Ethics and the Physician-Patient Relationship: Medico-moral Consequences of Commodification

Matthew W. DeCamp
Duke University School of Medicine
Department of Philosophy
Durham, North Carolina 27710

ABSTRACT

Health care exists in an environment increasingly dominated by free market economics. As currently practiced, this paradigm rests on the underlying belief that health care is a commodity, akin to other articles of commerce or commodity-driven relationships. Authors routinely discuss the consequences of this framework independently in terms of their moral (i.e., normative) and medical (i.e., non-normative) natures, though the two are distinct but inseparable. This essay serves first to review whether health care, the essence of which is the physician-patient relationship, can or should be considered a commodity, followed by a discussion of the effects of consumerism, business ethics, and microallocation. Finally, because these considerations do not exist apart from their influences on medical outcomes, including physician-patient trust, quality, and continuity of care, recent studies examining the trend in each of these areas will be presented. Taken in sum, the available evidence indicates that treating health care as a pure commodity, when it does not fulfill that definition, damages the physician-patient relationship with commensurate adverse medical outcomes severe enough to cause reconsideration of the current health care model.

INTRODUCTION

When Howard Hiatt (1975) conceptualized the medical commons based on a population growth essay by Garret Hardin, he envisioned physicians as herdsman, each of whom escorts his sheep to a common, shared pasture for grazing. If every physician, on behalf of his patients, maximally utilizes the common resources, the pasture becomes barren and benefits no one. By analogy, overgrazing can be as problematic for medicine as for herdsman. Availability confounds the issue, particularly for medicine in the United States, because not all people—and they are people first, before they are patients—have access to the commons. This is the world of health care, as we know it. Resources and access are limited, allocation is in some sense inevitable, and costs continue to skyrocket in spite of managed care's attempts to control them.

Enter the physician-patient relationship. Its modern archetype, whereby a physician pursues only the best interests of his individual patient, thrived in an era of fee-for-service and unconstrained resources. Patients and physicians alike came to expect the most and pay the least. Today, bottom lines receive as much attention as central lines, and we must ask: is health care a commodity, to be treated as an article of commerce no different than the proverbial widget? Do free market economics, the paradigm of managed care, fundamentally affect physician-patient relationships, the essence of health care? Undoubtedly they do, with medical and moral implications on the physician-patient relationship so intertwined they are best described as medico-moral. Volumes on this subject exist. Scrutinizing a few select points, including consumerism, business ethics, microallocation, and their medical consequences, will illuminate how commodification—i.e., treating health care, and, as a result, the physician-patient relationship, as simply an article of commerce—sells both short.

Meaningful discussion first requires a basic understanding of the essence of the physician-patient relationship. Emanuel and Emanuel (1992) have proposed four models, each illustrating an important aspect of the interaction. Referencing the physician's role, they include the paternalistic, informative, interpretive, and deliberative models. These four models can be briefly summarized as follows. Physicians operating in the paternalistic model make medical decisions for their patients, sometimes contrary to their desires; on the other hand, informative physicians present facts buffet-style from which the patient alone chooses. The interpretive model of the physician-patient relationship requires the intuitive skill of the provider to clarify the needs and desires of the patient, even if these are unspoken. Finally, the deliberative model resembles an open dialogue between the two individuals to come to a mutual decision regarding the best course of action. Certain situations, such as life-threatening emergencies, necessitate paternalism, but others are more amenable to the deliberative model espoused by the authors for its informed autonomy. No model specifies exactly how clinicians should act, but each serves as a reminder for how actions reveal underlying conceptions of health care, and vice versa. Though differing in specifics, the essence of any model is its fiduciary nature, relying on trust, honesty, and acknowledgment of patient vulnerability in the hands of a physician-healer. Vulnerability cannot be neglected, implying that the patient confers trust somewhat involuntarily and deserves special protection when in need.

Nonetheless, this fiduciary duty has never meant placing the patient's interests above all others. Physicians routinely perform social medicine, and with good reason. This might involve vaccinating when adverse

reactions to the vaccine occur more frequently than the disease itself or prescribing antibiotics that yield suboptimal coverage but limit the emergence of resistance—not to mention the entirety of medical research. Non-medical ends include forensic psychiatry's role in determining whether criminals (e.g., patients) are fit for trial and possibly execution, or social phenomena such as circumcision that have uncertain clinical benefits (Bloche, 1999). More pertinently, consider medical doctors who serve as utilization managers for managed care organizations. Which of these qualify as medical practice? Though fervently debated, the general conclusion remains that the absolute patient-first mentality is a myth.

COMMODIFICATION OF MEDICINE

Having laid ground rules regarding the fiduciary physician-patient relationship and the fallacy of the patient-first, we may commence scrutinizing commodification. Edmund Pellegrino's (1999) investigation into the moral consequences of commodifying health care frames the issue clearly. Defined as fundamentally as an object of trade, Pellegrino asserts that commodities are in essence fungible, proprietary, consumable, and independent of personal interest beyond that necessary for trade. Apply these criteria to a loaf of bread: bread is a commodity because all loaves of bread are alike (in kind) and permit transfer of ownership (i.e., fungible), involve proprietary creation through recipes, obviously entail consumption, and require no personal relationship between the baker and customer beyond the business transaction. Being fungible, of course, does not imply that quality is everywhere equal. At first glance, health care fits this bill. Physicians, with their medical degrees and board certifications, prescribe and perform proprietary medicines and procedures, treat patients, and send them on their way.

However, examine more closely some other implications: doctors are exactly alike; likewise, all patients are fungible. Their individuality lost, both serve as a means to profit's end. Medical knowledge is proprietary; physicians own their knowledge. When a patient is treated, some amount of "health care" has been consumed, and neither party has any personal interest in the matter. Are these assertions true? In some sense, medical care is fungible; a patient may receive the same antibiotic from whomever he sees. However, this medical knowledge is not truly proprietary, as it depends predominantly on the prior discoveries of others. In addition, health care itself is not entirely fungible: transfer of health care is limited in the most basic sense by time and place; unlike loaves of bread that crisscross the country, patients may not have any options other than an immediate visit to their only local doctor. Furthermore, if "commodity" implies the ability to trade a defined article, be it an item or a service, how is transfer of health, and by extension, health care, possible when definitions of sickness and health remain elusive? Lest one becomes overwhelmed by futility, the personal physician-patient relationship intervenes, making health care a journey to fulfill and restore the biological, psychological, and social consequences of illness. Perhaps this integrative approach distinguishes the fiduciary nature of the physician-patient relationship from other commodity-driven fiduciary relationships, such as that between attorneys and clients, which do not intimately involve society's uncertain definition of personhood on all three of these levels. Therefore, while health care undeniably involves commodities, such as medications and supplies, the healing relationship is not itself a commodity.

Yet this does not satisfy those who wish to see health care distributed in the free market. Even in the face of convincing arguments that health care is not strictly a commodity, it may nevertheless be best distributed as if it were. Commonly cited reasons include the price-lowering effect of competition and patient freedom, satisfaction, and fairness (Rice, 2001). One need only follow popular news media to realize that costs actually far outpace inflation. The patient-centered effects, insinuating Samuelson's (1938) economic "revealed preference," present more formidable justification. Every individual may be best off by merely selecting his or her own health plan, regardless of whether that plan is the best option for that individual or the group as a whole. Naturally, this assumes that adequate, informed choice is possible, a capricious assumption with employment-funded managed care. Advocates of commodification may nevertheless maintain that the system has not stabilized. This notwithstanding, enough concerns exist that reconsidering the status quo is worthwhile.

MORAL AND MEDICAL SIDE EFFECTS OF COMMODIFICATION

Alluded to previously as an advantage of free market health care, patient consumerism presents the first challenge. In extreme form, consumerism requires acceptance of the informative physician-patient relationship, whereby a doctor or health plan purveys all the necessary facts in buffet-style; the patient chooses the preferred option, though what constitutes enough choice is a separate issue. While consumerism is psychologically pleasing, advertising is prone to gear itself toward patient satisfaction above medical outcomes, exploiting patients' knowledge deficits and mistakenly equating satisfaction with quality. In other words, consumerism does not fit health care because of the specialized understanding required to make informed decisions (Robinson, 2001). Consumers understandably make different decisions than patients, placing themselves at undue risk. For example, while a consumer chooses a less expensive plan that refuses to offer treatment "X" with 20% efficacy, the consumer-turned-patient in need of "X" may find "tough luck" a difficult pill to swallow.

A corollary of consumerism is the invasion of business ethics into the health care setting. While business ethics are not inherently bad, the practices of bluffing, spinning, and puffing require deliberation (Illingworth, 2000). If commodification advocates, or possibly necessitates, their use in the physician-patient relationship, trust is at stake. "Bluffing" is a method of withholding information; for example, a seller overstates a price to conceal his minimum bargaining position. In medicine, this occurs when a physician or health plan hides the existence of treatments that are not offered. Disagreement abounds regarding whether contracting into a plan denotes "prior consent" to have this information withheld; others argue that a contract's very existence repudiates trust (Goold, 1998). "Spinning" means shining a positive light on an otherwise negative attribute, such as putting a "positive spin" on denied treatments by deeming them unnecessary or potentially harmful without reason. The last technique, "puffing," occurs more at the administrative level, where plans tout themselves as having the best doctors or most complete coverage. These claims are clearly questionable and have no more truth-value than television commercials lauding a particular product as "the best." Unfettered commodification condones these practices, threatening the fiduciary relationship's foundation of trust.

The attention given to these two issues pales in comparison to the attention awarded to microallocation, including bedside rationing and gatekeeping. Neither concept is intrinsically deplorable. Any physician who denies care or chooses a less expensive treatment effectively rations at the bedside, and any primary care provider who decides whom not to refer is gatekeeping. Only in the context of commodification have these acquired negative connotations, perhaps because of patients' beliefs that financial incentives used to encourage such behavior directly oppose their best interests. Of course, every financial arrangement involves incentives of some sort; fee-for-service medicine encourages more, unnecessary care that may lead to iatrogenic conditions. The question is not whether incentives are right, but how to ensure that such motivational tools are not misaligned with patient interests. Bedside microallocation of resources performed on the basis of capitated payment places patients at risk for unknown macroallocation of the fiscal gain. Can physicians be expected to reduce expenditure of resources on one patient when they cannot ensure the savings actually improve another? Particularly concerning are studies that suggest gatekeeping systems reduce costs by only six percent (Martin et al., 1989); thus, they appear unable to accomplish their stated goal, perhaps at the expense of physician-patient trust. Interestingly, the Supreme Court has ruled (*Pegram v. Herdrich, 2000*) that such incentives cannot be limited because the fiduciary relationship extends only from patient to physician, not from physician to plan. Consequently, benefit decisions made away from the bedside are not medical decisions subject to malpractice, though the Court left unanswered the legal responsibility of gatekeepers (Bloche and Jacobson, 2000). Nevertheless, in current forms of gatekeeping and bedside rationing, financial incentives appear at odds with fiduciary trust.

A natural solution to the physician's uncomfortable responsibility in bedside rationing involves allocation guidelines to obviate her, in the patient's eyes, of guilt when saying no. Such guidelines, including "evidence-based medicine," have two drawbacks, though they clearly address a patient's best medical interest in some circumstances. First, they can never include every patient, or as yet, every clinical syndrome or situation, and therefore require exceptions. Second, they invite "gaming the system," the dishonest practice of exaggerating diagnoses to obtain more resources for a patient (perhaps contributing to the failure of gatekeeping systems). Whether physicians should abide by rules they deem unfair has been addressed and refuted by Haavi Morreim (1995). Fundamentally, gaming should be discouraged because it potentially harms patients in terms of future medical care, encourages only more stringent rules without changing the existing ones that are subverted, and, most importantly jeopardizes the trust and credibility of physicians. Morreim enters the mind of a patient and asks, "if my physician lies to the health plan, might he also lie to me?" A patient who asks this question does not trust her physician. Furthermore, were everyone to adopt gaming the system, the medical commons would undeniably suffer.

While the above arguments from the standpoint of trust in the physician-patient relationship are moving, few of the issues can boast of a consensus among ethicists. However, moral issues do not exist within a vacuum, and empirical studies increasingly reveal medical ramifications of these same issues. While such studies cannot address the normative question regarding commodification, they do compel one to pause and rethink the current trend of managed care. At least three lines of evidence reference the adverse consequences of commodification.

First, physician-patient trust can be directly studied. Patients' attitudes indicate that nearly three-quarters see cost control bonuses as "…a bad idea." If such bonuses exist, 91% favor disclosure (Gallagher et al., 2001). More importantly, those who perceive difficulty in obtaining referrals from physician gatekeepers are more likely to report low trust and satisfaction with their provider (Grumbach et al., 1999). An alternative, though equally deleterious, interpretation of this finding is that patients who feel distrust are more likely to perceive referral barriers. As for physicians, half view changes in health care during the past 5 years as erosive to trust, while 80% see changes in the past decade as diminishing a commitment to loyalty (Sulmasy et al., 2000). The previous moral arguments postulated that distrust was a possible

outcome of commodification; these studies suggest that the growth of managed care correlates with declining trust.

Second, researchers examining quality of care, as measured by administration of services such as β-blockers after myocardial infarction, eye exams for patients with diabetes mellitus, Pap smears, mammograms, and psychiatric hospitalizations, can contrast investor-owned and not-for-profit health maintenance organizations, or HMOs (Himmelstein et al., 1999). On all well-controlled measures, not-for-profit HMOs provide statistically significant more care—care that is likely to be clinically significant as well. This is particularly concerning given the market dominance of investor-owned HMOs, who generally function at the same overall operating cost. Physicians in these plans may be forced to cut services across the board, not merely unnecessary ones, for the sake of investors.

Finally, a less often cited complication relates to commodification's influence on continuity of care. If physicians are interchangeable, health plans have little incentive to provide continuity when discontinuity is cost-effective according to overwhelmingly near-sighted financial statements. Why not salary physicians from nine-to-five, reduce their obligations to particular patients, and require phone calls in lieu of office visits? The advent of internet-based physician services highlights this issue. As a plausible outcome of pure commodification, this stands juxtaposed to evidence that continuity of care results in a 50% decline in emergency department use among different patient groups, an effect that is temporally related and dose-dependent (Christakis, 2001). Continuity is equated with better health and better physician-patient relationships; discontinuity, a logical extension of commodification, undermines both.

CONCLUSION

To summarize, our conception of health care as involving a uniquely fiduciary physician-patient relationship is not commensurate with health care as a commodity. This care occupies a special place in the treatment, on all levels, of human beings that is inadequately defined as a consumable good or article of commerce. Furthermore, and in some ways most importantly, any qualms we have on the moral level regarding consumerism, business ethics, financial incentives, and dishonesty among doctors are being reinforced by research. Studies indicate that the rise of managed care has paralleled a decline in trust between physicians and patients, as well as poorer performance on specific medical measures by investor-owned HMOs. These consequences interact with the moral ones on a basic level to create inseparable medico-moral implications raising important ethical questions that require answers should the trend toward commodification continue. Looking to the future requires a weary eye as vital components of the physician-patient relationship come under increasing scrutiny by those concerned more about dollars than our true sense of health care. Perhaps this means a move toward not-for-profit managed care, or national health insurance; either way, unalloyed commodification must be stopped until these questions are fully addressed.

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