

Daniel Callahan Redux – Business and Medicine, “Can This Marriage Work?”¹

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Medicine has claimed to be a profession based on altruism and dedicated to the ends of providing technically competent and morally sound care to persons in need. The highest ethical standard, a fiduciary ethos, prevails in, and sustains these ends of medicine. It requires that physicians put patients' best interest ahead of their own legitimate self-interest(s). When those ideals are compromised, so is the mission of medicine. We believe that this lament is at the core of Janice Tildon-Burton's presidential commentary as presented in the February 2007 issue of the *Delaware Medical Journal*.² Doctor Tildon-Burton well-illustrates the numerous burdens that the business model of medicine has placed upon both medicine as a practice, and upon the individual practitioner.

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In our experience, the majority of medical students are still compelled by humanitarian interests to endure the arduous path of medical school and residency, and as Tildon-Burton astutely notes, "...physicians just entering practice have some of the same idealism... [as] 25 years ago."² Yet, the reality check that she describes is that young physicians' idealism is far too often tempered (if not deflated) by the stark imperatives of "market-model" medicine. We believe that the dissonance between the values of physicians and those of the system in which their practice(s) are enacted causes this deflation of idealism, and perhaps may be eroding the integrity of medicine as a profession.

We agree with Doctor Tildon-Burton that medicine has become "...big business"; but not rightly so. Simply, the market ethos doesn't comport with the millennium-long ethos of medicine as described by Plato in Book 1 of the Republic: "...the physician, as such, studies only the patient's interest, not his own...The business of the physician, in the strict sense, is not

to make money for himself...all that he says and does will be said and done with a view to what is good and proper for the subject for whom he practices his art.”³ Thus, while there is a business to medicine, medicine is not business.⁴ The ends of medicine are humanitarian; the ends of business are profit, enabled by the two instrumental values of productivity and efficiency. The market has no concern or mechanism for just distribution of goods and services. Competition and price determine who gets health care services. These agenda are furthered by the imperatives to use technology, not universally as a means to enhance the humanitarian dimensions of medicine, but evermore as a competitive tool by which to exact fiscal productivity, and economic and temporal efficiency.⁵

Indeed, we may not sufficiently appreciate how thoroughly technological imperatives and the market have already infiltrated the practice of medicine. The research agenda, much of which is sponsored by industry, is being increasingly shaped by commercial criteria, not simply scientific criteria and/or the notion of the science in the service of the “common good.” Use of new technologies, techniques and services among specialty and community hospitals may be as much motivated by competitive market share and revenue as it is by best serving the community’s most pressing health care needs.⁶ The practice of “boutique medicine,” while satisfying certain goods, compromises others and clearly relies upon economic differences to accommodate patients’ access to health care. Physicians regularly experience the consequences of direct-to-consumer advertising of drugs and certain medical technologies, and may render a mixed verdict on these products’ overall value based upon economic bias(es). (As an aside, in light of this, we suggest that the role of pharmaceutical manufacturers in funding CME and professional meetings bears scrutiny given the potential of commercial values to unduly influence medicine’s professed priorities and values.)⁷

This is not to say that we must abandon technology or new techniques, for the diagnostic and therapeutic benefits that technology (and its applications) have achieved are responsible for many of the successes of (the curative model

of) modern medicine.⁸ But we must also recognize the limits of technology and medicine – the use of technology is not a medical imperative, and medicine cannot cure everything. Thus, while the mortality of many diseases has been lowered, we are now faced with a growing prevalence of chronic disorders that manifest longitudinal as illness in a longer-lived population. Hence, the very success(es) of medicine to date has created a situation that illustrates the limits of technological value-ladenness, as well as those of the business ethos and market model. The contemporary market model of medicine is ill-prepared and inappropriate to effectively and ethically deal with the increased chronic morbidity that biomedical progress has created. If we are to heal and care for those chronic disorders that cannot be cured, we must recognize the limitations and strengths of medicine that affect these goals.

Robert Kuttner speaks of the “virtues and limits of the market.”⁹ In this regard, we may surely respect and honor the market’s appreciation for efficiency and productivity in medicine as well as commercial endeavors. In fact, that is precisely what we do in our continuous quality improvement initiatives, our practice of evidence-based medicine, and stewardship of expensive health care resources.¹⁰ It is foolhardy not to adopt efficient billing and other office practices so as to maximize our revenues. But to prudently adopt appropriate market techniques is quite different from appropriating the market ideology, lock, stock and barrel.

But if the market unapologetically asserts that when self-interested sellers (e.g., physicians and health care organizations) enter with the intention of maximizing their own welfare, and encounter self-interested buyers (patients) concerned with maximizing their welfare, somehow, the collective is benefited, why are we still uncomfortable with the notion of a business model for medicine? We suggest that it is because much of the professionalism of medicine is lost when it is construed as business. The psychologist Howard Gardner recently stated that this is because business is not strictly a profession.¹¹ As such business lacks the “code” that holds inviolable certain rules, values and virtues that are ethically sound, not just legally

permissible. As Gardner notes, in business “professional standards are a vocational option, not part of the territory...”¹¹ We feel that this underlies the discomfort with business as purloining the purity of medicine, and the probity of the physician-patient relationship. After all, altruism and caring, key virtues in medicine, are surely extra-market norms whose very existence is jeopardized by the market ethos.¹²

So to reconcile the art of medicine with the business of medicine, we feel that an important first step is the acknowledgment that medicine is not business, and that the business aspect of medicine should be constructed and construed to enable right and good patient care. In other words, we must work to align the “business of medicine” with the ends of medicine.^{4, 12} This calls for a sea change, and certainly such a major paradigm shift requires a pervasive and progressive alteration in education, training, research, and practice; in actuality a change in the “culture of medicine.” Recently, Ezekiel Emanuel of the National Institutes of Health has called for sweeping changes in the medical curriculum to meet this challenge for change.¹³ As Doctor Tildon-Burton recommends, there is the need to bring business courses into the medical school (rather than sending physicians to business school). But Emanuel also sees the need to enhance critical thinking courses (e.g., statistics, evidence-analyses) and the humanities (e.g., history and philosophy of medicine, and inculcating ethics throughout all of medical training). We agree with Doctors Tildon-Burton and Emanuel. We are not advocating that the ‘pendulum of technological efficiency’ reverse its swing. Rather we are calling for the philosophical and ethical grounds that form the base of the pendulum to catch up, and to advance in-step with (if not lead) technological and market

progress. Committing to these values will keep medicine as the most scientific of the humanities, and the most humanistic of the sciences. It is a matter of personal and professional integrity that we are grounded in these foundational commitments, lest we uncritically succumb to the pressures and allure of the market, and lose the meaning of medicine altogether.

REFERENCES

1. Callahan D. *False Hopes: Why America's Quest for Perfect Health is a Recipe for Failure*. NY: Simon and Schuster; 1998.
2. Tildon-Burton JE. Reconciling the art of medicine with the business of medicine. *Del Med Jrl*. 2007; 79: 49-50.
3. Plato. *The Republic*. CDC Reeve (trans.). Indianapolis, IN: Hackett Publishing; 2004.
4. Giordano J. Pain medicine, morality and the marketplace: time for a change. *Pract Pain Manage* 2006; 6: 88-89.
5. Herzlinger RE. *Market-driven Health Care*. Reading MA: Perseus; 1997.
6. Starr P. *The Social Transformation of American Medicine*. NY: Basic Books; 1982.
7. <http://www.pharmedout.org>. Accessed on 3 March, 2007.
8. Porter R. *The Greatest Benefit to Mankind: A Medical History of Humanity*. NY: Norton; 1997 .
9. Kuttner R. *Everything for Sale: The Virtues and Limits of Markets*. Chicago: University of Chicago Press; 1996.
10. Giordano J. Pain, the patient and the physician: Philosophy and virtue ethics in pain medicine. In: M. Schatman (ed.) *Ethics in Chronic Pain Management*, Informa, NY; 2006: 1-18.
11. Gardner H. The ethical mind. *Harvard Business Review* 2007; 3:51-56.
12. Giordano J. Cassandra's curse: Interventional pain management, policy and preserving meaning against a market mentality. *Pain Physician* 2006; 9: 167-170.
13. Emanuel E. How to redefine a medical education. *Chron High Educ*. 2006; October 20: B12-13.