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WHY PHYSICIANS OUGHT TO LIE FOR THEIR PATIENTS

Imagine you are a good and conscientious physician. You are a good one, because you master all the necessary skills to care as best as is possible for your patients and because you know perfectly well the duties imposed on you by the medical profession's ethical code. And you are a conscientious one, because you take these duties seriously – you don't mess with Hippocrates.

Now imagine further that, unfortunately, you are set in a not-so-good institutional environment. You work in a healthcare institution that does not provide all the resources needed to take adequate care of all your patients. In this context, the following commonly happens. According to your best medical judgment, patient X needs treatment Y. And the patient X, fully and clearly informed, consents to be given treatment Y. But, given the institutional setting, treatment X is not available. It may be that, in a healthcare system with private insurance, X's insurance plan does not pay for treatment Y and X cannot pay it out of pocket. Or it may be that, in a healthcare system with public funding, there are cost-containment rules that limit or restrict treatments of the Y-type for patients of the X-type.

Anyway, the result is the same: as an ideal physician, you judge treatment Y medically required; and as an agent of a given healthcare organisation, you are forbidden to administer treatment Y. Should you give treatment Y, or should you not? Should you act as your strictly medical ethics demands or as the system requires? Should you obey the dictates of your Hippocratic conscience or the rules prevailing in your institutional setting? That is the problem that I shall address in this paper.

More precisely, I shall focus on one answer by physicians: the strategy known, since a paper by E. Haavi Morreim (1991), as *gaming the system*. I game the system when I "break health care rules and regulations regarding

access to care and/or reimbursement" in order to grant patients the needed treatment (Régis 2004, p. 19). I game the system, in other words, when I lie to third-party payers for the sake of my patients (Freeman *et al.* 1999). In so doing, I give my Hippocratic duties precedence over the systemic requirements about reimbursement rules or prioritisation. Since such a strategy involves a clear measure of deception, lying or dishonesty, there is a prima facie case against it. And the question is: Is this prima facie case conclusive? I shall try to show it is not. Physicians are justified in putting their patients' good first.

I shall proceed as follows. Firstly, I shall describe in more details the deceptive strategy just outlined. Secondly, I shall rehearse the main objections, both deontological and consequentialist, put forward against it. Thirdly, I shall present a *Hippocratic* argument in favour of gaming the system. In a nutshell, the argument says that physicians should obey the *internal morality of medical practice* based on taking the physician-patient relationship seriously, that the cornerstone of this internal morality is the duty or virtue of beneficence requiring physicians to aim above all to take best possible care of their patients, and that such a duty, in certain cost-containment circumstances, implies the violation of the reimbursement rules. At that stage, the *pros* and *cons* will have been introduced. I shall thereafter endeavour to strengthen the Hippocratic argument by showing how the objections to gaming the system are tied to what will be called the *idealistic fallacy*, which consists in judging the behaviour of *agents set in non-ideal circumstances* on the basis of *normative criteria drawn from some ideal theory*. As Michael Phillips (1985) or Ingrid Robeyns (2008) have warned us, this kind of "transmodal" judgment raises serious and maybe insuperable problems.

1. Gaming the System: A Portrait

Our problem is premised on two elements. One the one hand, it concerns the behaviour of an *ex hypothesi* good and conscientious physician – i.e. a physician eager to act as well as possible from a moral point of view. She is as compliant as possible with the requirements of morality. She cannot be described as fully compliant, in the rawlsian parlance, because genuine full compliance implies a (quasi-)perfectly just environment. But the justice of the environment is part of the problem, as we shall see. On the other hand, our problem presupposes *restrictive* environments. By this, I mean that the environment where our physician works does not allow her to give every medically adequate treatment because of cost-containment rules: the system involves a private or public *third-party payer*, whose reimbursement policies do not match the physician's judgment[1]. Sometimes, those policies may result in a *denial of treatment*. So the environment is restrictive from a

[1] Restrictive environments, thus defined, are not equivalent to *catastrophic environments* such as Haiti after the recent earthquake. In this case, there is a lack of resources and a consecutive restriction on available treatments. But the cause lies, not in the rules of the healthcare system, but in the absence of system.

medical viewpoint. This restrictive dimension may be justified or not. If it is, then it is a just restrictive environment; if it is not, it is an unjust restrictive environment.

When faced with limitations on the available treatments, a physician faces a wide range of options which I won't detail here. Let us focus on the most problematic one from a moral viewpoint – i.e. pretending to honour the rules while lying about one's patient's condition in order to secure an otherwise denied treatment. There are four ways to bypass reimbursement rules, from the most benign to the most serious:

1. Descriptive cunning: “When resource rules are substantially ambiguous, the physician might simply select whichever fully correct description of the patient’s condition will produce the most favourable application of the resource rules” – e.g. by choosing, for patients with multiple medical problems, to list the most serious one, hence the most likely to be reimbursed (Morreim 1991, p. 444).

2. Exaggerating the severity of the patient's condition – "as when physicians use *rule out cancer* as the indication for a test rather than *screening*" (Bogardus *et al.* 2004, p. 1842).

3. Changing the patient's official diagnosis. For example, a physician may discover pregangrenous skin changes "that the patient reports existed before her current insurance coverage began". Arterial revascularization is medically indicated. But the physician knows that the third-party payer will refuse to pay for a condition preexisting the insurance contract. So she tells the third-party payer that her patient presents "*new* skin changes" to secure reimbursement (cf. Freeman *et al.* 1999, p. 2264).

4. Reporting signs or symptoms that the patient does not have. It may happen for example that the third-party payer would refuse to pay for a screening mammogram without some disquieting symptom. But our conscientious physician knows that such a service is medically indicated for her patient, a 55 year-old woman with a rich family history of breast cancer. So she informs the third-party payer that her patients has "suspicious breast lump".

Of course, not every form of gaming implies straightforward lying, since not every form of gaming consists in conveying beliefs that one knows to be false. Only 3 and 4 are clear instances of lying. 1 is quite innocuous, and the dishonesty of 2 admittedly varies with the extent of exaggeration. But I shall focus on forms 3 and 4: if the most dishonest types of gaming can be justified, the least ones can be justified too.

2. Against Gaming the System: Social Responsibility, Integrity and Justice

What's wrong with gaming the system? Most authors on the question concur to say that it is an unjustifiable strategy. They put forward both deontological and consequentialist arguments.

The consequentialist arguments take three forms. The first states that gaming may hurt the very patient for the sake of whom gaming was first intended: it may hurt him by implying a falsification of his medical record, thus thwarting adequate healthcare in the future. Some authors add the contention that gaming is detrimental to the patient because, by seeing how his physician is prone to deception, he may lose trust in her (Morreim 1991, p. 445).

The second has it that gaming may hurt other patients. This could happen in two ways. Firstly, gaming may disrupt "priorities based on needs" (Régis 2004, p. 20). When resources are limited, indeed, gaining access to some treatment for patient A through gaming may entail denial of treatment for some needier patient B. Thus gaming may imperil the general quality of care. Secondly, it may give a premium to patients with privileged acquaintances in the medical "milieu", thus creating "second-class patients" (Régis 2005, p. 20). This point relates, of course, to questions of justice – if one admits that justice prohibits "second-class patients".

The third consequentialist argument states, with collectivist undertones, that gaming may hurt society or the community at large. The first way for gaming to hurt society is direct: massive gaming may undermine the whole resource system, notably by reducing trust in it. Knowing that the rules are regularly bypassed, and knowing that there are no trustworthy norms on which to base their expectations, the people concerned may come to despise the system originally intended to help them. The second way for gaming to hurt society is indirect. Two oblique routes are invoked. On the one hand, gaming involves distorting much relevant information – e.g. statistical data on the prevalence of given symptoms that could usefully be used to design efficient public health policies. Therefore, gaming deprives the relevant agents of precious tools to improve the system (Régis 2004). On the other hand, gaming may function as an easygoing substitute to openly challenging the system. Thus, Morreim (1991) contends, it "may help perpetuate unwise policies". From a consequentialist viewpoint, critics argue, gaming is not justifiable. It betrays a lack of responsibility for the social consequences of one's acts.

Now there also are deontological arguments. The first rests upon the principle of veracity: One ought always to tell the truth. Yet, the argument goes on, gaming – in its most developed forms – is essentially a kind of lying. Hence it amounts to infringing one of the most robust norms of common morality. More specifically, physician's professional integrity involves veracity. Hence in addition to being at odds with everyman's common

morality, gaming also conflicts with the specific moral requirements of the medical profession.

The second deontological argument is premised on the general duties of justice – both contractual and distributive (cf. Haavi Morreim 1991). On the first hand, gaming may offend contractual justice. In free-enterprise healthcare systems based on agreements between agents, medical services are provided according to contracts between patient and payer. Gaming, from this perspective, is a kind of contractual fraud. As such, to cite Morreim, gaming is both an "assault against legitimate agreements" and an "invitation to economic anarchy" (Morreim 1991, p. 445). On the second hand, gaming also offends distributive justice. The resources available for healthcare are necessary scarce – as even the friends of an extensively redistributive healthcare system must admit (Daniels 2008, p. 104 ff.). As a consequence, "not everyone can have everything that he or she needs" (Morreim 1991, p. 445). Therefore, even if the healthcare system is just, there will be limitations on available treatments. In that case, gaming conflicts with distributive justice. As Morreim forcefully puts it, those "who extract more than their share, even for the worthwhile goal of better health, are unjustly freeloading at others' expense" (Morreim 1991, 445). For contractual or distributive reasons, then, gaming is an unjust strategy.

If these arguments are sound, we must conclude that gaming is irresponsible, noxious to truth and integrity, and unjust. How could such an outrageous practice be justifiable? Let's turn, in the next section, to the tentative sketch of an answer.

3. For Gaming the System: the Internal Morality of Medicine

The best argument for gaming, and maybe the only, stems from what is usually called nowadays the *internal morality of medicine* – i.e. the idea that medicine, like some other morally loaded professions, is a practice governed by its own specific rules, values or virtues and that we should only pass moral judgement on physicians' behaviour on the basis of these specific requirements. As one commentator puts it: "A sufficiently robust medical ethic can be derived entirely from the contemplation of medicine's proper nature, goals and practice" (Arras 2001, p. 643). The internal morality of medicine thus contrasts with the *external morality of medicine* – i.e. the idea that one should judge physicians' behaviour, like any other conduct, on the basis of general criteria of morality applicable to every member of the moral community.

Defenders of the internal morality of medicine commonly put forward three main theses. Firstly, medicine is a *practice* – i.e. "a coherent form of human activity and related competences" (Hoogland & Jochemsen 2000, p. 463). To be a good participant in a given practice, one must *know how* to act according to the defining rules of that practice. A good participant in the practice of soccer must know how to follow the rules of the game in order to

gain victory. A good participant in the practice of philosophical discussion must know how to act according to the rules of argumentation in order to advance convincing positions. And so forth. Thus the defining rules of a given practice function as "quality standards for the performance of the practice" (Hoogland & Jochemsen 2000, p. 463).

Secondly, according to MacIntyre's famous theory, "X is a practice" implies "X has an internal good specific to it from which the defining rules of the practice derive". The internal good of the practice of soccer, for example, is winning the match without violating the formal rules of the game. And the informal rules of the game, the norms of knowing how to play, specify the ways to maximise one's chances of winning. The internal good of the practice of philosophical discussion is the development of adequate conceptual analyses and sound arguments. And the art of making fruitful distinctions is the philosophical analogue of the sportive art of making good penalties: a standard of practical excellence in striving to realise the practice's internal good. It follows that a practice may be described as "a coherent form of human activity in which [...] rules, related to the internal nature and finality of the practice, define the competences and standards of adequate performance of that practice" (Hoogland & Jochemsen 2000, p. 464). Hence a practice is identified by its internal good and the rules derived from it – its constitutive rules, in Searle's parlance.

Thirdly, medical practice has one main internal good: taking care of one's patient's health. And the most important constitutive rule of medical practice is thus captured by the well-known *principle of beneficence*, stating *in nucleo*: Always act to the greatest benefit of your patient's health. Of course, there are diverse interpretations of that internal good and the correlated principle. Some are highly restrictive and limit benefiting the patient's health to *curing* – which implies for example that helping incurable patients "to die with dignity and peace" (Brody & Miller1998, p. 387) is outside the frontiers of duty. Some are more hospitable to modern forms of medicine and include palliative care in the orb of medicine. Hence the precise formulation of medicine's internal good is no easy task. Maybe focusing on health strongly programs restrictive readings – notably if one understands health to refer to some complete and efficient functioning of the body. Since dying entails the end of functioning, promoting help in this sense cannot count as benefiting health. To prevent conservative interpretations, let's then switch to Brody's and Miller's formulation of the internal good: to "help patients who are confronting disease or injury" (Brody & Miller 1998, p. 386). This of course implies trying to cure disease when feasible, but it clearly goes beyond. Brody and Miller thus propose the following list of intermediate goals derived from the internal good of medicine (Brody & Miller 1998, p. 386-387):

1. Reassuring the 'worried well' who have no disease or injury;
2. Diagnosing disease or injury;
3. Helping the patient to understand the disease, its prognosis, and its effects on his or her life;
4. Preventing disease or injury if possible;

5. Curing the disease or repairing the injury if possible;
6. Lessening the pain or disability caused by the disease or injury;
7. Helping the patient to live with whatever pain or disability cannot be prevented;
8. When all else fails, helping the patient to die with dignity and peace.

From the internalist viewpoint just outlined, a good and conscientious physician is one who takes seriously the internal good of medical practice and the correlated constitutive rules and who employs her technical skills as best as she can to help those she meets in the "clinical encounter" (Pellegrino 2008, p. 63). Hence a conscientious physician ought to aim, first and foremost, at helping her patients. Using a common phrasing, a conscientious physician ought to exhibit "fidelity to the interests of the individual patient" (Brody and Miller 1998, p. 388).

It is now time to introduce what I earlier called "restrictive environments": our good physician works in a healthcare system whose reimbursement policies set limits on the available treatments. Which may lead to denials of medically indicated treatment. Imagine our physician has come to the judgement that patient X needs treatment Y. Assume further that this judgement is irreproachable from a medical viewpoint: no skilled professional could deny that treatment Y is required in the circumstance. And suppose now that treatment Y gets denied by the rules in force in the healthcare system. What should our physician do? According to the internal morality of medicine, the answer is quite straightforward: if helping patient X requires giving him treatment Y, and since helping one's patient is the prime mission of health professionals, then our conscientious physician ought to take whatever measure is necessary to grant patient X the needed treatment. If the reimbursement rules in force deny patient X treatment Y, then the internal good of medicine requires our physician to bypass these rules. If medically necessary, she has the professional duty to game the system. That is the price of living up to the excellencies of medical practice – given stern expression by Edmund Pellegrino:

> When the system harms the patient then the question of the physician's primary agency arises. If he is primarily the patient's advocate, agent and minister [rather than a bureaucratic pawn of the system], then he must protect the patient's interests against the system even at some risk and damage to his own self-interest (Pellegrino 1986, p. 31).

A this point, it looks like we are caught in a dead end. On one hand, we have discovered a battery of diverse arguments against gaming the system. On the other hand, we have discovered a single coherent "Hippocratic" argument for gaming the system. How should one decide with which position to take sides? Here comes the distinction between ideal and nonideal theory, to which we turn in the next section.

4. The Idealistic Fallacy

Since John Rawls (1971) introduced the concept, ideal theorizing is commonly characterised by two counterfactual idealisations (Robeyns 2008). Firstly, it assumes socio-political contexts within which background institutions are perfectly just. Secondly, it assumes that individual agents living in these contexts are fully compliant with the demands of justice. Ideal theory thus is normative reflection based on the hypothesis of a normatively perfect world.

There are logically three ways to depart from ideal theory. Firstly, you can suppress the first idealisation and assume a world where background institutions are not perfectly just, and imagine individual actors that take the demands of justice or more generally morality seriously. Secondly, you can suppress the second idealisation and assume a world where individual actors behave like knaves, but where background institutions are perfectly just[2]. Thirdly, you can suppress both idealisations – and imagine some form or other of hobbesian hell.

Our previous discussion of the pros and cons of gaming the system is best seen as arising in the first kind of nonideal theory. For we imagined a good and conscientious physician set in *restrictive environments* – i.e. institutional settings governed by reimbursement rules somehow designed as cost-containment policies. Now these rules could be justified in an ideally just society. Even ideally just healthcare systems, it is often admitted, cannot expect infinite resources: besides health, there are numerous other social goods to be provided; and satisfying every need for healthcare may imply sacrificing the provision of other important social goods – such as education, national defense and so forth. So even in ideal contexts, denials of treatment are possible. That notwithstanding, I shall focus on non-ideal contexts because, firstly, our real contexts are more probably non-ideal than ideal; and secondly, it allows us to examine the question of what an ideal agent should do in non-ideal environments. And the question of the justification of gaming the system can be seen as one instance only of the more general problem of how conscientious people should cope with our imperfect, and sometimes gloomy, world.

We are thus interested in agents eager to act as well as possible in circumstances that are not as good as possible. According to what criteria should these agents deliberate, and according to what criteria should the "external" observer judge their behaviour? One answer is what Michael Phillips calls *Moral Purism*. Moral Purism is the following thesis (Phillips 1985, p. 556):

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[2] On can doubt whether ideally just institutions are possible or viable if the individual actors submitted to them do not respect the demands of justice. But that has no importance here.

> We imperfect denizens of this imperfect world ought to guide our conduct and design our institutions in accordance with an answer to some question of Ideal Theory.

What question exactly? Phillips identifies several, but the most relevant to our purpose is the following (Phillips 1985, p. 553):

> What principles would an ideally structured society publically acknowledge and enforce to govern the behaviour of its members, on the assumption that all members comply with those principles?

Such a question encapsulates the two counterfactual idealisations mentioned earlier. (a) By making reference to an "ideally structured society", it assumes socio-political contexts within which background institutions are perfectly just. (b) By making reference to the "assumption that all members comply with those principles", it assumes that individual agents living in these contexts are fully compliant with the demands of the ideal. Thus Moral Purism consists in requiring us to deliberate on our own conduct and to judge the conduct of others on criteria drawn from some ideal theory *even if we live in non-ideal contexts*.

Now, according to Phillips' sober demonstration, Moral Purism is false. For it faces at least three problems[3].

1. It is sometimes *logically impossible* to act on ideal principles in "historical" non-ideal circumstances. Indeed "at least some of the obligations described by such a morality will presuppose a certain social and political setting" (Phillips 1985, p. 556). If this setting does not exist, then it is impossible to perform those obligations. For example, one cannot discharge "the duties of a citizen of a democratic state" in the absence of democracy; or one cannot perform the duties of a liberal lawyer in a society without due process of law. Hence duties and obligations that are premised on a given institutional setting cannot govern our conduct if those institutions are absent.

2. It is sometimes *psychologically implausible* to act on ideal principles in "historical" non-ideal circumstances. Imagine an ideal theory prescribing "free, non-possessing, caring sexuality" (Phillips 1985, p. 558). In ideal circumstances thus defined, jealousy would be considered immoral since it manifests a *possessing* conception of sexuality. Is it psychologically possible to live up to this ideal standard if "our characters" were "formed in the context of imperfect or corrupt institutions"? No, Phillips answers: for people raised in societies like ours, where exclusive sexuality is the norm, non-jealousy may be unattainable. According to Moral Purism however, I should conduct myself here and now as I would if I lived instead in a hypothetical non-

[3] Actually, Philipps presents more than three objections to Moral Purism. For the sake of brevity, I rehearse only the three most relevant.

jealous world. But, as John Lennon would say, "I'm just a jealous guy". And "ought" implies "can". So I cannot be obligated to act and react in a non-jealous way. So I cannot act as Moral Purism would have it. So Moral Purism is false.

3. It is sometimes *morally problematic* to act on ideal principles in "historical" non-ideal circumstances, for it may be *self-defeating* by thwarting the very realisation of the ideal itself. Suppose the ideal is some kind of egalitarian society. In such an ideal society, inheritance would be prohibited – for the reason that it promotes inequality. According to Moral Purism, we ought here and now to abstain to pass on our property to our children. But, Phillips contends, this purist imperative may defeat the ideal itself: "Consider the Vietnamese immigrant who worked hard all of her life in order to provide her children with a college education. If she fails to will her monies to her children [...], her failure serves to perpetuate their disadvantaged condition, i.e. to perpetuate inequality of opportunity and injustice" (Phillips 1985, p. 559). Another nice case imagined by Phillips is a university professor dedicated to an ideal of public truthfulness who lies to a "McCarthyist Committee" about what goes on in his university in order "to protect the classroom as a place where at least some truths may be spoken". Here the professor's reason to depart from the ideal is not to promote its full realisation, as in the immigrant's case, but to create "some breathing space for some aspect of [the ideal] in this corrupt world" (Phillips 1985, p. 560). Breaking the ideal may thus sometimes be justified as a way to make the world more hospitable to it.

Hence Moral Purism is false: it is not justified always to assess behaviour in non-ideal circumstances on the basis of criteria drawn from one's pet ideal theory. *Real life morality cannot be mechanically derived from ideal theory*. By doing so, one commits what I shall call the *Idealistic Fallacy* – i.e. the fallacy, put simply, of passing judgments in a non-ideal world by ideal standards.

Now our question is: How does the idealistic fallacy thus defined relates to the discussion about gaming the system? Here is my contention: most objections to gaming precisely commit the fallacy – and the other objections are not conclusive.

Let's begin with the deontological objections. There are two of them. The first states that gaming is a form of lying and that lying is always morally prohibited. The second states that gaming offends both contractual and distributive justice. It offends contractual justice because it implies bypassing the terms of contractual agreements with third-party payers. And it offends distributive justice because it implies overlooking the necessary and justified limitations on available treatments that even the most just healthcare systems would have to admit.

Regarding the objection from veracity, it is natural to ask: What does account for the prohibition on lying, and should it really be considered an absolute rule? Two ways of answering are open. Either we give the prohibition on lying a form of intuitionist grounding "à la Ross" (Ross 1930): the set of *prima facie* self-evident moral principles includes a rule against lying. Or we give it a more "theoretical" grounding "à la Kant". In the first case, the objection fades away. For it is well known that intuitionism does not give us absolute principles to be rigidly applied in every situation: *prima facie* principles often come into conflict, and judgement on particulars must then enter the picture in order to enable the deliberating agent to settle the issue. Intuitionist rules are not absolute. From that viewpoint, hence, it is always possible that the prohibition on lying gets *defeated* by countervailing reasons. So if we admit the normative credentials of the internal morality of medicine, then we should acknowledge the possibility of beneficence defeating veracity – albeit in a limited set of circumstances (to be elucidated later). Whence it follows that gaming the system cannot be automatically condemned without considering the particulars of concrete choice-situations. But the sceptic about gaming can make use of the second option – the "Kantian-theoretical" grounding of veracity[4]. The absolute Kantian prohibition is best seen, for reasons of time and space, in the light of the Formula of Humanity prescribing that one ought always to act so as to treat humanity's rational nature, in oneself as in others, as an end in itself and not only as a means. According to Onora O'Neill's illuminating analysis (O'Neill 1985), the Formula must be understood as requiring, for any action A affecting person P, that it be *possible* for P to consent or dissent with A or more precisely with the maxim that justifies or motivates the agent to do A. The best case to clarify that requirement precisely is deception and lying. As O'Neill puts it: "The victim of deceit *cannot agree* to the initiator's maxim, so is used, and *a fortiori cannot share* the initiator's end, so is not treated as a person" (O'Neill 1985, p. 262). The victim of deceit cannot agree to the initiator's maxim because she does not know that maxim, so she does not know to what exactly she could give or withdraw consent. Consenting to a hidden maxim is as *impossible* as aiming at an invisible target. So deception, whereby one hides one's maxim, is necessarily immoral. Here comes the charge of Moral Purism. Indeed such a Kantian derivation of the absolute prohibition on lying faces the third problem identified by Phillips: abiding by the absolute prohibition on lying in non-ideal circumstances may *defeat* the very ideal justifying the prohibition. Let's read Phillips extensively (Phillips 1985, p. 559):

> Were everyone to act on this [kantian] morality we could all speak the truth without fearing that the truth will be used against anyone in an unscrupulous way. But this is not the world in which we live. If an enemy of my friend asks me for an

[4] Of course, Kantianism is not the sole option in moral theory. Regarding absolute prohibitions, however, it is of course the most promising. On one hand, as is well known, Utilitarianism is hardly hospitable to rules – and when it is, the rules are hardly conceived as absolute side-constraints. And on the other hand Aristotelism seems closer to rossian appeals to judgement on particulars than to the kantian stress on rigid rule-following.

> account of my friend's weaknesses, and I respond candidly, my friend may rightly accuse me of betrayal. And if he is present, he may accuse me of humiliating him. In either case, I have not respected my friend. Moreover, the more I act in this way, the more I weaken the institution of friendship; one of the few havens of genuine respect in this world. Thus, it might even be that by my candor I have taken a small step toward making the world less hospitable to respect.

But, as Phillips rightly notes and as appears from the Formula of Humanity, Kantian morality does aim at a world where respect for persons prevails. So the purist Kantian position is self-defeating. Here the Kantian purist could invoke the distinction between honoring and promoting values (cf. McNaughton & Rawling 1992) and say that Phillips' argument confuses the two: as a deontological doctrine, Kantianism enjoins us to *honor* values, not to promote them; but Phillips reasons as if the point of Kantianism was promoting respect. Such a rebuttal, however, begs the question. For Phillips' point is precisely to cast doubt on the soundness of honouring ideal values in a non-ideal world. So here is the result regarding the objection from veracity: either one gives veracity an intuitionist grounding, or one gives it a more or less kantian grounding. In the first case, veracity cannot enter an argument for the absolute immorality of gaming – and it remains possible to justify gaming in some if not all situations. In the second case, veracity can indeed be used to mount an absolute condemnation of gaming. But it falls prey to Phillips' objections against Moral Purism. A physician facing the choice between accepting that her patient doesn't get the required treatment or lying to third-party payers thus faces a choice between abiding by a disputed absolute principle of common morality and the overarching duty of medicine's internal morality, i.e. beneficence. The common absolute ban against lying is disputed, because its status as an absolute or relative principle is a matter of controversy. The duty of beneficence, in comparison, is a robust principle of medical ethics – one that no ethicist seriously challenges. As importantly, beneficence is not only a principle of medical ethics, it is also a principle of common morality; whereas veracity, *outside the physician-patient relationship*, is not a specific principle of medical ethics – as clearly appears from reflections about confidentiality. Abiding by the principle of beneficence is thus required both by the internal morality of medicine and by our common morality. So beneficence may be seen as doubly binding on physicians. From this perspective, and without paying much attention to the particulars of choice-situations, it looks like physicians do have a weighty reason to give beneficence precedence over veracity: beneficence is, from their medical moral viewpoint, more robust than veracity; and beneficence counts double – as a specific requirement of their professional morality and as a general requirement of common morality. Hence the objection from veracity is far from conclusive.

The second deontological objection, based on the duty of justice, is more easily disposed of. To begin with, the duty to abide by the rules of *distributive justice* presupposes that these rules are just. Without that, we face, not rules of distributive justice, but mere rules of distribution. And the

duty of justice cannot command us to abide by any rules be they just or not. We encounter here the first problem of Moral Purism outlined above: it is logically impossible to discharge "institutional" duties when the presupposed institutions are absent. When physicians bypass distributive rules in the real world of non-ideal healthcare systems, they do not violate just distributive rules. Therefore the duty of justice, in these circumstances, cannot override the core duty of beneficence constitutive of the internal morality of medicine. What about *contractual justice*, then? Well, I'm not sure "contractual justice" refers to anything precise beyond the duty to fulfil one's promises – a contract being nothing but a legally enforced reciprocal exchange of conditional promises. Two ways of answering the objection are thus open. On the one hand, the duty to fulfil one's promises is subject to the same reservations as the duty to tell the truth: either grounded in an intuitionist list of ordinary moral requirements, or grounded in some form of kantian Moral Purism, it cannot be used to derive an absolute *a priori* condemnation of gaming. On the other hand, in many systems of private insurance, the relevant contracts with third-party payers are signed, not by physicians, but by patients. Therefore by gaming a physician does not break any contract of hers. If she has not promised anything to a given insurance company, she owes it nothing. Of course, she may owe it truth – as she owes truth to every one according to the common principle of veracity. But we fall back here on the first objection to gaming – and we know yet what to think about that. Compared with the physician's duty of beneficence and its constitutive centrality for the internal morality of medicine, thus, "contractual justice" does not seem to have much weight.

To summarise, the two deontological objections to gaming do commit the idealistic fallacy. For they consist in opposing physicians' efforts to live up to the standards of their internal morality in a non-ideal world where reimbursement rules are much less than perfect in the name of criteria (such as absolute veracity or distributive justice) drawn from ideal theory. To that attack, gaming-friendly physicians can oppose a simple answer: "Gaming the system is our best non-ideal way to cope with a non-ideal world without reneging on our Hippocratic professional morality". We should thus concur with this commentary by Bogardus *et al.* (2004, p. 1843):

> Deception may be a barometer of those areas in which the dissonance between care and financing rules has become so severe that physicians see lying as the only way to do their jobs.

Thus physicians' deception does not betray a problem with physicians, but instead a problem with the restrictive environment in which they work. Bogardus *et al.* do not approve of gaming: "Deception is the symptom, not the solution". Our discussion so far allows us to nuance such a diagnosis. Yes, deception is the symptom of ill-functioning health-care systems. The ideal systemic solution is the promotion of better-functioning systems, of course. But the immediate non-ideal solution, for physicians faced with needy patients, cannot wait for the ideal world to be born. In the meantime, gaming is at least part of the non-ideal solution.

5. Some Further Thoughts on Consequences

Of course, this does not settle the consequentialist objections. There are three of them: gaming may hurt the patient for the sake of whom deception was first considered, other patients and society at large. None of them is fatal.

According to critics, gaming may hurt the patient whose needs motivated gaming in the first place because gaming implies falsifying the patient's medical record and because gaming may diminish the patient's confidence in his physician. As regards confidence, the objection rests on pure conjecture about the psychology of trust. Indeed, it seems to rest on the contention that trust stems from an impartial moral scrutiny of people's character. If they display generalised and impersonal honesty, then I trust them. I cannot see what could make such a contention *prima facie* plausible. For after all, we all know some forms of trust that do not match such an "impersonal theory of trust". I may trust my friend, for example, in part because I know that, *qua* being my friend, she will be biased in my favour. Conversely, we may wonder whether a child would trust his parents if he knew that they would not give his interests partial precedence over the interests of strangers. At the normative level, that's precisely what so-called "special obligations" are about: giving one's relatives' interests special weight in one's deliberations. So without being given more warrants, Haavi Morreim's claim that gaming is detrimental to the patient's trust towards his physician can be put aside as a fancy conjecture. The point about medical records is more down to earth. But physicians may mitigate this negative effect of gaming by finding ways to deceive third-party payers without falsifying the records. Or, if that's not possible, they may try to coordinate gaming and to organise covert common policies to avert the effects of falsification. For example, the may imagine a kind of "coding" designed to deceive only third-party payers but not colleagues in clinical practice. The point is that one cannot condemn gaming *a priori*: *prudent gaming* is possible.

The next consequentialist objection advances that gaming may hurt other patients by disrupting need-based priorities and by creating "second-class patients" – composed of those individuals who, for lack of social capital and privileged acquaintances with the "medical milieu", are not apt to ask for gaming (Régis 2004). As regards need-based priorities, as with the problem of falsified medical records, the danger can be averted by coordinated action by the medical community rather than isolated decisions by individual physicians. If Dr Mafalda gains access to an intensive care unit for patient A through gaming, and if Dr Bob has a needier patient B requiring A's bed in the unit, good coordination between Bob and Mafalda can solve the problem: nothing makes it necessary that A blocks access to B. A may be removed for the needier B. This regularly happens in hospitals without gaming entering the picture. Of course this requires that Dr Bob does not condemn gaming

and would not e.g. denounce Mafalda would he come to know about her having gamed the system. Transparent cooperation between physicians thus implies a wider acceptance of gaming as a legitimate strategy than it is now the case. For the main obstacle to coordination, plausibly, is the fear of deceptive physicians of incurring sanctions or blame from their "legalistic" colleagues. The same holds true of the problem of "second-class patients". There are two ways to avert the danger. The first is an absolute ban on gaming. The second is a widespread acceptance and practice of gaming, maybe even a systematic recourse to gaming. If gaming, when medically necessary of course, becomes the informal norm, then inequalities in social capital won't make any difference. Whether you're rich or poor in social capital and useful acquaintances with the "medical milieu", you benefit from gaming if you need it. Which way is the best, no gaming or systematic gaming? Since gaming, in non-ideal contexts where reimbursement rules do not allow for every medically required treatment, is prescribed by beneficence, then systematic gaming has both advantage of being consonant with medicine's internal morality and the advantage of fostering cooperation and coordination in order to avert the dangers of falsified records, disrupted need-based priorities and the creation of second-class patients.

Finally, the third consequentialist objection states that gaming may hurt society at large by undermining trust in the whole resource system, by distorting much relevant statistical data and thus preventing actors to improve the system on the basis of reliable information and by helping "perpetuate unwise policies" (Morreim 1991). To begin with the problem of diminishing trust in the resource system, two points must be made. On one hand, the causal link between gaming and loss of collective trust in the system in no more warranted than the previously discussed link between gaming and patients' lost confidence in their physicians. On the other hand, and more importantly, trust *per se* is not necessarily a good thing: as many moral pro-attitudes such as disapprobation or gratitude, trust may be *deserved or not*. Socially and psychologically, it is possible to trust a knave who only deserves defiance. Why should we consider such a misplaced trust to be valuable? Well, if we acknowledge that, then collective trust to a given institutional system must pass the following test: is the system worthy of trust? If the healthcare system is unjust, as our focus on real-world non-ideal systems implies, then should we trust it? As in the case of inter-individual trust, the most plausible answer is: No. Therefore, if physicians game the unjust rules of a non-ideal system, then diminishing trust in that system is no fatal problem. In this situation, an organised and coordinated form of gaming may even function as an incitation to improve the defective system.

What about the other two alleged social nuisances? Nothing in gaming itself prevents deceptive physicians from engaging in activist strategies aiming at reforming the system. And nothing prevents them from keeping covert and anonymous statistical records possibly available if some reformers set about reforming the system. In other words, nothing in gaming itself constrains physicians to help "perpetuate unwise policies". Once again, these

consequentialist reservations about gaming only point towards more coordinated forms of gaming and towards gaming being conceived as one tool among others in the physicians' "Hippocratic toolbox". To be sure, asking physicians to be good practitioners, conscientious representatives of the internal morality of medicine *and* political activists may be *overdemanding*. And overdemandingness is one chief problem of non-ideal theory (Murphy 2000). But this is a problem precisely for morally serious, and not irresponsible, people. If we do think that gaming physicians face this problem, then we implicitly acknowledge their virtue – not their vice.

6. Towards Collective Beneficence

Gaming may be morally justified by the principle of beneficence. But that principle has to be modified. Traditionally, medical beneficence is seen as an interpersonal principle gearing an individual agent to an individual patient's good. Faced with some patient, Dr Mafalda ought primarily to aim at that patient's good. This interpersonal interpretation of medical beneficence is clearly implied, for example, by Pellegrino's thesis that the "clinical, face-to-face encounter" is "the starting point for a philosophy of medicine" and "the root of its internal morality" (Pellegrino 2008, p. 66).

But in answering the consequentialist objections, I insisted that gaming should be coordinated rather than isolated – and that gaming physicians should transparently cooperate in order to prevent some sad possible consequences. Thus Dr Mafalda and Dr Bob have to deliberate together and, depending on the result of their deliberation, Dr Mafalda may have to accept that Dr Bob's patient takes precedence over her own patient. Hence she has to moderate her own beneficence. What is important, from this viewpoint, is not only Mafalda's face-to-face beneficence. It is also Mafalda's considering whether her own beneficence is not detrimental to Bob's beneficience. According to the traditional interpretation of beneficence, the relevant question is: How can *I* display maximal beneficence to *my* patient? According to the reformed interpretation proposed here, the relevant question becomes: How can *we*, physicians working in the same unjust restrictive environment, display maximal beneficence to *our* patients? At first sight, that modification may be considered a weakness in my account: instead of endorsing the internal morality of medicine, it betrays it. The answer has two parts.

Firstly, since Dr Mafalda takes care of more than one patient, she must accommodate multiple independent claims from different patients. As a good and conscientious physician, she cannot but give priority to some claims over others – e.g. she may have to cancel an appointment with a benignly ill patient A in order to rescue patient B, whose life is in jeopardy and who needs immediate medical intervention. Even traditional interpersonal beneficence, therefore, includes a germ of collective thinking since it links an individual agent to a *collection* of patients.

Secondly, the novelty in the full-fledged collective beneficence introduced here is that it links a *collection* of agents to a collection of patients. We thus switch from an agent-relative principle to an agent-neutral one, which implies beneficence is to be promoted rather than idealistically honoured. By collectivising beneficence, we acknowledge the fact that, in an unjust restrictive environment, maximal interpersonal beneficence is institutionally impossible. Hence we renounce honouring an ideal principle in a non-ideal world. Far from being a weakness, thus, this novelty protects the pro-gaming argument against a charge of Moral Purism. And by defending gaming, we still acknowledge that beneficence, even adapted to non-ideal circumstances, remains the core principle of medical ethics.

7. Conclusion

Our discussion so far suggests two provisory conclusions:

- Gaming is a justifiable response to non-ideal healthcare systems – and deontological doubts commit an idealistic fallacy.
- To prevent the possible nuisances of gaming, we need a more generalised and coordinated form of gaming – which implies that gaming, instead of being *a priori* condemned, be accepted as a legitimate Hippocratic way to face injustice.

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