Hippocratic Oath Versus Managed Care: Physicians Caught in Ethical Squeeze

When laypersons think about medical ethics, they tend to focus on such headline-grabbing issues as genetic testing, cloning, and physician-assisted suicide. Physicians, in contrast, are preoccupied with reconciling their traditional patient-centered ethic with the imperatives of managed care.

This concern was evident at a symposium held recently in Philadelphia to commemorate the 150th anniversary of the founding of the American Medical Association, along with the creation of its original Code of Ethics. AMA President Daniel H. Johnson, Jr., M.D., opened by noting that the AMA Code of Ethics "above all else dictates that we put the needs of our patients first and foremost."

The centrality of this concept was stressed throughout the meeting by physicians who are clearly finding it increasingly difficult to live by.

Third-Party Control

With third parties increasingly controlling access to services as well as payments, and fee-for-service a vanishing species, physicians' decisions are now often influenced by factors that have little to do with the patient's best interest.

"The gray areas of medicine are less often coming down in the patient's favor," noted AMA General Counsel Kirk B. Johnson, J.D., who offered several vivid descriptions of the situations faced by AMA members seeking his help. "Financial incentives to limit care are working. Doctors' professional values are challenged."

Maintaining that new anti-trust guidelines permit doctors to act collectively on quality-of-care issues, Johnson urged that they do so, adding, "It is an embarrassing failure that the profession has not found a way to organize itself locally to bargain over these issues."

Limited Resource Dollars

"Where can we best put this country's health care dollars and resources?" he continued. "In the last three months of life, as has been the tradition, or in the first three months of life? On those patients for whom there is no chance of meaningful survival, or for the approximately 33% of children in this country who are not adequately immunized? Who gets care and who does not? In every sense, rationing of health care services is here. . . . And only if our elected leadership and the medical community can come together can there be any hope of solving these problems."

Seconding these thoughts, geriatrician Christine K. Cassel, M.D., of New York's Mount Sinai Medical Center, noted that rapid advances in medical science and technology, along with the aging of the population, "make it inescapably true that we cannot and will not be able to do everything for every-
one." She suggested that the goal of cost containment as part of the contract between physician and patient needs to be explicitly recognized in a model of informed consent.

Cassel also offered a metaphor of present-day medicine in which physicians stand by the bank of a river and fish out drowning people, until it occurs to someone to go upstream to find out why so many people are falling in.

"Physicians must take into account the growing body of research demonstrating that the health status of populations is more directly related to socioeconomic factors — specifically to wealth or poverty and to education— than it is to medical care," Cassel said, urging that doctors redirect their focus to social conditions and public health.

The Role of Patients

Patients were called to account as well. Harking back to the code of medical ethics propounded by colonial physician Benjamin Rush, which included duties for patients as well as for their doctors, George J. Annas, J.D., of Boston University, proposed that the Hippocratic Oath and the AMA's Code of Ethics might usefully be replaced by the Boy Scout Oath, which calls upon Scouts to be trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, and reverent. "The first six items are what Americans want from their doctors," Annas said, to much laughter and applause, "and the last six are what American doctors want from their patients."

But patients want considerably more than good physician ethics and demeanor, and symposium panelists devoted considerable discussion to how much they should properly have.

"Patients, at least insured ones, have come to expect full access to any services they deem themselves to want," said Alexander M. Capron, L.L.B., of the University of Southern California, Los Angeles, "but that has nothing to do with good medicine or good medical ethics. . . . It's fine for the marketplace when the customer is always right, but not for the medical setting, where the normal checks of the marketplace do not apply."

The appropriate role of patients, or the public at large, in shaping medical ethics was also a subject of debate. Tracing the history of medical practice and its intersection with the upsurge of rights movements in the 1960s and 1970s, Capron noted that the push for patients' rights, along with the onslaught of new biomedical technologies, helped to create the new discipline of bioethics, which replaced the "hierarchy of the physician" with the "ascendancy of the patient."

Capron supports this development. "Although it would take a physician to clone a human being," he noted, "it is not for physicians alone to say whether anyone should be cloned."

Similarly, Capron argues that rationing of medical care can be justified only if it is "rational and participatory" — that is, if the rationing decisions reflect the "values and views of those who are directly affected."

But a posture of patient inclusion, even when officially adopted, does not necessarily shape reality. Mark Siegler, M.D., a physician and ethicist at the University of Chicago, noted the findings of a recent study showing frequent failure to respect the wishes of dying patients, even when these wishes were on record.

Much evidence suggests, Siegler said, that physician-ethicist Leon Kass, M.D., Ph.D., of the University of Chicago, was correct when he wrote that "Though originally intended to improve our deeds, the practice of ethics has, if truth be told, at best improved our speech."

One end-of-life story recounted by William H. Mahood, M.D., an AMA trustee who practices in Pennsylvania, may help explain why this is so. Mahood described a patient in a vegetative state whose relatives insisted that the patient be given a feeding tube despite contrary wishes expressed in the patient's living will.

When Mahood consulted his lawyer about dealing with this situation, the lawyer advised him that a patient in a vegetative state cannot sue.

New Technologies, New Problems

Speakers suggested that the slowness of the medical community, and of the rest of society, to deal adequately with such issues as end-of-life decisions and managed care does not bode well for a response to the genetic freight train that is now bearing down on us.

According to Francis S. Collins, M.D., Ph.D., director of the National Human Genome Research Institute, patients are already confronting dilemmas