The Primary Obligation of Physicians Should Be To Their Patients, Not To Society

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“If you think health care is expensive now, wait until you see what it costs when it’s free.”
— P.J. O’Rourke

There has been a disturbing trend in recent years to move physicians from their primary obligation to patients to a primary obligation to society. This can be seen at all levels of medicine. The attitudes of medical students have shifted noticeably in the last few years toward increasing attention to social problems and acceptance of social obligations; the American Council on Graduate Medical Education has mandated a maximal number of house officers of working hours, which some studies have shown greater training; the fiftieth person on a list for a coronary bypass operation, this does not mean that you will be the 30th patient to have the operation, even if you get your needed operation in time to prevent your death from heart disease.

• People have a right to health care. Not true; if you are the fifty-third person on a list for a coronary bypass operation, this does not mean that you will be the 50th patient to have the operation, nor that you will get your needed operation in time to prevent your death from heart disease.

• People receive higher quality of health care. Not true; frequently repeated statistical evidence of U.S. inferiority—such as infant mortality and longevity—more much related to social and genetic factors than to health care; looking at diseases for which health care makes the primary difference, such as prostate cancer in men and breast cancer in women, the U.S. has far better outcomes than most other countries.

• Resources are allocated to maximize impact on health. Not true; the primary driver of resource allocation in national health systems is maximizing political advantage for those in political power—free ambulance rides to and from clinics, for example, consume a proportionately higher share of resources than high tech procedures that benefit small numbers of people.

• Racial minorities fare better than in the U.S. Not true. Aborigines in Australia and Asians in England fare just as badly or worse within their health care systems as racial minorities do in this country.

The examples of socialized medicine’s mythology are too numerous to cover in this brief article, but are discussed in detail elsewhere.

Increasing the priority of social obligations for physicians is often advocated as a solution to highly visible health care problems—access to and availability of health care at many levels, and the unsustainable rise in cost of health care. Physicians should support a centrally controlled system, designed and run by the best and the brightest, as advocated by the Physicians for a National Health Program. Some believe this is a logical strategy, yet it is deeply flawed.

The flaw in all centrally managed economic systems was described most clearly by Nobel prizewinner Friedrich A. Hayek in his book, The Fatal Conject. The concept is the belief that any one person, committee, or group can understand and predict the needs and wants of thousands or millions of individuals better than the individuals themselves, through millions of choices they make every day. Such choices are made in markets wherein cooperating individuals willingly participate every transaction, creating a win-win situation in every case. The fatality of the concept was well demonstrated by the spectacular collapse of Eastern European socialist states in the late 1980’s and the early 1990’s, which showed the unsustainability of centrally controlled economies, as well as by the history of health care financing in the United States.

In this country, the severe difficulties facing us in access and costs of health care have not arisen from market failure, as is often claimed, but from a crazy-quilt
of well-meaning but ill- advised policies over several decades. Examples of flawed policies include the Internal Revenue Service ruling in the 1940s that made health care insurance deductible for employers but not for employees, and National Labor Relations Board policy, also in the 1940s, that treated health care insurance as a non-cash benefit to employees, thereby making it a suitable bargaining chip in labor-management negotiations. Together, these produced our current employer-based health insurance system. In this system, health care insurance does not spread risks as other kinds of insurance do; rather, they serve as tax avoidance for medical expenses and as prepayment for health care. Factors such as these have created the central problem of health care in this country: when people buy health care, they do not have the perception that they are spending their own money. When 85-90 cents of every dollar spent for health care come from someone else’s pocket, the tendency is to choose more services at this highly discounted rate. Many other factors have produced perverse incentives in health care, not only for patients but for physicians and hospitals as well. Taken together, these have produced the high costs that have driven more and more Americans out of the market for health insurance and made health care less available to many.

The cycle of failed policies and their unanticipated consequences have led to corrective but flawed policies such as the 1946 Hill-Burton Act (oversupply of hospital beds), certificates of need (restricted competition), diagnostic related groups (gaming the system and dishonesty), relative value scales (socialism on stilts, pace Bentham), mandated health insurance benefits (escalated premium prices), and the Health Insurance Portability and Accountability Act (a massive volume of federal regulations that occupies tens of thousands of pages, understood by no single person). Central planning of health care has made physicians the beneficiaries of strangulating paperwork and unwarranted third party interventions in health care. The cycle of failed policies and their unanticipated consequences has produced the problem of diminished access to health care; Americans without health insurance is approaching 50 million, and this rise was predicted as new mandates and regulations were piled upon old mandates and regulations.

So, how are these problems to be solved? Certainly, more command and control is not the answer. Nor is redirection of physicians to service of the public good over the good of their patients the answer. In my view, common men and women are competent to live their own lives and competent to know where their own interests lie and how to pursue those interests. They do not need externally imposed presuppositions about what is best for them; in health care, as in most of life, one vision of the good does not fit all. The structure of society generally should reflect the needs of the majority, and should protect personal space in which people can make their own decisions and live their own lives, as long as their actions do not impinge on the freedom of others to act on their own decisions. At the same time, a safety net for the most disadvantaged can be put in place, much as we use food stamps to allow the poorest among us to access grocery stores rather than socializing the system of food distribution. The economic system that is best suited to this idea of freedom to live one’s own life without interference by others is a free market system, with only a few obviously needed constraints. No cogent argument has ever shown that health care is an exception to this general truth.

Markets are the social expression of freedom: the right of individuals to live their own lives with their families and with communities in which they participate freely. Markets support the right of human beings to pursue the values they find to be appropriate for their own lives. In this regard, health care is a right, but in a limited sense: the right to health care is the unimpeded freedom to seek care and to accept or decline offered treatment; it is not a claim that imposes obligations on others to provide health care.

An important observation frequently glossed over in public discussions is this: health is not the same thing as health care. It is likely that, over the last century or two, sanitary engineers have done more for health than physicians have, by providing us with clean water, indoor plumbing, and efficient sewage systems. Health is a state of well being that arises from many factors, such as proper hygiene, regular exercise, wise nutrition, safe driving, moderate use of alcohol, and enjoyment of the arts, among many other factors. When talking about the relationship of financial resources to health, the question is not how much money should be spent on health care, rather, it is how much money should be spent on all of the goods and services that contribute to health as a state of well being. Who is in a position to decide how resources should be spent to produce the healthiest outcomes? This can be done only by individuals living their own lives; no health czar or central committee can do it, no matter how brilliant.

Those who see some kind of single payer system as the solution to health care financing problems make the claim that markets result in some people being left out, and a variety of other errors and omissions. This observation is certainly true, but it is a huge leap to claim that errors and omissions are lower in single payer systems. Gordon Tullock and Nobel Prize winner James Buchanan developed the theory of Public Choice, which has been proven to be a powerful predictor of the outcome of real-world events. They showed that politicians use political power in centralized systems to pursue their self-interest and to further the interests of their supporters; the political decision-making process does not serve the whole group. In other words, politi-
cians are not less corrupt than businessmen, an observation not likely to astound anyone.

Much needs to be done to solve the U.S. health care problems. The goal should be affordable, safe, and quality health care for everyone. The current administration’s health care agenda is moving in that direction: it aims to empower people in health care as they are in other aspects of their lives. It is based on the belief that health care consumers should feel responsible for their health and for the costs of their health care. Certain reforms will provide them with the accurate information about pricing they need in order to be prudent buyers of health care; this will eventually lead to an accurate balance between high quality and low cost as can be achieved. The agenda also provides for a safety net for the truly medically indigent. Although health savings accounts, a revolutionary new form of health insurance, became law in 2003 and are growing rapidly, the playing field of taxes on health care dollars needs to be leveled so employees benefit from tax breaks in the same way their employers do, thus encouraging individual ownership of health care policies.

What role should physicians play in the evolving new health care system that is based on individual ownership of health insurance and individual responsibility? It is simply this: do not abandon the age-old primary obligation of physicians to their individual patients. Our role should be, first, advocates for our patients and, second, support for market reform in health care.

References