

Health-care Ethics and the Free Market Value System

The practice of medicine is not a business and can never be one; our fellow human beings cannot be dealt with as a man deals in corn and coal; the human heart by which we live must control our professional relations.

-Sir William Osler.

Ethics is an ever relevant aspect in every field of human activity in general and health care in particular. From the classical times, professional ethical codes and prayers directed the practice and distribution of the medical care. As the society and its institutions have changed since Hippocrates, so did the practice and delivery of health care changed as the current health care concerns include issues of consumer rights, managed care/insurance policies, and competitive hospital industry. In this article, we want to briefly review the status of the code of medical ethics, role of Ethics Committees (ECs), and the new developments in the organizational business ethics in the current context.

A BRIEF HISTORY OF MEDICAL ETHICS

History of health-care ethics starts formally with the Hippocratic Oath of the 5th century BC. It was noted later that numerous ancient civilizations have their own ethical systems or codes like the 7th century AD, Indian Oath of Initiation. Many of these societies developed elaborate codes which ethically guided a physician's work and thereby defining "professional ethics" for that group, or what is today more commonly called "professionalism."

Although professionalism was defined and taught in various medical schools, that tradition was not practiced to protect the field from abusing its position

and power. History of Science and Psychiatry, in particular, is marked by numerous instances of unethical practices.^[1] "Bedlam tours" in the 18th century England, where spectators were allowed to walk through the crowded Bethlem Royal Hospital to watch the curious behavior of the mentally ill for entertainment, Nazi and Soviet abuse of psychiatry and the enthusiastic experimentation of new biological treatments like lobotomy are only few examples which give a glimpse of the unethical treatment. These disturbing abuses were the reason for the Nuremberg code,^[2] Declaration of Hawaii^[3] and Helsinki^[4] were compiled to protect the patient in research contexts; in clinical settings, the study of ethics was emphasized and various ethical forums and committees were instituted to rightly handle the practice of medicine.

ETHICAL THEORIES AND THE FOUR PRINCIPLES

Over the centuries, various ethical theories were proposed to regulate the human moral behavior.^[5] Deontological theory (or simply, the Kantian theory, named after its proponent) holds that based on the rational grounds, we do the right thing out of a belief that it is a moral duty or obligation, and it also holds that we ought not to use a person as a means to an end, but we have a duty to respect every person. Utilitarian theory holds that the morally right thing to do is one which produces a greatest good outcome for the greatest number. While there can be a conflict between various duties as proposed by the Kantian system, the Utilitarian system makes it difficult to find the right thing to do in every situation.

Virtue theory argues that virtuous behavior resulting from the character of a person is the basis of an ethical

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life. However, it is criticized due to lack of objective and general criteria of what is good and also due to lack of clarity of whether the character which produces virtuous behavior is innate or acquired through practice. Casuistry is a case-centered ethical approach where moral insights come from analyzing specific cases, some of which may function as exemplars for future reasoning. This kind of ethical reasoning causes problems due to pressure to conform to societal ethical or unethical values and due to a difficulty in application to general issues like resource allocation, etc., Care ethics is another approach which emphasizes empathy and concern toward vulnerable people but can be charged as being very subjective without general criteria.

As each of the above-mentioned systems have their own restrictions, Beauchamp and Childress proposed what is today called principlism or the four principles approach to ethics. They try to reconcile the discrepancies between the Kantian and Utilitarian perspectives by basing their moral reasoning on the mid-level widely accepted principles like nonmaleficence (“primum nonnocere,” i.e., first, do no harm), beneficence (to benefit others), respect for autonomy and to treat everyone justly or fairly. This framework can be applied flexibly with the patient information.

ETHICS IN THE CLINICAL WORKPLACE

As discussed, historical abuse of medical power has given rise to various checks for the professional behavior through codes like Nuremberg code and Declarations of Hawaii and Helsinki, etc., which guide the ethical aspects of medical research today. ECs were formed to address the ethical issues either in research or clinical settings. ECs today function mainly in the research contexts where the focus is on protecting the vulnerable patient from any harm or violation of rights during the research process. Obtaining consent, asking for the justification of the methodology and sample characteristics, data, and safety monitoring board review for any serious adverse effects, etc., are done routinely these days.

ECs are not so common in clinical settings, at least in India. When present in clinical settings, these are seen as restrictions to clinical work and not as guiding entities. ECs bring a new aspect to overall clinical work which is quite different from physician-centered professional ethic. They insist on collaborative work which includes various medical personnel such as nurses, technicians, and lay people like patients and their relatives. With regards to psychiatry, it can mean that there will be the following members in the EC: Medical professionals, administrators, lay people like patient relative, lawyer,

police, person from a mental health nongovernmental organization and human rights activist, etc.^[6] The institutes which have formed such committees report that it is a slow but very fruitful enterprise. ECs in clinical settings^[7] recommend policies related to ethical matters, promote activities for ethical education and research related to ethical dilemmas and also support clinical team when they face difficult ethical questions. An example is given about do not resuscitate physician order, where various aspects of when to write such an order, how to convey such an order to other medical personnel like nurses who carry out the orders, how to resolve doubts and disagreements between staff, etc., will be addressed.

Involuntary admission to the psychiatric practice is one such a case in point. Many people see it as an encroachment onto the person's autonomy, but equally so one has to understand the chances of harm to self or others which such a person poses without his clear will and motive (i.e., the absence of clinical insight). It becomes a physician's duty to reduce the dangerousness of the person by helping him regain his sanity through treatment, acting in his best interest. Hence, as we have discussed in the principlism view, beneficence over-rides autonomy of the person in this case. However, in view of past abuses of psychiatry, many have argued for a “self-critical and a chastened” paternalism in such a scenario.^[11] It is here in such an ethically difficult situation that the EC may support and strengthen the clinical work by its approval and prescription of a clear protocol for managing an agitated or a harmful person. Other similar situations like physical restraint and the use of surreptitious medication can be resolved with the help of an EC which can formulate certain standard operating procedures.

Resolving conflicts^[8] among the members (staff or patient) during the clinical management can be done in the following way: Recognize the circumstances leading to the ethical conflict as many times the disagreements arise due to misinterpreting the facts of the case, identify the specific ethical question that needs clarification (e.g., which of the four ethical principles needs support), consider hospital or organizational values, delineate the available options for response, recommend a response and anticipate future ethical conflicts and prepare beforehand. Staff can be educated and trained to treat the patient with the best possible respect. “Three stories” model helps analyze the ethical aspects in patient care and leads the way to the process of feedback, analysis, revision, implementation, monitoring and feedback, and thereby enhance patient autonomy.

ETHICS FOR OUR TIMES

In the current scenario, the medical decision making happens in a new economic, political, technological, and social reality. Many professionals work in an organization (whether public sector or pay-for-service private sector) which becomes their employer and thereby the clinical decision-making not just depends on the medical situation but also depends on the larger issues of insurance claims, targets, and organization policies and values. It is, therefore, very important to come up with an ethical structure for work and to implement it. Following strategies are recommended for constructing and implementing the ethical structure:^[9]

- Integrating values with the mission and vision statement of the organization which either is created by wide consultation of everyone involved in the organization or by disseminating it after formulation, i.e., high-level buy-in is required
- Facilitating communication and learning about ethical issues through awareness, trial and experimentation, and adoption methods whereby individuals are helped to understand, internalize, own and act on the vision of the organization
- Creating structures that encourage the resulting culture and these structures should continuously help in quality improvement
- Creating processes, like ethics and integrity audits, to monitor and give effective feedback on an ethical aspect of clinical practice.

Business-related management has become the dominant mode of working in the health-care organization (HCO). This has redefined the way health care is practiced, delivered, and distributed. We will examine about the way this style of management has affected HCOs and whether it is morally tenable.

HEALTHCARE WITH A FREE-MARKET VALUE SYSTEM

When healthcare is considered as any other commodity to be traded in the free-market, it is thought that the free workings and competition of the marketplace will give us a “quality product” as the health-care providers will compete in quality, price, and consumer satisfaction with each other to keep their market share and profit. Consumers or “buyers” will choose their “best product” from among the providers or “sellers” resulting in the reduction in costs and maintenance of quality. It is understood that the health-care buyers will ultimately maximize their utility of the goods/commodities by their rational choice as they can assess and buy the best product (referred to as rational choice theory). In this perspective, there are no problems with physicians

being “money-makers” as long as their work happens in a managed environment and their “product” is traded in an open/free market. This view is postulated and defended by libertarian economists such as Robert Nozick and Nobel Laureate Milton Friedman. According to Friedman, the only social responsibility of business is to increase its profits as far as there’s no fraud or deception.^[10]

As we read this description of healthcare what catches our attention is the foreignness of various terms applied to the physician-patient interaction. Physicians are referred to as - service providers, technocrats (exclusively using high-end technology in treatment), supplier, seller, money-maker, etc., while patients are referred to as - consumers, cases consuming technology, customers, buyers, payers, the insured, etc., Even the oft-used terms like “hospital industry” and “health-care provider” are part of this particular economic view. The medical insurance (or managed care) companies work with this above-mentioned view and are being criticized as damaging the healthcare.

Specialists in bio-ethics like Edmund Pellegrino termed this as the “Commodification of Healthcare.”^[11] The questions which are raised against this are - Is health care a commodity as any other commodity? Will the free-market ethic work for the healthcare? If healthcare is not a commodity like any other commodity, then what is it and how to handle it? Pellegrino suggests that healthcare is not a commodity as any other commodity because of two reasons. First, selling a commodity is described as a transaction with no relationship between the seller and the buyer except for the transaction, which is not true of the health-care interaction between a physician and a patient. Second, another aspect of a commodity is that it is proprietary, i.e., the seller owns the thing that he or she sells, which again is not true when applied in the health-care scenario. Medical knowledge is gained from centuries of observation and is learnt from either the clinical subjects or research subjects, and the process of learning happens through the society’s sanction, therefore, no physician completely owns what he “sells,” i.e., his medical knowledge. Acquisition of the medical knowledge happens within a social contract between society in general and the physician. Healthcare is best described as comprising a fiduciary relationship which works to benefit its user, the patient.

PROMISE AND FAILURE OF MEDICAL INSURANCE

Health Insurance advertisements promise cost savings and customer’s freedom and satisfaction by choosing

the healthcare he or she wishes but in reality limits treatment options and physician decision making. As the young and healthy insurance subscribers age, they might need and demand more health services, and this is when the insurance policies get strained in providing the care they promised, they will have to choose between reducing the number of services initially promised or providing care with reduced quality. As the doctors and medical services are just interchangeable “products” for sale, the insurance subscriber does not, in reality, have the option to choose the doctor or the service he wishes; he will only get what his insurance plan allows thereby giving no regard to the long-term healing relationship between the doctor and the patient. Moreover, there will always be the people who will not be able to pay the high premiums or the uninsured ones who will not fit the health-care structure. Insurance usually does not cover the people with chronic physical and mental diseases who, more than anyone, need the healthcare most, and it will also not cover the common illnesses which need frequent and short admissions, as these will not produce any revenue or profit.^[11] It has also been shown that “visionary companies” which do ethical business last longer and make a profit as any other business company.^[10]

These problems are due to at least two problems.^[12] First, there’s asymmetric information between the service provider/seller and the consumer/buyer because the patient can never be certain about issues like the quality of the service, estimated cost of the admissions and overall fees of the physician which precludes the rational choice of the patient in choosing the best service thereby utility maximization. Second, physician acts as the agent who can direct the patient about the best treatment available as the patient cannot by himself take such a decision, unlike the independent agents in the marketplace who help the customer make the best economic decision with regards to buying a commodity. Apart from being an agent, physician is also the service provider or supplier, in the health-care context, this dual role of the physician can produce the spurious supplier induced demand. This is supposed to be the reason for the increased number of hysterectomies and cataract surgeries in the Rajiv Swasthya Bima Yojana and the Aarogya Sri schemes. Camps by the insurance companies select the patients who do not access healthcare to identify people who fit the insurance defined disease profile and thereby contribute to the supplier induced demand. Induced demand is also the reason for the increased rate of cesarean section operations in several Indian states. Another aspect of this is the exaggerated and inappropriate usage of medical services just because of the state-sponsored insurance coverage this is called the moral hazard.

PATIENTS AS PRIME STAKEHOLDERS IN HEALTH-CARE ORGANIZATION

Business models work very well in the free market but cannot help the health-care field. Mixed economy as proposed by Adam Smith includes a free market for all commodities except the common goods such as national security, education, and health.^[11] Market in a free market only works to increase profits for the shareholders, as the dominant libertarian economic view describes that as the social responsibility of any business. A better way is to give equal importance to the claims of all the stakeholders in the health-care enterprise, i.e., patients, patient relatives, doctors, nurses, other medical staff, managers, technical staff, and the broader community. The corrective approach is to understand that patients are the primary stakeholders in a health-care organization and excellence in patient care is the primary value creating activity. The second most important stakeholders are the professionals who work for it. Financial stability should also be aimed at for long-term organizational viability.^[10] As healthcare is a common good and not a commodity, there is an emphasis on public health in which both the organizations and the welfare state should focus on.

CURRENT ETHICAL CHALLENGES IN HEALTHCARE

- Conflicts of interest: Even small freebies have been shown in recent surveys as influencing physician decisions
- Balancing patient service and preserving financial viability of a health-care organization
- Dealing with equal treatment of many versus the special/very important person treatment of few
- Managing vulnerable people like mentally ill and who are at extremes of age who have difficulty in decisional capacity
- Addressing health-care worker’s distress while managing people with poor prognosis whose treatment might be burdensome and taxing
- Dealing with issues like referral fee when primary care physicians find cases for specialists
- Deteriorating facilities in the government hospitals and public health sector which increase financial burden on the patient.

CONCLUSION

This review emphasizes the need for teaching and practicing professional ethical codes and for being cautioned about the free market value system which does not show any promise in the health-care organization. Healthcare is a common and public good which has to be preserved equally by the health-care organization

and also the welfare state. In the concept of distributive justice the two aspects of individual's duty toward the poor or uninsured and the society's improvement benefiting the individual work reciprocally and benefit everyone. In this new economic, political, and social reality, the medical community should focus beyond the professional codes and committees onto the health-care organizational and business ethics.

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