how this problem is conceptualized by drawing on insights from recent focus groups with physicians (Sabbatini et al. 2014). Secondarily, I hope to begin sketching the kind of reconstructive work necessary to address dual agency constructively in the profession and that might inform further specification of or revisions to professionalism statements and codes.

PROFESSIONALISM REQUIRES COMPETING COMMITMENTS

Cases like the one just described illustrate the moral difficulties physicians face in 21st-century professionalism. While physician roles in cost containment have been discussed for nearly 30 years (Angell 1985), the ABIM Physician Charter on Medical Professionalism (hereafter, the Charter), the most widely accepted international declaration of professionalism, espouses three core principles—primacy of patient welfare, patient autonomy, and social justice—along with its 10 derivative commitments: (1) professional competence, (2) honesty with patients, (3) patient confidentiality, (4) appropriate relations, (5) improving quality, (6) improving access, (7) scientific knowledge, (8) just distribution of finite resources, (9) maintaining trust by managing conflicts of interest, and (10) professional responsibilities (ABIM Foundation 2004). While it is important to recognize that the Charter was a consensus document not fully supported or justified, it has nevertheless achieved quasi-reverential status in the profession. Here I hope to examine potential gaps in making the Charter logically consistent and actionable.

The Charter's limitations become apparent when applied to cases like the one just described. It requires a physician to uphold the patient's welfare—the first principle listed in the preceding paragraph—and also to uphold a commitment to just distribution of finite resources (commitment 8)—but does not specify how to uphold both values simultaneously. Rather, it seems to force conflicting obligations. In the case of Ms. S, gastric bypass is a scientifically established treatment option for this patient's obesity and would improve her long-term health.

Medicaid distributes health care to those with less opportunity and thus promotes just distribution of health care resources. If physicians regularly made individual decisions without regard to Medicaid sustainability, those choices would threaten the just distribution called for in the Charter. In the case under discussion, near-term budget shortfalls threaten the viability of the entire state Medicaid program. Even if gastric bypass may be cost-effective for managing long-term complications of morbid obesity, in the short term it would likely dramatically increase the costs of care for this patient and (if treating like cases alike) hundreds of other patients like her in her state. If generalized to the whole state, widespread adoption of efficacious bypass to similarly needy Medicaid patients would greatly exacerbate short-term budget shortfalls and thereby further exacerbate this state's Medicaid finances before its revenues recover.

Following the Charter, what is the physician to do? How can physicians caring for patients like Ms. S reconcile the welfare of this patient with the compelling need to maintain a justice-promoting program? There is no clear answer in the Charter. Pursuing, not pursuing, or delaying gastric bypass each appear to contradict an important commitment absent a clear spelling out of how those commitments relate.

Historically, the compelling and overwhelming commitment to patient welfare lent a common sense resolution to this apparent dilemma: Individual patients' interests come first. Full stop. Under this common sense consensus, physician commitment to social justice was construed narrowly and pertained primarily to avoiding discrimination. Increasingly, for good or ill, this commonsense consensus interpretation cannot be taken for granted. The prevailing dialogue in the general medical literature suggests that justice is overtly part of every physician's job, and the scope of the justice commitment stretches way beyond avoiding discrimination, to actively working to preserve and reallocate health care resources for society. Whether that shift in the ethos of medicine is justifiable and logically coherent under the said norms of the profession lies as the heart of this article. At a minimum, what we say are the norms of the profession should be logically consistent and attainable. The Charter, as written, leaves open a more expansive interpretation of the commitment to justice, which in turn forces a potential conflict. Thus, it is imperative to get more specific about the norms of professionalism so they can be logically consistent and attainable.

THESE COMPETING COMMITMENTS CREATE THE PROBLEM OF DUAL AGENCY

The Charter and other ethics declarations without being specified create an untenable demand on the moral life of physicians because they appear to require physicians to uphold simultaneously two compelling ethical norms that often conflict. This situation insists that physicians exercise "dual agency" (Abrams 1986). Dual agency means simply an avowed requirement to act simultaneously on behalf of two different parties with competing interests.

Fortunately, many circumstances exist in health care where the cost-effective and just action for society's interests aligns with the individual patient's best interest. Those situations raise no moral dilemma. In recent focus groups I helped administer, primary care physicians affirmed that they do have an obligation to address health care costs by helping patients figure out *what they need*, not necessarily *what they think they want*. This process of stewarding patients

toward appropriate care creates no conflicts of professional role, but rather reinforces the prudent practice of medicine (Pellegrino 1986; Pellegrino and Thomasma 1988).

However, in other circumstances, like the case just described, doing what is right (beneficial, consistent with their values, and clinically "indicated) for the patient is expensive to the point that (if consistently applied across a population) it could jeopardize the sustainability of justice promoting structures of service delivery, thereby creating the dual dilemma. In the same focus groups, participants were asked what their role was in these sorts of dilemmas. According to these doctors, if a patient really needs a treatment, expensiveness should not be the determining factor in whether the patient gets it. Clinical need trumps. Thus, many physicians echo the commonsense interpretation described earlier. They also affirm that as the treating physician, they ought not to be placed in the role of making societal resource determinations: not because they do not have some societal responsibility—they believe they do—but rather, because physicians should not be asked to hold the scales of justice in their individual hands in their daily work with patients. Implied in these physicians' responses was some need for clarity or prioritization of the expectations of professionalism; when push comes to shove, our respondent physicians prioritized "primacy of patient welfare" over "just distribution of resources" based on their hunch that it is the right thing to do, not because the Charter specifies they should. As health care cost concerns deepen, relying on a commonsense consensus prioritization may no longer be a given in the profession.

Professionalism's potential for dual agency unfairly places physicians in a position where they are asked to make allocation decisions for scarce and or expensive therapies. That obligation limits a physician's ability to garner the trust of individual patients (Angell, 1985). In the case described, the physicians may have difficulty forming a therapeutic bond with the patient if the patient is worried that her best interests are not the physicians' sole (or at least primary) objective.

Conversely, the physicians' ability to think clearly about fair resource allocation could be further clouded by a strong subconscious bond with some (but not all) of their Medicaid patients, exacerbating attempts to distribute resources fairly. Moreover, dual agency propagates hypocrisy by perpetuating a public image of physicians being solely devoted to the well-being of individual patients, while privately and paradoxically encouraging (or at least permitting) the profession as a whole to withhold beneficial therapies (Abrams 1986; Sulmasy 1992). Eventually, if dual agency persists in the professional psyche, its consequent hypocrisy could well create a backlash and collective worsening in the mistrust of the profession.

CONVENTIONAL DUAL AGENCY COPING STRATEGIES FAIL

In order for professionalism to mean something—to be logical, consistent with historic norms of the profession, and achieve the Charter's objective—the profession needs greater clarity on how best to cope with dual agency. Typically, responses to this challenge can be summarized into *balancing*, *bunkering*, and *bailing* strategies.

Balancing

Balancing accepts the dual obligations of the Charter as truly dual, equally valid, and morally binding expectations of individual practicing physicians. Balancing has an intuitive appeal. It allows the profession to hang on to the image of fidelity to patient welfare while maintaining a façade of relevance to societal issues and the "social contract" with the profession. Balancing invites physicians to value their relationship with all patients—including future patients—with similar regard to their relationship with individual current patients. In practice, it asks physicians to keep other patients in mind when they are with *this* patient. Balancing recognizes there are many ways individual physicians cannot be exclusively devoted to individual patients. After all, a given individual physician's time, energy, and other finite resources are limited (Rulli, Emanuel, and Wendler 2012). Balancing, therefore, acknowledges that physicians must make tough choices all the time—how much time to spend with *this* patient when another one is waiting; whether to call a patient back or make it to the soccer game on time. These conflicts weigh on the integrity of physicians and must be acknowledged, embraced, and managed under the balancing strategy. Individual patient welfare is just another wheel squeaking for the grease of a caring doctor. Promoting just allocation of health care resources on behalf of society is another competing expectation that (for balancing proponents) rightly competes directly with individual patient need. This sort of scenario seems to be what Brennan and Lee (2004) advocate in a discussion of generic versus brand name prescribing. They believe societal demands compel physicians to recommend generic medications even if a patient requests otherwise.

In the case described, balancing means the physicians must figure out how to meet the patient's needs while somehow not giving up on their commitment to societal resource allocation. No set metric can guide balancing, but it is still a physician's job to do it. The scales might tip toward societal resource needs. Surgery, even if clinically indicated, might need to be delayed. Or the scales might tip toward doing some sort of bariatric procedure to meet the patient's basic need, but perhaps the doctors would advocate for a less invasive, less expensive procedure, even if it is less efficacious. In the moral fog surrounding the Charter's language, proponents of balancing would argue physicians are expected to "just figure something out" that bears some sort of resemblance to affirming both patient welfare and just resource allocation, but the Charter offers little guidance on how to weigh those competing moral considerations.

Balancing, however, represents a serious departure from the historic norms of medicine because it abandons the idea that physicians' special obligations to their

individual patients are exclusive and may supersede their general obligations to any/all patients or society. In the case described here, if the doctors treat the individual in front of them as just one of hundreds of obese, single-mother patients in the state, all of whom have equal claim to the physician's time, attention, and advocacy, the physicians would be giving up on how special obligations to individuals have been interpreted in the profession.

Bunkering

Advocates for a traditional ethic of the profession may espouse the *bunkering* position to deal with dual agency. They argue that all this talk of resource constraints in medicine should not bear at all on what physicians recommend to patients. This interpretation has an intuitive appeal. In our focus groups, physicians reflected on the "good old days" of medicine when medicine was more personable, less corporate, and less bureaucratic. Physicians long for a practice of medicine that allows them to focus on the real work of patient care, unencumbered by finances and accounting or its broader economic impact. In response to calls for a greater societal role, some proponents of bunkering resist those calls. Instead, they insist physicians should withdraw from discussions regarding resource constraints (hence the term "bunker") and just take care of patients one at a time. Case closed. Let others deal with health care financing.

The best supporting analogy for the bunkering position comes from the legal system. Lawyers are the sole advocates of individual's interests. A defendant can be confident that the representing attorney has that defendant's best interest as their sole motivation. Judicial systems thrive when exclusive individual advocacy thrives. Apart from a few circumstances where public safety is concerned, the legal profession upholds client loyalty and advocacy very seriously (American Bar Association 2012). So, too, physicians should be the sole advocate of the patient's best interests. Bunkering advocates could reason by analogy: If society does not expect lawyers to take both sides in a court case, so the argument goes, neither should it expect individual physicians to defend both patient and societal interests in conflicts over health care resource use. And while circumstances of public safety constrain even attorney–client privilege, fidelity to the interests of the individual runs strong and deep in the legal system. Should not the same be true in medicine?

Bunkering offers compelling and attractive solutions to the case here, summed up by the phrase "not my job." Proponents of this position, under cover of Hippocratic principles, simply assert that fixing societal health care costs is not their problem; their job is only to figure out what is medically indicated, and recommend what is indicated to individual patients, one by one, without attention to the "externalities" of health care financing or the generalizability of the individual strategy for just health care systems.

Bunkering aligns well with the principle of patient welfare but gives little credence to the Charter's identification of just distribution of health care resources as a key physician commitment. Moreover, bunkering blows past the implicit value judgments in determining what is "medically indicated" (Fuchs 2012), and thereby accepts the existing political economy of health care as morally neutral. Bunkering fails to see the ways in which the profession as a whole is complicit with nonbeneficial consumption of health technology in the name of patient welfare (Relman 1980).

In this respect the analogy with the law breaks down. Unlike medicine, most lawyers use low-tech systems to think and act on behalf of clients. There is typically no third-party payer (including government) and lawyers charge what they believe to be a fair price. If law had gone the direction of medicine with increasing use of technology driving professional behavior, government investment in subsidizing legal services, and the associated skyrocketing prices, they might be facing similar challenges. (In the case of public defenders, there is arguably an analogous dual agency consideration where public defenders represent the interests of their client but in a publicly sanctioned position and for the purpose of the common good.) Thus, bunkering ignores the realities of the world in which physicians operate and from which they benefit economically. A pure bunkering position would also require amending the norms of professionalism to less than its current scope and would entail refusal to participate in at least government-sponsored insurance.

Bailing

Bailing, a third strategy for dealing with dual agency, goes the opposite direction of bunkering to resolve the problem of dual agency. Bailing calls upon physicians to own their societal obligations fully. Conversely, bailing implies that physicians should abandon the parochial norms of the professional guild (hence, "bailing") for a more enlightened, modern view of medicine's obligations. The bailing strategy espouses that the moral status of the profession rests solely on the collective interests of society. Any obligation to individual patients derives from the "social contract" with the profession as a whole. Physicians have no special obligations to an individual patient they have taken care of. Patient-specific special obligations (so the argument goes) are antiquated and must be abandoned for the social justice cause of medicine. In the described case, the advocate of "bailing" simply would tell the patient the predicament along these lines. "I'm very sorry, Ms. S. You are eligible for gastric bypass; it would be the best thing for you. However, you have to understand that while I took an oath to help you, I'm put in a position where I cannot do that because when it comes right down to it, medicine's fundamental responsibility is to serve the health of the whole population. The social contract with the profession means sometimes I have to withhold beneficial treatments from you. Even if I advocated for bypass for you, I couldn't in good conscience do the same for all patients like you because doing so would cause Medicaid's demise. My

advocating for your getting surgery would be unfair to others. Maybe in the future when budgets are better we can revisit this option. Meanwhile, let's look for some cheaper ways to address your weight." This position takes seriously the societal role to distribute health care resources, but discounts the "primacy" of individual patient welfare called for in the Charter and implied in the very notion of the profession being a voluntary spoken obligation to individual patients.

In a recent provocative book, Greg Bloche (2011) argues for a version of bailing. He argues that physicians have said one thing and done another for too long. Physicians still publicly espouse the said ancient Hippocratic norms of fidelity to patient individual interest while in several key ways privately (or in some cases not so privately) embodying actions that affirm the lived pressures, appetites, and allegiances of the judicial system, markets, and government public health mandates. He concludes that given the extensive social role that physicians do play, the profession ought to eradicate the myth of the Hippocratic ideals and renegotiate a new honest agreement with society about their role. In effect, Bloche espouses an open and honest approach to bailing that he hopes would unshackle the profession from its hypocrisy and salvage the profession's credibility. (Whether Bloche's solution is the best thing for medicine, society, and patients is an open question. After all, one could just as easily imagine a process of cleaning house within the profession to address corrupt appetites and allegiances underlying the hypocrisy and thus bolster the high-minded ancient ideals of the profession.) Bailing gives up on the idea of medicine as a profession altogether (i.e., a voluntarily spoken calling with special obligations to individual patient welfare) and merely subsumes the meaning of being a physician under the collective consequentialism of a public health ethic.

GETTING SPECIFIC ABOUT WHAT PHYSICIAN PROFESSIONALISM REALLY SHOULD EXPECT

The profession cannot cope with dual agency by balancing, bunkering, or bailing, for the reasons just articulated. If the problem of dual agency exists as I have argued, and if common coping strategies fail, professionalism currently expects something physicians cannot deliver. In turn, and as a key expression of professionalism, the Charter risks an anachronistic fate as a merely aspirational document. For the Charter (and the whole of professionalism) to be more than a fanciful hope, its norms must be logically coherent, attainable, and consistent with what it means to be a professional.

One might accurately argue that the lack of clarity of how physicians should reconcile these competing commitments is an unsavory by-product of our society's inability to achieve meaningful, just structures within which physicians can practice. If a closed system with societally negotiated limits were arrived at fairly and classes of technology were rationed but not at the bedside (Sulmasy 1992), physicians could act as the "ideal advocate" for the best interests of patients within the constraints of that system (Daniels 1987). Commentators from across the political spectrum agree on these as viable options. Absent these structural changes, however, the Charter asserts a kind of "ambivalence and vagueness" about physician ethics that we've known about for decades (Wolf 1994) and that plagues the profession. It is willing neither to fully embrace nor to let go of individual physician roles in limit setting. Absent those larger structural changes, however, physicians interested in professionalism will need to sort through how to reconcile the dual agency problem.

The current lack of clarity in the expectations of professionalism suggests physicians must either give up on some major tenet of the Charter or get a lot more specific about how these dual expectations might fit together.

Assigning Priority

One strategy for getting such clarity would be *assigning clear priority* in the principles and commitments. By structuring the Charter with 3 principles and 10 commitments, its framers may have been implicitly assigning priority to the principles, believing the commitments were derivative of the principles. For instance, the Charter could have clearly stipulated something like "In circumstances when commitments appear to conflict with principles, principles take priority, and when principles conflict, individual patient welfare takes priority." But priority is not spelled out in the Charter. Physicians may fill this lack of clarity with their own intuitive, ad hoc prioritizing strategies like the commonsense interpretation described earlier. In our focus groups, physicians shared a variety of strategies they use to reconcile their dual-agency obligations. They fear that failure to prioritize leads to erosion of the therapeutic bond, capricious resource allocation, and public hypocrisy. Other physicians may reject the commonsense interpretation for a different set of priorities. Failure of the Charter to articulate how principles and commitments interrelate when they conflict almost necessitates the ad hoc solutions from physicians whose intuitions are anything but unified.

In the preceding case, as long as Mrs. S has access to bariatric surgery and she decides together with her physician whether it is best for her, a prioritized view of the Charter could support her getting bariatric surgery. If societally mandated rationing demands she wait in a queue for the surgery, the physicians are exercising their duty to her welfare within the constraints established by the state. Within those constraints they can help her manage her weight as best they can until surgery is available. Delineating more clearly the priority of principles and commitments would not eliminate all conflicts in the norms of professionalism, but it would officially acknowledge the fact that logical inconsistencies exist and need to be adjudicated.

Admittedly, assigning priority could have disagreeable consequences as well. For instance, if stated too strongly, assigning priority in such a way that "primacy of patient welfare" always "wins" could run the risk of a kind of

"functional bunkering." In such a scenario, one might run the risk of saying physicians are committed to multiple norms, but on the other hand acting as if the only thing that really matters is primacy of patient welfare. Whether prioritization is the right way to resolve the problem of dual agency remains an unanswered normative question worth further in-depth analysis.

Specification

Similar strategies that *specify clearly how principles apply* in specific situations and that provide transparent and reproducible moral reasoning for how those norms can be reconciled would further delineate the seemingly contradictory expectations of the Charter. For instance, if one could define why in a given circumstance it may be defensible to withhold gastric bypass for 12 months for justice reasons, but not categorically exclude it as a last-resort treatment option, one would be operationalizing the relationship between primacy of patient welfare and just distribution of health care resources. This would at least acknowledge the tension between the two said professional norms.

Or one might invoke a conceptual distinction between perfect and imperfect duties to further specify the relationship between competing norms. Perfect duties imply agents holding those obligations are blameworthy and face enforcement of consequences if they fail to conform to the norm. Imperfect duties derive from a "qualified supererogationism" in which a duty is real, not optional, but is not universally enforced or does not imply the same amount of blame when violated (Heyd 2012). In the case of a conflict between a norm of fidelity to patient welfare and commitment to just resource distribution, one could interpret the norm of fidelity to patient welfare as a perfect duty and the norm of commitment to just resource distribution as an imperfect duty (or vice versa). In such an instance if commitment to justice were an imperfect duty, the doctors in Ms. S's case are responsible to uphold both norms of professionalism, but if their actions failed to conform to principles of just resource distribution they might not face the degree of specific reprimand that they might expect if they violated fidelity to patient welfare. Whether framers of the Charter or leaders of the professionalism movement would be satisfied with such an interpretation is an open question. Nevertheless, drawing distinctions like those between perfect and imperfect duties is the kind of conceptual clarification that documents like the Charter need so that they can be logically consistent and attainable.

Some may argue that this kind of specification represents little more than a post hoc justification of a heuristic or gestalt judgment or functional dismissal of the importance of one of the conflicting norms. If so, specification of the relationship of competing norms suffers from the same problems as balancing, discussed earlier, namely, that there is no uniform measure by which (or vantage point from which) to independently evaluate different kinds of goods.

Defining Distinct Roles and Spheres

Another such strategy could include *defining different roles and spheres where the different expectations of professionalism* are more or less operative. This approach is called "role morality" (Applbaum 2000). Using a "role morality" tack, one might argue from a premise that within the profession, individual physicians may occupy multiple roles including care provider, administrator, public health official, medical educator, policymaker, and others in overlapping spheres. I favor such an approach. Each of these roles entails a distinct set of obligations specific to that role within those respective spheres. Role morality manages competing obligations by delineating in which settings those obligations apply.

Clarifying the role moralities of physicians could bring clarity to the dual agency problem of professionalism. For instance, *in the role as patient care provider* in the sphere of a resident continuity clinic, for example, as in the case described, a faculty member's moral obligation is to seek and defend the best interests of individual patients seen in that clinic, as the faculty teaches the resident. The faculty member's obligations as a care provider overlap with (but in this case do not conflict with) his or her obligations to teach. However, arguably the care provider role takes precedence over and constrains the secondary obligation in the teacher role. In the sphere of the individual patient clinic, that faculty member's role obligations determine what information is relevant to the clinical deliberation. In that role, the fact that the physician (for example) also may sit on the state Medicaid policy advisory committee is irrelevant to the patient care sphere and role of care provider. While the externalities of the state Medicaid budget constrain treatment possibilities offered in coverage, a clearer account of role morality of medicine (practiced with the best interests of patients at heart) might argue that other roles and responsibilities can never trump the best for patients when the patient is in front of them within the constraints of the system that exists. Such an interpretation could be consistent with a traditional ethic of medicine and the commonsense interpretation of the Charter.

A second derivative part of a role morality argument could include a "profession-wide" citizenship role in the sphere of public health and health policy. This is a secondary level of obligation. Arguably, the profession as a whole has a collective citizenship role in society at large. In that collective role in the public health sphere (distinct from clinical medicine), the individual professional as a derivative member of the profession must advocate for justice in systems, payment, and structuring of care. This citizenship role is typically exercised through participating in professional societies. Physicians may not agree on such an active level of participation, but a role-morality strategy for addressing dual agency could explicitly entail some sort of citizen-professional role in the sphere of public health. Individual physicians participate in the collective medical profession's citizenship—what the Charter calls "commitment to professional responsibility"—to advance

the good for all patients. Through this role in the public health sphere, members of the profession exercise citizenship obligations, contribute to policy debates and defend the just allocation of health care resources as they see it.

It is plausible to argue that physicians attain resolution of dual agency not by balancing, bunkering, or bailing in their role as caring professional, but by distinguishing the roles and responsibilities that professionalism requires in distinct spheres and tangibly devoting themselves to advocate for welfare and justice in the most pertinent sphere. In the case presented earlier, the physicians should in their clinical role advocate for this patient and get her the best care she has access to. At the same time, in a citizen-professional role they should contribute constructively to the common good by advocating for policies that fairly extend the benefits of basic health care and bolster the efficiency and sustainability of health care coverage for those who would not otherwise have access to it. Such a conceptualization would need further explication. For instance, ought we to construe the obligations associated with individual caring professional roles and collective citizen-professional roles as perfect or imperfect duties?

This position is not without its problems practically and theoretically. Practically, due to the nature of physician work and health care financing, most days, most of the time, this role morality strategy would functionally insulate physicians from the responsibility of advocating for just structures of care because 99% of the time, most doctors are wearing their patient care hat (so to speak). Professional organizations may bear that role, but individual physicians could largely feel like they are off the hook and resort to a role very similar to bunkering under current conditions of voluntary professional group affiliation. Theoretically, some might argue that such a distinction does not really solve the dual agency problem but merely relabels it. Instead of having a conflict between two professional principles, with role morality, one trades a direct conflict in principles for a conflict in roles with no way of reconciling how those roles should be prioritized.

Admittedly, this article does not satisfactorily solve the issue of dual agency. Articulating specification, prioritization, role morality, or some combination thereof may offer only incremental clarity to the dual agency problem. It does begin at least to manage the logical inconsistency of asking an agent to hold to "p" and "not p" obligation at the same time. Role morality if worked out more completely or combined with some version of specification at least acknowledges that one can really only wear one hat at a time, and when one is wearing "x" hat, one's main job is "y."

BEYOND DUAL AGENCY

Leaders in medicine and society cannot hold the profession to a moral standard that is not logically or practically possible, as currently appears to be the case in the wording of the Physician Charter on Medical Professionalism. At the same time society can ill afford the Charter to become a merely aspirational anachronism of the late 20th century. Holding one another accountable for the moral demands of professionalism is only possible if physicians acknowledge the problem of dual agency and address it robustly.

Getting to a workable solution surrounding the tensions and paradoxes of dual agency will require either drawing better distinctions like those I have outlined in the preceding, narrowing the scope of what society holds physicians accountable for, or reimagining altogether the nature of physicians' obligations. Arguably, there could be a role for empirical investigation in devising better solutions. After all, physicians have been grappling with multiple roles and divided commitments for quite some time. Even in the permissive environments of fee-for-service insurance, physicians are creating workarounds every day to deal with constraints imposed on their practice from forces outside the doctor–patient relationship. Presumably some physicians have found ways to make that imperfect process more patient-centered. What is going on in physician thought processes when they face such challenges? How do physicians handle resource constraint issues empathically in the clinical encounter? In those every day frustrations of practice, there may be lessons about how physicians can operate with integrity as advocates for the patient while meeting their obligations to payers and society that finesse the dual agency problem better that the theoretical conflicts would suggest.

At the same time, further conceptual articulation of the relationship between said norms of professionalism could be valuable. Whether through making better ethically defensible distinctions, defining levels of obligation, assigning clear priority in the principles and commitments, specifying more clearly how principles are applied, or defining different roles and spheres, or through some other means, those articulating professional norms need to wrestle with the expectations of professionalism in a vigorous and logical manner so that physicians of today and tomorrow can both embrace and be held to that standard.

Without grappling with those seemingly impossible expectations, physicians will suffer moral paralysis, stuck with irreconcilable anguish over their impossible dual roles, saddled with untenable self-expectations and unavoidable hypocrisy. With a lot more grappling, the expectations of the profession might still be salvaged and the profession might still be able to constructively contribute to the changing landscape of health care as citizens and professionals in the coming decades. ■

ACKNOWLEDGMENTS

Bernie Lo, Christine Cassel, and Baruch Brody generously commented on earlier drafts.

FUNDING

This work was supported by the Faculty Scholars Program of the Greenwall Foundation.

REFERENCES

ABIM Foundation. 2004. Medical professionalism in the new millennium: A physician charter. Available at: http://www.abimfoundation.org/Professionalism/Physician-Charter.aspx (accessed February 21, 2014).

Abrams, F. R. 1986. Patient advocate or secret agent? *Journal of the American Medical Association* 256(13): 1784–1785.

American Bar Association. 2012. *Compendium of professional responsibility rules and standards, 2012 Edition*. Washington, DC: American Bar Association.

Angell, M. 1985. Cost containment and the physician. *Journal of the American Medical Association* 254(9): 1203–1207.

Applbaum, A. 2000. *Ethics for adversaries: The morality of roles in public and professional life*. Princeton, NJ: Princeton University Press.

Bloche, M. G. 2011. *The hippocratic myth: Why doctors are under pressure to ration care, practice politics, and compromise their promise to heal*. New York, NY: Palgrave Macmillan.

Brennan, T. A., and T. H. Lee. 2004. Allergic to generics. *Annals of Internal Medicine* 141(2): 126–130. doi:10.7326/0003-4819-141-2-200407200-00011 [pii]

Daniels, N. 1987. The ideal advocate and limited resources. *Theoretical Medicine* 8(1): 69–80.

Fuchs, V. R. 2012. Major trends in the U.S. health economy since 1950. *New England Journal of Medicine* 366(11): 973–977.

Heyd, D. 2012. Supererogation. In *The Stanford encyclopedia of philosophy* (Winter 2012 ed.), ed. E. N. Zalta.▒ Available at: http://plato.stanford.edu/archives/win2012/entries/supererogation (accessed February 21, 2014).

Pellegrino, E. D. 1986. Rationing health care: The ethics of medical gatekeeping. *Journal of Contemporary Health Law and Policy* 2: 23–45.

Pellegrino, E. D., and D. C. Thomasma. 1988. *For the patient's good: The restoration of beneficence in health care*. New York, NY: Oxford University Press.

Relman, A. S. 1980. The new medical–industrial complex. *New England Journal of Medicine* 303(17): 963–970.

Rulli, T., E. J. Emanuel, and D. Wendler. 2012. The moral duty to buy health insurance. *Journal of the American Medical Association* 308(2) 137–138.

Sabbatini, A. K., J. C. Tilburt, E. G. Campbell et al. 2014. Controlling health costs: Physician responses to patient expectations for medical care. *Journal of General Internal Medicine*. Published online. 29 May 2014. doi:10.1007/s11606-014-2898-6.

Snyder, L. 2012. American College of Physicians Ethics Manual: sixth edition. *Annals of Internal Medicine* 156(1 Pt 2): 73–104.

Sulmasy, D. P. 1992. Physicians, cost control, and ethics. *Annals of Internal Medicine* 116(11): 920–926.

Wolf, S. M. 1994. Health care reform and the future of physician ethics. *Hastings Center Report* 24(2): 28–41.