Medicine as Business: Are Doctors Entrepreneurs?

Revolutionary changes in the health care system raise serious questions about the role of the physician as exclusive advocate for the patient: A debate

DURING the past several years, it has gradually become apparent that the health care system in the United States is no longer a loosely organized network of benevolent hospitals and selfless physicians; it is a giant and economically very important industry.

As Eli Ginzberg of Columbia University has pointed out, the "monetarization of medical care"* has been a gradual process, even though it has become the subject of extensive public discussion only recently. Since the 1950's, Ginzberg observes, a number of changes have taken place as the "money economy" penetrated the health care system. For instance, there has been a shift from voluntary to paid, full-time physicians staffing teaching hospitals. Interns and residents, who used to work for little more than room and board now receive reasonable salaries. Hospital workers are paid at rates competitive with other large industries. The introduction of Medicare and Medicaid by the federal government greatly reduced the amount of free care given by any hospital. And, there has been a marked decline of philanthropy as the financial mainstay of most of this country's not-for-profit hospitals. In 1940, Ginzberg reports, philanthropy accounted for 24% of the total operating budget of not-for-profit hospitals in New York City. Today it is barely 1%.

As the health care system converted to the money economy, it also grew dramatically in terms of numbers of workers and dollars expended. Money spent for health care now consumes an all-time high of 10.7% of the gross national product. In 1985, that came to $425 billion.

As health care became big business in a broad sense, certain companies that provide health care became big businesses themselves. The growth of the for-profit sector has been a dominant feature of the health care landscape in the past 10 years or so. At present, a handful of multimillion dollar enterprises that own and manage hospitals, nursing homes, ambulatory care centers, health maintenance organizations, and medical insurance firms are trying to demonstrate that the system can be made efficient and profitable to stockholders while also providing decent medical care.

The changes taking place in the health care system represent a very real departure from the way things were during the first half of the twentieth century. Not surprisingly, an important public debate focuses on these changes, a debate that asks, at heart, whether it is possible for money and medicine to mix without seriously compromising traditional medical values. In some ways, the for-profit industry has come to symbolize one pole of that debate.

The Institute of Medicine recently completed a study of the for-profit enterprise (*Science*, 29 August, p. 928). During the course of its work, two committee members engaged in a debate of their own. Through correspondence that came to be published as part of the study report,† Princeton economist Uwe Reinhardt and Arnold Relman, editor of *The New England Journal of Medicine*, highlighted the issue of the role of the physician and the complexities in judging how or whether it will change. Their correspondence provides a framework for the debate that will no doubt continue for years to come. Relman deeply believes that medicine is a calling. Reinhardt argues that doctors are professional businessmen like others, some better, some worse. An edited version of their letters written between August and December 1984 follows.

Dear Uwe:

. . . Do you regard the health care system as just another industry, and physicians as just another group of businessmen? Where does the professional commitment to service fit into your view of medical care? Do hospitals have no responsibility to serve the community, or do you reserve that obligation only for public tax-supported hospitals? It seems to me that this issue goes to the heart of the matter.

Dear Bud:

. . . Let me assume [that you wish us to revert to the world as it was circa 1970], to the world as it was before the for-profit institutions appeared on the scene. It was a world in which physicians had the right to organize their practice as private entrepreneurs on a for-profit or for-income or for-honorarium or for-whatever-you-want-to-call-it basis, and in which they were supported by non-profit institutions that were financed by someone else, but freely available to physicians as their workshops.

Let me, then, turn your question around and ask: What, in the history of the American medical profession, aside from the profession's own rhetoric, should lead a thoughtful person to expect from physicians a conduct significantly distinct from the conduct of other purveyors of goods and services?

Arnold Relman. *"In decrying entrepreneurialism in investor-owned hospitals, I also decry similar behavior by voluntary hospitals and among physicians."*

Surely you will agree that it has been one of American medicine's more hallowed tenets that piece-rate compensation is the sine-qua-non of high quality medical care. Think about this tenet, if you would, Bud! We have here a profession which openly professes that its members are unlikely to do their best unless they are rewarded in cold cash for every little ministration rendered their patients.

To make the case you have sought to make . . . , you must present us with an at least testable theory according to which the ethical standards of essentially unsupervised, self-employed, fee-for-service physicians affiliated with non-profit hospitals can withstand the severest economic pressure (mortgage, kids in college, alimony, lovers with expensive tastes, and so on), in the face of ample opportunity to be venal, while the ethical standards of physicians affiliated with for-profit hospitals, or em-

*Eli Ginzberg, "The Monetarization of Medical Care," *The New England Journal of Medicine*, **310**, 1162 (1984).

†*For-Profit Enterprise in Health Care*, Institute of Medicine, $39.50 from National Academy Press, 2101 Constitution Avenue, NW, Washington, DC 20418 (1986).

ployed at a salary by the latter, will wilt at the mere suggestion by some corporate officer to set aside medical ethics for the sake of corporate profits that do not even accrue, dollar for allegedly corrupt dollar, to the allegedly corrupt M.D.

Until you make that case convincingly, Bud, I shall continue to subscribe to the theory that, whatever erosion in medical ethics we shall observe in the future will be the product of excess capacity all around.

Dear Uwe:

The questions I was trying to raise with you concern the broad issues of public policy and social philosophy. Does the concept of a profession, as applied to physicians and other health care professionals, have any meaning in our society and, if so, does that meaning imply ethical obligations for health professionals which do not apply with equal force to businessmen?

Uwe Reinhardt. *Physicians are essentially no different than other businessmen.*

Unfortunately, you have avoided a direct answer by inveighing against the moral hypocrisy of the medical profession.

[Your description of physicians] has some truth, but it overlooks the basic element in our health care system, which is the relation between doctor and patient. That relation is based on trust by the patient and a commitment by the doctor to serve the patient's interest first. The fact that most doctors are also interested in being well-paid for their services, whether by salary or on a fee-for-service basis, doesn't change the primacy of their ethical commitment to the patient. This commitment is unfortunately being more and more eroded by new economic forces, but it is still there, and it is one of the several reasons why health care is different from other economic goods and services.

Dear Bud:

[You] finally put to us concisely the central question that appears to have troubled you all along. What revisions in the medical profession's code of ethics need to be made to minimize conflicts of interest inherent in the transformation of health care from a labor-intensive to a more capital intensive activity? You seem to argue that the primary focus of our [IOM] inquiry should have been the *physician* and not the *hospital*.

The shift from labor-intensive to more capital-intensive medicine confronts society with two distinct questions: 1. Who should finance, own and control the equipment and structures used in modern health care? 2. Should physicians ever be among the owners?

In the United States, we have increasingly looked to private capital-markets as sources of financing health-care capital, and physicians rank prominently among the investors. We have answered both of the two questions . . . with a definitive "Yes."

You argue that physicians should not enter joint ventures with other entities in the ownership of health-care capital and, presumably, that they should not own expensive medical equipment as sole proprietors either. I am persuaded by that argument, particularly because I view physicians as regular-issue human beings.

But suppose the Committee agreed on the recommendation that, wherever it is technically feasible, physicians should minimize the conflict of interest they already face under fee-for-service compensation by avoiding direct or indirect ownership of health-care capital. (The Committee did agree to this.) I am still of the view that investor-owned hospitals, for example, are quite compatible with the strict code of medical ethics you espouse. As long as physicians can keep their noses clean of economic conflicts of interest in their role as the patients' agents, they should be able to act as their patients' powerful ombudsmen in dealing with investor-owned institutions.

You ask me again whether I truly see no differences between physicians and other purveyors of goods and services. Honestly, Bud, I don't.

Frankly, I remain a little puzzled by your own views on medical ethics. Sometimes you seem to suggest that physicians are endowed with a strong commitment to ethical conduct. If that is true, why do you worry so? At other times you lament the erosion of medical ethics in the face of capitalist medicine. If medical ethics erode so easily, what then does set physicians apart from "other purveyors"?

Until we meet again, Bud, keep on trucking. I salute you for having the courage to propose for your brethren a strict code of ethics on the ownership of health care capital. It takes guts to go to their fiscal jugular in this fashion. As to the success of your campaign, I can only send that Navajo salute: Mazeltov!

Dear Uwe:

It is simply that a sick patient is dependent upon his doctor in a peculiarly critical and intimate way that isn't matched by any commercial relationship. Up to now, at least, society has recognized this special relation by surrounding it with a network of legal and ethical constraints on the behavior of physicians, which makes it very clear that physicians are *not* to be regarded simply as purveyors of expert services in a commercial market. The ethical obligations of a car mechanic or any other purveyor are to be honest in his business dealings, and to offer a good product or service, if the customer *wants* it enough to pay the price. An ethical physician's obligation to his patient go far beyond that.

In criticizing the for-profit system, I fully recognize the limitations of the system it seems to be replacing. And in decrying entrepreneurialism in investor-owned hospitals, I also decry similar behavior by voluntary hospitals and among physicians. I am frank to admit, however, that I am not sure what the best alternative would be. I do believe that we will need considerable reform in the present fee-for-service practice of medicine, and that we will also need more, not less, public regulation and subsidization of health care. But I still don't have a clear idea of what the "ideal" system for the U.S. would look like. All I am sure about at the moment is that the commercial marketplace isn't the answer.

This society has a very powerful notion of what a physician should be—an idealized image, perhaps, but one that is deeply ingrained and fervently wished for. The new monetarization of medicine challenges that ideal. The physician's first responsibility has always been to the patient. Now, a second duty is being imposed—a duty to control costs, which may not be in the best interests of an individual patient. The Relman-Reinhardt debate is symptomatic of the complex issues created by the radical changes taking place in health care, and is indicative of the difficulty in reaching consensus. ■

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This is one of a series of occasional articles on the implications of major changes that are taking place in the health care enterprise in the United States.