# Ethic's, Economics and Professionalism

**EDITOR'S MESSAGE**

By Ed Rudin, MD

Recent amendments to the AMA's Code of Ethics have significantly added to our ethical obligations to patients and the public. Two new principles, the first additions in three generations, clearly respond to medical marketplace pressures.

Half of the Hippocratic Oath deals with physicians' obligations to each other; the other half with obligations to patients. Its homage to the goddess Hygeia acknowledges the physician's obligation to community health. The Hippocratic Oath does not mention competition in the hostile status quo medical marketplace of the day on the island of Cos, but built its survival on Coan collegiality. Since then, collegiality has dominated the profession's ethics, and has left the ethics of competition ill-defined.

A hallmark of professionalism is its ethos. Historically, ethical practice, not economic success, has determined a profession's social standing. Indeed, economic success inevitably evokes suspicion about a profession's ethics, even whether it is a profession. Consider Moliere's satire The Imaginary Invalid and today's cynicism about the ethics of Enron's economically self-serving outside accountants and lawyers.

Doctors, tired of being beaten up by the existing healthcare system, compete aggressively with each other. They establish competitive surgery centers, imaging centers, weight reduction centers and psychiatric centers to serve full-pay, low-risk patients. Their advertising is often more compatible with marketplace ethics than with medical ethics. Not burdened with under-compensated care and onerous mandates, these doctors can earn better incomes and generous returns on their ownership investment, though that may weaken hospitals and fellow physicians.

Business and general circulation media have reported the economics of the competition between and among doctors, hospitals and managed care organizations, but not the health care effects. The short-term financial interests are clear, but what about the short and long term effects on patients and the public?

Our new Code of Medical Ethics requires physicians to:

- *"recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."*

  Does it improve the community and better the public health to "skim" the full-pay, low-risk patient from the hospital's revenue, leaving the hospital mandated or contracted to serve low-pay, high-risk patients - in earthquake-proof facilities with mandated staffing standards? Does forcing a hospital to close its doors or reduce its quality or availability improve the community's health? Does duplicating the demand for scarce and costly professional resources serve the community and the public health better?

- *"regard responsibility to the patient as paramount."*

Are free-standing services, whoever owns or operates them, as able as hospitals to provide patients with timely, seamless, quality care if an emergency or complication arises? Are the facilities equally safe? Is patient recovery equally assured?

- *"support access to medical care for all people."*

  Do free-standing ambulatory services return us to a two-tiered system of health care - a 1950s low-quality public hospital service for high-risk, low-pay patients, and a high quality private non-system that serves low-risk, full-pay patients? With personnel, equipment and facility costs as high as they now are, would the difference in quality and availability of medical care for the frail and poor create a life and death difference?

Free-marketers can invoke a so-be-it "economic Darwinism," but the medical profession must answer these questions of medical ethics. Is a proposal that serves doctors better as good for patients? For the community? In a contest for market share, who looks out for patients and the community?

Market dominance whets the appetite for monopoly. When physicians dominated, they sought monopoly by owning hospitals, pharmacies and labs. As hospitals, employers and managed care successively sought monopoly, prices rose or access fell. As government achieves dominance in health care, it too seeks monopoly, and patients and all the others will again suffer.

For many years, hospitals were urged to provide on-site outpatient, urgent care, rehabilitation, long-term and day treatment alternatives to traditional inpatient care. Such alternatives promised an extended range and continuity of care, real-time consultation, less fragmentation, and lower costs. When physicians were in control, they blocked these alternatives, claiming they competed with private practice. When medical staffs lost control, hospitals developed such on-site alternatives. In successive waves of dominance, HMOs, managed care and hospitals each expanded to off-campus siting in their reach for bigger market share.

It is in the best interest of all patients and of the public's health, for doctors to collaborate with other health service providers, patients and government to:

- answer the professional questions that remain or arise about medical standards, availability, resource utilization and quality and outcome of services in all health care facilities, including free-standing ambulatory facilities;

- arrive at policy consensus about professional standards, patient eligibility, and continuity of care that ensures equal or better services at a lower cost for all patients, public or private, fully insured or uninsured; and

- protect and advance the public's health.

These ethical responsibilities of the medical profession have repeatedly complicated the free market delivery of medical care. They complicate the simple "cost-plus" and "supply-demand" formulas of the marketplace. Whenever doctors have put economic considerations above patient considerations, the profession has suffered.

Regulations and mandates protect constituents only when they are adequately funded. Surely, patients need safe and affordable hospitals, safe and affordable medications, safe and affordable community-based resources, staffed by well trained, ethical physicians and allied personnel. We cannot achieve these for our patients unless we join, not oppose, allied personnel, patients, hospitals, the insurance and pharmaceutical industries and governments in seeking the funds that provide fair and adequate compensation for mandated services.

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