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Beyond the Market Place

As I left my office one afternoon not long ago, I was startled by an enormous billboard with the message:

VISIT YOUR DOCTOR TODAY

Below this unabashed invitation were listed the telephone numbers and the franchised locations where I might make his acquaintance. It dawned on me in the twilight of that evening how in this commercialized version of medical practice "my doctor" would be whichever doctor happened to be on duty that day, probably a young physician who needed to pay off debts incurred in medical school, a company doctor, whose individuality was masked and distorted by his employers' demands. As I stare at the billboard, the traffic signal on the street corner changes to green. Municipal busses careen up the avenue. Below their windows, where last week the Commonwealth cajoled its citizens to gamble away their hard-earned wages, or photographs of Elysian landscapes seduced the viewer to nicotine addiction, there, on large placards the fast-medicine franchisers offer themselves again. At home, I find in my mailbox a brochure from a second similar medical establishment, this one also promising me a personal care physician, endorsed with testimonials from satisfied patients. Twenty five new offices in convenient locations are ready to serve me, and at each one my very own physician is said to be waiting. A new medical market-place has opened for business.

The entrepreneurs and the consumer advocates who invite us to go doctor-shopping believe that they are breaking new ground, but this is not entirely the case. Medical advertising has a long and interesting history. It was so prevalent during the Renaissance that a special name was coined for physicians who advertised. They were called "montambanco", a contraction of "monta in banco", literally "climb on the (speaker's) platform", an etymology, incidentally, that is relevant to our professional meetings as well. The anglicized term "mountebank" soon acquired a pejorative connotation. Among those who disapproved was Sir Francis Bacon who lamented that "Men ... will often preferre a Mountabanke or Witch, before a learned Phisitian." (OED)

As usual, it is not difficult to surmise why the established profession deprecated those who attempted to insinuate themselves into its hierarchy. Aside, however, from the obvious interest in protecting social and economic privilege, there is an additional, more cogent reason for the aversion to advertising in medicine. The reputation of the traditional physician rests upon the satisfaction of his patients, and his conduct is directly controlled by the contentment of those whom he presumes to help. To the extent that any physician advertises, he makes himself independent of satisfied patients. He relies instead on publicity and promises to persuade patients to entrust themselves to him. Given these differing mechanisms of referral, it is axiomatic that the conventional physician will come away with the superior reputation, and this would be the case, even if the advertising physician were objectively more competent. Nor is there reason to conclude that the patients of the advertising physician are dissatisfied. The essential point is that their satisfaction, great or small as it may be, is of less importance to the maintenance of his practice than if he refrained from such self-promotion. The Oxford English Dictionary shows us the mountebank on his elevated platform, as he "appealed to his audience by means of stories, tricks, juggling, and the like, in which he was often assisted by a professional clown or fool."(p.1863) If the billboards don't do the job, we can expect to see the like on our television screens before long.

The notion that the practice of medicine is in very important respects a commercial enterprise is no secret to economists and to those more practical souls who size up the customer's credit-worthiness, a secret that is sometimes revealed by physicians' actions even when it is denied by their words. Physicians prefer to think of themselves as heirs of the learned doctors of medieval universities rather than of the itinerant showmen of healing, a "learned profession" whose standard of conduct should be distinguished from that of the market place. For decades it has assured the health of the country and incidentally the economic well-being of its members as well, by

creating an extraordinarily complex and expensive curriculum of medical education, which, so long as government did not intervene, severely limited the number of available physicians. In such a seller's market there was no need to advertise, and a rigorous prohibition of overt commercialism was readily accepted and enforced.

Until a few years ago, the courts tended to accept the profession's view of itself, holding that physicians should be judged by higher standards of conduct than (other) business men, and that the proscription of advertising was not an unlawful restraint of trade. The Hippocratic vow to refrain from teaching medicine to all but the sons of physicians was translated into a formal legal sanction against the aiding and abetting of the unlicensed practice of medicine. Efforts of corporations to inject themselves into the delivery of medical services were rebuffed on the hypothesis that the practitioner of medicine was required to have a soul, and whatever qualifications to practice medicine a corporation might be able to proffer, possession of a soul was not one of them. As a result, medical practice remained the domain of individual practitioners responsible only to their patients, to their consciences, and to whatever standards of professional conduct their peers established among themselves.

Of late, this system has been crumbling. The causes of its decay are so obvious that one wonders how it could have lasted so long. With the complexity of medicine came specialization and subspecialization, until, except for minor matters, no one physician was competent to care for all of the patient's problems. The profession responded with co-operative endeavors of various kinds. The team approach to medical care proved indispensable when the patient's disease straddled the boundaries of two or more specialties. The onus of corporate medicine was avoided by presuming that each physician was directly answerable to the patient, and that there was one, an attending physician, ultimately responsible for his care. In this manner the time-honored physician patient relationship was thought to be preserved. Unavoidably, however, physicians working together assume responsibilities also to each other and to the group. This responsibility to the clinic or the corporation tends to dilute the responsibility to the patient. A physician's decision in the context of co-operative practice is commonly determined more by what colleagues expect than by what he might independently deem best for the patient. Only a prejudiced observer would insist that this consequence of co-operative practice was never in the patient's interest. But it requires a prejudice in the opposite direction to overlook how often and how systematically co-operative practice requires the physician to conform his treatment of the patient to the requirements of the institution.

While the physician becomes a player on a professional team, if not indeed a wage earner on a corporate payroll, the patient assumes the sophistication of the consumer who understands that the visit to the doctor is in fact an encounter with a vendor of medical services. What transpires in the consultation room of the physician and in the operating room at the hospital turns out to be nothing more than a market transaction. This concept shifts the emphasis from the individuals who render and receive medical services to the socio-economic framework within which the medical transaction takes place. The subject of the transaction is a service, be it a diagnostic opinion, therapeutic advice, a surgical operation. The vendor, and as appreciative recipients of uncounted reimbursement checks, we have become quite comfortable in that role, is the physician who sells his services on a market. The purchaser is the patient and his insuror, in many instances, the government.

The transaction consists in an exchange of goods, entailing costs and providing benefits to both participants. Besides financial remuneration, the physician derives from it clinical or surgical experience, reputation and prestige, not to speak of the satisfactions of wielding power and exercising authority. It is also possible that now and then a physician will approach his work with unclear sentiments of philanthropy, wishing to see himself and to have himself seen as a benefactor of mankind. That would be yet another reward which the physician derives from his relationship to the patient, albeit one that is qualitatively different from money. These benefits to the physician are offset by the expenditure of energy and time on the one hand, and by social and legal risk on the other.

The benefits which the purchaser receives are if anything more difficult to quantify, both in general and in the specific instance. This is the case not only because the course of disease and its response to treatment vary so greatly, but because the value of much therapy is marginal, and its non-financial costs may be impossible to assess. This difficulty, incidentally, has the broadest of consequences, and appears to cast an impenetrable shadow over all attempts to quantify the value of medical services in the context of cost-benefit analyses. In some instances the benefit is plain. If a patient with hand movement vision in both eyes has his vision restored by cataract extraction in one eye, the benefit of such an operation requires no discussion and is disproportionately great compared with its cost. But there are also surgical procedures, and I shall forbear to enumerate them here, where the candid question: "In

what way did the operation make the patient better off?" can only be answered with embarrassed silence.

A cardinal tenet of the market place view of human interaction is that the price of the product is set by an agreement between the purchaser and the seller. But sometimes price is not at all commensurate with value. In theory the market will take care of that too, for if the value of a product is disproportionate to its price, the latter will rise or fall to meet it. In matters of medicine, however, this reality principle is often ineffective because the patient has no independent judgment of the worth of the services he is receiving. Newspaper and broadcast journalism assiduously cater to the public's appetite for novelties and miracles and make a business of manufacturing the molds of fantasy in which the most bizarre of hopes and fears take shape. In general the patient's valuation is unrealistic, he being inclined to place far too high a value on some and too low a value on other services. Paradoxically, patients commonly infer value from price, and there are few who do not believe that the best physician is he who charges the most, and that inexpensive medical services are worth what one pays for them.

Unavoidably, the rationalization of medicine as a marketplace entails a reinterpretation of the physician-patient relationship. Implicit in the market place model is the assumption that each of the parties to the transaction, the physician on the one hand, and the patient on the other, participates in the transaction to further his own self-interest. This may be acceptable so far as the patient is concerned. It is reasonable that he should wish to purchase as much health as he is able for the funds at his disposal, although it is clear that he seldom knows how to get the most for his money. But in regard to the physician, the implications of the market-place model are disquieting. Can we really condone that he should exploit commercial transactions with his patient?

Unavoidably also the market relationship entails an estrangement of the parties to the transaction. Consider a sale of tangibles as the simplest of market exchanges. Here the attention of the participants is focussed upon the object exchanged, and for each of them the purpose of the transaction is essentially selfish, his own aggrandizement. The personality of the other participant is a means or an obstacle to the achievement of this end. The buyer wants the service or the commodity; the seller cares only for the proceeds of the sale. In the market perspective, physicians and patients both become anonymous and interchangeable, no less than the purchasers and sellers of securities on the stock exchange. The physician is turned into an approved vendor, strictly comparable to any other physician in his specialty, and the patient for his part becomes a recipient of services, a Medicare or Medicaid number, a beneficiary on the books of the insuror, a cipher whose personality, if not anonymous, is nonetheless irrelevant to the transaction in question.

While the interpretation of medical practice as a market place constitutes a schema which confers undisputable benefits on both the patient and the physician, each of them has reservations and fulfills the role assigned to him with a measure of ambivalence. The physician is dogged by the awareness that remuneration is seldom if ever commensurate with what he does for the patient. He is rewarded with disproportionately large fees for efforts that are trivial, irrelevant, or even harmful. For what he knows to be valuable, he often receives little payment and no recognition. The patient, for his part, inveterately attempts to construct a relationship of affection and trust and admiration for his physician that goes far beyond the dispassionate respect that is due the vendor of medical services.

This reluctance of both the physician and the patient to play the roles that the market theorist would assign to each of them is a reminder that the market theory of medicine is only a conceptual model analogous to the biophysical hypotheses that have such an important place in our understanding of disease. For many purposes, this description is evidently useful, but it does not replace experience. At best, the model illustrates important facets of reality. At worst it confounds and conceals them.

Let us, however, accept the model for what it is, and in the spirit of experiment, observe the effect of one crucial modification. The market theory of medicine which we have described holds that the physician and his patient are primarily economic adversaries, and that the value of the relationship depends on what each obtains from the other. Our modification consists in postulating a relationship whose value to the participant should be proportionate not to what he receives but to what he invests. On first thought, the hypothesis seems absurd. The economics student who came up with such a notion would fail the course, and the economics professor who did so would be the laughing stock of his profession.

But we who are not professors are free to explore the hypothesis further. The idea that value should be measured by what one invests rather than by what one receives explains a wide range of experience. It explains the satisfaction which the scientist derives from his research, even when the research is fruitless. It explains why artists paint pictures, why poets write sonnets, why musicians compose

symphonies, and why all these activities are satisfying, even if the painting is never exhibited, the poem never published, or the musical composition is never performed. Not only the behavior of the scientist and of the artist is rationalized, but even more important, the most diverse relationships among human beings who care about each other, between children and their parents, between brothers and sisters, between friends. The values of all these bonds are commensurate with what one invests in them, not with what one receives, and that is a prospect to which the market place is blind.

Let us designate this aspect of medical practice which the economists have overlooked as the existential relationship between the physician and the patient, and let us distinguish this existential relationship from the market relationship which it supplements and with which it is sometimes confused. Then value for the physician does not consist in what he acquires from or through the patient, but rather in the investment of intelligence and skill and affection which he makes. It is then beside the point whether or not his effort is acknowledged or rewarded, except insofar as the acknowledgement would tend to disturb rather than to confirm the relationship, to the extent that it might blur and confuse, even in his own mind, the self-sufficiency of his devotion. Whether the patient be rich or poor, whether he be afflicted with a serious disease or only an imaginary ailment, whether he recovers because or inspite of the physician's efforts, whether he succumbs because or inspite of them, makes no difference. It is the physician's absorption by his task which rewards him. Described in this way, the existential commitment exhibits unanticipated hazards, and we begin to understand that it requires to be balanced by the sober rationalizations of the market.

An existential intention on the part of the physician is a natural consequence of his humanness. But what about the patient? Can he possibly derive any other satisfaction from his encounter with the physician than the acquisition or maintenance of his health? That his contact with the physician may indeed have an analogous dimension often becomes apparent in circumstances where the physician's efforts have proved manifestly ineffective and the patient is dying. Paradoxically, it is in this situation, where he would have every reason to abandon the relationship and devote his remaining resources to other ends, that the patient often clings most fervently to his physician. At this juncture the patient values the relationship irrespective of its benefits. He has lost the ability to be critical. To inquire about the competence of the physician becomes irrelevant. Now the patient approves of his physician not because of the credentials or because of the reputation, not even because of the skills, but because he is "my doctor". It is from this affection for his physician as a trusted friend that, given the chance, the dying patient will forgive him the presumptuousness of having undertaken to alter the course of life, and it is this forgiveness, a remuneration safe from the burglar and from the tax collector, which is the most precious recompense a physician can receive. It has no market value.

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