Ethical Impact of Changes in Health Care on the Role of Medicine in Society and the Physician - Patient Relationship

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CHAPTER I: INTRODUCTION

Patients contact a myriad of different health care personnel in their trek through the American health care system. In the 1950s on the numerous TV shows about medicine, it was easy to discern "who was who" in the health care cast of characters in these portrayals. The physicians, like Dr. Kildare, were always male, clean cut and serious looking. Nurses wore starched white dresses with nursing caps and distinctive pins; they instantly obeyed the doctor's orders (including the one to make the doctor a cup of coffee).

For better or worse it is a different world now than it was in the 1950s. Social role changes will soon have the doctors being mostly female and a large number of the nurses being male, no one wears a starched white dress, and any health care worker of any gender can have hair of any length, ear-rings and usually will be dressed in the generic scrub suit with white running shoes that has come to signify the American health care worker. Needless to say it is difficult to tell "who is who" in the health care system today by appearance. The stereotypical health care professional role identification related to dress is largely a thing of the past. So how do health care professionals distinguish themselves? Is it in roles, actions or responsibility?

Medicine and society have enjoyed a special relationship over time; society supports the training of medical professionals by investing resources for education and practical experience at publicly funded hospitals. In return, medical professionals provide service and work to serve the greater benefit of society even at risk of their own health (as in the case of epidemics of infectious diseases). They place the benefit of the patient foremost, even over concerns of profit to themselves. Medicine is trusted to police its own ranks, to safeguard its own integrity. Until recently, medicine has largely been taken at its word that it has served these functions diligently. With the introduction of managed care, questions have arisen about the role of medicine in serving both the public interest and that of the individual patient. These concerns are voiced over such issues as the allocation of care, and the role of profit in managed care medicine. The very value of trust in the physician by the patient has been shaken by reports of using the bottom line as a barometer for treatment instead of what is in the best interests of the patient. This questioning has raised issues in the most basic of elements of medicine, the physician-patient relationship.

This paper will examine the issue of ethical impacts of selected changes in the health care system on the role of medicine in society and the physician-patient relationship. To accomplish this task, discussion will briefly outline the underpinnings of what constitutes a health care professional, self- regulation and the relationships of the profession of medicine to society. The impact of managed care and medical futility on these relationships will be used as a framework to illustrate some of the ethical issues society and medical professionals face as a result of changes in societal expectations and the manner in which medical care is currently delivered.

Underpinnings of a Professional
Entry into a health profession entitles one to certain privileges and also provides for specific obligations. Certainly there is a discrete body of knowledge that one masters as a professional. The traditional health professions of medicine and nursing have oaths that their members swear to uphold upon entry into the profession. These oaths contain essential qualities or virtues that the professionals aspire to. There is an identity that accompanies being a health professional that transcends what uniform a person wears. That identity is embodied by the traits the person manifests in their actions (Flynn, 1997). Over time that identity has engendered respect from the public for the individual by being a member of a health profession (i.e. doctor or nurse), not so because of who they are, but the tradition that they are now a part of.

Professional Obligations
Belonging to the ranks of a health profession also carries specific obligations (Flynn, 1997). The first is competence in the professional role, mastery of the specific set of skills and knowledge. Secondly, one is obligated to a commitment of service and life long learning to be current in practice. Health care professionals also have obligations to control entrance to the profession and "police the ranks", protecting patients from unqualified practitioners. These obligations carry over from the individual practitioners to the institutions that they work in (Garrett, Baillie and Garrett, 2001).

Public Protection
In addition to the role that individual providers play in policing their ranks of unqualified or dangerous practitioners, government has an additional important role to play in regard to public safety. Each state is invested with regulatory and legislative power to form laws and rules to provide for the public safety in health services, by setting entrance standards for licensure and regulating practice. This is a specific power at the state level (not federal) that is usually administered by the respective professional board (i.e. board of medicine).

All of the factors mentioned above work synergistically to set the foundation of professional standards for conduct, duty and performance of health professionals. The following discussions illustrate problems that arise with ethical issues related to the standards of good medical practice, professional conduct and the relationship of medicine to society.

CHAPTER 2 : PROFESSIONALISM AND SELF-REGULATION
Typically, the regulation of the medical professional has been done by the process of licensing through the state board of medicine. Beyond that licensing process there is an important social contract between society and the medical profession that speaks to the heart of the ethical values of what it means to be a professional.

Relation of Medicine to Society
On a broad scale, this contract with society deals with the provision of adequate numbers of physicians and other practitioners through medical education and training (Richmond and Eisenberg, 2000) to provide services and safeguard the public health. Changes in the structure of medical practice have brought about questions concerning how this contract now functions. Many view the shift to managed care as a way that the distribution of medical services can be done on a basis of cost rather than on the basis of need. This perceived shift in allocation has, in the view of some, violated the social contract between the medical profession and patients (Richmond and Eisenberg, 2000).

The criticism is that the medical profession has let entrepreneurs determine how medical care is practiced and how health policies are formed. One could view this as a failure of the medical profession to self regulate and be proactive with health policy and to deal with the concerns of government officials regarding costs and waste. Another manifestation of this issue is the crackdown on Medicare Fraud and Abuse. In 1997, the U.S. government overpaid Medicare providers by more than $23 billion, such fraud and waste has driven politicians to enact legislation to cut expenses (Bloche, 1998). Both of these examples indicate a loss of faith in the medical profession by society, as medicine seems to have lost the ability to exercise self-restraint in relation to self-interest.

This is a subversion of the ethical responsibility that the medical profession has to society to see that the welfare of patients has priority over profit margins in medicine. Flynn (1997) offers that the role of the gatekeeper physician in managed care is in perpetual conflict acting between what is in the patient's best interest and the bottom line.

Beneficence, Autonomy and Allocation
Who is harmed here? Certainly there is circumstance for the patient to suffer if the gatekeeper physician is too concerned with the costs and not the care that is provided. More over, the integrity of the physician is damaged as well. However, I would offer

that there is much more harm here than either to a particular patient or physician. Indeed, this type of situation has damaged the very fabric of the social contract between health professionals and society. It has damaged the basic ethical relationship between doctor and patient on a grand scale. The ethical constructs of non-malfeasance, beneficence and non-abandonment that the physician brings to the patient-physician relationship has been taken for granted by patients for hundreds of years as they entrust themselves to the care of their doctors. Historically, patients had every reason to trust the their doctor would be committed to their well-being. Managed care may have altered this relationship forever. Now the doctor may have a reason to consider other things in addition to the welfare of the patient. Is the patient's welfare now just one of a number of factors the doctor will consider, having to ponder cost or number of specialty consults already ordered in the overall equation? This dilemma impacts most directly on beneficence. The concept of beneficence is linked to both ends and duties (Fowler and Levine-Ariff, 1987). Removing harm, preventing harm and positively benefiting another is a duty. By doing benefit for others we seek conditions that are considered good and thus realize an end. The physician has a duty of beneficence to the patients under his/her care that emanates from the patient's needs. Utilitarian views would support that the physician owes the patient general beneficence because of their relationship. Even thought the physician has a contract with the managed care organization, their duty of beneficence to the patient overrides the contractual obligation to the organization (Beauchamp and Childress, 1994).

It is not difficult to see that the HMO may also cause an ethical problem with autonomy. By denying a particular treatment for a patient (under the guise that rationing of treatments by knowledgeable physicians is justified since many treatments are over utilized in conventional private practice settings to make the patient happy), an HMO may disrespect the autonomy of that patient. Kant indicated that persons are capable of making choices according to moral principles and thus should treated as ends in themselves (Fowler and Levine-Ariff, 1987). In the patient-physician relationship, the physician has the obligation to act as the patient's advocate. Presenting treatment options to the patient that is consistent with their values and lifestyle is consistent with this advocacy role. In the managed care situation, treatment options may be severely limited due to financial constrains placed on the physician by the HMO. In this situation the advocacy role of the physician and the autonomy of the patient would be compromised.

Another criticism of the managed care system that may impact on self-regulation concerns the physician who may not be practicing good medicine but who is very efficient from a cost saving standpoint (rationing). Will this type of physician be maintained because of their economic impact despite their failure of provision of good standard of care medicine? One would expect that in private practice such a physician would be identified by the self-policing efforts of colleagues who would identify this doctor as a danger to patients. However, in the managed care arena, would the same criteria apply? Flynn (1997) points out that typically, physicians are not put in the position to ration care. Such decisions are made on a societal level and not by an individual physician (on behalf of a collective, the HMO). This is another instance where managed care may distort the fabric of the patient-provider relationship and the ethics that govern behavior and decisions. It does so by taking an issue that is a macroscopic issue (allocation of health care resources) and attempts to apply it at the microscopic (individual patient) level (Anhronheim, Moreno and Zuckerman, 1994). This attempt causes a dilemma in an ethical sense with justice, the HMO physician has a conflict between the interests of resources the patient needs and the allocation interests of the employer (the HMO). Once again the gatekeeper physician is put in an untenable position of conflict by the structure of managed care.

Paternalism in Managed Care
Supporters of the managed care concept may ethically defend the allocation and rationing issues raised above under beneficence, advocacy and allocation by claiming that in this case paternalism is indicated because of the good it creates. Edge and Groves (1994) define paternalism as the intentional limitation of autonomy of one person by another (in this case the physician limiting the patient's autonomy as a surrogate for the HMO). Kant lamented that a government may cancel freedom using the phrase, imperium paternale; he did not envision a situation where in some cases the government may intervene in a benevolent fashion for someone who is incompetent of action. In some situations paternalism maybe indicated, particularly where it is used to justify interventions and decisions made for a sustainable, yet non-autonomous person. Take for example the patient who has no family, no advanced directives, is incommunicable and is maintained on a ventilator. In this example intervention by the court in a paternal fashion on behalf of this patient maybe justified. The managed care application of paternalism is usually quite different, here the patient is communicative and a competent adult. The argument could be made by managed care proponents that this adult patient has a medical knowledge base inferior to that of the physician (and by extension the policy makers at the HMO who look at effectiveness data of interventions and decide which are appropriate for which patient groups) and thus has limited competency to choose medical courses of action. The patient may think a particular course of action is desirable, but would be unable to understand that in the larger picture, choosing that action may not affect outcomes, and thus, not be justified. Stated another way, the good produced by making the patient feel better because they received the

desired action, but that did not make a difference in the outcome of a disease process, did not outweigh the bad, because it used scarce resources from a limited pool of HMO resources.

The above discussion of paternalism highlights a situation where the intimation was that the patient desired a certain course of treatment and that was denied to him by the HMO on primarily financial grounds. This introduces the next concept that creates ethical dilemmas stemming from the physician-patient relationship, medical futility.

CHAPTER 3: MEDICAL FUTILITY
The concept of medical futility is often discussed in the framework of beneficence, autonomy and the integrity of the physician (Brett and Mc Cullough, 1986). On the surface this seems to be a straightforward topic, after all there is a limit to patient autonomy. If a patient would request neurosurgery for a simple head cold, no physician would concur simply because the patient desired this course of action. However there are many modifying situations that make the present day discussion of futility a complex subject and perhaps not as simple as the physician determining with a wave of the hand that a procedure is not necessary.

Working Definitions and Context
When a procedure or treatment is deemed futile, most would content that this judgment would be based of medical facts alone. A simple working definition or criteria for futility may be; does this procedure have a track record of success or does it only have a remote chance of success or clinical benefit to the patient? More specific criteria for futility has been proposed in the literature as a chance of less than 1 success in 100 attempts (Schneiderman, Jecker and Jonsen, 1990).

Many of the decisions in medicine would easily be categorized as futile or not futile without much debate, i.e. the decision to perform cardiopulmonary resuscitation on someone who has been dead over 20 minutes would obviously be futile. Technologic sophistication and managed care have spawned an increase in the number of situations where futility is more difficult to judge. For example many patients are subject to batteries of tests on admission to the hospital. Often one of these tests will reveal an abnormality of unknown clinical significance. Should such an abnormality arise, how vigorously should it be chased down? The patient is concerned that a test result has come back as abnormal (even if only slightly so) and would like an explanation. The physician realizes that many of these subtle (but not all) abnormalities are of no significance and that the stress caused to the patient by such a result can be more damaging than the abnormality itself. The physician also realizes that trying to chase down such an abnormality often results in more invasive testing, which may be very expensive and also involve some discomfort and risk to the patient. Should the physician label further testing futile and recommend that no further action be taken or should this matter be pursued to, if nothing else, alley the patients fears (or perhaps prevent liability for the physician if anything does develop)? These decisions become complex because there often is not substantial evidence to make a decision in one direction or the other.

Physician Considerations
Often the physician is confronted with the decision of whether or not to judge a treatment or procedure as futile. On one hand, if the physician offers unbeneficial or futile treatments without patient request as a standard of care they would be violating the professional standard of practice by disregarding criterion for medical indication (Flynn, 1997). This would also be a disregard for elements of the patient-physician relationship by neglecting the best interest of the patient.

When the patient requests an intervention that the physician deems is unneeded or futile this creates a divide between the physician's sense of what form of treatment that the patient desires and the physicians obligation to act in the patients' best interest. When the physician is faced with a futile intervention or test that the patient desires but the physician is convinced is not in the patient's best interest, the provider is not under any obligation to order said intervention (Brett and McCullough, 1986). It is however, an ethical imperative that the physician refers the patient to a colleague to pursue the desired intervention.

Patient Considerations
The discussion of futile interventions has to this point been centered on medical implications of the test or intervention. But are there other considerations that merit review in the decision to label an intervention as futile? Patients enter into the patient-physician relationship with a set of values and beliefs that are an important component of their being. These values and beliefs about disease and their health care may spark requests for testing that are aimed at developing a "piece of mind" for the patient. In the managed care setting the patient may be curious about the limits of what types of testing and interventions are available to them. An example of such an inquiry engendered by technology would be for a full body scan. In many sections of the country, these scans are operated by entrepreneurs who advertise on the radio and via other media outlets about the benefit of finding

occult disease or actually the benefit of finding nothing and then having "piece of mind". The medical literature has established that the value of these scans in asymptomatic individuals is negligible (Johns Hopkins Medical Letter, 2001). In these instances, when faced with a request for these interventions, the physician can act as a resource for patients to make reasoned recommendations about the ethical and prudent use of these interventions in the patient's care.

Ethical Responses to Futility
Historically, medicine has been a largely physician-centered endeavor. In the last decade, a new emphasis has been placed on incorporating the patient's viewpoint about treatment in more significant ways. This transition of thinking has been labeled patient-centered medicine (Laine and Davidoff, 1996). Patient-centered medicine provides a venue to develop an ethical response to deal with issues of medical futility that arise more and more commonly in today's society.

Traditionally, issues of futility arise in tertiary care settings and have been dealt with by specialty-oriented physicians. Often these requests are made in desperate situations when the patient is hospitalized and under duress. As elements of primary care penetrate more pervasively into all elements of medicine it makes sense to refocus the discussion of futility from the specialist to the primary care clinician, and to attempt to deal with the issue when the patient is in less dire circumstances. Such a refocusing relies on the trust built into the patient provider relationship that the primary care provider enjoys with patients. It also allows for a process of education and negotiation about futility that respects the autonomy of the patient and thus is a more ethical approach.

Dukas and McCullough (1996) point out that primary care providers are in the best position to assume this role of futility counseling because of the following three factors. Primary care providers know patients over longer periods of time and are more intimately aware of not only the patient's medical history, but also the patients value system. Dealing with the patient over time, the primary care provider has the opportunity to discuss issues concerning futility preemptively when the patient is not critically ill when their capacity to make decisions is reduced. Finally, primary care providers tend to be the most prevention minded of all subsets of physicians.

In dealing with requests for futile interventions Dukas and Mc Cullough (1996) suggest the following paradigm to respond in an effective and ethical fashion. Firstly, when a patient requests a futile intervention explore the request with the patient. Does the patient have poorly informed beliefs that could be corrected by insightful education? Does the patient have other underlying reasons or views that have prompted this request? If other values or agendas are discovered and explored it may be possible to suggest other alternatives that will support those values.

If the patient persists in their request to proceed with the futile intervention then it is prudent to negotiate with the patient in a respectful fashion to see if they can be dissuaded onto another course of action that may be in their best interest. If the patient is still intent on pursuing the futile intervention it may be best at this point to propose a trial of the intervention with negotiated endpoints or stopping rules.

For those patients that still insist on a futile course of action the provider is faced with two alternatives. Firstly, the provider can withdraw from the case and refer the patient to a colleague for continued care. This approach is ethical as long as arrangements are made for the continued care of the patient. Secondly, a consult can be made to an ethics committee at a local hospital or in the community to ask for a review of the case. The ethics committee can review the case to look for alternative strategies that were missed or to suggest new strategies to assist the patient in meeting their needs in a way that best serves the patient's interests.

Ideally, by taking this preemptive approach and capitalizing on the patient-physician relationship in the primary care setting, patients will choose not to request futile interventions or if they do, the issues may be resolved in one of the earlier steps of the process before both the patient and physician are disenfranchised.

CHAPTER 4 - CONCLUSION
The medical profession holds a special identity with society concerning the duties it has to patients and the manner in which it conducts itself. Medical professionals enter into a lifestyle that demands dedication, sacrifice and the willingness to put the best interest of the patient first. In return, medical professionals are held in special esteem by society, and its practitioners are admired for their dedication and sacrifice to the greater good.

The key element in this relationship is trust, the trust that exists between the medical profession at large and society, and the trust that each patient has in their provider, the trust to share intimate details of their lives, seek counsel, and receive the care they need to make them well. Indeed, quite literally to have their lives in the providers hands. This trust is based on ethical principles of conduct and action laid down by Hippocrates, Mills, Kant and many others over time. Changes in society and the medical profession have recently threatened this trust. The entrepreneurs of managed care, capricious litigation and the greedy have eroded away some of this trust. This paper has pointed out some of the pitfalls that have arisen to shake some of the basic ethical values such as beneficence, autonomy and nonmalficence that are pillars of the physician-patient relationship.

Advances in technology, a plethora of new medications and sophisticated scanning devices have allowed the importance of dialogues with the patient to slip from its place of priority in both our medical education system and at the bedside. To stem this crisis we must once again teach the importance of the word of comfort, the laying on of the hands and considered counsel. Only then will we restore the confidence and trust of society in the medical profession, and only then will medical professionals be able to heal, both literally and figuratively.

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