

REENVISIONING MISSION AND MORAL LEADERSHIP IN HEALTH CARE

an interview with Sachin Jain

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ABSTRACT To many participants in today's US health-care system, it can seem as if health care has lost its way. Complex, fragmented systems. Difficulty accessing care. Strain on physicians. Financial burdens for patients. Yet there are also many opportunities to improve care, patient and provider experience, and—ultimately—health. It won't be easy, according to SCAN Group and Health Plan President and CEO, Dr. Sachin Jain, MD, MBA. It requires nothing less than examining the paradigms of thought and practice that tend to maintain “business as usual” in the health-care industry. It will require reenvisioning mission, moral leadership, and what patient-centeredness means in health care.

ETHICS AND MANAGEMENT SCHOLAR Lauren Taylor and ethics and policy scholar Kelsey Berry spoke with SCAN Group and Health Plan President and CEO, Dr. Sachin Jain, MD, MBA, about health-care mission, markets, justice, and how he maintains a moral lens in health-care organizational leadership and strategy.

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BERRY: Sachin, you are President and CEO of SCAN Group and Health Plan, one of the nation's largest not-for-profit Medicare Advantage plans and also a provider of innovative health care and community services for older adults. SCAN's revenues top \$5.5 billion, and the organization serves more than 300,000 patients. Could you start by telling us about your journey to SCAN? What brought you to where you are today?

JAIN: Sure. My journey starts in New York City, where I was born in 1980, a million years ago, now! I was the youngest son of an immigrant physician, my father, who came to the US to pursue advanced training and eventually planted roots here. I grew up in a physician family in northern New Jersey and I went to Harvard for my undergraduate studies.

When I came home for Thanksgiving during my freshman year, I told my parents I was thinking about going to law school, because I was really interested in questions about justice and how to change society. My father, in his own way, said I had two options: I could either be a doctor or a physician [laughter]. He said, you can go to law school after you go to medical school. So I was an undergraduate student who ended up studying political science and was really interested in bigger questions of how to make a better health-care system for people. I wasn't at all sure how I would put that together in a career.

During my junior year, I wandered into a class called "Quality of Healthcare in America," which was taught by some of the giants in the field—Don Berwick, who founded the Institute for Healthcare Improvement, and Howard Hiatt, who had been the dean of the Harvard School of Public Health. They invited their friends to give lectures, and these were some incredibly impressive friends—people who were trying to change the health-care system in various ways, including health services researchers, government officials, and leaders of large organizations. I had a sense I had found my tribe: a group of physician change-leaders who committed to addressing health-care access, quality, and disparities.

I went to medical school with that lens, thinking I'd later pursue a master's in public policy. But my brother suggested I apply to business school instead, recognizing that I had already studied government as an undergraduate and much of health care does happen at the interface of business and medicine. I applied and ended up at business school, forgoing the public policy master's.

Around that time, I connected with Michael Porter, who was beginning to advocate for value-based health care. I ended up working with him for several years as the term "value-based health care" was entering the health-care mainstream.

Several years later, during my residency, Barack Obama was elected president. I saw this as a once-in-a-lifetime opportunity to help change health care, so I reached out to everyone I knew who was joining the Obama administration in

a senior capacity and said, “Do you need someone to carry your bags?” The first person who called me back was David Blumenthal, and I ended up working with him as his chief of staff during the implementation of the HITECH [Health Information Technology for Economic and Clinical Health] Act. I also worked at CMS, helping to found the Center for Medicare and Medicaid Innovation under Don Berwick’s leadership.

I knew at that point that I was someone who wanted to change health care. I had gotten a taste for it at the policy level, and I wanted to be part of implementation in the real world. Yet as I talked with health system leaders across the country, many of whom were trying to implement policies from the ACA, I started to notice a real disconnect. There was a gap between what people were saying and what they were doing, and this led to a real crisis of confidence for me in the US health-care system.

Since then, in my work at Merck, Anthem, CareMore, Aspire, and now SCAN, the thing that wakes me up every morning with a certain degree of anxiety, in addition to whatever the day’s crisis is, is this gap between who we say we are and who we *actually* are in American health care. I see this everywhere, especially in the context of ethics.

At every stage of my career, there’s been an ethics component. At Harvard Medical School, I took a bioethics course taught by Walter Robinson. At Harvard Business School, I took Michael Sandel’s course on justice, and a course called “Leadership and Corporate Accountability.” These courses—on ethics, distributive justice, and how to lead a just organization—have shaped my thinking throughout my career.

Some of the texts I read in Sandel’s course still come to mind regularly. However, I feel we don’t grapple with these tensions enough in health care. I think about the concept of “ethical erosion,” which I first encountered in medical school to describe the loss of ethical behavior among medical trainees from the first to the fourth year. In a corporate context, I believe there’s a similar erosion. People enter the business side of health care wanting to help people and make a difference, but over time, they become more focused on paying for their vacation homes and their children’s graduate school. The ethical tension that they should feel about their daily decisions isn’t felt as acutely. And that’s abnormal.

One of my core ideas is how in health care we have systematically normalized the abnormal. In the managed care industry, for example, we’ve normalized practices like putting older adults through long, inefficient phone trees that lead nowhere when they call member services. That’s an abnormal thing we’ve normalized. Through utilization management, we also normalize practices like putting sick cancer patients through bureaucratic hoops when they can least manage to jump through them. These are not behaviors that kind, normal humans would engage in, but we do them every day. My company does it every day in some form. This normalization of abnormal practices ties into the notion of ethical erosion, and it’s something I think about constantly in my work.

BERRY: I'd like to focus on the concept of "ethical erosion," as it's such an accurate term for what seems to be happening at the helm of health-care organizations. Recent news stories have highlighted how health-care organizations, which ostensibly should be mission-driven and support doctors in fulfilling the Hippocratic oath, are instead behaving more like corporate, profit-driven entities. This includes prioritizing cost-cutting, using aggressive billing practices, and even denying care or refusing patients due to insurance limitations. Could part of the solution lie in providing more ethics support to organizational leadership, similar to how clinicians have access to ethics consults when facing difficult decisions? Or are there other support structures or accountability measures we might be overlooking that could help counteract ethical erosion within the business side of health care?

JAIN: I believe we're facing an epidemic of shallow thinking at senior levels of health-care organizations. I recall the first time I heard the phrase "no margin, no mission," proudly stated by a health-care executive, in the sense that, "If we don't make money, we can't do the things people really need us to do." I've since heard this phrase used repeatedly, but it has been deeply distorted in its meaning. I don't think there's adequate reflection on what the mission actually is or should be for a health-care organization. Consider any health system in the country—they all have some version of this "no margin, no mission" conversation daily when ethical tensions arise. It leads them to practices like surprise billing, aggressive debt collection—even though these don't necessarily materially impact the bottom line. It leads them to redirect their payer mix away from Medicaid, away from the frail and vulnerable populations that nonprofit health-care organizations are supposed to serve, in favor of prioritizing commercial business. And they justify it by saying, "no margin, no mission." It pushes them to focus on fee-for-service payment models, rather than value-based health-care models, simply because they can make more money under the former. I see this happening daily. And they say, "We need to keep the lights on." My question, though, is why? Why is it so important to keep the lights on? Are these the right lights to keep on?

I think about the difference between hospital systems and health systems. In America, we have very few true health systems. We mostly have hospital systems whose business model revolves around keeping hospitals full, but few organizations whose business model is to actually keep people healthy and out of the hospital, and who see hospital admissions as a failure of the system. Most health-care organizations believe they should operate at full capacity. They believe there's an infinite backfill of patients who need their services. This is the first assumption we need to challenge. If we had a financing and delivery model focused on keeping people healthy, it would look dramatically different. Our behaviors would change.

Many organizations are successful doing exactly what they do, so they don't pause to reflect on these bigger questions. The question then becomes: how did

we get here? Part of the issue is the change in corporate governance. Look at the boards of large health systems—they're largely made up of business leaders whose own companies rely on continuous top-line growth year over year. Now, how do these business leaders measure the success of the organizations they are governing in a board capacity? By top line growth year over year. How do they compensate executives? Based on these revenue numbers. Everything is tied to growth. It's all about doing more, when for many patients, the right answer might be doing less.

When we use terms like “medical-industrial complex,” we're describing the idea that we will have a continuous level of inflation in health care, which has certainly been the case to date. Thirty years ago, health policy papers predicted that the portion of GDP spent on health care would be unsustainable. Today, that number is two to three times higher, and the same economists are still warning that we're spending too much on health care. But health care is big business in the US. It's the largest employer in almost every congressional district. Many people depend on our so-called sick-care health-care system for their livelihoods. Ultimately, it's more convenient and comfortable for us to hide behind glib statements like “no margin, no mission” rather than really grappling with these tensions.

TAYLOR: I want to return to the idea that most health or hospital systems assume there's unlimited demand for their services. I agree with you that we need to question that assumption, but if I put myself in the shoes of a health-care executive, they might argue, “In an ideal world, we'd be structured differently. But that's not the reality, and it's not the reality we've lived with for the past 100 years. There is *actually* a backlog of people who need hospital services.” Do you really think that's not the case, empirically?

JAIN: I really don't think that's the case. Here's the thing—what I'm saying is that every health system has the ability to organize itself differently and get paid for keeping people healthy, rather than keeping them sick. What's the capacity to do this? They can engage in risk-based contracts with commercial and government payers and participate in programs from the Centers for Medicare and Medicaid Innovation. These programs offer incentives to organizations that invest in outpatient chronic disease management. Take the top three Medicare diagnoses—most of them are linked to hospital admissions that could be avoided with intensive outpatient care. For example, with heart failure patients, we might want to see them weekly, monitor their weight, and intervene earlier. Instead, we don't do these things, and when they arrive in extremis with dyspnea on exertion, we admit them to the hospital for a week-long stay costing \$100,000. That's the state of care in America.

There's a well-known Harvard Business School case study about the Duke University Congestive Heart Failure Program. They focused on outpatient

management for heart failure patients, seeing them frequently, sometimes daily, which drastically reduced hospital admissions. And what happened? The CFO of Duke University Medical Center called over to the cardiology department and asked, “Why aren’t we admitting as many patients?” The cardiology department was told to shut down the program. And this isn’t an isolated case. I heard a similar story from another Ivy League medical center that built a great outpatient substance use disorder program to reduce inpatient admissions. The executive who supported the program faced a lot of opposition from colleagues who were worried about less volume, saying, “What’s going to keep the lights on if we don’t backfill these patients?”

So, while I do think there are some geographies where there’s “infinite back-fill,” I also think that there are other places where, if we prioritized health and wellness, we would organize our services very differently and see fewer admissions.

TAYLOR: What needs to change for the CFO to not shut down successful programs like the Duke Congestive Heart Failure Program or the substance use disorder program? Is it a policy failure—where financial incentives aren’t strong enough? Are we missing organizational structures, like management ethics committees? Or do we need to train the next generation of health-care leaders to develop a different ethical intuition?

JAIN: I believe we have a leadership crisis. The qualities that help people rise to the top in these organizations aren’t the ones we need at the top. Additionally, many health-care system board members are well-intentioned but view health-care businesses the same way they think about their own businesses. If you’re in the business of selling hats, as one board member I’ve come across was, you benefit from selling as many as possible. Similarly, if you’re in the business of inpatient admissions, you benefit from selling as many as possible. When the numbers go down, instead of thinking, “Wow, they’re doing a great job keeping people healthy,” they think, “Why aren’t they managing the business better?” That’s why I think we have a leadership crisis. The people at the top of health systems and health-care organizations think their job is to keep the organization running, not to keep people healthy.

That’s the assumption we need to challenge. There are a couple of organizations that have boldly embraced the idea of putting themselves out of business. MD Anderson, for example, has long said, “Our job is to put ourselves out of business by eliminating cancer.” What an ambitious and inspiring goal! Similarly, Mount Sinai Medical Center in New York published an ad years ago stating, “If our beds are filled, it means we’ve failed.” This was a nod to population health and the idea that their job is to keep people healthy. They truly believe their job is to manage patients intensively on an outpatient basis, where it’s less expensive.

If you've worked in the health-care business, you know that the most expensive line item in US health care isn't drugs, even though that's often the public perception. It's hospital bed days. We manage many patients on the inpatient side who could be cared for more affordably on the outpatient side or whose admissions could be avoided altogether if the business model were aligned with health. I've worked in those environments, and I can tell you it's possible, though it doesn't scale as easily, because many organizations are highly successful doing what they currently do.

BERRY: It seems there's a lot of pressure on health-care leaders to hold onto their moral compass, to prioritize keeping people healthy above all else, amid fairly strong countervailing forces and norms in the health-care industry right now. We also know from situationist research in psychology that individuals' behavior, including their moral behavior, is highly shaped by contextual features of the situations they're in, including something as small as whether they are in pleasant surroundings up to whether they have others standing in solidarity with their action. So I'm curious—where do you see the clinician workforce in this? Are they part of facilitating moral leadership in health organizations? Or would you tend to look outside the organization instead, into policy and the regulatory frameworks within which organizations operate, as creating a supportive environment for moral leadership?

JAIN: This might be a bit controversial, but I'll go out on a limb and say that I think physicians have largely abdicated their moral responsibility to exercise more power in the leadership of health-care organizations. What I mean is, there is always that one physician in every group who stands up and says what needs to be said, but that person usually disappears after a few months—whether it's three, nine, or 12 months. The question is, why do they vanish? It's because no one else stood up and said, "I agree." And when they vanish, they often get reemployed somewhere else a week or a month later because we have a physician shortage in this country. So physicians have a unique ability to advocate for a different way of doing things because their services are in high demand, more than in most other professions.

At the same time, the grumbling that happens in the workroom rarely turns into anything constructive. When it does, it's usually because someone was either smart or bold enough to speak up. But organizational culture tends to expel people who stand out. So my strong push here is that we need to create cultures where there is a swarm around doing the right thing. We know there are issues in American medicine—consolidation, poor implementation of electronic medical records, and unrealistic productivity standards for clinicians—that need to be addressed. But they don't always get addressed because we haven't created spaces and cultures in organizations where people can actually step up and respond.

Physicians, out of all the professional lines, are most capable of speaking up and speaking out. When I have private conversations with practicing physicians about their problems, they're happy to vent to me. Yet when I ask why they don't speak up, they say, "I don't want to. It's a waste of time. I don't want to engage in that." It is because, as frontline physicians, we haven't taken ownership of the health-care system. Instead, we've become the objects of the system, not the drivers. Physicians have largely become line workers—invisible cogs in larger and larger systems.

I believe there's a movement to be built by physicians who are willing to speak up more. But this requires resetting our organizational dynamics so that the one bold person who speaks out isn't the exception; it becomes how we show up as a profession. This is my personal view. It may be controversial, and some may think it's unrealistic, but without this change, everything will continue the way it's going.

BERRY: Let's talk for a moment about the burnout that physicians are feeling. Even physician-led organizations have high levels of burnout among frontline clinicians. How we might reset and address the distress at the level of practice?

JAIN: I think things might get worse before they get better. The idea that we can fix burnout and the entire health-care system at the same time seems unrealistic. What needs to happen is more physician advocacy at a higher level. I've seen a lack of physician advocacy in crucial moments. For example, during the implementation of the HITECH Act, which gave federal funds to doctors and hospitals to implement electronic health records, I was working for David Blumenthal and opening all of the mail that crossed his desk. We received countless letters from trade associations, but almost none came from frontline physicians, even though this was a huge change affecting their daily work. There was a real opportunity to weigh in and advocate, and say, "This is how it should be done right," but many frontline clinicians didn't seize it.

I think we all have a tendency to hide behind burnout. It's a hard message. But many other professions do find ways to advocate for themselves. Physicians need to step up and own that part of their profession. If they don't, things will only get worse. Many key decisions, like how fee schedules are set and how payment programs are implemented, significantly impact physicians' livelihoods. If we lean out and say, "I'm burnt out," things will only get worse—not better. And in the meantime, we do need to rethink the training of physicians to have some awareness of the systems and organizations they work in and the policy issues that affect them. Whether in medical school, where it still seems to be a devalued part of the curriculum, or in premedical training at the undergraduate level, we need health policy education as part of this training.

TAYLOR: Given your policy experience, and seeing firsthand how policy implementation can go wrong because the right voices weren't at the table, what makes you so confident that the current state of affairs is more of a leadership crisis than a policy crisis?

JAIN: There's definitely a policy crisis as well, but I think leadership is a big part of it. There are vehicles available today through which organizations could do the right things more consistently, yet many of them leave the opportunities on the table. Frankly, we're rewarded for incrementalism, rather than driving big-scale change. How many health-care systems are making big bets on population health and value-based care today? Many say they are, but when you look closely, and really drill down into how much is risk-based, it's often just window dressing over a fee-for-service chassis. Even a renowned system like Geisinger, one of the largest integrated health systems, serves only 25% of its patients through its own health plan. That's not a fully integrated system. And the majority of payments to clinicians are still fee-for-service. We've haven't made the move to do more of the right thing and less of the wrong thing.

Let's also talk about what true leadership is. We tend to think of title holders in health care as the leaders—the chief of the service, the chair of the department, the vice president of ambulatory care, the CEO. But I don't think that your title correlates with leadership at all. When I think of leadership, I think of Malcom X, Martin Luther King, Gandhi—people who go against the grain, maybe even go against their personal interest or financial interest to pursue a higher good. Who are those people in American medicine today?

One of the biggest losses of innocence for me occurred when I realized that many people who write great books on important topics also contribute to the very system they criticize. For example, I reached out to one of these authors to ask them to speak at an event, and the speaker fees were \$100,000 to \$150,000. So, the very people who write about how dysfunctional the health-care system is are, in some ways, profiting from that dysfunction. They're personally benefiting from it.

This is why I think we need to drive higher degrees of self-awareness all around. We have a medical-industrial complex, and an academic complex, that thrives on the dysfunction of the health-care system. We need to go to war with this a little more deliberately. Going forward, we may need to embrace more shame-based tactics. Shame can be a powerful motivator, and we see so much shameful conduct going unrecognized, unaddressed, or unmanaged. Let's name names. Let's disclose the speaker fees people charge and where the money goes. Let's talk about the organizations with predatory billing practices targeting poor communities. Let's discuss the hospitals that no longer accept Medicare. We need to start speaking up about these issues.

We've been very polite so far, but we must also recognize that many of us are in privileged positions. Some of us have tenure, making it impossible for us to be fired. Once you're in that position, it's time to speak out more forcefully. This is something I've struggled with as a rising health-care professional and executive: the hypocrisy. We're seeing this play out now with health equity. Many organizations have appointed Chief Health Equity Officers who give speeches and attend conferences, but they rarely address the hard truth: their own organizations aren't doing enough. They get C-suite titles and are part of a team, but often their self-preservation takes priority.

Sometimes we become the thing we rebel against. We can get co-opted into the very medical-industrial complex we criticize. I have to constantly monitor myself in this regard. There are things I've been involved in that I later regret. But we need to have these conversations, this honesty, and do it with kindness and compassion. That's how I think about it.

TAYLOR: If we have a leadership crisis, and yet you exist and feel the way you do, how do you guard against your own ethical erosion?

JAIN: Honestly, I think about that quite a bit. My path to leadership wasn't typical. I had some incredible mentors early on. I came from a role at Merck, which was focused on entirely different things, when I got a call out of the blue from Leeba Lessin, who had been leading CareMore Health. She asked if I would be interested in joining as chief medical officer and succeeding her when I was ready. I was 34, hadn't been jaded by corporate culture yet, and had experienced a rapid rise in my career. Because of that, I avoided learning some of the bad habits that come with long-term tenure in an organization. I think that gave me the ability to stay closer to who I really am.

That said, I'm not entirely sure if I got lucky or if this is a bit of a punishment because I can't unsee the things happening every day that don't feel right. I sometimes wish I could. I once asked a health-care leader how they handle the challenges we face daily, and they said, "When it gets too stressful, I just pull the blanket over my head." It made me think about how many people do just that, waiting for a time to come out when it feels safer.

No one says they want to deny claims when they grow up or wakes up saying they want to make health care harder to access for a better bottom line. But over time, we tell ourselves a different story about just those things. We convince ourselves that we are promoting affordability by eliminating unnecessary care. That's partly true, but the challenge is knowing when these measures are actually necessary and when they get in the way.

TAYLOR: One thing I've noticed is that many of our ethical failures are often managerial failures—simply not doing the work to change incentive structures

or workflows. What's your take on the relationship between ethics and management? Do you think we need to be talking about ethics more explicitly, or should we focus on management and a more ethical organization will follow?

JAIN: Honestly, I don't think most people in management have the space to think critically. People often just focus on doing what their boss asks them to do—hiring, building teams, executing initiatives. They don't reflect on the bigger ethical questions. That said, ethics might even be the wrong frame because it leads people into inaccessible places, theoretical dilemmas with no clear answers. In reality, there are often clear right and wrong answers, but most managers haven't been trained to recognize them.

I see a huge opportunity to shift things. If you were to ask me, what is one intervention that would have the greatest impact on health care today, I know what I'd do. I'd work to provide education for boards of health-care organizations and help them to understand one thing: health care is different. It's not like other industries. When you're dealing with life and death every day, the considerations, hierarchies, and priorities are different. When I think about board orientations in health care, rather than starting with the typical information—"This is our business, how we make money, key people and players, etc."—I'd like to see an orientation that starts by saying: this is our mission and our purpose. And it's the board's job to understand this and to surface and grapple with the tensions that are inherent to that mission and purpose.

I have a strong board in this regard. I operate a Medicare Advantage program, which, for better or worse, is structured to align incentives so that we succeed when patients are healthier and not frequently hospitalized. There are certainly many issues with Medicare Advantage, and I'm open to discussing those as well. As an example, the average for-profit Medicare Advantage plan targets a 5% margin and will often manipulate utilization management, cut benefits, or exit markets if they don't achieve that margin. Remarkably, our board is open to adjusting our profit target. During favorable years, we aim for a 1% margin; for the last three years, due to cuts in Medicare Advantage, we have targeted 0 to negative margins to ensure stability for our beneficiaries and maintain the trust that's vital to our mission. We are by no means perfect, and I'm wary of the toxic positivity in our industry that suggests, "We're great, and it's everyone else who has problems." We have issues, too, and I'm clear about that.

Furthermore, our board includes four physicians, soon to be five, which makes a significant difference. They understand health-care trade-offs intuitively, because they've been directly involved in patient care. Often, health-care organizations are governed by financial experts who are crucial for funding, but their perspective needs to be balanced with that of practicing physicians. The contentious divide between administrators and doctors needs to be bridged, and appointing more physician leaders can help achieve this.

TAYLOR: I want to discuss your experience at SCAN and the concept of organizational trustworthiness. In academia, there's a debate over what it takes for an organization to be considered trustworthy. Some say it must put the patient or beneficiary's interest first. Some argue this standard is unrealistic. SCAN's website explicitly states, "You come first," referring to the beneficiary. What's your take on this debate, and operationally speaking, can you really prioritize the beneficiary?

JAIN: I believe we're good but not great at this. It's certainly a claim we make, and I think we're better than our competition. For instance, every member has my actual email address and knows that if necessary, they can escalate something to me. This has been invaluable. It gives me insight into our shortcomings and helps drive process improvement and trust with our beneficiaries. However, we can improve further. We compete against a lot of other folks in our field and have to think about what we offer in the context of what they're doing, which has sometimes led to our adopting strange practices. For example, we provide a benefit for members to use on over-the-counter purchases. The benefit looked extremely generous on the surface, but with the vendor we were using, there was quite a high mark-up on the over-the-counter products, so the benefit didn't go as far as it would seem. A member actually wrote to me saying that the benefit felt insulting to their intelligence. We're switching vendors now and offering a more genuine benefit instead. But I will tell you that it gets harder to remain member-focused as organizations grow. To counter this, we're reinstating a program where any employee who is not in a patient-facing or member-facing role will have a member they talk to on a regular basis, reminding them who we serve.

The other thing we've done recently at SCAN is to rename our employees as "rebels." This goes back to the idea that we need to reset our thinking if we are going to have transformative change in health care. The system we have currently in academic health care favors a gradual rise through the ranks, which can stifle the kind of energy and fresh thinking that leads to innovation. We should encourage the people who are willing to push, to try new things, to change the face of the game. In deciding to call our employees rebels, we're encouraging them to rebel against unjust health care.

BERRY: There are many things that come to mind when you mention "unjust health care." It can encompass various aspects, from the unnecessary difficulty of accessing necessary medications to the demoralizing experience of working in a system that prevents health-care professionals from truly helping vulnerable and marginalized patients. It also includes the significant racial, ethnic, and socioeconomic disparities that remain under-addressed. You've written elsewhere about the need for a civil rights movement within health care. Could you expand on that? Thinking historically, what elements of the Civil Rights movement would most benefit health care today?

JAIN: It's about the spirit of protest. Consider the cost of health-care benefits, the structure and organization of the US health-care system, and the proliferation of middlemen who add expense without value. Many people today fear going to the emergency room—not because of medical procedures or diagnoses but because of the bill they're going to get. This fear of health care is something we have to do away with once and for all. It will come through a broader movement that rebels against the status quo. We've normalized issues such as lengthy wait times to see a primary care doctor—mine has a nine-month wait for an appointment—and then many people congratulate themselves for finding backdoor methods to access health care. We have to stop accepting these conditions and we have to demand something different of ourselves.

BERRY: In addition to on-the-ground protest, are there actions the government could take now using its power to implement required changes?

JAIN: Interoperability is one thing. Medical information is currently viewed as a competitive asset rather than as your own information that could facilitate your care across a fragmented system. Interoperability should be a prerequisite for participation in Medicare and Medicaid—a simple pen stroke could facilitate data-sharing that helps patients. Ending predatory billing practices is another thing. If you have the misfortune of getting hit by a car and taken by an ambulance to an emergency room, that can financially devastate people. The health-care system exacerbates cases of bad luck by compounding them with financial burdens. Interoperability and billing reform, and other practical policy reforms like administrative simplification and creating a unified quality reporting infrastructure certainly don't seem like glamorous changes, but they're necessary for a functioning health-care system.

BERRY: As we're wrapping up, what advice do you have for ethics leaders hoping to support change within health-care organizations? Is there a role for working with hospital and system executives to support a more deliberate and intentional ethics lens in their decision-making?

JAIN: I'm actually pretty pessimistic about this. I'll be honest with you. I've been a CEO for 10 years now, and if you read any CEO handbook, it's mostly about surviving in your role. It's about being cautious about your board, worrying about this or that, balancing one issue against another. And over time, something happens—you forget why you're in the role. You end up focusing more on staying in the position rather than using it for good.

I'm just giving you some observations from the field here. So, the idea of risking your job for a moral stand—that's a really hard pill for most people to swallow. I don't think the change will come from reeducating CEOs because, honestly, many of them don't even think of themselves as leaders, even though

they use that label. I'll tell you why. If it benefits their bottom line and helps them secure more commercial clients, many CEOs will walk away from a program for underserved populations in a heartbeat. There's rationing happening in all sorts of ways—where they place clinics, how they structure their system, how they treat people in the emergency room. These are deeply ingrained practices, and the duplicity is often normalized. They don't even realize the disconnect between what they're saying and what they're doing. It's uncomfortable when you call it out, and often, they just ignore you when you bring it up.

So, I believe the real work has to start at the board level, where people are a little more open to these discussions. I think most board members are genuinely curious about their role. Good board members often ask, "How can I be a better board member?" And because they feel secure in their position—there's less immediate risk to them—they're more open to exploring these issues. I think the real movement begins with organizations building board education programs and then actively enrolling people in these initiatives. Making it freely available, holding it in an inspiring location—so that people feel compelled to attend and know they're gaining something valuable. I truly believe this is the kind of work that the Institute for Healthcare Improvement or the Robert Wood Johnson Foundation or the Commonwealth Fund should be funding right now.

I'm calling on folks to step up and do this. This is the work we need, because health care is different. It's not the same as other industries. Medical ethics aren't the same as corporate ethics. There are daily trade-offs that must be confronted, and the answer isn't always margin over mission.