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An International Perspective on Health Care: THE CASE FOR TERMS ABROAD FOR FUTURE PHYSICIANS

The State and Professional Domi Health Care

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As David Hornung and Cathy Shrady demonstrate in their paper in this volume on different healing traditions, societies differ on how they define illness and health, how they explain the lack of health, and in how they apply local values to problems of health. The purpose of this paper is to expand this insight to some larger issues, including the role played by the health care system, as organized by the modern state, in the way physicians do their work.

States differ in the size of their public sector, their willingness to own or regulate private economic activities or interfere in the lives of its citizens with regard to decisions about health and quality of life. In the view of many Americans, it has become a truism that the growth of the State not only is synonymous with the decline of personal liberty but also is associated with inefficiency, low quality, and high costs. Professionals in all sectors are also often wary of government since it is assumed the power of professionals to control their work will be replaced by bureaucrats who will be making decisions previously reserved for experts. So the recent fight over health care reform in the United States from the point of view of practioners was really a fight over autonomy. What was at stake was the control over medical work. If this view held by American physicians is correct, then it should be the case that physicians in nations with a large public sector and either a national health insurance system or a national health care system should find physicians with less autonomy than in the United States.

These issues should not be oversimplified. The threat to physician autonomy may have a lot to do with trends that are cross-national in scope as well. As several authors have pointed out, the potential for the "de-professionalization" or "proletarianization" of medicine (Hafferty and Mckinlay, 1993) is clearly present in most major industrial nations. These forces include the growing availability of medical information from books, computer networks and the media, as well as the development of new physician- extender occupations, the rise, of a vigilant consumer movement and the growing cost of health care in almost all societies. Each of these changes pose significant threats to the previously unchallenged dominance medicine has taken for granted (Friedson, 1989,1993).

Nonetheless, Friedson (1993) and others argue that while physicians may have had to concede control over the context and conditions of work (pay, organizational type and so on) they remain in control over the content of medical work. They alone decide on what is a proper diagnosis and appropriate treatment. Even if an individual doctor is following a protocol for treatment, the protocol was written by other physicians, so the profession has not lost dominance, though each

individual physician may experience some loss of autonomy. This view of medicine's ability to withstand these changes without a real loss of professional dominance has not gone unchallenged. The changes in the United States on how medicine is organized-the rise of HMOs, PPOs, and other forms of prepaid group practice and the changes in how hospitals are reimbursed, such as the policy of DRGs, seems on the face of it to have had a very real impact on the nature and content of medical work and clinical autonomy. As Hafferty and Mckinlay state:

There is increasing evidence that forces other than medical-professional ones are inflvencing the physician-patient encognter . . . we believe that something meaningfzzl has happened if other organizational sites of power, sgch as insvrance companies, refsse to pay for a particwlar treatment and as a conseqsence physicians modify or drop this alternative from their clinical armamentarivm (1993).

For those physicians still in the fee-for-service system as well as those working directly for prepaid group practices,the intrusion of utilization review (as described above) into the doctor-patient relationship has become a major source of dissatisfaction with the profession, leaving U.S. physicians the best-paid and least-happy group among industrial nations (Marmor,1994).

Without going into much detail, let it suffice to say that the major reason why in the United States the loss of autonomy has been so significant is not because the government is too strong, but because it is so weak. The budget crisis, which is in large part due to uncontrolled spending on health care, has led to enormous intrusions into what doctors do with patients. This has happened because in a system that does not have global caps on spending at any level-even at the hospital level-there is no choice but to control what doctors do. Their clinical decisions are the major drivers of the spending in the health care system. Physicians have made a Faustian bargain with the government, they have preserved for the time being their income at the expense of their autonomy. The tragedy, I think, is that they do not know they have done so. The fear of a strong state and the fear of a loss of income has paralyzed the physician community in the United States. Why has this happened? I believe it is a result of a hundred years of misinformation and ethnocentrism. Physicians are bombarded with portraits of "socialized medicine" that suggest physicians as employees of the state, hospitals owned by the state, bureaucrats deciding medical questions and poorly paid doctors working in poorly funded hospitals .

Our physicians need to get out more often! These views increasingly describe parts of the system here in the United States and in many ways are less true of other systems (Abraham, 1993). The case for sending future medical students abroad to learn first hand how health care actually is provided in other nations is critical if they are to ever to play a constructive role in the health care system's evolution. What American physicians will discover, when they actually observe what their colleagues do elsewhere, is that patients can choose their doctor, that hospitals are usually private, not government owned and operated, that physicians are rarely the employees of the state, and that when the state does have control over costs it is more likely, rather than less, to delegate the control over medical work to physicians. However, we must also be cognizant of the fact that a physician's ability to do all that he would like to do for patients is now constrained by the political and economic system in all nations.

The irony in the way physicians perceive the health care systems of other nations is that U.S. physicians have chosen to support an alternative to a strong state system that will likely do to them what they have feared most from a strong state system. The rise of what Donald Light (1991) calls "buyer dominance" and the corresponding decline in "provider dominance" is the main result of a system increasingly "market -based" and "rationalized" by the role of large corporations. So physicians in the United States will increasingly find themselves working for

"for-profit" health care corporations as employees or reimbursed by them with strict controls on their clinical autonomy.

The need to study abroad is not just confined to American physicians, however. As state-dominated systems face the problems of increased demand and rising costs as well as challenges by consumers about quality and long lines for elective services, reforms are being introduced into these systems that often borrow on trends in the United States. England, for instance, has introduced an internal competitive market into the BNHS that separates providers and purchasers. Sweden and other nations are borrowing the concept of the HMO in order to improve primary care and divert patients away from more expensive specialists and hospital clinics. Managed care and the gatekeeper function of general practitioners is a growing phenomenon in other nations as well. The ideas of prospective reimbursement and DRGs have also been borrowed elsewhere as efforts to control costs by changing the incentives for less medical intervention increase. Consequently, the physician communities of European and Asian nations could clearly benefit from more detailed knowledge of the evolving patterns of organization in the United States health care system.

The State and Biomedical Ethics

The nature of the sociopolitical system has a significant effect on the ideology underlying the physician-patient relationship. In market-dominated, capitalist societies the ideology of ethical individualism is likely to prevail over the competing ethics of utilitarianism or solidarity, which often place more emphasis on the health and well-being of the population rather than the individual and are found in social democracies or socialist nations. These views will have an impact on how physicians approach a variety of ethical dilemmas in physician- patient encounters. For instance, in the United States we take for granted such things as informed consent, truth telling, patient confidentiality, and the right of individuals to be treated without regard to their ascriptive characteristics. However, these ethical codes of behavior are neither inevitable nor superior to other normative practices elsewhere that place more emphasis on the larger good of the family, community or society, as they make these decisions.

In health care systems where the state is more intrusive, it is not surprising that more utilitarian approaches might be more salient since the larger role of the state is the result of a cultural acceptance that their are limits to medicine as well as the resources that can be given to the health sector. Physicians themselves will internalize these views and "mask" for the political system the rationing of care as clinical decisions about treatment as has been reported in studies of English physicians (Klein, in Hafferty and Mckinlay,1993). In England, the practice of age discrimination, for instance, is widely denied, yet the data suggests that it is practiced, particularly with regard to access to kidney dialysis and transplants. Also, England and other nations rarely provide coronary bypass surgery on patients over eighty, yet in the United States it is fairly common.

Societies with socialist governments such as China also often have far different approaches to ethical dilemmas than found in the United States. In China it is not uncommon to put significant pressure on the family of a potential organ donor and even take them to the family of the potential recipient (Veatch, 1989). This would be a violation of confidentiality that would be unthinkable in some nations. The utilitarian approach even leads Chinese doctors to report that death only need be "imminent" before procuring the organs, while in the West it is necessary to be declared dead before an organ could be removed.

Other differences in ethical decision making can be observed in the experimenting with

euthanasia in Holland, the hesitancy to inform terminally ill patients of their prognosis in Japan, and the willingness to treat, even over patient objections, in the former communist nations of Eastern Europe. These practices elearly demonstrate that physician codes of ethics are influenced by both culture and political ideology.

The Case for International Experiences for Future Physicians While international experience is recommended for all health care professionals if possible it seems that, in particular, future physicians should be exposed at an early point in their educational experience to the differences in the health care systems of other nations. It will allow them to (1) see for themselves the relationship between culture and medicine as described in the paper by Hornung and Shrady; (2) benefit from a first hand account of how physicians' work is influenced by differing roles the state may play in determining access, cost and quality; (3) explore how their own health care system deals with important ethical issues and reexamine those views in the light of greater experience. We can all benefit from a less parochial, better educated and informed physician community, as it is inevitable and appropriate that they will play an important role in determining the future of the health care system.

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