

The Deconstruction of Medical Ethics

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Ethics arguments are dogmatic as a rule, so politicians have tried to frame the issue of “healthcare reform” in ethical terms. They enlist ethical concerns in the service of an agenda to federalize medicine and thus complete its bureaucratization.

“Healthcare delivery” has become the headless horseman, driven by “blind and indifferent market forces.” Americans have been reduced, in business-speak, to covered lives generating revenue streams in which our diseases are no longer individual tragedies but rather adverse business events. We physicians did little to prevent the shift from serving the patient’s best interest to meeting a system’s standards. “Reform” does not address this problem; in fact, it has little to do with healthcare, less to do with patients, but rather a great deal to do with insurance payment modalities, political agendas, and resource allocation. The single-sided discussion readily appeals to those not yet sick enough to need care, but well enough to vote.

Bernard Lo, M.D., defined the goals of bioethics committees in 1987.

The consensus on medical decision-making that emerged in the medical literature [post-*Quinlan*], court decisions and President’s [Reagan] Commission required that competent patients give informed consent or refusal to the recommendations of physicians. In cases where the patients are incompetent, decisions should be based on their previously expressed preferences or, if such preferences are unclear or unknown, on their best interests. The goal of an ethics committee should be to assess these preferences.¹

Lo offered a word of caution about the lack of explicit goals by ethics committees. “Some so-called ethics committees have as goals confirming prognoses, providing emotional support to caregivers, or reducing legal liability for physicians and hospitals.” Lo warned that the process originally constructed to buffer the inherent paternalism in the patient-physician relationship would be co-opted by legal posturing called “risk management,” or by the fiction of prognostication. Apparently he did not foresee that the ultimate hijacker would be the federal government.

Mark Twain stated that salesmanship is the art of selling the solution to a problem that you didn’t know you had.

The tactic of repeatedly misconstruing and re-defining ethical issues, plus reinforcing the cost of care compared to its value, have made the American electorate hear “futile care” and “end-of-life” issues as a monotone, reinforced by media,^{2,5} pop culture,⁶ the Internet, and its blogosphere. (A “Google” search on “end-of-life” or “medical futility” produces more than a million hits.) The perception is that we, the medical profession, have created and somehow fraudulently foisted off on an unsuspecting public—namely our

patients—expensive, unnecessary, excessive, deceitful, and corrupt medical services based on physician personal greed and self-aggrandizement. This view has met little or no opposition. Our profession’s repeated calls for tort reform, adjusted reimbursement and Medicare fee schedules, as well as *ad nauseum* advertisements for medical services such as longevity, plastic surgery, vision correction, erectile dysfunction, depression treatment, diabetes management, hypertension treatment, as well as the host of the just-ask-your-doctor ads or the relative merits of one hospital system’s care delivery versus another’s, has done little to reduce the sense that medicine is just another business casting for more clients. It’s no surprise then that the public seeks relief from our greed and our sales pitch, and that it universally wants a “better deal.” Such notions are easy for politicians to exploit. They have sold political partnerships and federal mandates as a “solution” to greedy physicians hawking futile or unnecessary care.

A History of Bioethics

Let’s set a stage for defining post-modern medical ethics. This discipline has come to be known as “bioethics” since the 1960s or so. Medical ethics has enjoyed a remarkable degree of continuity from the days of Hippocrates until its long-standing traditions began to be supplanted, or perhaps supplemented, in the middle of the 20th century.⁷

In effect, sophisticated modern medical technology that is at once life-saving and life-prolonging, though it will also prolong the process of dying, has created populations which, in the past, would have died simply because the knowledge, the skills, and the technology to salvage them did not exist. Now that it does exist, selective application of these treatment modalities saves some, yet condemns others. This dilemma was the crucible into which the discipline of bioethics came into being nearly 50 years ago.

In 1960, Belding Scribner, M.D., of the University of Washington, Seattle, introduced the shunt that made it possible to treat end-stage renal disease by long-term hemodialysis and, along the way, brought into being the first bioethics (“candidate selection”) committees. Because there were insufficient numbers of dialysis machines available between 1960 and 1972, not all chronic kidney disease patients could receive treatment. Some patients were rejected because they were too young, or too old, or had offsetting medical problems, or did not live in the state of Washington.

Scribner’s hospital formed a treatment committee whose membership included physicians, members of the hospital staff, and lay members of the community. The committee’s job was to review the cases of patients who were considered to be medically qualified

for dialysis, and to select from among them the one or two who would receive medical treatment. Those who were not selected died. News media had an absolute feeding frenzy with what appeared to be selection processes based on a scale of relative social worth. As a result, *Life* magazine pilloried Scribner.⁸

The treatment committee was very different from former ethics committees, which were not intended to be the decisionmakers or the experts. Concerning the problems in many of the cases presented to ethics committees there is no consensus about which course of action is most correct, or which social values are most important. Thus, the ethics committee represented a forum through which different values, perceptions, and information about treatment decisions could be discussed, assessed, and resolved by patients, their families, and the medical team:

[E]thics committees have intentionally been given no authority by anyone to make decisions: they are authorized only to discuss treatment decisions and to provide education explaining the ethical standards for such decisions. They may recommend policies and guidelines, but they have no authority to put them into place without the approval of some institutional authority.⁸

In other words, the point of the committee discussion was and is process, not product; forum, not decision; thinking about decisions, not decision-making; sharing knowledge, not displaying expertise. They attempt to clarify, remove contradictions, and reduce redundancy.

Bioethics committees were born of the hemodialysis treatment committee and similar experiences, and were pushed along by legal mandate (*viz.*, *In re Quinlan*, 1976), after public interest in bioethics was galvanized by the media in 1975 around the issues of feeding a young woman who was in a persistent vegetative state. The tragedy of 21-year-old Karen Ann Quinlan of New Jersey became the first case for withholding and withdrawal of life support to be heard by the U.S. Supreme Court. George Annas presented a brilliant discourse on the meaning of the Quinlan case at an April 1996 conference at Princeton entitled “Quinlan: A Twenty Year Retrospective.” Annas stated:

The more disturbing legacy of the *Quinlan* opinion is that medical ethics will likely be followed only if society grants physician’s legal immunity for following their medical ethics..., and that physicians have increasingly sought legal immunity before they would do anything from peer review to setting enforceable standards of care in medical practice. And as a result, American society sees physicians more and more not as professionals governed by a strong ethical code, but as merchants who sell their goods and services to customers. This model has meant that consumer demand is the most important determinative of provider conduct, and permitted health plan executives to dictate medical practice to their physicians.⁹

The tension and debate within the bioethics community evolved rapidly following the events of *Quinlan*, based on the perception and the reality of legal mandates that followed. Medicine historically has been divided into two camps: old medical school ethics, and new school bioethics. The former concerned itself with individuals, the latter with humanity. The camps pitted private practice against public health. The disciples of Aesculapius, god of medicine contrasted with

those of Hygeia, the goddess of health; those intent on curing disease against those devoted to preventing it. The tension forced a debate amongst all the players who would eventually come to be characterized as “providers,” but with a commonality: *to help resolve for the good of the patient the issues of understanding and choice in the increasingly complex and technological care of human beings.* The net result was the Doctrine of Informed Consent. But the tension between the Art of Healing and the Science of Medicine has not been and very well may never be completely resolved.

The debate has created a legacy of professional discomfort, even guilt, which has been exploited by political and commercial interests. Attempting to define the differences and resolve the discomfort in the “health care reform” environment will be like painting over rust. In constructing a fabricated ethical debate that forces the question of physician loyalty to individual patient, issues of cost consciousness in patient care, the social purposes of medicine, and/or the notion of “public good” may appear to be ethical issues and may create artificial boundaries, but they do not represent a punch list of mutually exclusive choices. Nonetheless, we physicians are expected to listen, weigh, and choose.

Reconfiguring Medicine as a Business

Instead of responding to criticism, physicians have mostly agreed with our critics, sometimes tacitly, sometimes overtly. We have thereby allowed ineffective socialized medical systems, such as Canada’s or England’s National Health Service (or France’s or Greece’s or Spain’s or Japan’s or North Korea’s or Cuba’s, etc.), to be sold to the American public as superior to our free-market model, and held to be role models.¹⁰

When did we stop being “physicians,” and start being “providers”? Does this change support, or just symbolize the accusation that the business of medicine is more compelling than the practice of medicine? Consider this analysis from *JAMA* of April 7, 1999:

Although a moment of calm has descended on Federal legislative efforts to overhaul our national health care system, a quiet revolution is still at work. The driving force of that change will be U.S. business interests. Under a system pioneered by health maintenance organizations, doctors are now asked to deliver adequate care, instead of care that maximizes the use of medical resources....

[T]he medical case that does not fit a neat algorithm (or NOS [Not Otherwise Specified] code) quickly comes to the attention of a small battalion of case managers. It is not unheard of for discharge planning to begin even before the patient enters the hospital. Today’s (treatment) decisions are made further from the bedside (than ever before), and according to algorithms established by statisticians.¹¹ This reality has been further described as “rationing without justice, but not unjustly.”¹²

Before we as clinicians are asked to answer unanswerable questions posed by an unidentified third-party arbiter, now working for the federal government and likely as not with little medical but adequate legal training, we must establish whether we are answering

questions legitimately raised about how to do things right *for* our patients, as opposed to answering questions about doing the right thing for the system.

Is the Patient Protection and Affordable Care Act to be the platform that co-opts the language of bioethics in its attempt to reconfigure American medicine and effectively end all patient autonomy on the assumption that only government can establish the nature of societal good?

An even more painful question is how could we ever have signed any provider contracts thus establishing the precedent? How could we ever have agreed to onerous terms that controlled physician comportment without regard to patient care?

Let's start somewhere in the mid-1990s, somewhat arbitrarily, in order to have a manageable scope and perspective. Note that the body of medical, as well as bioethical and medicolegal literature, perhaps most notably the *Journal of the American Medical Association (JAMA)* as well as the *New England Journal of Medicine*, had an explosion of citations on physician behavior and the impact of managed care between 1992 and 1996.

Of particular note is the economist's model of physician behavior as described by Uwe Reinhardt of Princeton, who writes:¹³ "[P]hysicians will always behave so as to maximize the net hourly income that they can extract from the practice of medicine." Economists, he states, do not see physicians adhering rigidly to a professional code of ethics. In a parallel article by Baker,¹⁴ physician fee-for-service charges were said to be influenced by market penetration of managed care. It was asserted that managed care served to reduce the intensity of medical treatments and that, once adopted by physicians, this less costly practice style would spill over into non-managed care patients. This contrast was presented as a paradigm that inferentially would serve to control physician fiscal comportment.

The idea that physicians were motivated by ethical considerations and the desire to implement "best medical practice" was an illusion, these articles imply. Worse, it is alleged that physician greed and corruption has cost Medicare and Medicaid nearly \$300 billion dollars.^{15,16}

In sum, we physicians are portrayed as greedy, barren of moral purpose, and inherently shiftless. We are said to pursue only those activities that enlarge our personal worth or positions of power. And this characterization comes from our own literature and trade publications.¹⁷

Absent from such discussions are bioethical questions, the need for rationing and/or budgeting of care, the demands of patients, and the call for "fidelity" to the public good. It is assumed that a set of simplified and singular "best" responses exists—and the assumption has been codified into law in ObamaCare. The fact that we are not supposed to be debating the balance between individual patient advocacy versus larger population needs has been obscured and lost. The "reform" in fact has nothing to do with the care of patients, but only with money: how it will be allocated, and who should determine the ebb and flow. While the language of ethics may appear to have been applied to the discussion, the theorems of bioethics arguments have not.

Those who object to efforts to rationalize the protocol of government care are accused of being obstructionists. This is especially true for "out of network" physicians.¹⁸

Let us examine the notion of the "medical home," the premise required for "bending down the cost curve."¹⁹ It would eliminate the non-network provider and the non-system private practitioner, and at the same time divide the industry by specialty, placing the least trained (and thus the least costly practitioners) in charge of all decisions and triage. By the divide-and-conquer method, with adequate punishments and rewards, it would define and enable a population of physicians (and others) who have agreed to accept government-run care. Welcome to Cuba.

Grand Rounds will become a positional debate about adherence to committee rules of "best practices" and meta-analyses that "prove" that rationing or reduction of treatments saves money yet sacrifices nothing. With the support of ethical guidelines that once protected the individual, physician/provider comportment will likely follow the designed path. The AMA and several specialty organizations are approving and supportive, lending an unmerited and inexplicable approbation.

Bioethics Principles and Clinicians

In response to this scenario, let's define the position of the bioethicist, then that of the clinician.

The mantra of bioethics, the conventions or principles upon which most bioethics recommendations are based, are patient autonomy, provider beneficence (doing good), provider non-maleficence (doing no harm), and justice (or fairness, generally, treating similar cases similarly). In the U.S., enormous emphasis has been placed on individual autonomy as a primary value. Thus, the wishes of a competent patient can rarely be overridden and only with very powerful justifications. Even when issues seem identifiable, solutions are frequently compromises that are both unsatisfactory and troubling. Such, however, would appear to be the necessary tradeoff if we are to retain a pluralistic and free society, allowed to make free-will choices for ourselves without disavowing our personally cherished freedoms and convictions.⁷ These principles are meant to accommodate, complement, and supplement, not replace, Hippocratic principles in this technological age.

The principles of bioethics focus more attention on the primacy of the one-on-one encounter of patient and doctor than on the societal context of American medicine. According to David Rothman, "a commitment to patient autonomy presumed that the most critical problem in America was the nature of the doctor-patient relationship and that, by implication, such issues as access to health care or the balance between disease prevention and treatment were of lesser import."²⁰

Bioethics, in Rothman's view, crosses class lines. It is at least responsive to the concerns of both the haves and the have-nots of society. Not everyone is poor or a member of a minority or socially and economically disadvantaged group, but everyone potentially, if not already, *is* a patient. And in the final analysis, if nothing else, bioethics approaches the exercise of medical authority from the

patient's point of view. But that fails to address the issue of physician clinical loyalties and the social purposes of medicine.

"Physicians increasingly face conflicts between the ethic of undivided loyalty to patients, and pressure to use clinical methods and judgment for social purposes and on behalf of third parties," writes Gregg Bloche in *JAMA*.²¹ In an interesting and somewhat convoluted interpretation, the contract language of insurance policies (so-called "prior-approval programs") is being construed as a meaningful consent document for both patient and physician.

Proponents of competition between managed health plans as a way to contain medical costs argue that subscribing to a plan constitutes consent to its subsequent rationing decisions. This *ex ante* consent authorizes plan physicians to withhold potentially beneficial care based on cost, without saying so at the bedside. In effect, the logic of consent has transformed from protection against medical paternalism to justification by third-party authority (read: government) to weigh group interests over those of the patient. This is a position that simply has not been addressed by the bioethics community.²¹

The Obama health plan consolidates the managed-care paradigm into government policy, at the same time that the insurance plan will now become an enforceable mandate or tax, with its provisions non-negotiable "for the public good." Studies will support the limitations on care and care decisions.²² End-of-life issues will blend in with autonomy, futility, choice, assisted suicide, and the remaining bioethical dialogue.²³

Trust

Trust is not a governmental issue; it is a professional issue. And it has been and is compromised unequivocally in the current version of healthcare reform. Yet Bloche argues, "Public trust in physicians as caring professionals is a social good" that must not be discarded in the rush to assert managed-care paradigms. Trust is nonetheless at issue.

The *Hastings Center Report* of March 1999 asks, "Can today's professionals seriously claim to be distinguishable in any occupationally important way from business?"²⁴ Government care threatens to preempt professional judgment in the way medical treatment and care is administered. The scope and speed of these changes has so altered the professional landscape that the challenge to reform the treatment paradigm must be answered, if it's not already too late.

Successful American social reform has always blended or at least balanced moral and political concerns with the demands of economic efficiency. The blend or balance, however, works only when it is understood by the majority as clearly in the national interest. The Clinton effort at health care reform lost because the cause of reform became polarized....²⁴

Though the "progressive" notion of healthcare reform remains polarized, political thuggery and tricks have advanced the version of healthcare that suggests "patient protection and affordability" were and are goals.²⁵

Medicine as a profession must re-assert a leadership position and re-visit instituting a workable reform that provides access to care without government intervention.

Jerome Kassirer articulated in 1998, in an editorial in the *New England Journal of Medicine*, that the reorganization of healthcare has profoundly influenced the roles, responsibilities, and even the loyalties of physicians. Much of the discontent among physicians, in Kassirer's view, was the consequence of the requirement that the kind of care be balanced against the cost of care. Kassirer felt that the inequity that existed between fee-for-service patients, covered patients, and non-covered patients had created a tension that would not go away until we physicians demanded a national health system. "A system in which there is no equity is, in fact, already unethical."²⁶

In a lot of ways, this position held by the editor of the iconic *New England Journal of Medicine* required physician response to the implied omissions of fairness and ethics of the medical community. There were no adequate replies, and those that were offered went unheard. His views are arguably being tested today with government healthcare as configured. And yet most of America does not feel under- or poorly served by American medicine.²⁷

What Is the Ethical Response, and Where Are the Clinicians?

What are physicians really being asked, and how are we to respond? Is there truly a new ethic, a new moral fabric, a new code of loyalty? Are physicians really "double agents" who cannot maintain trust in an era of multiple accountabilities?²⁸

Are we debating trust, or greed, or morality, or business, or politics? Who stands to gain? And who stands to lose? Are we solving an ethical dilemma for government, for business, for hospital administrators, for the medical profession, or for the generic "provider" population?

And, most critically, in case we somehow have forgotten: how does this help the patient?

More specifically, how does this help *my* patient—his headache, her breast lump, his failure to thrive, her unexplained weight loss and night sweats, his chest pain, her cough?

With no apologies to any of the experts quoted here, physicians should insist that if an action does not advance the care of that patient, then that action is simply not justified. But if it does help the patient, then it is justified. And this is not predicated on the answer to the universal first question of every patient encounter now in America: namely, not "How do you feel?" but "What is your coverage?" The chief complaint, rather than the insurance number, is still the dominant historical necessity in every patient encounter.

Have we clinicians forgotten this? Perhaps. Have our patients? Not really. Patients do not want the best insurance or the best government policy or the best informed consent. They want the best care.

We did not attend medical school to create disease states from which we could then derive personal profit. The physician is a witness, an objective, dispassionate, trained observer of fact—not a profiteer, not a cop, not a federal agent, and not an agent of an insurance company or business consortium. Not some of the time—all the time.

The facts are not determined by the patient, the federal government, an insurance company, or a managed-care plan, but rather by the requirement to assess, address, and treat the pathophysiology of the patient's disease. There simply has never been, nor is there ever likely to be, a disease that negotiates with the government, adheres to a best-practices protocol, or discusses a managed-care deal first. Perhaps the government needs to be reminded of that observation. Perhaps that is also the job of the physician. It is up to us, the physicians, to help establish a framework of general principles to help guide clinical decision-making.

George Eliot reminds us that "the strongest principle of growth lies in human choice."

Answers are simple, but not easy. The physician's duty to each patient is illustrated in this tale from Aesop:

An incredible storm had passed and the first post-tempest tides were coming in. The day was cold and crisp and clear. A young boy was walking along the beach with his father. With every crash of the waves, the child noticed that dozens of seahorses were being cast onto the beach, where they lay gasping and squirming. Hurriedly, the lad ran to the first seahorse he could find; and gently tossed it back into the surf. His father watching all of this, approached the boy and said, "Son, what you are doing won't make a difference." To which the boy replied, "To that seahorse, it will."

Conclusion

There has been a steady erosion of public confidence in the medical profession, and a disconnect that our patients both feel and suspect based in part on the profession's acceptance of the comportment of the insurance industry, and our inability to mobilize on behalf of our patients. The use of the language of bioethics co-opted from a patient protection and education strategy, as well as a bridge through adversity, anxiety, and pain, and now morphed into a concerted effort to ration care and control physician comportment by our own government, must now be addressed. We, the medical profession, are in part responsible for these circumstances for we have remained silent while witnessing the transitions. And our medical societies have largely supported the establishment of this transition for power, for influence, and for overwhelming financial considerations.

We understand our role and responsibilities and can yet exert an influence on the outcome. A different kind of peer pressure is now needed: respect for autonomy, beneficence, nonmaleficence, and justice—the medical equivalent of Margaret Thatcher's "character, conduct and social ethos"—and a clearly voiced opposition that exposes the hypocrisy of a stolen ethics argument. We can no longer remain silent and passive.

In the guise of "bioethics," "healthcare reform" is attempting to cement into place the transformation of medicine into a managed-care business. Physicians must have the courage to expose and to resist this effort to bend ethical principles while trying to bend the cost curve. We must defend and live by the physician's true ethical obligation—to the patient.

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