Physicians Have a Responsibility to Meet the Health Care Needs of Society

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In one of the televised debates among Republican primary candidates for the 2012 U.S. presidential election, moderator Wolf Blitzer presented this hypothetical case to candidate Ron Paul:[1]

> A healthy 30 year old young man has a good job, makes a good living, but decides — you know what — 'I'm not going to spend 200 or 300 dollars a month for health insurance because I'm healthy, I don't need it.' But something terrible happens, all of a sudden he needs it. Who's going to pay if he goes into a coma?

Paul, known for his libertarian views, initially responded that the patient "should assume responsibility for himself," and that he should have purchased a major medical policy before he became ill. But Blitzer pressed on, noting the reality that this particular patient has no insurance and needs life-saving medical care:

> Blitzer: "He needs intensive care for 6 months... who pays?"
>
> Paul: "That's what freedom is all about, taking your own risks."
>
> Blitzer: "But congressman, are you saying that society should just let him die?"

At this juncture, several people in the audience shouted "Yes!" The media focused on that chilling outburst, but largely ignored the fact that Paul himself did not endorse that reaction. Instead, he answered "No," and then added:

> I practiced medicine before we had Medicaid, in the early 1960s...and the churches took care of them...we never turned anybody away from the hospital.

This exchange is instructive in three ways. First, Blitzer's example involved a man who could afford health insurance, but chose not to buy it. A more representative example would have been a low-wage-earner who (1) wants health insurance for himself and his family, (2) works for a company that offers no health insurance benefit, and (3) either cannot afford

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the prohibitively high premiums generally charged for non-employer-based health plans, or is not even eligible for insurance because of a pre-existing medical condition.[2] Philosophical or political arguments about personal responsibility, freedom, and risk-taking must account for people who want and accept the idea of personal responsibility, but are nevertheless excluded from access to health care. Such people become sick or injured — through no fault of their own — and cannot afford timely health care that is otherwise available in their own communities.

Second, the idea that the churches (or, more generally, charitable organizations or individuals) offer a sufficient safety net in 21st century American medicine is simply implausible. Moreover, this response ignores the problem of freeloading: If the hypothetical patient had the means to buy insurance but acted irresponsibly and did not, then why — according to an argument from personal responsibility — does he deserve charitable health care? If charitable care were consistently available to freeloaders, what incentive would they have to purchase health insurance?

Third, despite Paul's political view that government should not subsidize health care, he essentially agreed with the proposition expressed in the title of this essay, "Physicians have a responsibility to meet the health care needs of society." Paul is a retired physician; he implicitly acknowledged that physicians have a professional obligation to care for people with legitimate health care needs, regardless of ability to pay. He could not bring himself to allow Blitzer's hypothetical patient to die.

In the rest of this essay, I first demonstrate that society is already organized— at least in part — to rescue sick people regardless of ability to pay, and that society is not prepared to abandon that general guiding principle. It follows that physicians — society's principal instrument for provision of health care services — are expected to meet society's health care needs. I then argue that the current configuration of the U.S. health care system undermines the ability of physicians to fulfill this mandate effectively. And finally, I argue that the medical profession's responsibility to meet society's health care needs also carries a responsibility to practice cost-effectively. My perspective is pragmatic, based on several decades of experience practicing and teaching primary care internal medicine in academic settings.

The Social Responsibility to "Rescue" Sick People

The American health care system embodies a tension between personal responsibility to pay for one's health care and a social responsibility to care for sick people. The current system — a product of decades of tinkering — is configured such that the social responsibility sometimes trumps the personal responsibility, in two senses. First, society has endorsed the practice of "rescue medicine" regardless of ability to pay. A law known as EMTALA (the Emergency Medical Treatment and Active Labor Act) requires emergency departments to provide at least stabilizing medical care for those who need it.[3] When such patients require additional inpatient hospital care beyond what the emergency department can provide, they are generally admitted to the hospital — even if they are uninsured and poor. Additionally, emergency medical services in the community respond to all 911 requests for help. No societal pressure exists to repeal EMTALA or to have emergency medical technicians or 911 operators inquire about medical insurance or financial resources when they respond to such calls. In American society, injured people or those with heart attacks are not permitted to die at the hospital door or in the field. Instead, uninsured or poor people with urgent or emergent medical needs generally receive basic clinical services if they seek them; it is only later on that physicians, hospitals, and other medical service providers address financial arrangements that may range from "writing off" bills, on the one hand, to demanding payments that bankrupt patients and families, on the other.

The second sense in which social responsibility sometimes trumps personal responsibility is the existence of government-sponsored health care facilities and insurance plans. Society has seen fit to subsidize health care for groups considered to be vulnerable or otherwise deserving of assistance — through Medic-

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aid, Medicare, and the Veterans health care system, for example. While these entities certainly are not perfect, they are here to stay for the foreseeable future. Even socially conservative politicians generally do not advocate dismantling these programs because they know it would be politically unwise. It would be unwise because society — that is, a majority of Americans — would object. And that objection, in turn, reflects human compassion and a shared sense of responsibility to provide and subsidize health care when sick fellow citizens are unable to afford it.

Having It Both Ways: A Dysfunctional System

The system of health care delivery in the United States is a patchwork consisting — among other things — of reasonably universal access for urgent medical care, barriers to non-urgent but necessary care for uninsured or under-insured people, and government-sponsored coverage for some (but not other) populations. As a result, the system is clinically illogical and operationally dysfunctional. We try to have it both ways: as a matter of human decency we provide urgent medical care without regard to cost, but along the way we demand individual patient responsibility for costs. We boast about offering the best medical care in the world, yet we knowingly provide substandard care (or deny care) to large numbers of people, and we experience health outcomes inferior to those of comparably developed nations.[4] Here are some of the consequences:

- For people without adequate funding for health care, we deny evidence-based preventive or timely medical interventions and wait for bad things to happen. In many cases, this backward approach increases costs to society — both direct medical costs, and the economic cost of a less productive workforce. I am not referring here to interventions that benefit relatively small proportions of the population, such as routine check-ups or screening tests for healthy adults. Rather, I am referring to basic interventions that keep people from requiring expensive and labor-intensive rescue medicine — for example, treatment of severe hypertension and diabetes, or effective maintenance therapy that prevents exacerbations of chronic diseases such as asthma or heart failure.
- We bring financial ruin to patients and their families. Medical debt is one of the leading causes of bankruptcy.[5] Charitable groups and family friends hold picnics or other fund-raising events to raise small — and usually inadequate — amounts of money for families with prohibitive medical bills. The idea of having picnics to rescue sick people might be superficially uplifting, creating "feel-good" news stories, but ultimately these efforts are undignified and even degrading.
- Physicians and health care institutions are expected to exercise charity and "write off" some medical bills. But this practice ultimately results in cost-shifting, and paying patients ultimately subsidize non-paying patients through higher charges and higher insurance premiums. This result happens to be the opposite of what advocates of "individual responsibility" intend.
- We establish various "band-aid" solutions to provide impromptu health care. For example, community "free clinics" often consist of a revolving door of volunteer health care providers and arbitrarily changing medication formularies. One-day health fairs offer one-time dental examinations, eye examinations, and simple health screenings in parking lots or churches or sports arenas. At best, these activities are mediocre ways to provide treatment — the hit-or-miss provision of health care typical of impoverished developing countries, not technically advanced 21st century societies.

Social Responsibilities of Medical Professionals

Medical care provided or initiated by physicians represents only one facet of health care, alongside services provided by non-physicians and complemented by public health initiatives. Nevertheless, much of the medical care delivered by non-physicians (e.g., nurses, physical therapists, etc.), and most diagnostic tests and prescription treatments, can be implemented only by physicians' orders. That these responsibilities are delegated to physicians reflects society's decision that on balance, medical care is more effective and safer when directed by licensed physicians. Correspondingly, people who choose to become licensed physicians are obligated to implement that social mandate. Most people clearly would reject a system of health care in which physicians were marginalized and practice was unregulated.

The physician's responsibility to meet society's health care needs also derives, in part, from the fact that society subsidizes medical training substantially. A majority of medical schools in the United States are state institutions that receive taxpayer support.[6] Many medical students receive government-sponsored grants and low-interest loans. Publicly funded health care facilities, populated disproportionately by unin-

sured and underinsured patients, frequently serve as teaching institutions from which trainees gain valuable experience. And finally, after reaping the benefits of public subsidies for medical training, U.S. physicians participate in a health care market that rewards them handsomely, as indicated by average salary figures.[7] Taken together, these characteristics of training and practice create an obligation for medical professionals to help meet society's health care needs.

Finally, from the earliest stages of training, students are asked to recognize societal obligations, and to offer their services without discrimination. For example, one popular modernized version of the Hippocratic Oath states, "I will remember that I remain a member of society, with special obligations to all my fellow human beings."[8] Curricula at most medical schools include so-called "patient-doctor" courses that emphasize respect for patients, empathy, and moral obligations. Those who would argue that physicians are not obligated to meet society's health care needs would be arguing against the ethos of contemporary medical training in the United States.

But can we recognize physicians' responsibility to meet society's health care needs while putting physicians in the untenable position of having to choose between paying and non-paying patients? After all, modern medicine is a business that requires financial resources, and there are practical limits to providing charitable care. Moreover, a system in which it is considered acceptable for some physicians to refuse service to poor patients — while other physicians shoulder the burden of so-called "indigent care" — is fundamentally unfair, antithetical to humanistic qualities that we hope to instill in all medical trainees, and ultimately unsustainable. Such a system surely creates cognitive dissonance for young physicians whose training emphasized the social obligations of the profession.

This problem can be solved through provision of universal access to health care, as is done in nearly all other developed countries. Indeed, public opinion polls have shown consistently that a majority of Americans favor some system of guaranteed universal access.[9] Politicians and analysts who claim that "American individualism" or "American exceptionalism" are antithetical to universal access are simply misrepresenting the values of the majority (while representing narrow interests with economic or political motives to maintain the status quo).[10]

A system of government-guaranteed access — if properly designed — would eliminate logical inconsistencies in the current system that result in preventable human misery, and would eliminate the administrative waste that plagues the current system.[11] Several models are available, including a Canadian-style single-payer system, a United Kingdom-style national health service, and highly regulated private-public hybrids that exist in several other European countries. My personal view is that the best model for the United States is a Canadian-style system that consists of private medical practice, universal access to medical care, a single government payer, and abandonment of employer-based health insurance. Arguments for this system, applied to the United States, have been made elsewhere and are beyond the scope of this discussion.[12] The point here is to emphasize that a system of guaranteed universal access — in which physicians are compensated fairly for provision of medical care to the rich and poor alike — allows physicians to satisfy professional obligations to meet society's health care needs, and to meet ethical obligations to treat patients without discrimination. Until such a system is in place, physicians should continue to provide charitable care. However, the scope and quality of charitable medical care within the current system will necessarily remain unsatisfactory, because the institutional structures in which clinicians practice tend to undermine the provision of high-quality care to unfunded or underfunded patients.

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Implications for Medical Training

Medical students and residents tend to train in facilities that serve large numbers of uninsured and underinsured patients (I provide supervision to trainees in several such facilities). During clinical encounters in those settings, trainees and their supervising faculty often spend disproportionate time and energy trying to secure needed services for uninsured and underinsured patients. As a result, trainees have less time to experience the very activities that attracted them to medicine in the first place — the intellectual excitement of diagnostic and therapeutic clinical reasoning, and the satisfaction of building strong interpersonal relationships with patients. Students and residents become disillusioned, and are less likely to view careers in primary care practice as attractive.[13] In my experience, most young physicians would prefer to provide the same standard of care for all patients, rich and poor.

Even well-to-do patients should regard disillusionment of young physicians-in-training as problematic. First, everyone benefits if society has an ample supply of well-trained primary care physicians, and everyone benefits from a healthy citizenry and workforce. Second, well-off patients should want physicians whose personal and professional ethic includes respect for all people with health care needs, and who practice in a system that permits physicians to apply similar standards of care to all who seek their services.[14] And third, all patients — regardless of socioeconomic status — should want their physicians to be focused, without distraction, on practicing high quality medicine. They should not want physicians who have become "burned out" by having to beg specialists to see their underfunded patients, or who have become cynical by having to treat medical complications that would be preventable in a system without barriers to timely health care.

The Physician's Social Responsibility Includes an Imperative to Practice Cost-Effectively

The physician's responsibility to meet society's health care needs should be coupled with responsible stewardship of health care resources.[15] A responsibility to expend medical and financial resources wisely has not traditionally been considered a professional obligation for physicians. Indeed, physicians in the United States have long practiced as if no resource constraints existed. Moreover, many physicians have placed their own financial interests above the interests of patients by providing unnecessary medical care that is highly profitable under fee-for-service arrangements.

There is strong evidence that provision of useless medical care accounts for a substantial proportion of health care costs — up to 30% by some estimates.[16] Physicians tend to blame the steep rise in health care costs on patients ("patients demand things, and I don't have time to fight with them"), on lawyers ("I do more things than necessary so I won't get sued"), and on drug company influence on physician prescribing. Then, having driven up costs, physicians blame payers for interfering with medical practice. Although demanding patients, lawyers, and drug company advertising are an inescapable part of the health care landscape, their existence does not excuse physicians from practicing evidence-based, cost-effective medicine.

Cost-containment obviously requires a fundamental restructuring of the U.S. health care system, with improved access to timely medical care and elimination of financial incentives that increase physician income without benefiting patients. Such restructuring should compensate physicians for spending time with patients to explain why certain interventions are marginally effective, unnecessary, or even harmful.[17] Narrowing the income gap between primary care physicians and subspecialists would help to facilitate these changes.[18] Although moderate differences in income can be justified, the huge income disparities that exist among U.S. physicians cannot.

The imperative to address health care costs should also be addressed more directly in medical education. Currently, attention to responsible stewardship of resources is a haphazard, hit-or-miss, aspect of medical training. Instead, the obligation to practice cost-effectively should be incorporated into curricular offerings in ethics and professionalism, and cost-effectiveness analysis should be incorporated seamlessly into the biomedical and clinical portions of the curriculum.[19] Educators should select students who take these obligations seriously, and policymakers should finance medical training so that students do not graduate with huge debt, which distorts career choice and practice incentives in ways that oppose cost-effective medical care.

Conclusion

People often need medical care unexpectedly — through no fault of their own. Although our system of health care is seriously flawed, we nevertheless rescue people with urgent medical needs. Our doing so reflects several beliefs and values: We have compassion for people who are suffering; we derive comfort from knowing that a safety net exists, given that any of us can become vulnerable at any time; and we recognize that society flourishes best when pain and suffering are minimized.

As society's primary instrument for provision of health services, the medical profession shoulders a responsibility to meet society's health care needs. In carrying out that responsibility, physicians should advocate for a less chaotic, more compassionate, and ultimately more effective system with universal, timely, access to health care. Such a system will increase physicians' job satisfaction, allow physicians to focus more sharply on clinical problem-solving and building relationships with patients, and improve the general health of the population. At the same time, the medical profession must embrace a responsibility to eliminate useless medical interventions and to practice more cost-effectively.

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