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A Reflection on Physician Rights and the Medical Common Good

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For almost a decade Dr. Robert M. Sade, chief of pediatric heart surgery of the Medical University of South Carolina, has been the leading advocate for the autonomous and traditional fee for service physician. The reverberations from his original salvo ("Medical Care As a Right: A Refutation," *New England Journal of Medicine*, December 2, 1971) and the answers it provoked, still vibrate within the pages of the many medical ethics anthologies that carry it. His articles can also be found in the *Linacre Quarterly*, *Private Practice*, and other medical publications. His central affirmations can be summarized as follows:

1. The notion that health care is a right is a perversion of the concept of natural rights.
2. Health is an individual, not a community or state, concern.
3. The omniscient, modern state is in the process of destroying natural rights and reducing the medical profession to bureaucratic enslavement.
4. Medical care should be constrained by the free market system.
5. Socialized medicine in other countries has serious faults and the American delivery of health care is the best in the world.

This article is a reflection on the insightful and the partial in the Sade perspective, for it seems that however honored and historical might be medical autonomy and fee for service, it will continue to retreat as cultural complexity increases.

The Formation of American Medicine

The character of American medicine took decisive shape during the 19th century, the era of buccaneer capitalism. Robber barons, men on the make to domesticate a continent, were the popular heroes of the time. Their ethos, for good or ill, influenced the unique entrepreneurial nature of American medical practice. For example, the

1847 Code of Ethics of the American Medical Association reveals a guild in the making. The housekeeping rules of etiquette (no advertising, gratuitous advice, stealing of patients, etc.) are fortissimo. And while there are appeals for virtuous and righteous character, physician concern for the common good is but pianissimo. Fee for service, the mechanism for professional autonomy, was assumed to have the validity of Holy Writ. Even today, 130 years later, in spite of the growth of institutionalized medicine and H.M.O.'s, 65% of American physicians still sell their services on the open market for so many dollars per injection, examination, consultation, or operation. For most of them, fee for service is not only as American as the 4th of July and apple pie, but it is also the bulwark against becoming governmental functionaries.

The case for medical freedom is as follows: the medical professional is a self-made healer who, because of long hours of study, heavy financial investment and adverse working conditions, has achieved professional status. His profession, therefore, is as intrinsic to him as his property and he has the autonomous right to dispense such skills and knowledge as he wishes. The public does not have a "right to health care" if that means the expropriation of his professional "property" without just compensation. Physicians are neither philanthropists nor saints. Like other mortals, they are, as the English say, "in trade." If sociopolitical conditions change, a physician, in order to protect his autonomy, might decide not to sell his "property," but grow tomatoes or hawk life insurance instead!

The Case for Professional Autonomy and Fee for Service

While fee for service is under increasing attack today because it escalates costs and tends toward professional monopoly, there are values inherent in the mechanism.

Take human motivation, for example. Capitalist societies usually have been overly cynical about human nature, insisting on the primacy of selfish monetary incentives as a motive for work. Dogmatic socialists, on the other hand, have been utopian in trusting altruistic and social incentives. Both systems have been uncritically praised by their advocates. On balance, socialism is having a harder time of it worldwide than is capitalism. Most of the work humans do, it seems, is not so intrinsically rewarding as to be done for the love of humanity. Both Israel and Cuba have found to their chagrin that "volunteer" youth brigades will give up only so many week-ends to dig irrigation ditches and cut sugar cane.

In spite of the mystique of the ever popular medical TV program, much of medical practice is routine and a grinding bore. If physicians weren't well paid for seeing people complaining of colds, backaches and being "all run down," and for doing physicals for athletic teams,

they might avoid them. It's not a question of a loss of medical heroism but of human nature.

I remember being stricken with dysentery in Cairo several years ago. An Egyptian physician took one look at the puny American pills I was taking and said, "That won't touch what we have here!" He came within 15 minutes of my 7 a.m. call, brought an effective prescription, and called back twice at the hotel where I was staying. Although a salaried government physician, he probably responded with such alacrity because he could collect a fee. As a foreigner, I felt fortunate to have the monetary power necessary in order to entice him.

I have ambivalent feelings in thinking about some salaried physicians. I recall a cardiologist at a small New England veterans' hospital who said, with undisguised moral supremacy, "I believe in socialized medicine." I mused, "You should, you have it made." Rounds began at 9 a.m. in the half-filled hospital, there was one patient in the cardiac ICU, his "perks" were sizable and there seemed to be plenty of time for coffee and banter with the nurses. I wondered whether he had ever worked the medical "trenches."

Those who wish to eliminate fee for service may overlook the fact that the physician-patient relationship is one of deep intimacy and trust. The patient's monetary power, large or small, is the symbol attesting to the fact that the physician is the agent of the patient. Surprisingly, "unholy mammon" more adequately protects the fiduciary-covenant relationship of physician and patient than if the former is salaried by a company, the military or the government. As the professor of an undergraduate course in biomedical ethics, I like to use a case history where a company doctor does a pre-employment physical for a potential fork-lift operator. The results of the physical are normal except that the potential worker volunteers he had been "addicted to hard drugs" but believes he has "kicked the habit." He is in love and needs the job in order to get married. Question: Should the physician mention the confession about drug use in his report? Invariably in sympathizing with the worker's need, the students want the doctor to withhold the information, thus missing the issue of whose agent is the physician.

When compared with teachers, social workers, clergy and some other medical professionals, physicians seem overpaid. Yet, when contrasted with professional athletes, movie stars and some corporate executives, they appear underpaid. Pilots who fly Boeing 747's make between \$80,000 and \$120,000 a year for flying only 11 days a month. Yet they struck a major airline in April and turned down a contract that would have awarded them a \$30,800 increase over three years. Our society doesn't know how much money is proper or fair for a physician — or any other professional — to make, and it might be Orwellian to even attempt to implement a "social usefulness" criterion. Perhaps fee for service will continue to diminish as much from guild

relinquishment as from outside critique. Salaried physicians at prestigious clinics who could triple their income by going "solo" seem to realize that beyond a certain point, money is not what is important in life.

Rights to Health and the 'Medical Commons'

There has been a lot of sloppy thinking concerning "rights" and "equality" regarding health. The utopian statement of the World Health Organization — "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"— is little help. Some ethicists speak of "negative rights" whereby a state allows arenas of openness and liberty for citizens but which do not require public financing. Thus, the "right" to free speech, public worship and assembly indicate the state must "get out of my way," not that it has to provide a printing press, church or assembly for those who demand them. "Positive rights," on the other hand, have been construed as claims, obligations or entitlements that the state owes its citizens. Thus, for those who cannot walk, the state must provide a ramp in front of every public building. It owes a kidney transplant or dialysis to those whose kidneys have failed; pacemakers, artificial hip joints and mammillary implants belong by right to those who have had trouble with their hearts, hips or breasts. And over the medical horizon is the artificial pancreas and the total mechanical artificial heart.

The problem is, of course, that imprudent legislation regarding "positive rights" has brought our medical system close to collapse. Three reinforcing contingencies — "health perfectionism," an "I want mine" rights explosion, and an exponential growth in medical technology — have brought us close to anarchy. Garret Hardin in *The Tragedy of the Commons* indicates how an English village commons can be destroyed by herdsmen being allowed absolute grazing rights for their cattle. Positive rights or freedom in any commons — legal, environmental, educational, social security, as well as medical — will bring ruin to all. The further in distance, whether geographical, political or socially an agency is in dispensing aid, the less the impact of the motto, "There is no free lunch."

Is it heartless to use fee for service, entire or in part, to protect the medical commons? Is it a proper means of triage in separating the well and worried well from the near sick and the sick? Should it be used to fend off the "malingerers" and shunt them to less expensive therapies? Countries that have nationalized health services discover that, in spite of significant gains in longevity and infant mortality, individuals with financial means gladly pay for a private physician. Can it be that state medicine is given plaudits only by its administrators and those who are relatively powerless?

There are other problematic aspects regarding "rights" and health. Thomas Szasz affirms that the medical profession cannot grant health any more than a church can bestow piety or a university dispense wisdom. Life-style, genetic inheritance, society and philosophy of life are more important to health than medical care. Practicing the seven medical virtues is far more important than annual physical checkups. Moreover, where is the locus for the determination of what is disease and illness? While we have consensus on cancer, hypertension and diabetes, can those afflicted with obesity, racism, introvertism, spirit possession, bachelorhood, homosexuality and the like present claims for treatment? Do those with a sense of "nobodiness" have a right payable by the state for "personality reconstruction"? Can those with a "new life" free from fat, booze or drugs claim a "new face" as did Betty Ford to harmonize the whole? Who is a physician — one who has a certain degree, conforms to the medical model, has so many credits, is accredited by his guild, claims healing powers, or what?

What definition of "equality" should we adopt if all citizens have an equal "right to health"? Should we spend the same amount of money on each individual, bring each to the same state of health, treat certain diseases while ignoring those that are expensive and devastating? "I treat all my football players equally," Vince Lombardi claimed, "like dirt!" Is it possible that quality of care and efficiency may decline if we move toward equity of service?

Thus, there are virtues in preserving a relatively autonomous medical profession and in the traditional fee for service mechanism. Moreover, there is a great deal of fuzzy thinking about rights to health care. Let me indicate, however, why I think, on balance, medical autonomy in health care is basically flawed.

The End of Professional Noblesse Oblige

Reformers within and without the guild believe that the "fee for service" issue is really a question of "who owns the profession?" They maintain that all professions belong to the society that created them. Societies have socio-economic, political, cultural and health needs. They thus create, given their technological and economic sophistication, institutions that train interested individuals to supply those needs. What individuals acquire — whether in medicine, law or education — is knowledge, not ownership; scientific skill, not the monopoly of a profession. Fee for service, the reformers hold, maintains an unhealthy dichotomy between the rights of the individual as a professional and the needs of society. It allows physicians to see "their" training and skill as investment capital on which they have the right to the highest rate of return. They conveniently overlook the fact that medical students pay only 4% of their educational costs and physicians practice in hospitals provided by the public purse.

All human associations, from the nation state on down, have a vested interest in maintaining and extending collective self-interest. Decades ago, Reinhold Niebuhr informed us that collective will-to-power was infinitely stronger than the solitary individual will-to-live. All human groups are predatory. All are myopic when it comes to fairly appraising the just needs of a competing group. The professions, however, are usually more successful in masking their guild interests behind protestations of serving the common good than are, say, the labor unions. For example, pharmacists, attorneys and physicians have always pointed to the principle, "Thou Shalt Not Advertise" with smug assurance that their efforts were dedicated to "human service" and not in lowly "trade." Only recently has society, through the Federal Trade Commission, in demystifying the claim, seen it to be an improper limitation on consumer information and an accentuation toward professional monopolization.

The State: The Enemy of the Profession?

Sade's authority for autonomous physician rights over against the state are "natural law" philosophers such as Aristotle, Plato, Cicero, Augustine, Aquinas, John Locke and the like. Unfortunately, he interprets them through Ayn Rand and begins with the near anarchistic premise that the state is the enemy. A portrait of man in constant enmity with his *polis* who, like the lonesome cowboy, must constantly move west to escape its entrapment, has nothing to do with classical Western political thought. It is pure *mythos Americana*, reinforced by Social Darwinism. Neither Greek nor Roman saw the state as the *bete noire*. Neither stoic nor medieval theologian reduced its function to that of only a "retaliatory force" to prevent the life and property of its citizens from being taken by force. Rather, in the West the state and the individual have been seen in complimentary function instead of "over against each other." Both have ends that can be harmonized; the individual-community dialectic is *neither* the minimalist state with social anarchy *nor* state totalitarianism conjoined with individual enslavement. The 4th century Athenian, for example, knew he was free because of his *polis*. He served in its army or navy when needed, participated in the state cults, paid his taxes, spoke and voted at public assemblies and raised public memorials and monuments. Thucydides says it well in *The History of the Peloponnesian War*:

Realize the power of Athens and fill your eyes day by day with the sight of her, and become her lovers, remembering that what made her great was courage, knowledge of what is right, and a sense of honour in action (II, 43).

How different the spirit of Jay Gould, a "robber baron" of the 19th century, who said, "the public be damned." Or Charles Wilson, pres-

ident of General Motors, who pontificated, "what is good for General Motors is good for America." Or Robert Sade, when he admits there is a "right to life" but denies a "right to health care."

The case for autonomous medical rights would be on firmer ground if physicians were potters, painters, sculptors, or novelists. The pot, painting, statue, or novel created from their subjective genius could with justice be said to be "their own." And by offering the same to the open marketplace, they could either eat or starve, thus trusting the ideal he so devoutly reverences.

Although Sade holds to a minimalist, "dike against sin" position vis-a-vis the state and protests its intrusion between the pure (paternalistic?) relationship of physician and patient, methinks he has a covert "general good" principle somewhere! I suspect that he supports state power in denying those outside the medical model access to public health care facilities and public monies. Most people committed to the medical model believe chiropractors, witch doctors, homeopaths, charismatic "lay-on-hands" types, Christian Science "healers" and the like are unscientific, deluded, or "rip-off" artists. Because the "common good" may be jeopardized by their "right to practice," we exclude their healing "art" from the public arena. Does Dr. Sade defend state curtailment of their professional "rights" and this "restriction of free trade"? If so, he does so on the basis of state guardianship of the common good.

One must live a "double-fronted" existence. It is too reductionistic to ask: "Is a physician to aid 'individuals' or 'society'; do they function as 'independent contractors' or 'servants of the public good'; should care aim for 'excellence bestowed to individuals' or 'quantitative distribution to society'?" If Sade's occupational turf was the pulpit rather than the surgical arena, he would "save souls" and not solicit for the United Fund; thunder against the fornicator but go pianissimo with the slum lord; he might counsel his flock to "love everybody" but not connect this with fair housing and employment opportunities for minorities. The private versus public and self versus social world is a schizophrenic reality and, as such, is impossible to live within.

Rights to Care and the Growth of the Medical Armamentarium

Social regulation should be proportional to social complexity. When medicine had little to give, fee for service worked well, and rights of the profession were at their maximum. The pre-World War II modalities of mustard plasters, simple X-rays, cod liver oil, routine tonsillectomies and appendectomies required no third party. Simple payments followed simple procedures. Now "Cadillac" medicine, with all of its iatrogenic potentiality, has replaced "Model T" medicine.

Obviously the complexity regarding physician and patient rights, how specialists divide up the medical turf, conflicting responsibility and culpability, payment mechanisms, etc., continues to grow. As a general practitioner in a small town, my father did "the little of everything," for praise or blame, that could be done. It was a neat and tidy world but one that's gone forever. Even banks nowadays can't operate without computers. They give instant credit, but not character loans!

It is ironic that Sade criticizes the very mechanisms — Medicaid and Medicare — that have extended care to the poor and aged and have allowed physicians to profit handsomely as a result. In spite of red tape and multiple forms, HEW eventually does pay. I remember the long hours my mother and the "office girl" spent on the "ledger" in the 30's and 40's. Some patients paid by chickens, a side of pork, ducks or eggs, with the refrain, "Doc, deduct it from my bill." Once, 25 fat hens were delivered to our home, and I cut their heads off in the back yard. Many bills were simply uncollectible and others were turned over to a collection agency that took 50% of what it was able to recover. Physicians were less affluent then but many had the inner satisfaction of giving service gratis to those who could not pay.

Sade believes our benevolent and autonomous society began to collapse with Franklin Delano Roosevelt. Our government began to act "immorally" by invading "rights of action" and promising "goods and services." However, my study of American history indicates that the private sector of our economy, in spite of near autonomous rights, collapsed in the 1930's. President Roosevelt was later to be hailed as the savior of a more responsible, socially controlled free enterprise system. In spite of his devotion to natural law, Sade overlooks a recognized "middle axiom" of that position: "Greater social (or professional) power requires greater social responsibility." Moreover, real rights are not abstractions. They are not merely rhetoric but are connected to authentic human needs. To proclaim a theoretical right to bread or medical care when a sociopolitical system cannot provide the opportunity to purchase them is a sham.

Like Dr. Sade, I wish sometimes that both in my personal life and my professional life, I could be more autonomous. I sometimes "trip nostalgically" back to the 1930's. Then I had the "right" to hunt rabbits without a license; we had the "right" to have chickens behind the house (our neighbors had hogs!); capitalists had the "right" to pollute; teachers the "right" to beat-up students; and medical colleges the "right" to be bastions of white, male chauvinists. Awake, all physicians and professors who dream that yesteryear was more godly, virtuous and pure than the present! The yearning for a bygone "golden age" blinds us to the evil of the past and causes undue pessimism about the future. Our society is fairer and more just today than it has ever been. Fortunately, this struggle toward equity has come through democratic process rather than revolution.

Medical Mystique and the Fiduciary Relationship

Sade is alarmed at the "infamous Bill 41" of Quebec that threatened imprisonment and fines to physicians who went on strike versus new medicare legislation a few years ago. In his reduction of healing to a mere commodity, a buy-or-not-buy mechanism, Sade ignores the medical mystique of our culture. Physicians are now linked with firemen, policemen, water and sewage workers (sorry about this novel association!) whose work is crucial to social cohesion. In comparison, teachers are not indispensable; pedagogues can empty classrooms for weeks and the life of society goes on, in spite of the pleas of mothers whose children are underfoot. However, Calvin Coolidge, as Republican governor of Massachusetts, said during the Boston police strike of 1919, "There is no right to strike against the public safety of anybody, anywhere, any time." Sade is caught on the horns of a dilemma: he wants medicine treated as a consumable much like toothpaste, paint, or aluminum siding in a culture which has elevated it to a near sacral quality. He wants the profession to market its wares in a society whose sanctuary is a medical center and whose priests are in white or green instead of black. Ivan Illich is right. The mystification of medicine in our culture is such that we believe its miracles and will not subject its potents to the crass mammon of the marketplace. To do so would be analogous to the hawking of indulgences which was done in the Middle Ages.

Moreover, in his attempt to reduce the physician-patient relationship to the commercial mode, Sade ignores that the relationship has always been held to be a fiduciary one. The patient has less knowledge and power in this transaction than perhaps in any other service he might purchase. In spite of subscribing to the *Harvard Health Letter* and memorizing a home medical encyclopedia, "medicalese" remains a foreign tongue. The physician makes most of the decisions about diagnosis, treatment, hospitalization and length of treatment. When one begins having moments of double vision or swelling in the groin, it is nonsense to say one can choose to buy some drapes or a stereo set, put a new roof on the house or see a physician. Sickness, because it is a threat to one's "being," is in a different reality than most other goods and services. One can live with faded drapes, imperfect music, and a leaky roof.

The Profession and Its Wider Social Responsibility

Obviously, Dr. Sade raises issues that need serious consideration. He is correct that we don't have a physician shortage, that individuals need to take increased responsibility for their own health, and that nations which have nationalized health services have not reached a medical utopia. His thesis is a good tonic, however, but poor medicine.

Today, medical costs are at about 10% of our gross national product. Medicine is without a guidance system; we are close to collapse. Yet, all that Sade can suggest is a doctrine of rights that seem to be a facade for professional privatism, power and security.

All other industrial and democratic nations of the West have restricted the "natural rights" of professional autonomy in the interest of the common good. Those nations whose medical societies have not participated in designing a more equitable and cost effective delivery system have not only been forced to work within a system they dislike but have forfeited immense reservoirs of patient and public good will. During the Progressive Era — 1905-1920 — the American Medical Association was concerned about the social and preventative nature of medicine, a perspective that Sade denigrates. It helped pass the Pure Food and Drug Act (1906), supported the creation of the Children's Bureau in the Labor Department (1912) and did not hinder legislation concerning workmen's compensation in 30 states between 1910-15. Before 1920, the AMA was progressive in political philosophy and favored compulsory health insurance. Since that time it has railed against "state medicine" — any form of medical treatment given, controlled or subsidized by a public agency — including Social Security, Medicare, Medicaid, HMO's and the like. Many Americans believe that however strongly their physician is committed to healing them, guild interests stand against necessary programs in public health. With AMA membership at an all-time low, President Hoyt G. Gardner gave utterance to these fears in his annual address in Honolulu last December:

More people are thinking that medical services have become less available and accessible. More people have lost confidence in their ability to pay the basic as well as catastrophic costs of health service... we must believe the public believes we just don't care. As the collective abstraction of what the public feels about physicians, this federation has to share the stigma of indifference.

All professions need to be aware of the "as-a" syndrome — the mistaken carry-over of technical expertise in a narrow field applied to a larger, more complex dilemma. Example: "Speaking *as a* theologian, the solution to our national defense is . . ." "Speaking *as a* surgeon, the ideal medical care delivery system is . . ." Medicine, like education, is too important to be left in the hands of the guild. As we cannot do justice to the profession by excluding them from future health planning, so, too, are our attempts to move toward greater equity in medical care delivery frustrated by excluding non-medical talent. Just as I would defend the profession from becoming but the medical agent of the state, so too would I resist it in not sharing power with a responsible public whose expertise is necessary in solving the medical crisis. The medical "monster" that now bedevils us cannot be tamed by reductionistic appeal. Political scientists, economists, statisticians,

ethicists and business administrators research from "think tanks" and the like will be needed for rational health care planning. To be sure, conservatives will decry "red tape," "Washington politicians" and "bureaucracy" and yet, there can be no real escape. For all of its real or imagined evils, the state is the final means by which a people do collectively that which they cannot do individually: resolve conflicting power conflicts and strive for justice.

Medical care delivery programs may change significantly in the 1980's. Hopefully, the norms of efficiency, quality, equity, fairness and responsible professionalism will always be paramount. Dr. Sade should join the arduous struggle to find that point where a responsible professionalism meets the social common good.

OLD AND NEW TESTAMENT REFERENCES TO HEALING

Psalm 30:2 — "Yahweh, my God, I cried to you for help,
and you have healed me."

Psalm 41:1-3	John 4:47-50
Psalm 103:2-3	Acts 3:3-8
Psalm 107:19-21	Luke 6:19
Isaiah 35:3-6	Luke 7:12-16
Jeremiah 17:14	Acts 9:32
Psalm 71:19-21	John 5:5-9
Isaiah 38:15-17	John 9:1-7
Isaiah 53:4-5	Acts 19:11-12
Ecclesiasticus 38:1-15	Matthew 4:23-24
2 Kings 4:32-36	Matthew 9:5-8
Isaiah 57:18	Matthew 9:22
Ecclesiastes 3:1	Mark 2:17
Romans 5:10-11	Mark 3:5
James 5:13-16	Mark 5:34
Mark 1:29-31	Mark 8:25
Mark 1:32-34	Mark 8:37
Romans 8:10-11	Luke 17:15-19
Mark 1:40-42	Matthew 15:28