

Editorial

## Physicians, Payments, and Practices: Moral Issues, Public Perceptions, and the Stark Laws

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*"...our private relations do not make us lawless as citizens... against this... is our chief safeguard... the laws, particularly such as regard for the protection of the injured, whether they are actually on the statute book or belong to that code which, although unwritten, ... cannot be broken without acknowledged disgrace"*

-Pericles (1)

*"...do not gain basely, base gain is equal to ruin"*

-Hesiod (2)

Since antiquity, the most salient and durable quality that defined the physician, and by extension, the practice of medicine has been the primacy of the patients' best interests, to the point of relative subordination of the self concern of the physicians. Certainly, this notion was central to the concept of medicine — as a practice — within

the Hellenistic and medieval traditions (1-3), and it has been preserved in modernity, as evidenced by the successive works of Thomas Percival, who instructed that "...your noblest call to duty arises from the spirit of philanthropy..." (4), William Osler, who exhorted that "...we are not here to get all we can...for ourselves, but to try to make the lives of others happier..." (5), and the American Medical Association's Code of Ethics that secures medicine to a perdurable responsibility to "...both patients and society" (6). Yet, while a central tenet has been the deferment of self-interests to those of the patient, none of these suggest or require that this separation from self-interest should be absolute.

In prior work we have relied upon Alasdair MacIntyre's definition of "a practice" (7); that definition is equally useful here to illustrate the continued relevance of Hellenistic-medieval accounts of medicine to more contemporary applications. MacIntyre defines a practice as the exchange of "good" between individuals in a relationship, as defined by the nature and needs of that relationship.

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While a complete discussion of what constitutes “the good” — as broadly construed — is beyond the scope of this work, we can turn to Frankena for a description of the range of “good” that spans from the expected to the completely supererogatory, dependent upon the nature and circumstance(s) of the situation or practice (8). Thus, defining what is good as focal to the practice of medicine can be derived from examining the needs and roles of the participatory parties in the medical relationship. Most directly, these are the patient — who seeks a therapeutic intervention, and the physician — who seeks to provide such care as consonant with both the commitment to, and public declaration of, their responsibilities and obligations as a medical professional (9). The individual and public good of medicine are enacted under the aegis of particular societies. Previously, we have posited how the facts and realities of medicine interact with the structure, prescriptions, and proscriptions as provided by policy and law (10). We maintain that this mutuality of purpose is relatively straightforward: the nature of the practice must inform the elements of policy such that these policies and laws can best protect the good of the practice, and the needs and interests of those served (both individually and publicly).

In this issue, Manchikanti and MacMahon describe the history, evolution, and iteration of current Stark III regulations. Their work, and the Stark regulations themselves, should provoke reflection on 1) the nature of medicine as a practice, 2) the “good” afforded to individuals and society by this practice, 3) the obligations entailed by both the relationship and the nature of this good, and 4) the importance of physicians’ agency in both shaping policy to insulate the good of the practice and enacting the practice itself.

In this essay, we argue that any realistic account of medicine would ground this practice as an altruistic enterprise based upon the inherent asymmetries of power that exist in the physician-patient relationship. We will articulate how such altruism is consistent with a relative effacement of self interest, but will also posit that such self effacement need not be absolute and that there must be room, need, and respect for claiming reasonable material reward for the consistent dedication and execution of skills and wisdom that the practice of medicine entails and demands. We illustrate the tenuousness of this position in an increasingly market-driven model of medicine, address what we feel to be key issues that affect the objective and subjective balance of “just reward” and/or market

oriented profit, speak to moral considerations that are important to uphold the probity of practice, and offer a set of ethical parameters to better define physician’s roles in establishing economic relationships. We hope that this discussion might, in some small way, prevent further decontainment of market model approaches that lead to the gross commodification of medicine. Toward these ends, we will reclaim beneficence (as both principle and virtue) as the basis for enacting medical practice, but also argue that such beneficence is enabled by permission — here construed socially as the acceptance, if not consent, of the served public to grant physicians tangible reward(s) for the provision of medical good. Such consent must be informed by complete transparency of physicians’ economic capacities, and through the protection that is afforded (to the populations of patients and physicians) by sound, well conceived policies and laws.

### **PHYSICIANS, PROFESSION, AND PROFESSIONALISM**

Medicine is considered to be one of the three learned professions (ie., medicine, law, theology, although some also would include education), that by definition involve and require both specific education and the codification of unfringeable rules and values (11). Recently, we have described how such rules establish the structure of the professional practice of medicine and define the fundamental constructs of its ethical framework (12). Simply put, if one is to be a physician, he/she must recognize and acknowledge these parameters, and accept the responsibilities and obligations of this profession. Despite the fact that such rules arise from the realities of medicine, and therefore describe what the practice and practitioner should do, the decision to pursue medicine as a vocation, and the acceptance of these rules as resonant with one’s own values, speaks to the importance of personal character to professionalism. In other words, professionalism represents the actions of personal character in the consideration and application of moral and practical rules and responsibilities.

Clearly, the practice of medicine dictates a number of well described responsibilities that reflect, and are derived from the asymmetry of the physician-patient relationship (13). While there is some contention as to whether or not there is an internal morality of medicine (14), it is clear that the physician yields tremendous power (in a number of dimensions), and that the possession and use of such power is literally “con-

fessed before" the public (viz., literally from the Latin, *professus*) to be used for the best interests of those who are suffering and seek healing (i.e., patients). Therefore, we argue that this single act of profession describes not only an adherence to particular structural parameters of the practice, but is also a more complete commitment to the notion of the practice itself as a relationship that is based upon providing "good."

Such commitment to good can be construed as principle and/or virtue. In either case, we should consider what constitutes "the good" in the physician-patient relationship. A short list of these qualities would include compassion, gentility, prudence, humility, generosity, and perhaps most importantly, fidelity (15,16). Each and all of these regard the vulnerable condition of the patient, and the right and sound use of the knowledge, skills, and capabilities of the physician. Compassion and gentility are essential to apprehending and caring for the predicament of each patient's suffering; these are enacted in medical practice through the prudent use of various types of knowledge (in medical decision making (17). Humility refers not just to the acknowledgement of intellectual and practical limits, but to the recognition of the need to limit one's intrinsic power to those applications that benefit the individual patients within the clinical encounter and, more largely, the population of potential patients that medicine encounters as a public good. In many ways this bespeaks the generosity of medical practice that is borne by the actions of the individual physician. The physician gives his/her knowledge, skills, and time to each and every patient that comes before him/her. This is the promise of medical practice, and while it contains certain contractual characteristics as Robert Veatch contends (18), we agree with Pellegrino and Thomasma (19), and May (20) that it also possesses a strongly covenantal quality. Taken together, we believe that these characteristics convey the fidelity (faithfulness) of physicians to both individual patients and society.

### **MEDICAL MORALITY IN THE MARKETPLACE**

How does such faithfulness translate (or survive) in an atmosphere of competition and profit? There are few who would argue that medicine is not a profession, in the strictest sense of the word. Inherently, it is the values, virtues, and rules that ground medicine to its professional identification. But this prompts the question of whether medicine can exist within the

increasingly pervasive market-driven infrastructure of contemporary society. We believe that this is possible; but the humanitarian qualities of medicine can only be preserved if the (beneficial) values and virtues of business are employed toward achieving the ends of medicine, rather than the practice of medicine being employed to serve the ends of business (21-23). When medicine assumes the business ethic and ethos, it is increasingly regarded and delivered to the public as a commodity.

It is this very issue that generates such concern and discomfort about physicians' involvement in "business aspects" of practice, many of which are addressed by the Stark legislation. But what is it exactly that instigates this public squeamishness? We maintain that the issue here is one of actual or perceived professionalism. One needs only to look at the popular media to see caricatures of "wealthy preachers" or "financially corrupt attorneys" that are depicted as predators or scavengers. While exaggerative, these portrayals reflect public stereotypes, and the fear and contempt for any perceived manipulation or extortion of vulnerable persons that arises when (supposed) benevolence is subordinated to goals of personal financial gain. More directly put, there is an abiding perception that "medicine as business" is wrongful.

This is not to say that the physician must be totally effacing of any financial self interest. To paraphrase the physician-philosopher, H. Tristram Engelhardt, there is no power in poverty, and in the absence of proper power, the good of a practice can be lost (24). But we argue that a critical balance must be maintained between the inherent altruism of medical practice and the exercise of individual rights in the procurement of "just reward(s)" for physicians' dedication and acts. This balance is well depicted in a dialog between Socrates and Thrasymachus in Book I of Plato's Republic:

*"... would you call medicine wage earning, even if someone earns pay while healing?"*

*"No"*

*"... anyone who intends to practice his craft well never does or orders what is best for himself... but what is best for his subject. It is because of this, it seems that wages must be provided to a person if he is willing to rule..." (25).*

Ideally, policies and laws provide prescriptions and proscriptions to guide the safe and sound practice(s)

of medicine. While this is the intent, in reality many policies and laws can interfere with, if not frankly limit, the provision of good medical care. We opine that one of the reasons for this is a lack of direct physician involvement in the formulation, development, and process of policy- and law-making. If we consider that laws are intended to protect the public and conceptually preserve the good of individual persons, then the goals of law and medicine would appear to be aligned, at least as constructs.

Is this the case for the Stark (III) legislation? Manchikanti and MacMahon raise an interesting point in that the costs of such health care regulations may incur a greater burden to the health care system than physicians' actual, infrequent involvement in practice ventures that involve kickback profits. As matter of fact, this may be so; however, there are a number of reasons why we must be cautious about the conclusions that we draw from this information. First, it is important to note that the failure of government to lessen the costs incurred by the process of developing and implementing regulations in the public interest is not (and should not) be grounds to: 1) abandon the basis and premises that initiated such regulations, 2) adopt an "... if they can incur costs, then why can't we?" posture, and thus, 3) claim that the wrongs or collateral insults incurred by one group justifies (equal or equivalent) participation in wrongs by another. In other words, the burdens imposed by the government do not support the incursion of similar burdens by the medical community. Somewhat more colloquially, we suggest that while this may indicate the need to reexamine the values and costs incurred by the process of giving "the baby a bath" (i.e., cleaning or clearing up the process of lawmaking and resultant regulations); while we may choose to discard the "bathwater" (i.e., the negative aspects that we seek to remedy), we need not denigrate the value of "the baby" (i.e., the intent and process of laws and policies) itself. Surely, costs of government regulations are often high and escalating, and translated into burdens upon particular sectors, such as health care. But as Manchikanti and MacMahon note, this is reason to consider government regulatory costs and spending as problematic, rather than impugning the purpose or need for such processes, and the underlying morality and ethics that laws and policy attempt to uphold.

This speaks to the second point, namely that Stark legislation in some way reflects a valid, public concern

about the involvement of physicians in certain business aspects of medical practice(s). As such, both the laws themselves, and the perceptions from which they arose need to be seriously regarded as a reaction of (moral) discomfort by the public. Together with Ann Neale, we have stated that much of medical professionalism is (perceived to be) lost when medicine is construed as business. This is because the cardinal medical virtues of beneficence and altruism are extra-market values that are frequently subordinated, if not altogether lost, to the business ethos, ethic, and its ends of profit (23).

But if beneficence is critical to medicine, we argue pro Engelhardt that it is enabled by (the principle and/or virtue of) permission (24). We believe that such permission is executed on both an individual and public level as "informed consent". Just as individuals consent to treatment through the reasonable provision of information, public informed consent is gained by transparency of physicians' financial practices, involvements in economic enterprises, and continued validation that any and all interests do not conflict with the prudent rendering of right and good care. *That* and *how* this occurs is equally the responsibility of physicians. The former is accomplished through adherence to policies and laws that insure against interests that diverge from the ends of medicine. But these policies and laws must meaningfully reflect 1) the role(s) of physicians in providing the best care for patients, 2) the needs of patients (and the public) to have access to economically unencumbered, sound medical practice(s), and 3) the realistic needs of physicians to be justly reimbursed for the provision of medical treatment(s). For this to occur, both physicians and the public at large must have equal voice in the processes that contribute to and sustain effective healthcare laws and policies, and these voices must be well informed and mutually sensitive. In this way the tenor of an effective society — that unites government and its people — is not unlike that of the clinical encounter which brings physician and patient together in community, as both share the purpose of achieving what is right and good.

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