# The impact of market forces on the physician–patient relationship

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## Introduction

The canons of the medical profession in both the USA and the UK, as in almost all western societies, have always insisted that a physician's responsibility to his or her patients should take precedence over economic self-interest. This is the basis of a *de facto* contract between modern society and the profession. In the USA, state governments grant physicians a licensed monopoly to practise and allow them considerable autonomy in setting their own professional standards and working conditions. The education of physicians is heavily subsidized. The information, tools and techniques physicians use to practise their profession are usually developed through publicly supported research. Hospitals provide physicians with the facilities, trained personnel and specialized equipment which they need to practise their profession with their hospitalized patients, thus relieving them of many kinds of overhead costs. Physicians enjoy a privileged position in American society which usually assures them high social and economic status. All of these privileges are accorded doctors in the expectation that they will remain competent and trustworthy and will faithfully discharge their fiduciary responsibilities to patients.

The distinction between what society expects of physicians and what it expects of people in business is clear. Both are expected to earn their living from their occupation, but the relation between physicians and patients is quite different from that between businessmen and customers. Patients depend on their physicians to be altruistic, to advise them on their health care needs and to provide or recommend the necessary medical services. Most patients (even those who are well-informed) do not have the ability or the inclination independently to determine their own needs for medical care. The quality of their life, sometimes life itself, is at stake and price is of little importance: not only because of the unique value of the services rendered, but also because patients usually do not pay for services at the time they are received. Although physicians are paid for their services (usually by third parties), the assumption is that they are acting in the best interests of patients rather than of themselves. Underscoring this assumption is the fact that advertising and marketing by physicians were, until recently, considered unethical, and even now marketing and advertising are still avoided by most physicians, although professional associations are prohibited by law from interfering with these activities.

In contrast, competing businessmen rely heavily on marketing and advertising to generate demand for their services and products (regardless of whether they are needed) because each businessman's primary concern is to increase his sales and maximize his income. Although commercial vendors are expected to offer a good product and to advertise it truthfully, they have no responsibility to consider the consumer's interest, to advise the consumer which product, if any, is really needed, or to worry about those who cannot afford to buy any products. In a commercial market, consumers are expected to fend for themselves in judging what they can afford and want to buy. *Caveat emptor* is the rule. How different is the situation in medical practice, where the provider of services must be trusted to protect the consumer's, that is, the patient's, interests by acting as advocate and counsellor. This double role of physicians as purveyors of services and patient counsellors has always raised questions about conflict of interest, and has generated scepticism about the motives and trustworthiness of physicians. Until recently, such views had little influence. Most people considered medical care to be a social good, not a commodity, and physicians usually acted as if they agreed. Physicians are not impervious to economic pressures, but the pressures were relatively weak and the tradition of professionalism was relatively strong.

## The medical business

The situation is now rapidly changing. In the past two decades or so health care has become commercialized as never before, and professionalism in medicine seems to be giving way to entrepreneurialism. The health care system is now widely regarded as an industry, and medical practice as a competitive business. Let me try briefly to explain the origins and describe the scope of this transformation. First, the past few decades have witnessed a rapid expansion of medical facilities and personnel, leading to an unprecedented degree of competition for paying patients. Our once too few and overcrowded hospitals are now too numerous and on average less than 70% occupied. Physicians, formerly in short supply and very busy, now abound everywhere (except in city slums and isolated rural areas), and many are not as busy as they would like to be. Professionalism among self-employed private practitioners thrives best when there is more than enough to do. When there is not, competition for patients and worry about income tend to undermine professional values and influence professional judgement. Many of today's young American physicians have to worry not only about getting themselves established in practice but also about paying off the considerable debt they have accumulated in medical school. High tuition levels make new graduates feel that they have paid a lot for an education that must now begin to pay them back and handsomely. This undoubtedly influences the choice of specialty many graduates make and conditions their attitudes toward the economics of medical practice.

Along with the expansion of health care has come a great increase in specialization and technological

sophistication, which has raised the price of services and made the economic rewards of medicine far greater than before. With insurance available to pay the bills, physicians have powerful economic incentives to recruit patients and provide expensive services. In an earlier and less technologically sophisticated era, most physicians were generalists rather than specialists. They had mainly their time and counsel to offer, commodities that commanded only modest prices. Now a multitude of tests and procedures provide lucrative opportunities for extra income. This inevitably encourages an entrepreneurial approach to medical practice and an overuse of services.

Another major factor in the transformation of the system has been the appearance of investor-owned health-care businesses. Attracted by opportunities for profit resulting from the expansion of private and public health insurance, these new businesses (which I call the medical-industrial complex) have built and operated chains of hospitals, clinics, nursing homes, diagnostic laboratories, and many other kinds of health facilities. Recent growth has been mainly in ambulatory and home services and in specialized in-patient facilities other than acute-care general hospitals, in part because most government efforts to control health-care costs and the construction of new facilities have been focused on hospitals. Nevertheless, the growth of the medical-industrial complex continues unabated. There are no reliable data, but I would guess that at least one-third of all non-public health-care facilities are now operated by investor-owned businesses. For example, most nursing homes, private psychiatric hospitals, and free-standing therapeutic or diagnostic facilities are investor-owned. So are nearly two-thirds of the so-called health-maintenance organizations, which now provide comprehensive prepaid medical care to more than 40 million members.

The corporatization of health care, coupled with the increasingly hostile and cost-controlling policies of private insurance companies and government, has had a powerful and pervasive effect on the attitudes of health-care providers (including those in the not-for-profit sector). Not-for-profit, non-public hospitals (voluntary hospitals), which constitute more than three-quarters of the non-public acute-care general hospitals in the country, originally were philanthropic social institutions, with the primary mission of serving the health-care needs of their communities. Now, forced to compete with investor-owned hospitals and a rapidly growing number of for-profit ambulatory facilities, and struggling to maintain their economic viability in the face of sharp reductions in third-party payments, they increasingly see themselves as beleaguered businesses, and they act accordingly. Altruistic concerns are being distorted in many voluntary hospitals by an overriding concern for the bottom line. Management decisions are now often based more on considerations of profit than on the health needs of the community. Many voluntary hospitals seek to avoid or limit services to the poor. They actively promote their profitable services to insured patients, advertise themselves, establish health-related businesses, and make deals with physicians to generate more revenue. Avoiding uninsured patients simply adds to the problems of our underserved indigent population and widens the gap in medical care between rich and poor. Promoting elective care for insured patients leads to overuse of medical services and runs up the national health care bill.

Physicians are reacting similarly as they struggle to maintain their income in an increasingly competitive economic climate. Like hospitals, practising physicians have begun to use advertising, marketing, and public-relations techniques to attract more patients. Until recently, most medical professional societies considered self-promotion of this kind to be unethical, but attitudes have changed, and now competition among physicians is viewed as a necessary, even beneficial, feature of the new medical marketplace. Many financially attractive opportunities now exist for physicians to invest in health-care facilities such as diagnostic laboratories and imaging centres, to which they refer their patients but over which they exercise no professional supervision. Surgeons invest in ambulatory-surgery facilities that are owned and managed by businesses or hospitals, and in which they perform surgery on their patients. Thus, they are paid for their professional services and also share in the profits resulting from the referral of their patients to a particular facility. A recent study in Florida revealed that approximately 40% of all physicians practising in that state had financial interests in facilities to which they referred patients. Nationally, the figure is probably less, but still distressingly high.

In other kinds of entrepreneurial arrangements, office-based practitioners make deals with wholesalers of prescription drugs and sell those drugs to their patients at a profit, or buy prostheses from manufacturers at reduced rates and sell them at a profit, in addition to the fees they receive for implanting the prostheses. In entering into these and similar business arrangements, physicians are trading on their patients' trust. This is a clear violation of the traditional ethical rule against earning professional income by referring patients or by investing in the goods and services recommended to patients. Such arrangements create conflicts of interest that go far beyond the economic conflict of interest in the fee-for-service system, and they blur the distinction between businesses and the medical profession. Not only practitioners but also physicians doing clinical research at teaching hospitals are joining the entrepreneurial trend. Manufacturers of new drugs, devices, and clinical tests are entering into financial arrangements with clinicians engaged in testing their products, and the results of those studies may have an important effect on the commercial success of the product. Clinical investigators may own equity interest in the company that produces the product or may serve as paid consultants and scientific advisors, thus calling into question their ability to act as rigorously impartial evaluators. Some medical schools have taken stands against such arrangements, but unfortunately this obvious conflict of interest has so far been ignored, or at least tolerated, in many other institutions.

Business arrangements of this kind are also common in postgraduate education. Respected academic clinicians are frequently hired by drug firms to give lectures or write articles about the manufacturers' new products. The assumption, of course, is that these experts are expressing honest and dispassionate opinions about the relative merits of competing products, but such an assumption is strained by the realization that an expert is being handsomely paid by the manufacturer of one particular

product in a market that is often highly competitive. Similarly, drug manufacturers offer inducements to practising physicians to attend seminars at which their products are touted, and even to institute treatment with a particular drug. In the former case, the ostensible justification is furtherance of post-graduate education. In the latter, it is the gathering of post-marketing information about a new drug. The embarrassing transparency of these subterfuges has recently caused pharmaceutical manufacturers to agree with the American Medical Association that such practices should be curtailed. In short, at every turn in the road physicians both in practice and in academic institutions are being attracted by financial arrangements that compromise their professional independence and inevitably erode trust in their fiduciary role.

As a result, criticism of physicians by government and by the public has grown, and the old social contract based on trust is threatened. The American health care system is inequitable, inefficient and much too expensive. It cries out for reform and all signs indicate that political action is finally at hand. The task will be arduous, but I believe an essential condition for success is to gain a firm consensus on what kind of medical profession we want. We cannot expect to solve our problems simply by changes in health insurance and funding. The delivery of medical care, and that means the behaviour of doctors, must also change. Physicians must regain the high ground from which the commercialization of health care has driven them, and they must once again become trustworthy advocates for patients rather than act like competing businessmen.

**The future**

The emerging shape of the new American health care system is just barely visible. Although many details remain undefined, the system will almost certainly depend heavily on prepaid care. This inevitably means organized systems of doctors and other health care providers. To control costs within these organized systems, medical care will increasingly have to be managed. The question is: who will do the managing and with what incentives? There are already many signs that for-profit insurance companies and other health care businesses are seeking to position themselves as the purveyors of prepaid medical care and will therefore do the managing. Physicians will be employed by them or will provide services on a contractual basis. The risk is that professional autonomy and professional values may be subordinated to business interests and that the ethical basis of the doctor-patient relationship may erode. To protect the interests of patients and preserve professional values we need a new delivery system with different incentives: a system that allows physicians to be advocates for their patients and rewards them for their clinical diligence, competence and compassion rather than for the over- or under-use of resources in the pursuit of profits.

I conclude that the American medical profession is now facing a momentous dilemma. Will it become increasingly a part of the medical-industrial complex, or will it take new action to restore its self-respect as an independent profession dedicated to the public interest and the welfare of its patients? The future of medical practice in the USA will be determined by that choice.

# A response

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Medical doctors have always had the option of behaving as practitioners of a profession or as salesmen of technical expertise. Both methods of practice can be honourable but play to different rules. 'Members of professions minister to people', according to Vannevar Bush[1]. They minister with dignity, demand the respect due to their skill and devotion and do not merely advise, but insist upon being heard. They do not submit their opinions for judgement by their clients, no matter how important they may be, but insist that they enjoy their complete confidence or turn elsewhere for help. The ethics of trade are somewhat different, and based upon the precept that the customer is always right and the unspoken premise that he should beware. It is implicit in the concept of trade that the client is the sole arbiter of his requirements, and that the role of the tradesman is to satisfy them. It is no part of a tradesman's responsibility to advise on whether a customer's perceived needs correspond to his true needs; indeed it is perfectly ethical within the concept of trade for the tradesman to encourage business by advertising and such other means of persuasion as are available to him.

For generations, most doctors in this country, and others that have adopted similar ethical standards, have chosen to act as professionals rather than as tradesmen, and this has accorded with the wishes of the vast majority of their clients or patients, as demonstrated by the very low litigation rates compared with those that have had a more commercial attitude to medicine. The UK was particularly favoured during the four decades beginning in 1948, during which the professional status of all medical practitioners, whether involved in direct or indirect provision of care, was recognized. Providers of what are now often, and wrongly, referred to as clinical support services, such as pathology and radiology, looked