Greed and the medical profession

Ralph Crawshaw

Organised medicine is not giving proper attention to the disturbing presence in the profession of a universal human trait: greed. Perhaps doctors' greed is less of a problem in Britain where an estimated 70% of the doctors are generalists, and reimbursement in the main is controlled by the national health system. Not so in the United States where 70% of doctors are specialists and an open health care market allows doctors to charge "reasonable and customary" fees. This is interpreted by some as "all the traffic will bear."

Despite considerable evidence at the other end of the generosity scale that 64% of US doctors give away considerable amounts of free service there is no end of opinion, verging on explicit protest, from patients, their families, insurance operators, legislators, and the general public that doctors are a greedy lot. In my opinion, which I discover I must leave my native land to voice, it behoves the medical profession to address any problem vexing its relationship with the public. Doctors' greed is just such a troubling problem.

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The profession is aware that greed best describes how some of its members place profit before patient wellbeing. Before addressing the 1991 annual meeting of the Federation of State Medical Boards of the United States I asked the solons of the profession to indulge me by responding directly to a question. "Do you believe the medical profession has a problem with greed?" Out of approximately 150, 90% raised their hands in assent.

The US medical profession as a whole nevertheless seems hesitant to move beyond acknowledging the greed problem and to comment on its scale. The profession has a curious propensity to avoid the issue by relegating possible doctor greed to the status of a non-problem. The subject seldom, if ever, appears in professional journals. The side stepping is accomplished by labelling any focused concern about greed as doctor bashing and thus beneath the profession's purview.

Little data exist for doctor greed. One rough approximation of the problem is implied in a bell curve for doctors' incomes postulated by the editor of *JAMA*, Dr George Lundberg. Heuristically he divides the profession into four categories along a continuum of reimbursement, starting with altruistic missionaries, moving to professionals, then business people, and finally money grubbers. The professional and business people form the vast majority under the curve. The money grubbers, the greedy ones, occupy about 3-5% of the area. Three per cent seems a fair beginning for considering those within the profession for whom "greed has become too dominant an ethic."

Some still ask, "What is the importance of the problem; greed among human beings is as common as fleas among dogs?" For the medical profession greed presents three fundamental problems.

Firstly, greed compromises quality of care. An egregious example is in the case of a doctor in the US whose yearly income exceeds $4m. Literally busloads of patients from nursing homes arrive at this doctor's office and without a sham of a physical examination undergo a surgical procedure with the postoperative care left entirely to a nurse.

Secondly, greed limits access to care for poor patients. The income of specialty stars raises insurance premiums for all insured patients. As the premiums go up increasing numbers of citizens with marginal incomes are forced to forgo insurance coverage; their access to health care evaporates.

Examples of greed can be found in all specialties. Imagine a hospital in a small city considering opening a service for coronary bypass operations. To secure a thoracic surgeon the hospital board is prepared to offer a base assured income beginning at $1·25m a year, including full office support. Simultaneously, the area suffers from a lack of family practitioners, who, at best, can expect to make $80 000 to $100 000 a year without any office support.

Consider my city of Portland, Oregon. It has one hospital offering organ transplant services and two other "non-profit" hospitals planning competitive services. All three hospitals expect to offer high if not exorbitant staff incomes, ultimately to come out of the existing health insurance pool that makes no provision for the health care of the homeless. An editorial in the local newspaper labels this health care business at its worst, "greed-driven nonsense."

Thirdly, the most corrosive effect of greed and the tacit approval of greed is to the profession's philosophy of service. Where most of us were trained to believe that our service is based solely on trust, with firstly avoiding harm as the ultimate measure of every medical action, an ethic of greed changes our elemental belief that the buyer is always responsible. With an ethic of greed doctors cease to base their motivation on compassion and caring to become merchants selling medical services to the highest bidder.

Given these reasons for concern the first and essential action for the profession is to undertake an open discussion of the problem. The consequences of continued side stepping by the profession of the problem of its greedy members is loss of authority, autonomy, and honour. The erosion of the profession's position of respect with the public is clear. Further erosion will aggravate all the problems which now diminish the delivery of health care while blurring the moral goal of the profession.

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Without question doctors should earn incomes which genuinely reflect the training, time, effort, and trust that goes with their care of the sick. It is malignantly counterproductive for soaring medical reimbursement to diminish the stature of the vast majority of doctors.

It is imperative for the medical profession to open its published journals and collegial forums to a candid appraisal of the existence of greed in its ranks. There is no need, in fact there is danger of exaggeration and mindless regulation, for the discussion to be taken up by the media. This is not to imply the discourse should be secretive but that it should have the serious attention and encouragement of the leaders of organised medicine, including the editors of all specialty journals, to insure a scholarly and objective appraisal. The discussion should strive to determine objectively sane and prudent limits for medical reimbursement, but not be confrontational, pitting one doctor against another, one specialty against another. Those that exceed considered limits should no longer have the tacit approval of the majority, the 97% who do not let a desire for money determine their service to the sick. Clearly, a serious problem with an exaggerated and misanthropic human trait, greed, challenges the medical profession to move to higher moral ground in the care of the sick.—RALPH CRAWSHAW *is a professor of psychiatry in Portland, Oregon*