WHAT'S SO SPECIAL ABOUT MEDICINE?

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ABSTRACT. Health care has increasingly come to be understood as a commodity. The ethical implications of such an understanding are significant. The author argues that health care is not a commodity because health care (1) is non-proprietary, (2) serves the needs of persons who, as patients, are uniquely vulnerable, (3) essentially involves a special human relationship which ought not be bought or sold, (4) helps to define what is meant by 'necessity' and cannot be considered a commodity when subjected to rigorous conceptual analysis. The Oslerian conception that medicine is a calling and not a business ought to be reaffirmed by both the profession and the public. Such a conception would have significant ramifications for patient care and health care policy.

Key words: economics, efficiency of health care, ethics, health care as a commodity, medicine as a business, physician-patient relationship

1. INTRODUCTION

Language is an important part of the symbolic world in which human beings live. The linguistic symbols with which people choose to surround themselves help to shape their thoughts [1]. As the psalmist says of idols and those who fashion them, “their makers will come to be like them” (Ps. 115:8). This is no less true of medicine and its metaphors than of any other human endeavor [2].

The language of commerce has taken hold of the medical profession. Physicians have surrounded themselves with the linguistic symbols of the business world. New phrases like “health care industry,” “health care provider,” and “health care consumer” have been introduced. Hospital loudspeakers boldly announce lectures for physicians, sponsored by academic departments in medical schools, on “medical entrepreneurship.” Medical students explain how they plan to “market themselves” to residency training programs. Health care institutions “compete in the medical marketplace.” Hospitals and practitioners increasingly advertise.

Are these the linguistic symbols physicians wish to be surrounded by? Is the metaphor of “Medicine is a business” morally suspect? Will physicians become (or are they already) likened to the words they speak?

Buried deep beneath all these questions lies a more fundamental question
which must be addressed. Ought health care be considered a "special" good, or ought health care be considered a commodity, included among the goods and services considered as objects of production and exchange? Is health care, morally and economically, a commodity of the same class as, say, the consultation of an accountant or the selling of potatoes? Or is health care a service of an entirely different moral and economic order [3]? If the answer to this question is that there are no special moral and economic differences between health care and other goods and services, then there is no reason to think that the moral and legal principles governing transactions involving health care ought to be different from the principles governing transactions involving potatoes or the services of an accountant. If there are differences which make health care special [4], then by examining the attributes which make health care special one may discover special principles to guide the moral and economic interactions of practitioners and patients. Such principles would broadly inform the search for answers to many currently contested questions, such as the structure of a just health care system and the propriety of various patient referral arrangements.

The question being asked is really a very old one. In the Republic, Plato has Socrates ask Thrasymachus, "Now tell me, is the doctor in the precise sense, of whom you recently spoke, a money-maker or one who cares for the sick? Speak about the man who is really a doctor." Thrasymachus answers, and Plato agrees, "One who cares for the sick" ([5], Bk. I, 341c). How should Plato's question be answered today?

2. THE TRADITIONAL METAPHOR

Some argue that the actual behavior of physicians shows them to be primarily money-makers [6]. It has been further argued that any other description of physicians is merely the rhetoric of a profession intent on maintaining false beliefs among the public so that the profession can maintain its own monopoly on power and income [7]. Others have argued that since physicians have been paid in cash or kind for their services throughout history, it follows that there is nothing very special about the moral and economic rules that ought to govern the behavior of health care providers [8]. This conclusion does not follow. One might as well argue that since shamans and priests have always been remunerated for their services throughout history, it follows that there is nothing special about the moral and economic rules which ought to govern the behavior of clergy and conclude that simony is compatible with good religious practice.

Physicians have always been supported for their services, and well they should be. But the moral foundation for this support is not the same as that of profit derived from the sale of commodities. Traditional forms of support for
physicians can be understood by analogy to the support given to religious leaders. As pointed out by Osler, the traditional metaphor is not "Medicine is a business," but rather, "Medicine is a calling" [9]. It is no historical accident that the shaman was once both priest and doctor for his people. The rise of scientific medicine, in which the roles of priest and doctor have quite properly become separated, should not imply, however, that the moral foundation for the financial support of physicians ought to be any different now than it was when the roles were united. The shaman was traditionally paid not to purchase a cure but as a sign of ritual respect for the source of his "power", ([10], pp. 301–2) and as a sign of faith in his healing abilities ([11], pp. 86–93). The exact amount was often based on ability to pay and sometimes determined through ritual consultation with the gods [12]. Similarly, a contemporary rabbi is supported not because the congregation buys his prayers, but because the rabbi provides a special and invaluable service to the congregation. In recognition of their own needs and out of respect for the Almighty and his rabbi, the congregation provides sufficient financial support to assure that the rabbi and his family flourish, and that he continue to provide services for which a price cannot be fixed. On the strength of this analogy, the contemporary physician would be understood to be remunerated not as payment for healing skills sold, but in recognition of the importance of the need which the physician serves, out of respect for the knowledge and training needed to become a physician, and in trust that these priceless services are provided first and foremost for the patient's good. Similarly, Dougherty has called the work of such occupations "community service" [13]. The fact that physicians and clergy and other community service workers sometimes do not live up to expected moral standards is not a moral argument that the standards are incorrect, nor an argument that the work they do should be considered a commodity, and not community service.

3. THE MORAL NATURE OF MEDICAL CARE

This paper will present arguments to support the claim, which has also been made recently by Dougherty [13] and Dyer [14], that medical care is a special service and ought not be considered a market commodity. In this paper, the term commodity will be taken to mean "the general name given to goods and services [considered as] the basic objects of production and exchange" ([15], p. 45). To say that medical care is special will mean that medical care is qualitatively distinct from commodities, and that the moral obligations which ought to govern medical economics differ from the moral obligations which govern the production and exchange of commodities.
There are at least four reasons why, on a moral and economic order, health care should be considered a special good, even in relation to basic human needs like food and shelter. First, one may only sell what one may legitimately be understood to own. It will be argued that the physician’s skill is non-proprietary, and therefore cannot be considered a commodity. Second, it will be argued that the recipient of health care, the patient, is vulnerable in a special way not experienced by the ordinary consumer of commodities. Third, it will be argued that health care involves a relationship between practitioner and patient which is quantitatively special compared with the relationship between a businessperson and a client, and on this basis is not a commodity. Fourth, if health care is a commodity, one must be able to say what kind of commodity it is. There are only two types of commodities: the necessary and the adventitious. It will be argued that since health care is neither a necessary nor an adventitious commodity, health care therefore cannot be considered a commodity at all. Health care, it will be argued, is fundamentally a relationship of caring and is not fundamentally an object of production and exchange.

3.1. The Non-proprietary Nature of Medical Care

An accountant can claim “ownership” of accounting skills and sell such skills for market value. But a physician cannot make such an ownership claim. There is a subtle but real distinction between the conception that one’s income represents profit from the sale of the skill one owns as a market commodity and the conception that one’s income represents just remuneration for the non-proprietary skill one has offered as a service. Firemen and policemen, for example, serve the public trust and are not considered to “own” their skills. The skills of physicians are similarly non-proprietary. Justice demands, of course, that society provide for the economic needs of those who offer useful non-proprietary services. Society may even reward such persons more handsomely than those who can justly claim to own their skills, basing such decisions, for example, on the importance of the skill, or the difficulty of the required training. But clearly, not all skilled services are proprietary.

There are several reasons why medical expertise cannot be reasonably considered a proprietary skill [16]. First, society provides enormous economic support for medical education, whether public or private. Physicians pay only a fraction of the cost of their education, and cannot claim to have “bought” their skills outright. Second, medical students and physicians in training can only learn their skills by hands-on experience, made possible by generous and profoundly trusting gifts of time, privacy, and sometimes even risk, made by patients drawn from society at large. Patients generously volunteer to be subjects in clinical experiments. Society even offers its dead for autopsy, anatomy class,
and transplantation. One can, for instance, only become a physician because someone has been generous and trusting enough to donate his remains for one’s use as a medical student in anatomy class. People do not freely donate their bodies in order that strangers might own them, or own and sell the knowledge and skills that accrue from studying them. Medicine asks for and receives volunteers, organ donations, autopsies, and cadavers based squarely on the premise that these are gifts freely given for the good of other patients. To claim ownership of what accrues from such gifts, gifts requested in the name of the common good, is profoundly hypocritical. Third, physicians recognize a moral obligation to share with each other the new information that accrues from both human and non-human experiments, and are obligated to subject such information to rigorous scientific scrutiny so that all people may benefit. “Secret cures” are proscribed. As Fleck has observed, the increasing complexity of medical practice in the 20th Century has made this public feature of medical knowledge all the more salient, making it more difficult to support any claim that medical skill is proprietary [17]. It does not matter how many years one has needed to train to provide medical service, or how much one has suffered in acquiring the necessary knowledge and skills. It does not matter that medical students now incur enormous debts [18]. These claims are part of an argument for better remuneration for professionals or better social support for the training of professionals, but not arguments that one “owns” a skill as one “owns” a commodity and can “sell” it for a profit. Physicians serve the public trust. A physician’s income ought therefore to be interpreted as money given to support her in her invaluable work for the good of others, and not as profit accruing from the sale of a commodity.

The ancient historical tradition of the medical profession supports this understanding. Despite some inconsistencies regarding motive [19], the Hippocratic physician struggled to differentiate his art from that of a typical Greek craftsman selling his wares [20]. In the Roman and early Mediaeval world, physicians were expected to heal regardless of the patient’s ability to pay, and their remuneration was understood as an honorarium [21]. English law once regarded the services of the physician to be wholly philanthropic, and for many centuries English physicians were forbidden to sue for recovery of fees [22]. This tradition has certainly suffered from erosion, but this does not mean that the current state of affairs ought to be accepted as normative. It remains true that one cannot “sell” what one does not “own.” As argued above, it is especially true today that health care is non-proprietary, and therefore ought not be considered a market commodity.
3.2. Vulnerability and the Requirement of Self-effacement

It is nearly a truism to state that the patient is an exceptionally vulnerable person in the hands of the physician. The patient entrusts his body, his dignity, his secrets, and frequently his life to the physician. The physical effects of being ill compound this vulnerability, affecting to variable degrees the patient's decision-making, communicative, and motor capacities in ways that always limit, even if minimally, the autonomous agency of the individual who is sick. The most basic of all symptoms is captured in the common phrase, "I'm just not feeling myself today." Because of their diminished autonomy and objectivity, lack of skills, and the physical incapacities brought on by illness, the sick have little choice but to ask the professional for assistance. Cassell has argued, for instance, that the focus of the physician's beneficent aim is precisely to restore the patient's previous degree of autonomy [23]. The profound trust which the vulnerable patient requires of the physician is unique, and demands obligations on the part of the physician which are not required of the entrepreneur. It has been argued by Pellegrino that this includes a degree of effacement of self-interest which is not required of one who sells commodities ([24], pp. 27; 174). This makes medicine a "special" good.

3.3. Medical Care as Relationship

Medical care is profoundly relational. One speaks of the doctor-patient relationship using special terms like "covenant" ([25], pp. xi-xviii) and such a conception of this relationship is a very old one in Judeo-Christian thought [26]. This relationship is unparalleled in commercial life. We do not speak of a "butcher-customer relationship" in any sense which would lead us to conclude that the relationship is "special." There is even evidence that the doctor-patient relationship is itself therapeutic [27]. The act of providing medical care, with its deeply personal meaning, is as much a part of health care as the pill which the physician prescribes.

This is not to say that curing does not matter, but to suggest that the primary mission of the physician is to render health care, not health. When health can be restored, rendering care means rendering health; when health cannot be restored, health care does not cease [28]. The anonymous aphorism, "To heal sometimes, to relieve often, and to comfort always," is an apt formulation of the goals of medicine, even in our modern era of highly efficacious medicine. A relationship of caring and trust is the crux of the doctor-patient relationship. After all, as Peabody once noted, the patient is said to be under the doctor's care [29]. To say, therefore, that the profound relationship between doctor and patient is nothing "special," but only part of the "package deal" in a commercial transac-
tion for goods and services seems mistaken. Part of the reason why prostitution, for instance, is considered immoral, is precisely because it makes a deeply significant human relationship, the sexual relationship, into "an object of production and exchange". Significant human relationships like those between sexual partners, friends, confessors and penitents, doctors and patients, are not commodities for sale on the market.

3.4. A Conceptual Analysis

As defined earlier, a commodity is a good or service considered as a basic object of production and exchange. Two types of commodities will be defined, with the intention that these two definitions include everything one would consider a commodity. These two types of commodities will be called necessary commodities and adventitious commodities. Food and shelter, for example, are accounted necessary commodities. Commodities that are not necessary are adventitious. Adventitious commodities are of two types – basic conveniences (like electricity or mail service) and luxuries (like diamonds or the services of a stockbroker). If one wishes to claim that medicine is a commodity, one must answer the question, what kind of commodity is it? First, it will be argued that health care is not, in a very strict sense, a necessary commodity. Second, it will be argued that health care also cannot be considered an adventitious commodity. And if health care is neither necessary nor adventitious, the logical conclusion is that health care is not a commodity.

3.4.1. Health Care Is Not Just an Instrumental Good

Some who accept the notion that health care is a market commodity have nonetheless tried to make an argument that justice demands that health care be made available to all citizens. Daniels, for instance, has accepted the notion that health care is a commodity, and has tried admirably to found an argument for the just distribution of health care on the basis that it is an instrumental commodity [30]. Fleck [31, 32], while arguing that medicine is somehow special, still appears to argue that it is a special type of commodity, and draws heavily upon the reasoning of Daniels. Daniels argues that through its efficacy in restoring "normal species functioning," health care is a necessary commodity if people are to obtain access to the rest of life's commodities ([30], pp. 6–20). But in the analysis of Norman Daniels, one comes to the peculiar conclusion that there is no argument, in justice, to support the delivery of care to the incurable and terminally ill ([33], p. 107). Since much of medicine is unsuccessful in restoring "normal species functioning," and since those who are incurable seem to have at least as great a claim to health care as the curable, it would seem that
either medicine has been providing health care far beyond the bounds of justice for 3,000 years, or there is something wrong with Daniels' analysis. It might be that Daniels has too hastily accepted the notion that health care is a market commodity. Health care is good not just because of the opportunities it gives to people. Caring for the sick and being cared for are goods in themselves. When health care is viewed as a genuinely special good, and not as a commodity, the foundation for its just distribution will be seen to be secured not in its efficacy, but in the universality of the human need which is addressed.

3.4.2. Medical Care Is Not A Necessary Commodity

The word necessity is often used very loosely. In his *Metaphysics*, Aristotle ([34], 1015a20–1015b16) distinguishes several senses of necessity which can help to clarify the use of the word in this paper. Necessity in a strong sense can mean logical necessity – i.e. – that which cannot be otherwise. Clearly, no commodity is a logical necessity. Necessity in a weak sense can mean hypothetical necessity – i.e. – if one wants x, y is a necessity. But clearly, one generally means something stronger than hypothetical necessity when one refers to commodities such as food and water as necessities. There is another sense of necessity invoked by Aristotle ("that without which as a joint cause a thing cannot live") which forms the basis of the definition of a necessary commodity offered here. Using this Aristotelian definition to modify the definition proposed by Daniels ([30], pp. 26–28) results in a more accurate definition. Necessary commodities are goods and services which directly address a universal human need, are alone efficacious in meeting that need, and must be continuously or recurrently supplied for the normal functioning of the subject considered as a member of the natural species *Homo sapiens*. One must, on this Aristotelian account, acknowledge that medical care is not a necessary commodity. No one can live without access to air, food, water, and shelter adequate to the needs of the human species in a particular climate. Each of these must be continuously or recurrently supplied to be efficacious in addressing a universal biologic need of human beings, and each is therefore a necessary commodity. But even in the 20th century, many people are born, live full lives, and die without ever seeing a doctor ([35], pp. 36, 356, 362–3). Past cultures have arisen and flourished in the complete absence of biologically efficacious medicine. Medical care will never "relieve the human condition of the human condition" (P. Ramsey, quoted in [36]). Medical care is not, strictly speaking, a necessity, and every reflective contemporary medical practitioner must readily (and humbly) affirm this.
3.4.3. The Relationship of Medicine to Necessity

There is an interesting relationship between illness and the necessary commodities. According to the strict definition offered above, something can be considered a necessary commodity if and only if, when absent over some period of time varying according to the item, illness necessarily results. The privation of a necessity must necessarily cause disturbed species functioning. The absence of Vitamin C, for example, causes a disease called scurvy. In fact, we define the extent to which a necessary commodity is "necessary" precisely in terms of what is needed to prevent the dysfunction caused by its privation (hence, the "minimum daily requirement"). It makes no sense, however, to say that without medical care everyone will be afflicted with a particular illness. Medical care is not a necessary commodity.

Some might object that when a person becomes seriously ill, medical care becomes, in a sense, a necessity. While this might be true in the weak, hypothetical sense of the word necessity, this is not what is meant by a necessary commodity. Merely because something might be necessary under particular circumstances to maintain the normal species function of an individual does not suffice to say that this item or service is covered by what is meant by a necessary commodity. If one is drowning, of course, a life jacket may be necessary to one's survival in those circumstances. But this does not mean that one would ordinarily call life jackets necessary commodities. The need for life jackets is not universal to the human condition.

3.4.4. Medical Care Is Not an Adventitious Commodity

If a good or a service is not a necessary commodity, then it must, if it is a commodity, be an adventitious commodity. Adventitious commodities are goods and services which do not directly address universal human needs, are not alone efficacious in meeting such needs, and need not be continuously or recurrently supplied for the normal functioning of the subject considered as a member of the species Homo sapiens. Many adventitious commodities are really very basic conveniences, like electricity and mail service. They may be instrumental, of course, in obtaining and storing necessary commodities, but since they do not themselves directly address universal human needs, they are not necessary commodities. Other adventitious commodities are considered luxuries. No claim can be made that any luxury, neither a luxury of kind (like a diamond or the services of a stockbroker) nor a luxury of degree (like Beluga caviar or a Park Avenue apartment), addresses a need which all people will necessarily experience in their lives. Is medicine then an adventitious commodity?

Interestingly, the answer is no. All people experience sickness, and those who
minister to the needs of the sick can accurately make the claim that their services are directed towards fulfilling a need which all people will experience universally. Fleck [17] has recognized that the universality of human vulnerability to illness is undeniable, and important to the claim that health care is special. Even a person who claims to have been “healthy throughout life,” can mean merely that he has experienced only relatively minor illnesses to date, and need not be reminded that death, which is inescapable, comes only through injury or illness, no matter how brief the time interval between disturbed species functioning and death. The state to which medicine ministers, the state of illness, is a state of universal human need, regardless of whether at any point in human history medicine is available or actually capable of affecting that state. Despite the fact that for almost all of human history medicine has been almost completely inefficacious in a biological sense, medical care has nearly always been offered to minister to this universal need presented by the sick. But it must be recognized that at the limit, biological healing will ultimately fail everyone. Medical care must therefore be defined not by its efficacy, but as a relationship of compassionate outreach in which a person uses technical expertise with the intention of restoring, relieving, and comforting another person, who is sick. Disease is an inescapable condition of human being. Some disease process will ultimately result in death for everyone, even if the very best medical care is provided. Medical care is an enterprise which is justified primarily as a caring response to a universal need, and only secondarily because of its efficacy.

As was argued above, there are only two types of commodities — necessary commodities and adventitious commodities. It has been shown that on analysis of the terms necessary and adventitious, medical care is covered by neither. Medical care is special because it addresses a profound and universal human need — the need for healing — and cannot be considered adventitious. Since it cannot be said to reliably fill that universal need, and is not needed continuously or recurrently by all persons to maintain their normal species functioning, medicine also fails to meet the requirements of a necessary commodity. Unlike any commodity, medicine is neither necessary nor adventitious. Medical care transcends the category of commodities because it is not fundamentally an object of production and exchange but a human relationship. It follows that health care cannot be considered a commodity at all. It also follows that arguments regarding access to health care cannot be based on the conception that it is an instrumental commodity justly distributed only to the extent that it is efficacious. Unlike a commodity, the primary meaning and importance of medicine has little to do with its efficacy, and more to do with a relationship between one human being in need and another who cares and is trained to help. Efficacy is sought in medical practice because the healer first cares. Efficacy does not imply a commitment to caring, but caring does imply a commitment to
efficacy. Efficacy is the primary language of commodity transactions. Caring is the primary language of medicine.

4. RESPONSE TO COUNTERPOSITIONS

The idea that medicine is a commodity has often appeared as an unchallenged assumption in recent discourse regarding ethics and health care economics. Arguments for a “consumer choice model,” [37, 38] a “just price” for health care [39], the ethical acceptability of economic incentives in prospective payment systems [40], or “process utility” [41], all assume, at least implicitly, that health care is a commodity. Because a conception of health care as a commodity can make people intuitively uncomfortable, attempts have been made to shift the theoretical focus away from this conception. Such theories often wind up not rejecting a commodity conception, but instead trying to convince the reader that the commodity in question is something other than health care. For example, Menzel [42] has suggested that the commodity being consumed in health care is not life or health or even health care, but “safety.” Insurance is a market commodity, and so his theory, based on commodity assumptions, can continue to give “market” answers while not appearing harsh. But Menzel’s argument only obscures the real issues. Patients go to doctors for health care, and only buy insurance so that they can afford to go to doctors if the need for health care arises. The central action of health care, the action upon which the health insurance, pharmaceutical, biotechnical, and allied health industries all depend is the care physicians provide for patients. The real issue remains whether or not this healing encounter is rightly or wrongly conceived of as a market commodity.

The conception that health care ought to be considered a market commodity has been most directly and forcefully defended by Rainbolt [43]. He concedes that the contractual ethic epitomized by the butcher-client relationship is inappropriate as a basis for medical ethics. But he contrasts this with a fiduciary ethic epitomized by the accountant-client relationship, which he holds to be a business ethic appropriate for governance of commodity exchanges between doctors and patients. In a contractual ethic, according to Rainbolt, the supplier gives the consumer what the consumer asks for and pays for. But a fiduciary ethic is more stringent, and applies in cases where the supplier can take advantage of the consumer. The fiduciary supplier must give the consumer what the consumer asks for and must also consider the consumer’s best interest when giving requested advice. Rainbolt holds that this ethic is completely adequate to cover the doctor patient relationship, and that there is no need to invoke any special ethic beyond this.
Rainbolt's analysis seems inadequate on several accounts. First, the distinction between contractual and fiduciary ethics seems dangerous. A degree of trustworthiness would seem required of all persons who conduct business ethically, including those who sell food. This has been apparent since at least the time of Cicero, as detailed in his discussion of the ethics of price gouging in *De Officiis* ([44], III:50–7). Cicero criticized a grain salesman who, at the time of a famine, charged exorbitant prices even though he (and not his customers) knew that relief shipments were on their way. The recent ethical crisis on Wall Street would seem largely due to the fact that inside traders feel no fiduciary responsibility to the nameless persons with whom they trade stocks, bonds, and options. They give advice to no one, but still have a responsibility not to take advantage of others. So, in business ethics, it seems prudent to consider a fiduciary ethic as the standard, and if so, Rainbolt's distinction collapses.

But if one accepts Rainbolt's thesis that a doctor is more like an accountant than a butcher, are the ethical standards expected of accountants adequate to the ethical standards expected of physicians? When was the last time anyone called an accountant at 3 AM because of acute tax worries? Who has ever been impressed that a young accountant had a wonderful ledgerside manner? When was the last time anyone ever held a conference on the ethics of disclosing terminal bankruptcy? These questions sound absurd because there are differences in the ethical standards to which physicians and purveyors of commodities are held, and these differences can be philosophically justified.

Rainbolt fails to see the distinction in ethical standards because he makes no attempt to look at the distinction between medicine on the one hand, and accounting or other commodities on the other. No one ever died because their books did not balance. As Sokolowski has observed, when I go to the doctor, *I myself* am at issue, not my taxes or my car or my dinner ([45]). The special ethical claims made upon physicians result from a qualitative distinction between medical care and commodities, for the reasons detailed in this paper. To miss the significance of this distinction would seem to be an error.

5. CONCLUSION

Flexner once wrote that "medicine, curative and preventive, has indeed no analogy with business... The medical profession is supported for a benign, not a selfish, for a protective, not an exploiting purpose" ([46], p. 173). The business metaphor seems pervasive in medical discourse today, and may be shaping the way medical professionals regard themselves and their patients. It has been argued that the tendency to regard medicine as a commercial enterprise, and health care as a commodity, pays insufficient attention to the special nature of
health care. Health care is not a commodity because it is neither necessary nor adventitious, and is justified primarily as a caring relationship formed in response to a universal need, and only secondarily because of its efficacy. It is not a proprietary entity. Health care is a “special” good which helps to define what is meant by “necessity,” obliges the practitioner to engage in a degree of self-effacement, recognizes the special vulnerability of the patient, and involves a profound and priceless relationship of caring which ought not be considered an object of production and exchange. The special nature of medical care makes the moral and social position of the physician more compatible with the metaphor of “Medicine is a calling” than the metaphor of “Medicine is a business.” The ancient traditions of the profession support such a conception of medical care.

Because health care is not a commodity one should not conclude, as others have [47], that it is morally legitimate to take profits in exchange for medical care in a manner governed by the same moral principles which govern profit-taking by grocers, real-estate agents, or other purveyors of commodities. If medical care is special, the moral principles governing transactions for medical care will also be special.

The conclusion that health care is not a commodity has significant moral implications for many disputed questions in health care policy. It would seem to imply, for instance, that society ought to take more seriously its role in the economic support of medical students and physicians in training, and also share in the responsibility for untoward events in medical practice, paving the way for tort reform in medicine. Correlative with this, if medical school debts and malpractice premiums were dramatically reduced, physician income expectations might not need to be as great as they currently are. Yet, society might still wish to decide to reward physicians amply in recognition of the actually priceless nature of what physicians contribute to society and out of respect for the rigorous training and the commitment to service required of clinical practitioners. This would be analogous to the manner in which certain religious groups decide that it is important to remunerate their clergy amply, although not obscenely.1 The conception of health care presented here would seem to be compatible with a system in which private practitioners practiced virtuously and understood their remuneration as honoraria received for the non-proprietary services which they rendered (provided that the fee-for-service system were to otherwise remain a viable option for American society). This conception of health care would also seem compatible with a just system of national health insurance. However, it would be difficult to reconcile this conception of health care with a system which treated medicine as a commodity and explicitly encouraged competition and free market forces as a means of distributing health care and controlling costs. For instance, direct financial incentives to physicians working in managed care settings as rewards for limiting patient access to
subspecialists would seem incompatible with this conception. Corporations manufacturing medical equipment or pharmaceutical agents also have a critical impact on patients. This impact, however, is effected only in and through the physician as she relates to individual patients or to the public trust. Therefore, according to the thesis that medical care is not a market commodity, corporate profit-making and competition would be legitimate only insofar as these markets did not adversely affect the doctor-patient relationship. This conception of health care would also seem to imply that individual physicians or universities ought not be able to claim as property or derive profits from tissues or body parts which were donated by patients under the premise of helping humankind.

This list is sketchy and anticipatory, and is offered only to indicate the breadth of concrete implications which hinge on the answer to the question, Is health care a commodity? A fuller description of the arguments which lead from the conception that health care is not a market commodity to these and other concrete conclusions awaits further analysis.

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NOTE

1 Many physicians probably do make too much money, having crossed the threshold from ample to obscene. In addition, some physician’s fees are unjustly high even relative to other physicians, and the Resource Based Relative Value Scale [48] is seen by many within the profession as an effort to achieve a more just payment structure. But since, as argued in this paper, the service of a physician is not a commodity and is priceless, the recent arguments of Curzer [49] against high physician income would not apply, since all his arguments are based on the suppressed premise that health care is a commodity. High physician incomes are not necessary, but it would not be unjust for a society to guarantee high incomes to physicians.

REFERENCES