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Opinion

When Targets Target Patients

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Part of this essay was refined with the help of an AI language tool — a collaborator of syntax, not of thought.

Modern healthcare loves metrics. Dashboards glow with OKRs, growth curves, and key performance indicators. We measure nearly everything—except, perhaps, what matters most. Somewhere between spreadsheets and strategy decks, medicine's oldest compass—clinical reasoning—has begun to tilt.

When an organisation defines success as a financial OKR—"increase procedural volume", "boost uptake of device X", "convert consultations to prescriptions"—the logic of care bends. The physician is still reasoning, but not in the same orbit. Clinical reasoning begins to orbit around justification rather than exploration. Instead of asking "What is best for this person?", we ask, quietly and efficiently, "Can I justify this choice?"

This inversion is subtle and usually well-intentioned. No one sits down to distort judgement. But metrics have gravity. They pull thought towards their centre. When the centre is financial, the gravitational field is not clinical curiosity—it is performance.

Take contraceptive counselling. A target like "ten implant insertions per month" may sound harmless—perhaps even aligned with public-health goals. Yet once embedded in an OKR spreadsheet, it reshapes the encounter. The conversation starts from the product and works backwards to fit an indication. Evidence can always be found; contraindications can always be managed. The clinician, still convinced of neutrality, ends up arguing the case for a device rather than exploring the patient's priorities.

This is not an individual ethical lapse; it is a structural conflict of interest. We are used to declaring personal conflicts—consulting fees, stock ownership, speaking honoraria. But few institutions disclose their own built-in incentives: quotas, conversion goals, revenue-linked OKRs. These are system-level conflicts that quietly steer collective reasoning. They need no corruption to corrupt epistemology.

Medicine can learn from itself. In clinical ethics, "first, do no harm" begins with intent but ends with structure. Systems that make the wrong choice easy—and the right one costly—cause harm even without malice. Likewise, in governance, when our goals are financial first, clinical reasoning becomes defensive, not exploratory. We start with the answer and search for its justification.

This reflection is not anti-business. Dermatologists and plastic surgeons, whose work is inherently procedural, can thrive within systems that acknowledge commerce. The distinction lies not in whether one earns from procedures, but in whether indication

flows from patient goals or organisational ones. When evidence is ambiguous or preference-sensitive, the risk of target-driven drift is greatest—and so is the need for ethical design.

Clinical reasoning is the crown discipline of medicine. It demands curiosity, not confirmation. We cannot protect its integrity if we build systems that reward justification over discernment. A physician's mind should orbit around the patient, not the metric.

When targets start to target patients, care itself becomes collateral. Let us design OKRs that restore the correct orbit.

How financial OKRs distort clinical reasoning and create structural conflicts of interest.