The 25th John P. McGovern Award Lecture

Selling Our Souls: The Commercialization of Medicine and Commodification of Care as Challenges to Professionalism

by

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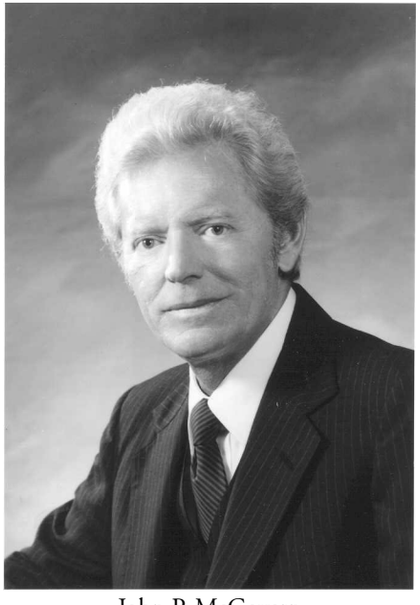

John P. McGovern

JOHN P. McGOVERN AWARD LECTURESHIP

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences — in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.

Sister Nuala Patricia Kenny
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Dr. Nuala Patricia Kenny was born in New York and entered the Sisters of Charity of Halifax in 1962. She received her BA, Magna Cum Laude, from Mount Saint Vincent University in 1967, an MD from Dalhousie in 1972 and did postgraduate training in pediatrics at Dalhousie and Tufts-New England Medical Centre, during which she held a Killam Scholarship. In 1975, she became a Fellow of the Royal College of Physician and Surgeons of Canada and in 1976 was certified by the American Board of Pediatrics. She has received five Honorary Doctorates (Mount Saint Vincent (1992), the Atlantic School of Theology (2000), Regis College, Toronto (2000), St. Francis Xavier University (2000), and The College of New Rochelle (2008). In 1999 was appointed an Officer of the Order of Canada for her contributions to child health and medical education. She has received a Queen's Jubilee Medal and in 2006 was elected a Fellow of the Canadian Academy of Health Sciences. She has received the Lifetime Achievement Award of the Canadian Bioethics Society, the Distinguished Service Award from the Canadian Health Association, the Catholic Health Association of Canada's Performance Citation Award, the Canadian Medical Association's Marsden Ethics Award, the 2009 Dalhousie University Alumni Achievement Award and the 2010 North American Osler Society's McGovern Award.

Doctor Kenny joined the Department of Pediatrics at Dalhousie in 1975 as the Coordinator of Regional Pediatric Services. In 1982, she became Director of Medical Education at the Hospital for Sick Children and the University of Toronto. In 1985 she was appointed Professor and Chairperson of the Department of Pediatrics at Queen's University, Kingston, Ontario. She returned to Dalhousie as Professor and Head of the Department of Pediatrics and Chief of Pediatrics at the Izaak Walton Killam Hospital in 1988. In 1995, she became the founding Chair of the Department of Bioethics of Dalhousie Faculty of Medicine. From February to November 1999, Dr. Kenny was seconded as Deputy Minister of Health for the Province of Nova Scotia.

Author of over one hundred papers and two books, Dr. Kenny is nationally recognized as an educator and physician ethicist. She has travelled extensively as a distinguished lecturer. In 1991 and 2005, she was a Visiting Scholar at the Hastings Centre for Ethics and in 1993 held a Royal College of Physicians and Surgeons of Canada Fellowship in Continuing Medical Education at the Kennedy Institute of Ethics at Georgetown University. In 2001, she was a Scholar in Residence at the Rockefeller Foundation Study Centre in Bellagio, Italy.

She has served on the Committees on Biomedical Ethics of the Royal College of Physicians and Surgeons of Canada and the Canadian Pediatric Society, the National Council for Bioethics in Human Research, the Tri-Council Working Group on Guidelines for Research with Human Subjects and the National Science Advisory Board. She was Chair of the Values Committee of the 1997 National Forum on Health and is past President of both the Canadian Pediatric Society and the Canadian Bioethics Society. She was a founding member of the Governing Council of the Canadian Institutes of Health Research (CIHR), the Health Council of Canada and Canadian Doctors for Medicare.

In 2009 she turned formally to faith-based ethics and is now Professor Emeritus Dalhousie University Department of Bioethics, Health Policy Advisor to the Catholic Health Alliance of Canada and on the Board of Covenant Health, Alberta.

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Introduction

I first thought of the history of medicine as a series of turning points, rather than a steady line of progress and development, in a conversation with Dr Edmund Pellegrino, my mentor as a physician-ethicist. He asked me if I thought medicine was at a crucial turning point in its history. Trained as I am in his philosophy of medicine as a deeply moral endeavour, I was intrigued by the question. Clearly modern medicine has been shaped by critical turning points in its history. Surely the genius of Hippocratic medicine was one; the invention of medical professionalism another and the shift to a scientific basis for medicine and medical education is a third. For us, today, these turning points seem to be quite concrete with historical markers and clear leaders but the shifts may have occurred more gradually over time. Only when we stop and reflect do we recognize the impact of such shifts and turns.

At the beginning of the 21 Century we may have already experienced a shift as least as dramatic and influential as these early movements but in a very different direction. A toxic stew of developments within 20 Century medicine and within contemporary Western society may have already shifted medicine off its foundational moral course or at least made it "profoundly disoriented."[1 (p.408)] What is unclear is how medicine will deal with contemporary shifting and ride and whether it will emerge with a new and re-vitalized notion of medical professionalism or sell out to market forces and become a business like any other. Amidst all this we see repeated and insistent calls for the renewal of medical professionalism. Some of this interest is motivated by response to the claims that medicine has become a business and is no longer the moral profession it has claimed to be. Various professionalism projects have focused on measurable behaviors and competencies. While these are important I believe the real issue goes deeper than that as some prominent medical leaders have observed.[2,3,4]

As I've pondered Dr Pellegrino's question I've concluded that medicine has already shifted in many ways from its professional ideals. What we are dealing with today is "an epic clash of cultures between commercial and professional traditions."[5] What is at stake in this shift to the commercialization of medicine, the commodification of care and rising physician entrepreneurship raises serious challenges to the future of medicine as a moral profession.

I offer here reflections in the tradition of the Oslerian lay sermon. I will briefly review the context and constant focus of the major turning points to date; re-affirm the importance of the moral core of medical professionalism; describe some important developments in medicine and society that present challenges to professionalism and conclude that physician enthusiasm for medicine as commerce without a strong professional ethic will result in the most dramatic shift in the history of medical professionalism and the transformation of medicine from a calling to service to big business.

Turning Points and Medical Professionalism

The moral core of allopathic medicine emerges with the Hippocratic tradition of medicine.[6] The genius of this tradition is the melding of the Aescalepian (priestly) and scientific roots of medicine. Its essence is the integration of empirical science and clinical skill with a public moral/ethical commitment to the patient's welfare. Because doctors make their living from suffering, pain, fear, and hope, this public *profession* of the physician's commitment to the patient's welfare has been a cardinal feature of medical ethics since Hippocratic times.[7]

As the Hipocratic tradition encountered early Christianity, the ethic of this early moral commitment focused intently on the character of the doctor as a moral agent. It emphasized the personal integrity of the physician precisely because of their power and privilege; the inherent uncertainty in the emerging medical science; and the reality that because doctors make their living from the sick and dependent, conflict of interest is inherent and inevitable. The nature of the health care encounter between the knowledgeable and powerful physician and the vulnerable patient requires this core moral commitment to

use the power of medicine for the patient's welfare even as cost to the physician's interests.[8] This self-effacing ethic developed in a time when payment was direct; there was no system of diagnostic and therapeutic services and the effectiveness and scope of medicine was limited.

The second turning point, elegantly described by Larry McCullough, identifies times of the laying open of medicine to scientific and moral accountability.[9] Here the notion of medical professionalism was conceived by John Gregory (1724-1773) and Thomas Percival (1740-1803). At the end of the 1700's medicine was a free market and,

> "There was then no licensure, no stable medical curriculum, no private third-party insurance, and no agencies of government to regulate the practice of medicine and the development and introduction of new drugs and devices."[10] (p.86)

In this era the sick experienced rampant entrepreneurial medical practice as a crisis of intellectual and moral trust.[11] Gregory set out to make medicine a profession worthy of its moral core. Drawing on Bacon's medical science and Hume's science of morals, he invented two of the three elements of medical professionalism: scientific competence and a primary commitment to the protection and promotion of the patient's health interests (their own self-interests were secondary).[10]

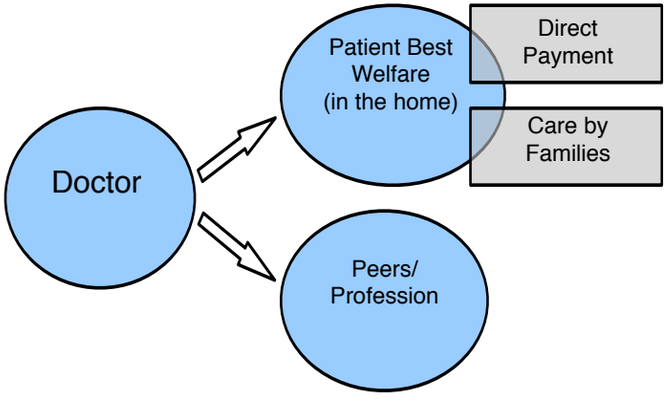
In 1803, Thomas Percival was charged with mediating conflicts that had erupted between physicians of different schools of medical science at The Manchester Infirmary in the United Kingdom. Within the Infirmary the patient consequences of different schools of medicine-Thomsonians, allopaths etc-became evident. Because of a tight link between medical competence and personal character, the consequences to patient outcomes now obvious in the hospital context had disastrous impact on patients and their physicians. Percival wrote the first code of medical ethics, *Medical Ethics* or, *A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*.[12] He affirmed the notions of commitment to scientific and clinical excellence and to primary duty of the physician to act for the interests of the patient He also made explicit the third element of

professionalism when he called for physicians to maintain medicine as a public trust, rather than as a merchant guild. This Code, ultimately the template for the Code of Ethics for both the American (1847) and Canadian (1856) Medical Associations, shifted the focus of physician ethics from personal character to a highly organized professional standard of conduct. These codes were "a decisive and revolutionary break with the British conception of character-based medical morality."[13] (p.20-21)

In North America the third turn occurs with the 1910 Flexner Report on the state of medical education in the US and Canada. Again, hucksterism and rampant entrepreneurship reigned. Most medical schools were physician owned and operated for profit. There was no system of accreditation, developed curriculum, or standards for admission or graduation. Codes of Ethics had been adopted but were applicable to few. The ethic was reduced to a kind of professional etiquette. The Flexner Report concluded that: "The medical profession has become diluted with practitioners of low ideals and professional honor."[14] (p.xiv) These concerns were shared by the great Canadian physician, William Osler (1849-1919) who saw medicine as a calling and was deeply concerned by the growing impact of commercialism in medicine.[15] This turn established empirical science as an essential component of *good* practice.

These major movements in medicine shaped medical professionalism as we entered the 20th Century. The physician's primary moral obligation to the welfare of the individual patient was clear; direct payment from patient to physician strengthened that commitment and there was no system of diagnostic or therapeutic support. The context for the commitment was simple (See figure 1).

Figure 1



So, we entered the 20th Century with some powerful myths about medicine and doctors as exemplified in Norman Rockwell paintings and popular culture. The compleat physician, in solo or small group practice, committed altruistically to patient welfare. However, in our brief review of major turning points in the history of medicine that

> "…physicians were historically influenced by economic considerations, rather than operating purely on the basis of serving the interests of patients and society."[16] (p.293)

The real history of the profession's repeated difficulty with conflict of interest, greed and bad medicine gets lost.

Contemporary Practice

The practice of medicine has changed significantly from its Hippocratic roots.[17] The requirement of competence-scientific, technical, clinical and ethical endures. The doctor-patient relationship has changed with more knowledgeable and demanding patients; and the formal requirements of informed consent and respect for patient autonomy.[18] The patient's welfare, now expressed as 'best interest', is often complex and contested because medicine almost always has

something else that *could* be done. The obligation of physicians to recommend interventions based on a critical calculus of the evidence of benefit and harm is challenged by patients with the expectations of a consumer society. When *more* diagnostics, drugs and intervention, whether indicated or not, make the "consumer" of health care happy and benefit the physician financially the challenge to the core moral commitment to act for the patients welfare becomes very real.

Social changes and increasing power of 20th Century medicine saw the development of modern bioethics, especially the principle-based approach which has transformed medical decision-making.[19] While medical ethics was dominated by the Hippocratic tradition and then codes of professional obligations and duties, bioethics is a broader concept. Physicians with their own particular ethical obligations are but one of the actors involved in complex decisions with patients. The dominant principle-based approach recognizes that all four core principles: respect for autonomy, beneficence, non-maleficence and justice are of equal moral weight. In reality, patient autonomy has become, in fact, the 'trumping' principle. There is confusion over the meaning of respect for the autonomy of the patient; the need for respecting the doctors autonomy and the doctor's duty to act for patient welfare-benefit and minimize risk and burden. Ironically,

> "The emergence of patient autonomy as a touchstone of the emerging field was hardly intended to bolster an increasingly commercialized healthcare economy but I contend this is exactly what happened. Moreover, empowering patients to determine the course of their medical care has not only turned them into consumers in a more overt sense than has traditionally been the case in healthcare; more to the point, bioethics has provided a neat justification for this qualitative change."[20] (p.415)

Changes in the funding and delivery of health care have increased the complexity of conflict of interest, especially for doctors. Funding has moved from direct payment to a variety of public and private

insurance schemes characterized by shared risk, fixed resources and insulation of both doctors and patients from costs. Some funding schemes actually penalize the physician for acting in the patient's best interest.[2]

Within medicine more broadly we see medical education's increasing dependence on industry funding; the commercialization of medical research and the radical rupture with the traditional understanding of medical knowledge as non-proprietal in the patenting of medical science.[21] All this raising new conflicts of interest in an extraordinarily complex context. (See Figure 2)

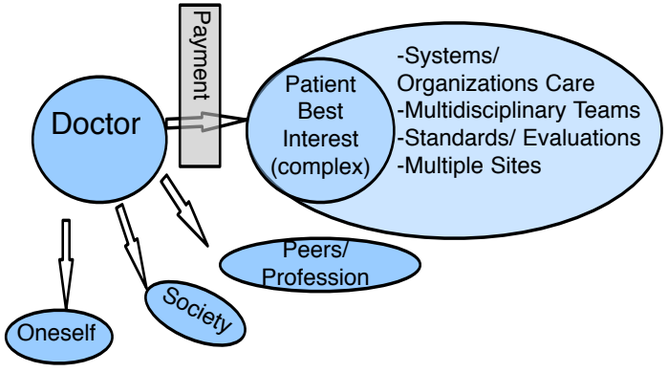


Figure 2

While these changes have been occurring, there has emerged a deep concern about the goals of medicine.[22] The development of enhancement technologies; the use of medical science for purposes quite different from the historical concepts of alleviation of suffering and promotion of health; and the medicalization of many aspects of life have fuelled debates regarding the very possibility of moral core to medicine. So, it is not surprising that there has been an erosion of trust in doctors and organized medicine. What is at stake here is the moral core of medical professionalism itself. As Relman has said,

> "Endangered are the ethical foundations of medicine, including the commitment of physicians to put the needs of patients ahead of personal gain, to deal with patients honestly, competently, and compassionately, and to avoid conflicts of interest that could undermine public trust in the altruism of medicine."[3] (p.2668)

Conflict of Interest and The Profession's Response

The elements of professionalism have historically included: a defined body of specialized knowledge, an ethical framework and a social mandate which allows wide autonomy in education and practice.[23] The special status of a profession has not been in the expertise but rather in the dedication, commitment and *profession* of something other than self-interest. This ethical core with its commitment to the patient's interest as primary has been understood to mitigate financial conflicts of interest, especially financial conflicts. With changes of the last century, things have changed,

> "At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important."[24] (p.1)

However, simply reaffirming the historical tenets of professionalism will not be easy. Changes in professionalism itself reflect and are affected by the broader social and political ecology which today can be characterized as globalization with dominance of the market. In this broader context conflicts of interest are increasingly complex. Simply put, COI exists when doctors have a duty to act in the patient's interest and incentives to act in their own or third party interests. There has always been COI but we've seen that the major shifts in medicine up to the 20th Century attempted to recognize and deal with this inherent issue.

The Challenges of Commercialization and Commodification

Rodwin has identified four general sources of COI in modern medicine:

Entrepreneurship
Incentives
Financial ties to third parties
Employment by third parties [25] (p.396)

In order to understand these sources and respond appropriately today, we need to reflect on a history that paralleled the shifts focusing on the moral core of medicine. That is the history of commerce in medicine. Commerce has played a role in medicine from the beginning. The commercialization of medicine is a problem when COI is created or worsened by policies and practices. Rodwin has described three phases of medical commerce and physician entrepreneurialism: from the American colonial period through the 19th Century; from 1890 through the mid 20th Century and the second half of the 20th Century. [25]

We've seen that in early North America there were few obstacles to practicing medicine and little regulation of training or practice. Medical care at this time was highly entrepreneurial even as medicine was relatively simple; doctors had few tests to offer and little in supplies or services to sell. Physicians could not collect more than patients could pay so they discounted their fees charging patients whatever they could pay. Personal financial conflict of interest was fairly obvious and limited. Almshouses aided the poor, elderly and mentally ill and, in the late 19 Century, many became charity hospitals. Most physicians worked in private practice with little or no contact with hospitals.

Few physicians participated in local or state medical societies. Market conceptions dominated elite understandings of medicine through the 1800's.[17] In 1847 the American Medical Association was formed and adopted a Code of Ethics based on Percival's 1803 Code. The Canadian Medical Association adopted a similar Code a few years later. These Codes held that medicine was different from other commerce but assumed that physicians would be self-employed and sell their services. It also restricted certain practices including advertising,

fee-splitting for referrals, secret nostrums (patent medicines) etc.

The transformation of hospitals from charity institutions for the poor into centers of medical practice occurred at the turn of the 19th Century. Access to hospital diagnostic and surgical facilities became crucial for practitioners. Physicians and hospitals became competitors for paying patients until the modern hospital system was developed. Physicians were still self-employed and billed patients for services delivered in hospital. In a sense, hospitals came to subsidize medical and surgical practice. Increasingly, private, for-profit and public insurance schemes were developed which insulated doctors and patients from costs. By the early 20th Century medical licensing and medical education were highly regulated. Medicine was held to be a "learned profession" exempt from antitrust prohibitions on the restraint of trade.

Financial conflicts of interest acquire a new complexity in the 1970's when the commercialization of medicine becomes a problem. Money was infused into health care in the development of hospitals, expanding insurance coverage-public and private, and the rapid expansion of medical science and technology. However, phenomenal medical advances, such as mechanical ventilation, cardio-pulmonary resuscitation, dialysis, organ transplantation, and drugs and medical devices development made it apparent that health resources were not infinite. Health systems realized difficulties providing *all* potential benefit for *all* patients.

Doctors have always played a role of gate-keeping for care related to ordering tests, initiating treatments and interventions, consultations, and ordering care. As complex systems of care developed, doctors became gatekeepers to resources above and beyond their own time and talents. At the bedside, ethical doctors should choose interventions with evidence of benefit, minimize marginally beneficial interventions, inform patients of cost constraints, advocate for the individual patient's benefit, and work to provide just and fair access to health care.[26]

In practice, physicians can become "double agents" in systems such as for-profit managed care because it modifies the doctor-patient relationship and creates a relationship with the managed care organization

itself.[2] Managed care has developed some practices that directly conflict with the doctor's duty to the patient interests even as they affect the doctor's financial interest. Negative gate-keeping uses physician's financial self-interest to limit the use of medical services, especially expensive ones. Positive gate-keeping encourage physicians to increase services —over-prescribe— for those who can pay and creates provider-driven market demand because of the profit motive.[27]

We have seen the loss of professional control of medical commerce as governments and health agencies challenged the authority of doctors over medical decisions with resource implications. At the same time we see opportunities for more physician entrepreneurialism than ever before as doctors still control the use of medical services, referrals, prescriptions and admission to hospital.

> "The central problem of commercialism in medicine today, as in the past, is physician entrepreneurship. It creates conflicts of interest that compromise the loyalty of physicians to their patients and their exercise of independent judgment on behalf of their patients. The challenge today is to find ways to cope with conflicts of interest in medicine while preserving those aspects of market and commerce that provide value."[25] (p.395)

Physicians are losing patient's trust because of worries about financial conflicts-of-interest in new systems of funding and delivery.[27, 28, 29]. Some question the very possibility of a fiduciary relationship of trust — that historically central notion of commitment to the patient's welfare — in market oriented medicine where "caveat emptor" (buyer beware) is the rule.[30]

The Commodification of Health Care

For doctors, the questions are clear. Is health care a commodity like any others? Are doctors simply vendors of services and products? What is the effect on the doctor-patient relationship and on professional ethics of commodification of health care?

What is a commodity? Commodities have certain characteristics:

they have a price which a seller receives and a buyer pays to acquire; they are fungible, i.e. they are interchangeable with each other; one widget is like all other widgets and the value of a commodity is instrumental, not intrinsic. The market is the system of interaction for the distribution of commodities. The market uses a price-centered principle of distribution. Both commodities and participants in the market are fungible; they have no identities other than those of buyer and seller. Moreover, the market assumes that buyer and seller are of roughly equal power and information. The transaction itself has no value.[31] Clearly, there are limits to any understanding of patients as consumers.

Commodification affects the way in which we view the good of health care. It is no longer a common good because the market understands commodities as goods designed to satisfy individual desires. Physicians should respect the informed decision of a patient to choose or refuse evidence-based treatment options. It is quite another to participate in a patient's redefining health care to meet their own desires such as patients demanding medical interventions to improve their athletic performance or drugs to super-ovulate so they can sell their eggs to infertile couples or cosmetic surgery and medicine, the 'cutting edge of commercialized and commodified medicine.

Medications, dressings, syringes and OR time are some of the many commodities used in the delivery of health care. But health care itself is not a commodity. The encounter itself is central to good care. The central reality of medicine is in a relationship of trust in the moral core of medicine. This encounter is a place of moral meaning and the healing of the whole person is a concern.

Commodification affects professional ethics in profound ways. The most immediate effect of understanding the care we provide as a commodity is felt 'at the bedside'.[32] The consequences of commodifying medicine are clear:

Depersonalization of the patient
Challenges to trust
Erosion of the moral agency of the doctor
Loss of the need for the physician's calculus of benefit/harm
What cannot be measured is not valued so, care becomes the drug, device or procedure.

Since commodities are fungible or interchangeable, in market conceptions of practice, both physicians and patients are interchangeable. The relationship itself does not matter; any doctor will do; fidelity to care and continuity of care are lost.

Conclusions: "Caveat Vendor"

The shift to the commercialization and commodification of medicine in the twentieth century stands in stark contrast to those shifts which recognized inherent conflicts of interest but established medicine firmly as a moral profession. Physician entrepreneurialiasm has risen again now with its cachet of science and technology. Today's snake oil salesmen (and women) wear white coats and OR suits as they sell modern medicine. This is not to impugn the integrity of most individual physicians but rather, to note that

> "…it is not so much a question of physicians making intentional self-serving decisions. It is a question of physicians unconsciously making such decisions based on perceptions and processes of judgment subconsciously or semiconsciously governed by monetary considerations that have permeated every corner and pocket of the contemporary culture."[33 (p.433)]

Is the shift irrevocable? I don't think it is, at least not yet. However, it is an issue of urgent concern. We all need to accept some basic principles that should guide us in dealing with COI such as

> "Financial considerations should never compromise physician decision-making Medical information must be kept free from financial entanglements. The profession should be accountable for avoiding inordinately high costs of care. Assuming financial ties will continue, all arrangements must be transparent, and as a corollary, attempts must be made to protect patients when there is a risk of harm."[29 (p.381)]

The history of medicine has more than its share of heroes and saints. It has also a core challenge inherent in bringing the power of science and technology to those who are sick and suffering. In reality

> "Medicine never in its history totally rejected the seductions of financial gain, but until recently most young physicians entered their profession with the primary intention to be of service to their patients…Financial ambition did not trump professional ethics, as it increasingly seems to do now."[3 (p.375)]

Accepting medicine as a business like any other rather than a profession with a deep sense of fiduciary obligations to patients and societal obligations for medicine as a public trust will result in doctors being nothing more than vendors. Doctors enthused about the market must beware of what they wish for, *Caveat Vendor*.

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