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Medical professionalism in a commercialized health care market*

Medical professionalism in the United States is facing a crisis, just as serious as the crisis facing the health care system, and the two crises are interrelated.

To understand today's crisis in medical professionalism requires knowing what a profession is and what role it plays in modern society. Freidson¹ considered a profession to be one of three options modern society has for controlling and organizing work. The other two options are the free market and management by organizations such as government or private businesses. Freidson suggested that medical work was totally unsuited for control by the market or by government or business and, therefore, the practice of medicine could only be conducted properly as a profession.

According to Freidson,¹ a profession is highly specialized and grounded in a body of knowledge and skills that is given special status in the labor force, its members are certified through a formal educational program controlled by the profession, and qualified members are granted exclusive jurisdiction and a sheltered position in the labor market. Perhaps most important, professionals have an ideology that assigns a higher priority to doing useful and needed work than to economic rewards, an ideology that focuses more on the quality and social benefits of work than its profitability.

Although this ideology is the most important part of medical professionalism, it is what is now most at risk. The science and technology of medicine and the special place that medical practice holds in the labor market are not presently threatened. The expanding professional health care responsibilities of nurses and

the increase in other health workers such as physician assistants and technicians are changing the mix of the health care workforce, but the central role of the physician as the manager and provider of medical services is not likely to be challenged.

Endangered are the ethical foundations of medicine, including the commitment of physicians to put the needs of patients ahead of personal gain, to deal with patients honestly, competently, and compassionately, and to avoid conflicts of interest that could undermine public trust in the altruism of medicine. It is this commitment, what Freidson called the "soul" of the profession,¹ that is eroding, even while its sci-

entific and technical authority grows stronger. Ironically, medical science and technology are flourishing, even as the moral foundations of the medical profession lose their influence on the behavior of physicians.

This undermining of professional values was an inevitable result of the change in the scientific, economic, legal, and social environment in which

medicine is now being practiced. A major reason for the decline of medical professional values is the growing commercialization of the US health care system.² Health care has become a \$2 trillion industry,² largely shaped by the entry and growth of innumerable private investor-owned businesses that sell health insurance and deliver medical care with a primary concern for the maximization of their income. To survive in this new medical market, most nonprofit medical institutions act like their for-profit competitors, and the behavior of nonprofits and for-profits has become less and less distinguishable. In no other health care system in the world do investors and business considerations play such an important role. In no other country are the organizations that provide medical care so driven by income and profit-generating considerations. This uniquely US development is an important cause of the health cost crisis that is destabilizing the entire economy, and it has played a major part in eroding the ethical commitments of physicians.

Many physicians have contributed to this transformation by accepting the view that medical practice is also

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Many of the ideas expressed herein were presented in a talk on medical professionalism before the President's Council on Bioethics, June 28, 2007, Washington, DC, and in *A Second Opinion: Rescuing America's Health Care*.²

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in essence a business. Medical practice is now widely viewed as a demanding and technical business that requires extensive, credentialed education and great personal responsibilities—but a business nevertheless. This change in attitude has important consequences. In business, increasing shareholder value through increased revenue and increased profit is the primary goal. However, medical professionalism requires that physicians give even greater primacy to the medical needs of patients and to the public health of the society in which their patients live. When physicians think of themselves as being primarily in business, professional values recede and the practice of medicine changes.

Physicians have always been concerned with earning a comfortable living, and there have always been some who were driven by greed, but the current focus on moneymaking and the seductions of financial rewards have changed the climate of US medical practice at the expense of professional altruism and the moral commitment to patients.³ The vast amount of money in the US medical care system and the manifold opportunities for physicians to earn high incomes have made it almost impossible for many to function as true fiduciaries for patients.

The essence of medicine is so different from that of ordinary business that they are inherently at odds. Business concepts of good management may be useful in medical practice, but only to a degree. The fundamental ethos of medical practice contrasts sharply with that of ordinary commerce, and market principles do not apply to the relationship between physician and patient.⁴ Such insights have not stopped the advance of the “medical-industrial complex,”⁵ or prevented the growing domination of market ideology over medical professionalism.

Other forces in the new environment have also been eroding medical professionalism. The growth of technology and specialization is attracting more physicians into specialties and away from primary care.⁶ The greater economic rewards of procedural specialties are particularly appealing to new graduates who enter practice burdened with large educational debts. Specialization is not necessarily incompatible with ethical professional practice, but it often reduces the opportunities for personal interactions between physicians and patients and thus weakens the bond between physicians and patients. It is too easy for even the best specialists to behave simply as skilled technicians, focused exclusively on their patients’ narrow

medical problems and unmindful of their professional obligations to the whole person they are serving.

The law also has played a major role in the decline of medical professionalism. The 1975 Supreme Court ruling that the professions were not protected from antitrust law⁷ undermined the traditional restraint that medical professional societies had always placed on the commercial behavior of physicians, such as advertising and investing in the products they prescribe or facilities they recommend. Having lost some initial legal battles and fearing the financial costs of losing more, organized medicine now hesitates to require physicians to behave differently from business people. It asks only that physicians’ business activities should be legal, disclosed to patients, and not inconsistent with patients’ interests. Until forced by antitrust concerns to change its ethical code in 1980, the American Medical Association had held that “in the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients” and that “the practice of medicine should not be commercialized, nor treated as a commodity in trade.”⁸ These sentiments reflecting the spirit of professionalism are now gone.

Professionalism is also compromised by the failure of physicians to exercise self-regulation that would be supported by law. Many physicians are reluctant to identify incompetent or unethical colleagues. Such behavior also undermines the public’s trust in the profession.

Yet another deprofessionalizing force has been the growing influence of the pharmaceutical industry on the practice of medicine. This industry now uses its enormous financial resources to help shape the postgraduate and continuing medical education of physicians in ways that serve its marketing purposes.⁹ Physicians and medical educational institutions aid and abet this influence by accepting, sometimes even soliciting, financial help and other favors from the industry, thus relinquishing what should be their professional responsibility for self-education. A medical profession that is being educated by an industry that sells the drugs physicians prescribe and other tools physicians use is abdicating its ethical commitment to serve as the independent fiduciary for its patients.¹⁰

The preservation of independent professionalism and its ethical commitment to patients still are very important because physicians are at the center of the

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health care system and the public must be able to depend on and trust physicians. There is currently much concern about the paternalism and elitism of medicine, and this concern is often used to justify policies seeking to establish so-called consumer-directed health care.¹¹ Although there undoubtedly is a need for patients to have more information and responsibility for their health care choices, without trustworthy and accountable professional guidance from physicians, the health care system could not function. In the absence of physicians' commitment to professional values, health care becomes just another industry that may, by continuing along its present course, be heading toward bankruptcy.

Physicians should not accept the industrialization of medical care, but should work instead toward major reforms that will restore the health care system to its proper role as a social service that society provides to all. Virtually every other advanced nation has achieved that goal. An essential part of the needed reforms is a rededication of physicians to the ethical professional principles on which the practice of medicine should rest. Such reforms will require public and political initiatives¹² and the active participation of the medical profession.

Medical professionalism cannot survive in the current commercialized health care market. The continued privatization of health care and the continued prevalence and intrusion of market forces in the practice of medicine will not only bankrupt the health care system, but also will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession. Physicians who care about these values must support major reform of both the insurance and the delivery sides of the health care system.² It is the one policy option most likely to preserve the integrity and values of the medical profession.

■ ADDENDUM

The foregoing commentary, published last year in *JAMA*, explains why I am concerned about the “ethical challenges in surgical innovation,” the subject of this conference. Although the legal status of patent applications for surgical methods (“process patents”) has not yet been fully defined,¹³ such applications fortunately are relatively rare. The great majority of surgical techniques are not patented and are freely available to surgeons—as they should be. However,

the devices, equipment, and implants that may be an essential part of new surgical techniques can be and are patented, and may therefore be profitable. If these patented items are developed by a staff physician or are the product of collaboration between such a physician and a company, should financial benefits accrue to the physician involved? Some say yes. They seem convinced that without some sort of financial incentive—royalties, direct payments from the manufacturer, or equity interest in the manufacturer—physicians would simply not be motivated to do innovative work, and the “translational” research essential for medical progress would languish.

I strongly disagree with this view, but unfortunately it has gained considerable influence in academic medicine in recent years, despite the fact that it conflicts with medical professional ethics. Court interpretation of antitrust law in 1975⁷ forced the American Medical Association to abandon its long-standing ethical injunction against practicing physicians earning income from financial interests in the medical products they use or prescribe. However, antitrust legislation is not relevant here, and no legal restraints prevent medical schools, teaching hospitals, and similar medical institutions from regulating or even prohibiting such outside earnings by their full-time salaried staff. These earnings constitute a clear conflict of interest, and there is a growing national consensus that such conflicts not only should be publicly disclosed but should be regulated by the institutions employing the physicians. If the institutions do not do this job, many now believe the government should.

What is the evidence that personal financial rewards are necessary incentives for physicians to work on “translational” research? I submit that there is little or none—only an assumption. But the fact is that even before commercialization began to transform health care 3 or 4 decades ago, and even before salaried academic physicians began to earn substantial outside income from their financial ties to device and drug manufacturers, “translational” research was thriving. In the 2 or 3 decades after World War II, salaried academic physicians conducted applied medical and surgical research, often in cooperation with industry but usually without any personal gain. It is true that today there is much more “translational” research going on, but that is probably explained by the greater number of researchers working now and the much greater

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public and private investment in research. It does not follow that the recent growth in applied biomedical investigation would not have occurred without personal financial incentives to academic physicians and surgeons. Such an assumption not only ignores medical history but demeans the professional values that we physicians swear to live by.

If we continue to encourage, or even allow, practicing physicians and surgeons to be entrepreneurs and have financial interests in the products they use and prescribe, we will surely undermine the ethical traditions of our profession, as I have argued in the above JAMA commentary. But beyond this ethical catastrophe, such policy would surely destroy the credibility and integrity of the whole US medical research enterprise, with dire consequences for society. I believe it is time for our best clinical research institutions to insist that research cooperation with industry be conducted in a much more professional and controlled manner. Academic-industrial cooperation can often facilitate advances in research, but any financial gains for the academic side should flow to institutions, not individuals, and should be strictly regulated by law to ensure that the public interest is protected and the integrity of the medical profession preserved.

I refuse to believe that academic physicians will stop their search for innovative devices and methods for treating their patients if they are not given extra financial rewards beyond their salaries. Of course, they need to be paid well and they need the time and resources required for their research, but that should be the responsibility of their institutions, not of industry. The present shortage of time and resources for research in not-for-profit medical institutions must be addressed, but turning the responsibility over to the free market of medical entrepreneurialism is not the

answer. It will lead only to a dead end for our profession and for the public stake in medical research. This is a challenge that the best and strongest US medical institutions must face up to, but government will also need to help. Our country depends on a vibrant but socially responsible and trustworthy medical research sector. That is an objective that unregulated commercial markets and private interests cannot achieve. We need academic institutions, supported by public policies, to lead the way.

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