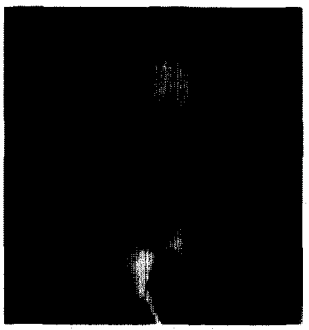
JACC Vol. 26, No. 4
October 1995:1090–1

EDITOR'S PAGE



# The Commercialization of Medicine: "Business" Ethics Versus "Medical" Ethics

WILLIAM W. PARMLEY, MD, FACC
Editor-in-Chief
*Journal of the American College of Cardiology*

In 1989 in his keynote address to the 21st Bethesda Conference: Ethics in Cardiovascular Medicine (1), Dr. Sam Thier (then President of the Institute of Medicine) listed what he felt were the four primary responsibilities of the profession of medicine. These included

1. the responsibility to maintain and transmit knowledge;
2. the responsibility to act in the patient's interest;
3. the responsibility to establish and enforce standards; and
4. the responsibility to evaluate performance above rewards.

We all feel comfortable with the implied ethical behavior inherent in each of these responsibilities. In fact, I believe that our ethical standards and behavior are a cut above most other professions in society, in part because of our trusted role to maximize both the physical and mental health of our patients.

Contrast the above with what appears to be emerging as the most important goal of for-profit health maintenance organizations (HMOs) and managed care organizations—the bottom line profit. As one views the multimillion dollar published salaries of chief executive officers of these organizations and the attempt to maximize profit for investors, one is struck by the foreign nature of these goals compared with what we were taught in medical school. It's almost as if an alien culture has taken over medicine, and we must now learn their rules. These rules use ~25% of medical costs for administration (2). These rules reward physicians for minimizing health care, diagnostic testing and therapeutic procedures and frequently punish them for "overutilization" of procedures. These rules will attempt to control us even more.

For example, in a recent Credentials Committee Meeting of the American College of Cardiology, we received an application from a candidate applying for membership who included a letter that he had recently received from a large HMO/managed care organization with which he was associated. After appropriate internal medicine and cardiology training, he passed the internal medicine boards of the American Board of Internal Medicine (ABIM) but had not yet passed the cardiovascular boards. The letter indicated that because he was not board certified in cardiology he would be listed as an internist. Furthermore, the letter went on to say, "You may no longer perform or interpret non-invasive cardiology testing which includes echocardiograms and Doppler studies, nuclear cardiology wall motion, function, and perfusion studies, and vascular ultrasound/duplex studies; you may no longer perform either diagnostic or therapeutic cardiac catheterization." Certainly, the ABIM has never linked certification with hospital privileges. In truth, the two may have little relation with one another. Perhaps an HMO/managed care organization could refuse to pay for procedures done by non–board certified physicians, but the additional step of saying that they cannot do them seems to have crossed over the legal line. Another large group of interventional cardiologists reported the following to me. In a contract with one of the managed care groups, the company has indicated that only the two high volume interventionalists can perform angioplasty, even though the rest of the group also meets the minimal ACC/American Heart Association standards for angioplasty.

Unfortunately, in this environment, physicians will have to choose between what they believe is best for the patient and what they must do to survive. As the new breed of medical plans owned by wealthy investors underbids more established plans, there will be progressive cuts in services. This is not dissimilar to an uncaring business shark in a hostile takeover. It hardly seems possible for our current ethical medical construct to survive. This will become especially acute when services are progressively cut. Because this whole process is market driven, it is unlikely to be easily reversed. However, medicine is not just a commodity. It carries with it a morality

Address for correspondence: William W. Parmley, MD, Editor-in-Chief, *Journal of the American College of Cardiology*, 415 Judah Street, San Francisco, California 94122.



0735-1097/95/$9.50
0735-1097(95)00397-M

(3) that may be destroyed by advertising hype and an emphasis only on the bottom line. It should be self-evident that if community medicine is struggling to survive in this scenario, academic medical centers will be hardest hit. It will be impossible to maintain quality teaching at all levels, together with all of the other missions of an academic center.

What, then, are we to do? We must certainly never sacrifice our traditional ethical values for some modern plastic and cash values. We must remain advocates for our patients' health, and their right to choose their caregivers. The HMOs should certainly be held to high ethical standards, although it is unclear who would write such guidelines and enforce them. Much of the political struggle in the near future will be related to Medicare and Medicaid. The American Medical Association's plan (4) has some general features of interest, including patient choice with higher out-of-pocket cost, or managed care or medical savings accounts. This would free doctors from Medicare price controls and even the playing field between fee-for-service physicians and large insurance company-run programs.

Whatever the outcome with Medicare and the rest of health care, I hope that physicians can retain their high professional ethics against the bottom-line mentality of the for-profit companies. Unless humanism and professionalism remain, medicine will become just another commodity in life's marketplace. As such, it will be governed by advertising hype and the never-ending corporate goal to maximize profits. The concept of "quality" care will become so distorted as to be unrecognizable. Our patients deserve better than this—and so do we.

## References

1. Thier SO. Keynote address. 21st Bethesda Conference: ethics in cardiovascular medicine. J Am Coll Cardiol 16:1990;5–6.
2. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the US health care system. N Engl J Med 324:1991;1253–8.
3. Kassirer JP. Managed care and the morality of the marketplace [editorial]. N Engl J Med 333:1995;50–2.
4. Meyer H. Moving medicare into the marketplace. AMA News 1995 July 3–10.