

THE MEDICAL ETHOS AND SOCIAL RESPONSIBILITY IN CLINICAL MEDICINE

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The medical profession will face many challenges in the new millennium. As medicine looks forward to advances in molecular genetics and the prospect of unprecedented understanding of the causes and cures of human disease, clinicians, scientists and bioethicists may benefit from reflection upon the origins of the medical ethos and its relevance to postmodern medicine. Past distortions of the medical ethos, such as Nazism and the Tuskegee Syphilis Study, as well as more recent experience with the ethical challenges of employer-based market driven managed care, provide important lessons as medicine contemplates the future. Racial and ethnic disparities in health status and access to care serve as reminders that the racial doctrines that fostered the horrors of the Holocaust and the Tuskegee Syphilis Study have not been completely removed from contemporary thinking. Inequalities in health status based on race and ethnicity, as well as socioeconomic status, attest to the inescapable reality of racism in America. When viewed against a background of historical distortions and disregard for the traditional tenets of the medical ethos, persistent racial and ethnic disparities and health and the prospect of genetic engineering raise the specter of discrimination because of genotype, a postmodern version of "racist medicine" or of a "new eugenics." There is a need to balance medicine's devotion to the wellbeing of the patient and the primacy of the patient-physician relationship against with the need to meet the health care needs of society. The challenge facing the medical profession in the new millennium is to establish an equilibrium between the responsibility to assure quality health care for the individual patient while affecting societal changes to achieve "health for all." (*J Natl Med Assoc.* 2001;93:157-169.)

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The medical profession will undoubtedly face many new challenges in the new millennium. Momentous advances in the biologic sciences in the 20th century and burgeoning knowledge of the human genome offer unique opportunities for greater understanding of human disease but also raise im-

portant ethical issues. While new understandings of the genetic basis of disease will bring new opportunities for genetic approaches to therapy, novel insights will also offer the potential not only to identify the genetic basis for disease, but also to predetermine intellectual, physical and functional characteristics through genetic engineering. Will individuals with special talents be genetically produced? Will individuals with genetic predisposition for certain kinds of cancer be able to get life insurance? Will individuals with the gene for violence be discriminated against? Ethical questions that have reverberated throughout the history of medicine have renewed relevance and significance as we an-

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icipate molecular genetic discoveries. While pursuing the bright future that advances in molecular genetics are likely to bring, clinicians, scientists and bioethicists should also reflect upon the past distortions of the medical ethos, such as Nazism and the Tuskegee Syphilis Study, and guard against “the eugenic temptation”¹ and the possibility of a “new eugenics.”²

Discrimination because of genotype may be a postmodern version of “racial medicine.” In considering ethical problems that may arise from future scientific advances, it is important to remember that society has not fully addressed the ethical challenges posed by the persistence of racial and socioeconomic disparities in health status and access to care. The growing acceptance of a new ethic of market-driven managed care also presents new ethical challenges. In addition, medicine must also confront an age old dilemma: the conflict between theories of distributive justice, in which the good of society as a whole is paramount, and the ethical principles articulated by Asklepios and Hippocrates, in which the individual patient is the first priority of the physician. In a just society, one based on the principles of moral right, equity and fairness, the allocation of scarce health care resources should be grounded on sound principles of medical ethics. A just and equitable distribution of health care resources is a theoretically attractive basis for the achievement of the goal of assuring the health of society. However, reconciliation of that far-reaching goal with the principle of the primacy of concern for the health of each individual has proven to be difficult for clinicians as well as bioethicists.³ As medicine struggles to come to terms with the conflicting demands of providing the best care for the individual patient and conforming to the rules of managed care, it will be useful to contemplate medicine in an ethical and historical context, in the hope that the profession can avoid repeating the mistakes of the past and benefit from the lessons of antiquity.

LEGACY OF THE TRADITIONAL MEDICAL ETHOS

In Western societies, the core principles of the profession of medicine have their origins in the traditions of ancient Greece and Rome. Modern understanding of the role of medicine and of physicians in society has been derived, in large part,

from the mythic traditions of the “physician-hero/physician-god”, Asklepios. Among his followers were the ancient physicians, Galen and Hippocrates. From approximately 1500 BC to 500 AD, Asklepios was the central figure of Greek and Roman medical tradition, and was the Greek archetype for the physician as healer, helper, “soother of cruel pangs” and hero to the common people. The Asklepiian tradition of equal service to princes, slaves, and paupers without regard to personal risk, self-interest or financial gain, provides historical insight into the timeless and enduring expectations of modern medicine and contemporary physicians.⁴ The medical ethos was further refined and disseminated by Hippocrates and his followers. Hippocrates introduced many of the original tenets of medical ethics: beneficence, altruism, relief of suffering, integrity, fidelity, honesty, compassion, humility, confidentiality, social responsibility and respect for autonomy. With these principles a universal truth of the human condition was articulated: that the predicament of illness, the vulnerability of the sick and the unique nature of the physician-patient relationship impose ethical obligations on anyone who professes to be a healer.⁴

The traditional recitation of the Hippocratic Oath by graduating students in the health professions serves as a reminder that the profession of medicine is based on an ethic that has evolved from the Asklepiian and Hippocratic tradition.⁵ The Hippocratic traditions in medicine have been difficult to maintain through the ages, largely because they are rarely expressed explicitly in medical education or through structured educational efforts directed at the health care provider. The traditional medical ethos has focused on the physician, the obligation to the individual patient and the primacy of the patient-physician relationship. National, state or local governments are now the major purchasers of health care. With the problems currently being recognized in managed care, it might be possible that a greater share of governmental, clinical and health policy attention will be focused on the social responsibilities of the medical profession and individual physicians. Renewed attention to implementing more socially responsible health care policy may occur because of unprecedented economic prosperity, or because the majority of medical care is provided through public financing. Irrespective of a minor shift in focus to societal needs, with the near total penetration of managed care into health care

markets, the more apparent challenge for medicine is to provide care for the greatest number of patients, with the least expenditure of scarce health care dollars, for the greater good of the economy.⁶

LESSONS OF HISTORY

The Nazi Era

Just as ancient history provides insights into the origins of modern principles of medical ethics in western societies, more recent history provides important lessons regarding the susceptibility of the medical ethos to distortion and subversion by social or political forces. History teaches us the consequences of disregarding of the fundamental ethical priorities of medicine. The events in Nazi Germany provide vivid examples of harm to the values of the medical profession caused by politically determined priorities. In an analysis of the medical ethos, Barondess² describes the conditions that fostered the distortions of the medical ethos that took place in Nazi Germany. In Germany, social Darwinism, a response to Darwin's *Origin of the Species*, stressed state intervention to assure racial integrity. Concern for the individual was replaced by the primacy of the welfare of the society as a whole. The "racial hygiene" movement grew to include physicians and others leaders of German society. Other scientific discoveries, such as Mendel's experiments in genetics, were subverted to support theories of negative eugenics, the prevention of reproduction by individuals possessing inferior or undesirable traits. The government promoted "euthanasia program" was the predecessor of the "Final Solution," which resulted in mass murder of Jews, "the feeble minded," homosexuals, gypsies and others. In the concentration camps, medical experiments, including freezing of humans, rapid decompression and experiments on twins by Josef Mengele, inflicted untold suffering on non-consenting and unwilling subjects in support of scientific and political goals, while subverting and perverting the principles of medical ethics.²

The Tuskegee Syphilis Study

In the United States, the most deplorable distortion of the medical ethos occurred in the Tuskegee Syphilis Study. The circumstances surrounding the study have been the subject of great attention in the popular media, including a Home Box Office (HBO) film, entitled "Miss Evers Boys," as well as

numerous less than factual press and electronic media descriptions. The most complete and factual published report of the chronology and historical context of the Tuskegee Syphilis Study is by Otis Brawley,⁷ who reviewed documents from the hearing conducted by the U.S. Senate, the original National Library of Medicine documents and the book, *Bad Blood*, by James Jones. The events surrounding the study have become, as Gamble has stated, "a powerful metaphor that has come to symbolize racism in medicine, misconduct of human research, the arrogance of physicians and the government abuse of black people." Reluctance of African Americans to participate in clinical research studies has been attributed to a climate of distrust and fear of exploitation by government researchers, created by the syphilis study and magnified by extensive media coverage.⁸

The Tuskegee Syphilis study, which lasted from 1932 to 1972, was conducted by the United States Public Health Service (PHS) and was officially titled, "The Tuskegee Study of Untreated Syphilis in the Negro Male." The most egregious aspect of the study was that black men with syphilis were not treated for up to 40 years (even with the treatments of the time), though penicillin, still the most effective therapy, became available in 1943. Initially, Macon County, AL, the home of the Tuskegee Institute, was the site of an early project to demonstrate that difficult anti-syphilis treatments could be successfully administered to southern rural blacks. In this demonstration project the treatment phase began in 1930, but the study ceased approximately one year later because of inadequate funding. Syphilis therapy at the time required a prolonged time course and was not completed in many participants because of the short duration of the project. Because of the high incidence of unusual syphilitic pathology, a more formal initial research study to "provide data on how syphilis differed in the 'Negro vs. the White'" was begun at Tuskegee in 1933.⁷

The first phase of the clinical trial in 1933 was to record baseline physical examination and laboratory data in black men with long standing skin lesions of syphilis and to treat those diagnosed with syphilis by laboratory testing for up to one year. Over the course of the year, 399 men with syphilis were enrolled and 201 uninfected men were enrolled as control subjects. Therapy was discontinued at the end of the yearlong initial study period, with some subjects receiving therapy for only a few

months. In 1934, reportedly because the pathology seen in the initial phase of the study was so impressive, a second phase of the trial was launched in order to study the natural history of untreated syphilis in black men. In collaboration with the Andrew Hospital in Tuskegee and the local medical establishment, it was agreed that Public Health Service (PHS) physicians would return yearly to assess the evolution of the disease. A local nurse, Eunice Rivers, was hired as data manager for the study and conducted yearly "round ups" of the volunteer research study participants, at which time physical examinations were conducted and blood drawn for laboratory analysis. Some subjects submitted to lumbar punctures. Several techniques were instituted to encourage participation and to assure complete follow-up. In the late 1930s, the Milbank Fund began providing \$50 burial stipends to the Tuskegee Institute, so that autopsies could be obtained. In order to preserve the trial, in 1941 (at the height of World War II), approximately 250 men, all less than 45 years old and likely eligible for the service in the military, were exempted from the draft, allowing them to remain in the area, but also avoiding military or other medical examination and limiting the chance of possible diagnosis and treatment of the syphilitic disease. The most tragic phase of the study occurred after the introduction of penicillin in 1943. In spite of the fact that penicillin was used in Macon County by the PHS, the decision was made (by parties unknown) not to administer penicillin to the men in the trial. Local physicians agreed not to treat the men in the study, but participants were not informed that a cure for syphilis was available to them. The study continued for three decades. Although the nature of the trial was well known in scientific circles and was the subject of at least 12 published reports, it was not until Peter Buxton, a PHS officer, raised questions about the trial and several newspaper articles were published, that a Senate committee investigation led to the closure of the trial in 1972.⁷

LESSONS OF MANAGED CARE

The end of the 20th century was marked by significant evolution of the science and practice of medicine, as well as by changes in health care expectations of patients, physicians and society.⁹ Recent advances in medical science and technology have provided unprecedented understanding of ba-

sic biologic processes and offer previously unimaginable possibilities for prevention, diagnosis and treatment of human disease. However, the cost attendant to medical and scientific discovery and the expense of widespread clinical utilization of advances in health sciences have contributed to rapid growth in the nation's expenditures for health care. As expenditures continued to increase, it became evident that health care was a limited and finite resource and that restraint in spending was needed. In the 1980s, as the public, employers and government recognized that the U.S. was spending an inordinate proportion of the nation's wealth on health care, (compared to other industrialized countries), efforts to identify a more cost-effective and socially responsible health care delivery system intensified. Managed care, which had been practiced by "health maintenance organizations" for many years, was selected by insurers, employers and government as a model for health system reform and cost containment. Managed care was envisioned as a system that would reduce expenditures on inappropriate or unnecessary health care and thus increase the availability of funds to improve the overall health of society.¹⁰

Over the last several years, managed care, in a wide variety of iterations, has become the dominant health care delivery system in the U.S. It has been credited with reducing health care costs, and has slowed the growth in physicians' annual net incomes.¹¹ However, as experience with managed care has grown over the last several years, patients and physicians have expressed a litany of concerns. These have included sub-standard quality of care, denial of necessary diagnostic or therapeutic procedures, adverse effects on the patient-physician relationship, improper financial incentives for physicians and restriction of information to patients regarding service limitations. Marginal experiences with diverse systems of managed care, as well as greater appreciation of the problems of managed care, have rekindled discussions of the bioethics of medicine and the responsibilities of physicians, the medical profession, the business community and government in responding to the health care needs of society, especially the needs of the poor and underserved.¹²

Managed care has emerged as the most pervasive and influential system of health care delivery for the insured in the United States. Managed care has also become the most common system of providing care

to the indigent. In many states, Medicaid managed care has become the major program for the provision of health care for the indigent. Managed care has been accepted by many as the health care delivery system, not only of the present, but also of the future. The rapid ascendance of managed care may be attributed to the promise, whether real or imagined, to contain health care costs and, thereby, increase the availability of resources for other socially responsible endeavors. However, the transformation of the health care system from one based on fee-for-service to one based on the managed care model has, from its very beginnings, been driven by the desire of large employers to reduce the cost of providing health care benefits for their employees and thus increase profits. Employee health care costs became a major focus for the corporate world during the 1970s, when the status of the U.S. as an economic power was waning and corporate profits were declining. When the economy was stagnant and health care costs were rapidly spiraling upward at twice the rate of inflation, the continuing rise in national health care expenditures was identified as an area of concern. Despite efforts at the time to reduce employer health care costs, such as increasing employee health insurance premiums, co-payments and deductibles, the rate of rise of health care costs continued to increase. Recommendations for abandonment of the fee-for-service system and institution of managed care systems were heard from Fortune 500 executives and other major employers. A concentrated effort to move employees into managed care plans was begun by employers, with the number of employees enrolled in employer sponsored HMOs rising from 15 million in 1985 to 50 million in 1996.¹³ By 1997, in medium and large size companies, approximately two thirds of employees belonged to one of several managed care plans offered by employers.¹⁴

The term "managed care" generally refers to a health care delivery system in which all services are coordinated and provided under a central administrative authority that also controls financial compensation to providers. Managed care was envisioned as an ideal system to reduce health care costs by increased utilization of primary care providers, decreasing unnecessary laboratory testing, eliminating excessive use of specialists, shortening hospital stays, and improving the efficiency of health care delivery.¹³ Primary care providers are central to the system and are encouraged (often through financial

incentives) to decrease costs by prudent approaches to diagnostic testing, hospital admissions, referral to subspecialists or to surgeons.¹⁵ By taking fee-for-service health care delivery out of the control of physicians and hospitals and changing to a mostly capitated system under the control of HMOs and managed care insurers, employers sought to slow the rise of their health care premium expense, while assuring substantial profits for stock holders (20%–30% of total revenues).¹⁶ In a health care environment typified by excess capacity in hospitals and a weakened labor market for physicians, managed care could demand discounted prices from providers and hospitals in exchange for referral of patients.¹⁷ By the early 1990s the rise in the costs of health insurance benefits paid by employers had slowed significantly. Initial assessment suggested that HMO costs had fallen substantially. Further analysis suggested that the decrease could be explained by the fact that HMO patients were healthier at entry into the plan.¹⁵ In addition, many of the reductions in health care expenditures were the result of a general slowing of inflation, as well as the consequence of reductions in the amount of employer sponsored health insurance coverage and of shifting the cost of insurance from the employer to the employee or government. Nevertheless, most observers acknowledge that, with the expansion of managed care over the last 10 years, acceleration of health care costs has slowed and corporate profits have increased. Whether there is a causal relationship between those events is much less certain.¹⁷

THE ETHICAL DILEMMA

While it is difficult to deny that managed care has had some early salubrious effects on health care costs, when compared to the "collateral damage" to the profession of medicine, the price of any cost savings associated with managed care may be of Faustian proportions. As predicted by Kassirer in 1995, the outcome of unchecked market-driven expansion of investor owned managed care has been "to alienate physicians, undermine patient's trust of physicians' motives, cripple academic health centers, handicap the research establishment, and expand the population of patients without health care coverage."¹⁸ Moreover, in the current managed care environment physicians are faced with a difficult ethical dilemma created by corporate and government pressures to keep costs down, ostensibly to

conserve resources for others in society, or to do what would be most beneficial for each individual patient's health. An unintended consequence of according group or societal concerns a higher priority than those of the individual patients may be a fundamental reordering of traditional ethical priorities of medicine and a transformation of physicians from healers of the sick to agents of HMO plans or insurers.¹⁹

Several new ethical positions have been proposed as substitutes for the priorities established in the traditional medical ethos. For example, Hall and Berenson,²⁰ have proposed a set of ethical principles which are intended to be more pragmatic and more accommodating to the realities of the modern practice of medicine under managed care. In their theoretical framework, "devotion to the best interests of each patient may be replaced with an ethic of devotion to the best interests of the group for which the physician is personally responsible." They maintain that "physicians should aim to do the best they can with the resources at hand for their own patients and others within the same practice group or insurance plan." They further contend that "each physician should adapt his or her clinical judgment to form a practice style that accommodates the mixture of financial incentives and resource constraints presented by his or her practice setting and patient population. Absolute impartiality is not ethically essential; physicians can make differential medical judgements on the basis of insurance status as long as they acknowledge the basis for the recommendation." They argue that, "if the 'system' nevertheless denies what is optimal, the physician can still claim full adherence to the traditional ethic of devotion to each patient's best medical welfare, as long as the system allows care that is at least minimally acceptable." They suggest that physicians may function under a financial conflict of interest that is not obvious or commonly known, as long as they disclose the nature of the financial incentives to patients. However, in the proposed new medical ethic, "maximizing group health does not require physicians to achieve universal social justice or perfect economic efficiency" and does not "allow physicians to compromise patient care in order to conserve resources for others in society at large."²⁰

The ethic proposed by Hall and Berenson²⁰ is an example of a medical ethic spawned by pragmatic responses to changing systems of health care delivery and contingent roles of physicians. When based

on a "morality of the marketplace,"¹⁸ such ethical constructs are likely to be antithetical to the traditional medical ethic, which has evolved from the truths inherent in caring for human illness. Such fundamental principles as beneficence (relief of suffering) are replaced by the profit motive, fidelity (devotion to the individual patient) replaced by devotion to the HMO or practice group, and integrity (the prerequisite for trust) replaced by conflict of interest. A new market-based medical ethic, such as that proposed by Hall and Berenson,²⁰ also places the goal of maximizing the health of the patients in a practice group or HMO above the broad principles of social responsibility that, for many, has also been a traditional part of the medical ethos. Arguments that managed care helps in meeting social needs because resulting health care cost savings may be transferred to other socially responsible functions or programs are, at a minimum, disingenuous. Experience has shown that much of the early benefit of the new health care paradigm accrued to share holders and company executives rather than the general public. Health care expenditures in the United States remain among the highest in industrialized countries and overall health care costs continue to rise.^{21,22} The lack of access to quality health care, as demonstrated by a large and increasing number of under or uninsured Americans,²³ and intractable disparities in health status between the rich and the poor²⁴ and between the majority population and racial and ethnic minorities,²⁵ raise serious questions regarding the commitment of the profession of medicine, as well as government, to equity and fair allocation of health care resources.

ECHOES OF THE PAST

Racial and Ethnic Disparities in Health

The principle of equal access to quality health care has received mostly rhetorical support from governmental and business. Real progress toward removing racial and ethnic disparities in access to health care remains a largely unfulfilled promise. Numerous examples of racial disparities in access to care and health outcomes have been described. For example, in a study of Medicare recipients by Gornick and colleagues,²⁵ the rate of mammography use was lower in black women compared to, white women and lower in less affluent women than in more affluent women regardless of race. Hip fracture repair was higher for white women compared

to black women, although not significantly different between income groups. Compared to whites, blacks were less likely to be immunized against influenza. The rates of operative procedures that may be related to complications of chronic disease (e.g., amputation of leg or bilateral orchiectomy) were dramatically higher in blacks compared to whites, while surgical procedures of accepted benefit (e.g., knee or hip replacements) were performed less commonly in blacks and in the less affluent.²⁵

Even though socioeconomic status and insurance coverage are among the strongest predictors of access to care, their effect is often confounded by factors related to race and ethnicity, such as cultural competency of providers, communication barriers (cultural or language) and lack of trust in the health care system. Racial disparities in access to cardiovascular care have been especially well documented. Studies have shown that African Americans are less likely to have coronary angiography, coronary angioplasty or coronary bypass surgery.^{26,27} In a study of physicians' decision making for referral for cardiac catheterization,²⁸ the race and gender of the patient impacted physicians' decision to refer for further diagnostic evaluation. Volunteer physicians were asked whether they would recommend further evaluation, possibly cardiac catheterization, after watching videotapes of "patients" (portrayed by actors) with equivalent histories of chest pain. "Patients" had comparable social and medical histories, as well as insurance coverage. Cardiac catheterization was recommended sixty percent less often for black women than for white women or black or white men. This study of physician decision-making is especially important since it suggests that disparities in access to care, in this case cardiac diagnostic testing, may be due to racial bias on the part of physicians. The study is a stark reminder that preconceived notions of "worthiness" (e.g., deserving to have your symptoms of chest pain taken seriously) based on race or other socially sanctioned hierarchical labels (Jewish?), may overwhelm ethical principles, making unconscious (hopefully?) racists of physicians who have sworn to be otherwise.

Inequalities in health status based on race and ethnicity, as well as socioeconomic status, attest to the inescapable reality of racism in America, and especially its role in access to health care and the delivery of medical services.²⁹ For some, this reality raises the specter of the distorted medical ethos of the Nazi era and of the Tuskegee Syphilis Study.

Racial and ethnic disparities in health status and access to care serve as a troubling reminders that the racial doctrines that fostered the horrors of the Holocaust and the Tuskegee Syphilis Study have not been completely removed from contemporary thinking. The myriad examples of racial disparities in health, not only in access to care, but also in life expectancy, mortality, morbidity, health status, disease prevalence and incidence, utilization of services, clinical outcomes, process of care, adequacy of pain management, do-not-resuscitate orders and end-of-life care, are evidence of society's tacit support of the notion of the "existence of hierarchies of human worth."² Implicit in the failure of the profession of medicine to aggressively advocate for equitable distribution of health care resources across the entire racial and ethnic spectrum, is an endorsement of the idea that poor health among African Americans (or women, the elderly, the poor, the nonwhite) is somehow warranted, because of their lesser worth as human beings and because of the superiority of the white (male, young or affluent?) majority.

THE UNINSURED

In addition to racism, another common thread connects the evils of the Tuskegee Study and the atrocities of the Nazi era: social Darwinism.² In the United States, as well as Europe, the rise social Darwinism in the 1930s led to acceptance of the idea that diseases like tuberculosis, leprosy and syphilis could be considered "racial friends" that removed weak and inferior persons from society. It is not hard to imagine that untreated syphilis might have been considered a "racial friend" in rural Alabama in 1934. Is the current lack of concern for the health of minorities, the poor and the uninsured analogous to the withdrawal of compassion and caring from those perceived to be racially inferior in the Nazi regime? What are the ultimate risks when society condones denial of rights (health benefits?) to a segment of society that is marginalized because of race, ethnicity or income? Since managed care has become the dominant health care delivery system in the United States, the number of uninsured persons in the population has increased to 44.3 million people, or 16.3% of the population in 1999 (U.S. Census data). Since the increase in the numbers of uninsured occurred in the era of managed care, some might conclude that managed care contrib-

uted to an exacerbation of a de facto medical hierarchy of human worth. Persons who can not afford insurance, or do not belong to an insurance plan for other reasons, are at the bottom of the medical hierarchy. Even when health care is available through government, as in the Medicaid programs, extremely low reimbursement rates for physicians providing service under Medicaid, make caring for these patients a financial hardship for physicians. This situation often forces physicians, who might opt to practice in medically underserved areas, to either limit the number of Medicaid patients seen or to give up practicing in neighborhoods with high proportions of the poor and uninsured. Under the current system, the uninsured are relegated to seeking health care in the emergency rooms of public hospitals, usually on an episodic basis. What is the ethical message being sent by the medical profession (and government?) in failing to adequately respond to the health care needs of the indigent, the “working poor” and the uninsured. Are their lives less valuable?

If, as stated in the Declaration of Independence, “all men are created equal,” we must reject an ethical system that allocates resources, such as access to health care, according to political expediency or contingent upon differential evaluations of human worth. Failure to do so would risk the possibility of another Tuskegee Syphilis Study, or worse. A return to the time tested tenets of the Asklepian medical ethos, the medical profession may be able to keep in check any subliminal urges to place political or governmental priorities, personal or business financial gain or the goals of special interest groups, such as for-profit-managed care, ahead of responsibilities to the individual patient. In the Asklepian tradition of equal service to paupers as well as princes, a modern medical ethos should emphasize responsibility to all segments of society, especially the vulnerable, the poor and persons who, because of the quirks of history or genetics, are marginalized by the majority.

SOCIAL RESPONSIBILITY: CHALLENGE TO THE MEDICAL ETHOS

That high quality health services should be available to all members of society has become a nearly universal expectation throughout the world. In articulating the goal of “health for all,” in 1978, the World Health Organization endorsed the concept

that all members of society should have the best possible health status.³⁰ However, in order to respond to the needs of individuals, as well as the needs of society, it will be necessary to achieve a balance between the competing principles that occupy the poles of the axis of the medical ethos. The debate is especially engaging when the choice is between two ethically defensible positions. Those supporting devotion to the needs of the individual are aligned with the traditional medical ethic and those supporting devotion to solving the general needs of society are aligned with a social-medical ethic. Boelen,³⁰ in describing the challenges facing health care institutions in meeting societies’ needs, places the goals of quality and equity at opposite ends of a “dream axis.” Quality refers to a commitment to the health of the individual (the medical ethic?) while equity refers to a commitment to provide the best health care to all of society (the socio-medical ethic?). Similarly, the medical ethos may also extend along an ethical axis, with beneficence and fidelity at one end and social justice and stewardship at the other. Private good and public good, as well as clinical medicine and public health, may be viewed as concurrent goals at the poles of the health policy axis. Given the realities of the current health care environment, achieving the highest quality health care for every individual and equitable distribution of health care sources throughout society will require a system that is both relevant and cost-effective. Relevance would be accomplished by making the most important health problems the highest priority. Cost-effectiveness would be assured by optimal reallocation of tasks and responsibilities among health professionals.³⁰ The continuing debate over whether or not physicians should be involved in “bedside rationing” is a practical example of the difficulty in balancing the competing ethical priorities of medicine.

“Bedside rationing” has been defined as “the withholding, by a physician, of a medically beneficial service on the basis of that service’s cost to someone other than the patient.”³¹ Should societal interests dictate physicians’ decisions at the bedside? While the ethical debate may be framed a choice between fidelity and stewardship, in the context of clinical practice, the conflict is between total loyalty to the medical interests of the individual patient versus utilization of the clinician’s skills in the pursuit of public health aims, non-health-related public health objectives, or as an arbiter for

third parties (e.g., participating in “bedside rationing” or as “gatekeeper” for managed health plans or government).³¹ Several commentators have articulated a rationale supporting the proposition that societal interests should dictate physicians’ decisions. Ubel³² suggests that, “perhaps by withholding discretionary services, we will be able to offer basic benefits to more people. Until we have done this, physicians need to think not only about the patient in front of them, but also about the collective consequences of their actions.” Advocates of bedside rationing by physicians would probably concede that withholding beneficial services is not in the patients’ best interests, although withholding *marginally* beneficial services might be.³² They have become reconciled with the certainty that rationing has become a fact of life in the modern health care environment. Proponents of bedside rationing argue that physicians are best able to make rationing decisions on behalf of government and third party payers because they are most familiar with the details of a given patient’s medical condition.

There is, however, substantial support for the position that the physicians’ imperative is service, above all, to the individual patient.³³ In an affirmation of the Asklepiian tradition, Cassel describes the patient-physician relationship as a covenant based on the ancient traditions of medicine. The physicians’ “first obligation must be to serve the good of those persons who seek our help and trust us to provide it.” “Like Asklepios, modern physicians must be either physicians or profiteers; they cannot have it both ways.”³⁴ McWhinney further distinguishes between a covenant and a contract. “A contract sets out the limits of what can be expected of the parties. It says: ‘I am committed to doing so much, but not more.’ A covenant is an undertaking to do whatever is needed, even if it goes beyond the terms of the contract.”³⁵ The directors of a for-profit corporation have a contractual fiduciary duty to their shareholders, which has a legitimate ethical foundation. However, the patient-physician relationship, because it is based on trust engendered by the expectation that the physician will place the interests of the patient above those of a third party, should at least be of comparable importance.³⁶ Emanuel and Dubler suggest that the fundamental elements of the ideal patient-physician relationship are: choice (of practice type or setting, primary care physician, specialist and treatment alternatives) competence of the health care provider, communi-

cation, compassion, continuity and no conflict of interest. The focus on the primacy of the patient-physician relationship is the consequence of centuries of consideration of the ethical basis of the relationship and of the critical elements that make up the relationship.³⁷

SCIENCE ABOVE ALL

Performance of clinical work for third parties in support of social or political goals is not only a concern in the clinical context. Scientific research may raise ethical questions related to the subjugation of individual rights by the interests of a third party. In the case of medical research the “third party” is not the state, industry or profit, but the rule of science. There is a risk of disregard for the fundamental ethical principles of medicine when the goals of scientific discovery are placed above the interests of the patient (or subject), *science regnant*, a term coined by Barondess.² In the human experimentation of the Nazi era and in the Tuskegee Syphilis Study, it is evident that the principle of fidelity to the patient became secondary to scientific inquiry. Even today, questions may remain regarding some practices in clinical research. For example, it was not too long ago that investigational studies of new antihypertensive agents required that all treatment be discontinued in patients who were already being treated for hypertension, so that the efficacy of the new agent could be observed without the confounding effects of prior treatment. Treatment was withheld, at least for a “washout” period. This policy has generally been changed, so that now in determining the efficacy of new antihypertensive agents, the new agent is generally added to prior therapy or, if there is a “washout period,” patients are not left untreated for dangerous periods of time.

Even if one puts aside the questions of racism and eugenics in the Tuskegee Syphilis Study, one is still left with the question of how withholding treatment after penicillin became widely available could have served any useful scientific purpose. It might be argued that the decision was actually made out of a desire to better understand the natural history of an important disease and that new knowledge would eventuate in better care for others in the future. However, the Tuskegee experience occurred in a scientific climate, similar to that in Europe, that allowed distortion of the traditional medical ethos

and perverted scientific interests to assume greater importance than the well being of human research subjects.⁷ The pursuit of greater understanding of biologic processes, in combination with the desire to obtain new knowledge in support of political objectives, rose to higher priority than the welfare of individual subjects.

What is the likelihood that similar events could occur in the present scientific environment? It can be argued that the ethical distance provided by the research relationship, and the absence of a therapeutic patient-physician relationship, allows the performance of clinical work for a third party to supersede the principle of faithfulness to the interests of the patient.^{20,31} The lessons learned derived from the Nuremberg trials and the experience of Tuskegee should not be forgotten. Those seminal events shaped current policies for the protection of human research subjects and resulted in the development of the current rules for human experimentation in the United States. More recent experiences in some of the most prestigious research institutions in the United States, have reminded scientists, the medical profession and society, of the need for constant vigilance in the protection of human subjects in medical research.³⁸ The human genome project and the accelerated progress of genetic sciences raise difficult and fundamental ethical questions that are not widely appreciated within society, nor fully addressed by the scientific, clinical and ethical communities.¹

CURRENT CHALLENGES

The challenge for the medical profession, for every health care provider, as well as for business and government, is to continually explore ways to balance the responsibility to assure that the interests of each individual patient remain the highest priority and the responsibility to seek "health for all." It is apparent, from the lack of access to health care for major segments of American society and the wide variations in health status according to socioeconomic status, race and ethnicity, that there is a need for a more socially responsible ethic, both for government and medicine. There is a need for a return to ethical principles that would foster more equal distribution of health care resources (e.g., an ethic of distributive justice, fairness and equity). Despite evidence of growing socioeconomic, racial and ethnic disparities in health status, there has been little

progress in improving access to care or implementation of universal health insurance. There has been some activity at the federal level and among a few health professional organizations. Prime examples are the programs to reduce disparities in health of the Surgeon General, Dr. David Satcher,³⁹ as well as those of professional organizations, such as the American College of Physicians/American Society of Internal Medicine.⁴⁰ There have even been calls for the passage of an amendment to the constitution stating that "All citizens and other residents of the United States shall have equal access to basic and essential health care."⁴¹ The continued growth of racial and ethnic health disparities and the fact that large segments of the population are without health insurance attests to the continued need for a more socially responsive health care system. The persistence of racial and ethnic disparities in health status and access to care should be constant reminders of the unresolved problem of racism in the U.S. The attitude of society and of government toward racism, particularly in the area of health care, should not be considered analogous to the behavior of the Third Reich. However, as long as major differences in disease prevalence, health outcomes, utilization of health services and access to care are drawn along racial and ethnic lines, the presence of American societal judgements of a hierarchy of human worth, the basis of the "Final Solution," can not help but be inferred.

With the acceptance of for-profit managed care, the medical profession has acquiesced to the demands of business and government to serve two competing agendas, to care for their patients and to reduce health care costs. Is it reasonable to ask physicians to become involved in activities that do not promote the interests of individual patients but are more for the alleged good of society? Throughout medical history physicians have performed clinical activities for a social good and may have placed advancement of community needs at a higher priority than individual patient interests. Medicine has performed social functions through the years and such practices have been viewed as within the ethical constructs of the profession, preserving the health of the public, as well as individual health. Examples include immunization against diseases that have minimal likelihood of occurrence in a given individual but where population wide vaccination would prevent epidemics (i.e., polio, small pox).²

The utilization of physicians as gatekeepers or as guardians of the financial interests of employers or insurance companies is the most current example of the conflict between clinical duty and social responsibility. Performance of a gatekeeping functions by physicians has been advocated as an effective means of limiting medical expenditures. The practice has been defended on moral and ethical grounds on the premise that funding would be available for others purposes beneficial to society. The performance of clinical work for third parties (insurance companies or the state) has been distinguished from other clinical work, because it did not involve a patient-physician relationship and therefore was not medical practice. It has been suggested that, since the subjects of such work were not patients, the possibility of harm (or benefit) to them was ethically irrelevant. Recently, the claim that consequent harm is ethically irrelevant when physicians serve the state or other third parties has been the topic of discussion in relation to the ethics of forensic practice. Questions have been raised regarding the ethics of determining the readiness, in terms of health, of a prisoner for execution.³¹ Although the situations are not comparable, some might consider the assertion that clinical work for the state is beyond the scrutiny of medical ethics to be an echo of the distorted medical ethics of the Nazi era.

While the problems associated with managed care can not be denied, the problems faced by patients are not the result of managed care per se but of an imbalance between the goals of business and government and the needs of individual patients. When appropriately structured, managed care may have many positive effects. As noted by Kassirer,¹⁸ in addition to contributing to reductions in the rate of rise of health care costs, several other beneficial aspects of managed care have been observed: "patients stay in the hospital far fewer days, many surgical procedures that previously required hospitalization are now safely performed in day surgery, there is far more attention to preventive care, many medical practices have been standardized to produce better outcomes, and satisfying patients has become an explicit goal." Unfortunately, not all managed care plans are as successful as others. When the profit motive is in equilibrium with the principles of the traditional ethic of medicine, broader access to care, as well as more responsible cost containment may result. With maximal concern for patient welfare, managed care could actually

improve collaboration among specialists and primary care physicians, leading to rational clinical decisions based on individual patient benefit and cost-effectiveness.⁴²

CONCLUSION

The U.S. has been blessed with abundant resources, including medical resources, over the last half of the 20th century. For some, the health care system has been typified by limited access to basic and preventive health services, poorer health outcomes and excess morbidity and mortality. For the majority population, however, health care in the U.S. has been characterized by an abundance of technology, physician manpower, pharmaceutical advances and an environment of nearly unlimited support for research and discovery. The perception that the health care system was guilty of unbridled spending and profligate resource allocation fostered a desire for health reform and the advent of managed care. The final years of the previous millennium were marked, however, by a change in the delivery of health care. Market-driven managed care became the pervasive health care delivery system. But, with the spread of managed care and the intrusion of cost-containment into the patient-physician relationship has come patient, as well as physician, dissatisfaction. The conflict physician's face in abiding by the principles of fidelity to the patient while also trying to adhere to the regulations of an economically driven health care system has created discontent for physicians as well as patients. The hypothesis that managed care would ultimately improve the health care system for all has been tested and not proven. Despite great economic prosperity, health care costs are increasing, employers are cutting back on coverage, the numbers of uninsured are growing, and the rights of patients are threatened. The imposition of economic incentives in the clinical decision making of physicians has undermined patients trust in their physicians and in the medical profession. It is likely that health care costs will continue to rise in the future because of demographic shifts (aging baby boomers), increasing costs of personal services in comparison to capital intensive industry, and the unlikely prospect of unlimited resources being available for health care. Therefore, there will probably be a need for prioritization within health care in the foreseeable future. Medicine in the new millennium is faced with the

challenge of increasing access to care and reducing economic, racial and ethnic disparities in health while also responding to a revival of patient-centered medicine. The growing importance of “outcomes research” and “evidence-based medicine” portend a system of health care that will be judged by the degree of success in improving the health outcomes and satisfaction of individual patients as well as the health of the public.⁴³ As Davidoff has observed, the institution of universal health coverage is unlikely because of “our deep distrust of central government control, coupled with our profound faith in the moral precepts of commerce and the market, our driving need for personal autonomy and our occasional spasms of intense partisanship.”⁴¹ Until there is a public outcry and the necessary political will, there is very little likelihood of a change from the current employer-based, market-driven health care system, with its inherent ethical conflicts, socioeconomic, racial and ethnic health disparities and “user-unfriendliness.”

As noted by Osler,⁴⁴ “As the practice of medicine is not a business and can never be one, the education of the heart—the moral side of the man—must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals with corn or coal; ‘the human heart by which we live’ must control our professional relations.”

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