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Commentary

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MEDICINE IS SO strongly identified with its science and technology and the things that it *does*, that it is sometimes difficult to remember that doctors are the actors who perform those things. However, in this era of concern for the costs of medical care, the focus has increasingly shifted to the physician, not as medical provider, but as an economic entity. The belief that doctors are subject to marketplace forces undergirds the major strategies of cost containment. It is my contention that the behavior of physicians (and, in fact, all others) is shaped primarily by the dominant force of the moral environment in which they work and live. When money is the major value of medical practice, the dominant force is greed.

It is essential to understand the medical endeavor if one is to comprehend the effect on medicine and medical care of differing payment mechanisms. In the last two decades, it has become apparent that medicine is a moral, or moral-technical, profession. While it is rooted in science and technology, the moral basis of medicine arises from several characteristics. First, it is directed at the welfare of patients, itself a good definition of the moral because of the basis of the word "welfare" in conceptions of the good and the right. Second, its primary tenets are to do good and avoid harm. Third, medical care rests on the relationship between doctor and patient. That relationship is generally considered fiduciary, although some writers on medical ethics, such as Robert Veatch,[1] have considered the relationship contractual.

Understanding the ethical implications of medical cost containment is confounded by the seeming dominance of science, technology, and technical values. The technological aspects of medicine are objective and measurable. Similarly, all medical goods that are directly technological (e.g., X-ray examinations, penicillin injections, appendectomies, laser treatments, endoscopies) are also objec-

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1. R. VEATCH, CASE STUDIES IN MEDICAL ETHICS (1977).

tively quantifiable. On the other hand, medical goods flow through a delivery system based on the value of doing good, avoiding harm, and remaining true to the patient's trust. Consequently, the central element of medical care is fundamentally nonmeasurable. One cannot know directly whether or not the patient's interest and fidelity are dominating the medical enterprise at any given moment.

Further complicating the attempt to understand what is happening to medical values as payment mechanisms change is the fact that medical care is not really health care, it is *sickness* care. Doctors actually know very little about health. Until the recent surge of interest in fitness and health, they had very little incentive to educate themselves about health. People visit doctors primarily because they *are* ill, *feel* ill, *expect* illness, or *fear* illness. Most preventive medicine strategies are designed, not to promote health, but to prevent sickness; and while related, these goals are not the same. In general, and with greatest frequency, doctors apply their teachings about science, technology, and disease to first find out what is wrong and then to treat it. While true that in some settings, such as well-baby care, illness does not seem to be the focus, it certainly is not far from any parent's mind.

It is absolutely crucial to realize that the whole process of medical care—from feeling ill, to finding the cause, to treatment—is a probabilistic enterprise.[°] This is not due merely to the imperfections of current knowledge, although that is a factor. It is ineradicably true because treatment is always directed at the biological future in which uncertainty inheres. In addition to the biological future, the patient's personal future contains uncertainties arising from the relative importance of things (e.g., the value of one outcome versus another, the disvalue of one condition versus another) which are, in part, determined by what is happening at any moment.

Because of all these nebulous characteristics, what doctors do and how they do it are matters of individual judgment based on the particular facts of the individual case. I do not mean by this the usual imperialistic cry of the doctor making a treatment decision. Rather, in *most* instances, and within very wide latitudes, what the illness is called, how many visits to the physician are indicated, what tests and procedures are ordered, can vary greatly from physician to physician. Because so many things in medicine seem to be standardizable (fit within diagnostic codes, DRGs, procedure codes, and so forth), the illusion of the ease of routinization of medicine and its practices is perpetuated. The latitude incorporated into most insurance or reimbursement systems with respect to coding

services and diagnoses makes this clear. The force that maintains the high medical standards which the diagnostic and reimbursement codes emulate (but do not set) is the moral code of medicine.

Medicine is not only a moral and scientific enterprise, it is also a business. As a practicing physician, I am a small businessman. I pay rent, employ five people, pay insurance, buy and inventory supplies, and have accounts receivable and accounts payable. I have been doing these things for the last twenty-five years. Private physicians make their living by selling individual services. The more they sell, the better financially they do. But their patients' interests are more often best served by selling less—sending them home from the hospital a day earlier, or scheduling fewer tests or office visits. In other words, practicing doctors' pecuniary interests are in conflict with their fiduciary responsibility. This is true whether the physician is in private practice or employed by an HMO, although in the latter instance, the financial incentive serves to encourage selling *fewer* services. Since HMOs are paid on a capitation basis, the fewer services they render, the more money they make. In either context, private or HMO, a physician may have directly conflicting incentives—financial self-interest versus patient well-being and economic interest—impacting on his or her decisions.

The problem of the conflict between physicians' responsibility to patients and their own financial interests has always existed in one form or another. Traditionally, it has been solved by socializing doctors to a rigid moral code based on duty and responsibility which *always* places the interests of the patient above all others. Firmly implanting that moral structure is one of the functions of the rigorous period of self-denying service that constitutes being an intern or a resident. When it has succeeded, the physician carries about forevermore an image of The Great Chief Resident in the Sky who waits only to chastise lapses in duty to patients. Charles Bosk's book, *Forgive and Remember: Managing Medical Failure*,[2] is an excellent description of the inculcation of moral standards in the training of surgeons. I have stated the goal of training in dramatic terms to underscore the fact that training is aimed at creating the *unnatural* drive to put the patient's needs above the financial (and other personal) interests of the physician. The moral code not only creates guilt when patient interests are subordinated, it also provides the rewards. Doctors pride themselves on the fact that they serve the sick, which makes them "special," and provides them

2. C. BOSK, FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE (1979).

high status. Indeed, when most people voice cynicism about the behavior of physicians, it is couched in the same moral terms—failure to serve the ideals of the profession, which are accepted by physician and layperson alike.

That this system of moral training and rewards is effective is demonstrated by both its successes and failures. Many years ago, the Teamster's Union funded a study of the medical care of its members.[3] One striking finding was that good doctors practice good medicine in good hospitals, but bad medicine in bad hospitals. The study was undertaken at a time when there was not nearly as much technology as today, so the difference between hospitals was more one of standards than of technical resources. These results should have come as no surprise, because any close observer of medicine can attest to how context-dependent the quality of medical performance is. In an environment where the social rewards go to proper (moral) medical behavior, doctors do the "right" thing, even when it is difficult and conflicts with their pocketbooks (or other personal needs). In an environment where high medical standards and ideals are either not rewarded, or actively disparaged, physicians act on narrow self-interest. Not surprisingly, most individuals respond in the same manner to group norms and similar pressures.

It is in the light of the foregoing that I want to comment specifically on Professor Capron's article. I am at a loss to know what has come over my friend Alex Capron; perhaps no one knows more about the legal and ethical issues that beset medicine than Alex Capron. After brilliantly dealing with (and going to the heart of) the technical "snow" of physicians and scientists during his years as the Executive Director of President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, I fear he has now been co-opted by the economists. On page after page he writes about the marketplace, market values, economic pressures and counter-pressures. Then he attempts to examine the effect of these factors on the moral, ethical, and value dimensions of medical practice. Not surprisingly, he finds some evidence on both sides of each issue. Ultimately, we are told that it is difficult to predict what will happen.

3. Quanity, Quality, and Cost of Medical and Hospital Care Secured by a Sample of Teamster Family Members in New York City (1962); A Study of the Quality of Hospital Care Secured by a Sample of Teamster Family Members in New York City (1964) (both studies published by Columbia University School of Public Health and Administrative Medicine).

This uncertainty should come as no surprise. The ethical effects of the emphasis on cost containment and marketplace medicine cannot be distilled from this or that datum. All the economic data and premises that are considered are not primarily things in themselves, nor are they "value free." Rather, they are inevitably information and ideas articulated in the service of some larger ideal or goal. In this regard, the economic data and premises are like scientific numbers and research statements. Science is also not value free. Although a particular scientific methodology may avoid value biases, it is always implemented in the service of some (usually unspoken) ideal or ideology. In this instance, the issues discussed by Professor Capron are in the service of a belief in the power of the marketplace. The "power of the marketplace" is not some isolated, independent, and irresistible force in human affairs. Marketplace forces feed primarily on narrow economic self-interest—in its most raw form, greed. There are many other forces in human behavior that may modify or defeat narrow, economic self-interest. Patriotism, compassion, the desire for power, love, the desire to excel or be admired by others, are all moral forces dependent for their power in affecting human behavior on the relative values of the society, on its prevailing ideology. "Economic man" is not the only human to be found.

The new marketplace orientation of medicine is not merely a shift to economic, as opposed to "medical," values. It is a shift in the moral climate of medicine. In this changing climate, an aura of anxiety has been created among physicians and in hospitals, medical schools, and other medical institutions. Physicians have become acutely aware of the increasing numbers of doctors and the resultant increase in competition. They are concerned about a fall in their incomes and about decreased social status in their communities. Medical students believe that they will no longer be able to look forward to the earning capacity characteristic of the past. Throughout the profession, there has been an increased emphasis on economic values. As Iglehart recently stated:

> [There is a] recasting of the medical profession in a different public image. Although this recasting is perhaps more the work of third parties than of the medical profession itself, and although the new image is fragmentary rather than complete, the profession is increasingly being seen as more nearly a commercial enterprise with vested economic interests than a calling of professionals whose foremost concern is the well-being of the patient. This shift in attitudes is occurring in tandem with the coming of the health care corporation and the proliferation of

profession-liability suits.[4]

It takes little imagination to realize the effect that this shift to economic values will have on: doctors putting patients' interests first above all others, including the physicians' pecuniary interests; doctors being true to medical-ethical values before economic values; doctors working together in their patients' interests, as opposed to competing with each other; and doctors putting love of the profession and its knowledge above concern for self. The shift will surely damage all these values which are essential to the superior practice of medicine. One should not be surprised at this effect of the new dominance of economic values in medicine. After all, it is the desire for money above other rewards that makes the marketplace work.

One of the issues raised by Professor Capron's article is the effect of cost containment and changes in reimbursement on access to medical care. Here we do not have to wait to see the effects, for they are occurring already. Professor Capron is correct when he states that access to care should not be measured by what happens to middle-class whites. Rather, one should keep one's eye on the disadvantaged: the infirm aged, the sick, and the poor. As Professor Capron has noted, these groups are already experiencing medical disenfranchisement. After years of decline, disease rates are climbing again among the poor. There are hungry people again. The aged who, as a group, use the most medical care are avoiding doctors because they cannot afford to pay. In addition, they are being discharged prematurely from hospitals because of the DRG system of prospective reimbursement adopted by Medicare. Power in the enterprise of medicine—the care of the sick—is shifting from the public and voluntary sector to the private. As a result, sick people that private institutions do not want—those who cannot pay or do not have insurance—are being "dumped" on public and municipal hospitals.

A goal of all these profound changes is being achieved; the cost of medical care is decreasing. But the price will be high, a deterioration in the quality of American medicine.

CONCLUSION

I am making the claim that as a result of the shift to marketplace values in medicine, the behavior of doctors and medical institutions will change. As a result, adherence to the ethical precepts

4. Iglehart, *Health Policy Report: Federal Support of Health Manpower Education*, 314 NEW ENG. J. MED. 324 (1986).

that Professor Capron identified—fairness, fidelity, and access to care—will suffer. I base my claim on the indisputable evidence that the moral climate of medicine has shifted from the traditional medical values that Professor Capron has identified towards economic values. My warrant for the claim is that the behavior of doctors and their institutions depends more on the moral climate than on microeconomic pressures (this or that method of payment). This has been true during the history of medicine, and it is true today. I believe the result will be a degradation of the moral and technical quality of American medicine which will take many years to reverse.

The changing character of medicine is only indicative of a more fundamental change in our society. The shift in the moral climate of medicine towards economic values and away from more idealistic traditional medical values did not occur in a vacuum. The medicine of the era that started in the 1930's and that is now ending is based on science and an optimism for the future. It has been successful by most measures. It peaked in the general cultural idealism of the 1960's, when the nation declared the "war on poverty" and aspired to "one class care," epitomized by Medicaid and the death of the free clinic. In this decade, there has been a decided retreat from that idealism, a retreat from the belief that people do things because of their ideals and faith in the fundamental goodness of people. We are all aware that this nation has turned from the advanced ideas of individualism of the 1960's and 1970's toward more conservative values. This has, I believe (a belief shared by many), resulted in a nation that is more self-centered and devoted to the good of the comfortable. Our country has turned its back on the disadvantaged. It is in this climate that the changes in medicine have occurred. The shift in medical payment systems is merely symptomatic. Medicine is at once the servant and the bellwether of society. It is the mirror in which a society can measure the degree of its concern for the sick, infirm, aged, and poor. At the present time, the picture in our mirror is not pretty.

What has been said of individual patients may be true of our entire nation—we will get the medical care we deserve.