

Medical Professionalism in a Commercialized Health Care Market

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MEDICAL PROFESSIONALISM IN THE UNITED STATES is facing a crisis, just as serious as the crisis facing the health care system, and the 2 crises are interrelated.

To understand today's crisis in medical professionalism requires knowing what a profession is and what role it plays in modern society. Freidson¹ considered a profession to be 1 of 3 options modern society has for controlling and organizing work. The other 2 options are the free market and management by organizations such as government or private businesses. Freidson suggested that medical work was totally unsuited for control by the market or by government or business and, therefore, the practice of medicine could only be conducted properly as a profession.

According to Freidson,¹ a profession is highly specialized and grounded in a body of knowledge and skills that is given special status in the labor force, its members are certified through a formal educational program controlled by the profession, and qualified members are granted exclusive jurisdiction and a sheltered position in the labor market. Perhaps most important, professionals have an ideology that assigns a higher priority to doing useful and needed work than to economic rewards, an ideology that focuses more on the quality and social benefits of work than its profitability.

Although this ideology is the most important part of medical professionalism, it is what is now most at risk. The science and technology of medicine and the special place that medical practice holds in the labor market are not presently threatened. The expanding professional health care responsibilities of nurses and the increase in other health workers such as physician assistants and technicians are changing the mix of the health care workforce, but the central role of the physician as the manager and provider of medical services is not likely to be challenged.

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. It is this commitment, what Freidson called the "soul" of the profession,¹ that is eroding, even while

its scientific and technical authority grows stronger. Ironically, medical science and technology are flourishing, even as the moral foundations of the medical profession lose their influence on the behavior of physicians.

This undermining of professional values was an inevitable result of the change in the scientific, economic, legal, and social environment in which medicine is now being practiced. A major reason for the decline of medical professional values is the growing commercialization of the US health care system.² Health care has become a \$2 trillion industry,² largely shaped by the entry and growth of innumerable private investor-owned businesses that sell health insurance and deliver medical care with a primary concern for the maximization of their income. To survive in this new medical market, most nonprofit medical institutions act like their for-profit competitors, and the behavior of nonprofits and for-profits has become less and less distinguishable. In no other health care system in the world do investors and business considerations play such an important role. In no other country are the organizations that provide medical care so driven by income and profit-generating considerations. This uniquely US development is an important cause of the health cost crisis that is destabilizing the entire economy, and it has played a major part in eroding the ethical commitments of physicians.

Many physicians have contributed to this transformation by accepting the view that medical practice is also in essence a business. Medical practice is now widely viewed as a demanding and technical business that requires extensive, credentialed education and great personal responsibilities—but a business nevertheless. This change in attitude has important consequences. In business, increasing shareholder value through increased revenue and increased profit is the primary goal. However, medical professionalism requires that physicians give even greater primacy to the medical needs of patients and to the public health of the society in which their patients live. When physicians think of themselves as being primarily in business, professional values recede and the practice of medicine changes.

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Physicians have always been concerned with earning a comfortable living, and there have always been some who were driven by greed, but the current focus on money-making and the seductions of financial rewards have changed the climate of US medical practice at the expense of professional altruism and the moral commitment to patients.³ The vast amount of money in the US medical care system and the manifold opportunities for physicians to earn high incomes have made it almost impossible for many to function as true fiduciaries for patients.

The essence of medicine is so different from that of ordinary business that they are inherently at odds. Business concepts of good management may be useful in medical practice, but only to a degree. The fundamental ethos of medical practice contrasts sharply with that of ordinary commerce, and market principles do not apply to the relationship between physician and patient.⁴ Such insights have not stopped the advance of the "medical-industrial complex,"⁵ or prevented the growing domination of market ideology over medical professionalism.

Other forces in the new environment have also been eroding medical professionalism. The growth of technology and specialization is attracting more physicians into specialties and away from primary care.⁶ The greater economic rewards of procedural specialties are particularly appealing to new graduates who enter practice burdened with large educational debts. Specialization is not necessarily incompatible with ethical professional practice, but it often reduces the opportunities for personal interactions between physicians and patients and thus weakens the bond between physicians and patients. It is too easy for even the best specialists to behave simply as skilled technicians, focused exclusively on their patients' narrow medical problems and unmindful of their professional obligations to the whole person they are serving.

The law also has played a major role in the decline of medical professionalism. The 1975 Supreme Court ruling that the professions were not protected from anti-trust law⁷ undermined the traditional restraint that medical professional societies had always placed on the commercial behavior of physicians, such as advertising and investing in the products they prescribe or facilities they recommend. Having lost some initial legal battles and fearing the financial costs of losing more, organized medicine now hesitates to require physicians to behave differently from business people. It asks only that physicians' business activities should be legal, disclosed to patients, and not inconsistent with patients' interests. Until forced by anti-trust concerns to change its ethical code in 1980, the American Medical Association had held that "in the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients" and that "the practice of medicine should not be commercialized, nor treated as a com-

modity in trade."⁸ These sentiments reflecting the spirit of professionalism are now gone.

Professionalism is also compromised by the failure of physicians to exercise self-regulation that would be supported by law. Many physicians are reluctant to identify incompetent or unethical colleagues. Such behavior also undermines the public's trust in the profession.

Yet another deprofessionalizing force has been the growing influence of the pharmaceutical industry on the practice of medicine. This industry now uses its enormous financial resources to help shape the postgraduate and continuing medical education of physicians in ways that serve its marketing purposes.⁹ Physicians and medical educational institutions aid and abet this influence by accepting, sometimes even soliciting, financial help and other favors from the industry, thus relinquishing what should be their professional responsibility for self-education. A medical profession that is being educated by an industry that sells the drugs physicians prescribe and other tools physicians use is abdicating its ethical commitment to serve as the independent fiduciary for its patients.¹⁰

The preservation of independent professionalism and its ethical commitment to patients still are very important because physicians are at the center of the health care system and the public must be able to depend on and trust physicians. There is currently much concern about the paternalism and elitism of medicine, and this concern is often used to justify policies seeking to establish so-called consumer-directed health care.¹¹ Although there undoubtedly is a need for patients to have more information and responsibility for their health care choices, without trustworthy and accountable professional guidance from physicians, the health care system could not function. In the absence of physicians' commitment to professional values, health care becomes just another industry that may, by continuing along its present course, be heading toward bankruptcy.

Physicians should not accept the industrialization of medical care, but should work instead toward major reforms that will restore the health care system to its proper role as a social service that society provides to all. Virtually every other advanced nation has achieved that goal. An essential part of the needed reforms is a rededication of physicians to the ethical professional principles on which the practice of medicine should rest. Such reforms will require public and political initiatives¹² and the active participation of the medical profession.

Medical professionalism cannot survive in the current commercialized health care market. The continued privatization of health care and the continued prevalence and intrusion of market forces in the practice of medicine will not only bankrupt the health care system, but also will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession. Physicians who care about

these values must support major reform of both the insurance and the delivery sides of the health care system.² It is the one policy option most likely to preserve the integrity and values of the medical profession.

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Health Care in the Age of Genetic Medicine

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OCCASIONALLY, THE EMERGENCE OF NEW TECHNOLOGY or knowledge propels medicine across a threshold that is so monumental it mandates changes in the structure of health care delivery. In the 20th century, a deep understanding of infectious diseases and cardiovascular risk factors triggered such changes, stimulating action at the governmental and population levels with the creation of organizations such as the Centers for Disease Control and Prevention and departments of public health.

Today, medical science is at another such threshold with the advent of individualized medicine. Driven by advances in genomics, emerging insight into each individual's unique susceptibility to disease promises to transform patient care. However, such advances will also compel a fundamental restructuring of the way medical care is delivered in the United States.

There are many reasons to pursue a rational, just, and workable system of health care for the millions of US citizens who have no health insurance and for the insured for whom the cost of medical care is a constant threat to financial security.¹ The potential success of genomic medicine provides a series of additional compelling arguments to embrace a system of care that provides universal coverage and broadly pools risk. It is no small irony that the emergence of individualized medicine ultimately mandates a shared approach to health care delivery.

Modern health insurance is based on the tenet that it is possible to accurately predict aggregate risk but much more difficult to predict individual risk. For instance, insurance actuaries can reliably estimate the percentage of a population that will develop breast cancer, but because they are unable to predict precisely which individuals will develop it, resources are pooled, enrollees pay similar premiums, and

all derive benefit. However, the emergence of individualized medicine, driven primarily by advances in the ability to dissect the individual's genome, undermines this traditional system. By learning to identify an individual's risks, that individual becomes less attractive to insure for the very maladies for which they require coverage. Pending legislation, such as the Genetic Information Non-Discrimination Act,² will help limit genetic cherry-picking by insurers and is critically important. However, in a fragmented health care system, such potential remedies ultimately run the risk of simply shifting the inequity back to insurers by enabling individuals to select coverage based on their own specific risks. Either way, the foundation of the system is undermined; the solution is for all to pool their risks.

Individualized Medicine and Prevention

One of the promises of individualized medicine is the possibility of engaging in a level of preventive care that far exceeds current abilities. Screening programs are, by their very nature, inefficient because an entire population is subjected to screening while relatively few individuals benefit and some are actually harmed.³ This inherent inefficiency is expensive for both the individual (in terms of morbidity) and for society (in terms of cost).

With increases in the ability to parse individual risk, screening programs for everything from heart disease to cancer can be more efficiently tailored, resulting in possible savings of time and money and reduced morbidity. However, genetic predispositions being discovered by such means as whole-genome association studies are often modest, typically demonstrating odds ratios of less than 2. Although the emerging ability to assess numerous risks may eventually

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