The Ethos of Medicine in Postmodern America: Philosophical, Cultural and Social Considerations

Practising medicine in the silicon cage

Reviewed by Thomas Murray OC ONS MD

About the Reviewer

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Arnold R. Eiser
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We need good data to practise good medicine. However, if a system becomes dominated by electronic health records (EHRs), computerized decision-making programs, and excessive guidelines and protocols, physicians can become pawns in “the silicon cage.”

Arnold Eiser, professor of medicine and associate dean at Drexel University College of Medicine, is concerned about the erosion of both the patient-physician relationship and professionalism in the corporate world of American medicine. This postmodern world is characterized by what he calls “the three big C’s” of American medicine: consumerism, computerization, and corporatization.

He notes that it is difficult to gain a broad perspective of the changes in health care when you are living through it. To provide an overview, he employs a wide-angle lens that includes postmodern philosophers, contemporary commentators, bioethicists, policy makers, and experiences from other countries (although this final aspect is relatively thin). Eiser begins by recounting the changes since 1970, when the health care system became more corporate. This business model increasingly viewed health care as marketable services and commodities, which was aided by challenges to the tradition of physician power and paternalism, coupled with social trends that favoured individualism, autonomy, and entitlements.

In the silicon cage, the myth of the physician hero has been replaced by the myth of powerful computerized systems. Computers may be able to simulate a clinical hyper-reality (e.g., when designing hospital care programs), but this does not mean they prioritize the needs of the individual patient. For example, a patient can be logged into a diagnostic category using a guideline-directed pattern of care that includes tests and treatment. However, Eiser wonders how well a patient is served by these computerized programs, particularly when the diagnosis changes or the patient has concomitant diagnoses.

Eiser challenges us to question how much of the computerization of health care is designed to enhance corporate control and profit margins. After all, corporations are prevented from practising medicine, while physicians should be free to make independent judgments. Corporate influence increases once we use computerized performance measurements, guidelines, order sets, and protocols, and de-emphasizes individual decision making by clinicians. He argues that unbridled enthusiasm for computerized

medicine is a perfect environment in which to increase bureaucratic control and erode professionalism; bureaucracies thrive on the centralization of information and power. The evidence for benefit to the individual patient is sparse, but computerized systems have become the prevailing cultural myth and are typically assumed to be superior. This approach is also driven by a corporate mindset toward efficiency and profit, agendas that are not always best for personal health care. Although the computerization of records has benefits, it changes the nature of the patient-physician relationship and reduces the individualization of patient care.

Eiser also persuades us to think about how much the information boom (including Internet and television advertising) serves patient autonomy and democratizes information, versus how much is just profit-driven marketing. It is probably both, but preserving the patient-doctor relationship in a marketplace system becomes more challenging. As Eiser notes, one problematic response has been the adoption by physicians of the business model.

He wisely asserts that we cannot just bemoan the loss of the old but, rather, must be inventive and perceptive with the new. Eiser suggests that a start would be to add a patient responsibility section to the list of patient rights, along with a section on physician rights and responsibilities. In addition, he recommends a list of duties and responsibilities for health executives.

How does one maintain humane medical practice in an era dramatically altered by consumerism, computerization, corporatization, direct-to-patient advertising and internet medical information? How does humanistic ethical medical practice survive in a corporate world that argues that a moral and ethical framework is unnecessary if market forces dominate?

Eiser states that recent enthusiasm for patient-centred care could be a reversal of the impersonal consumerism and corporatization of health care. However, he cautions that it could also be a smoke screen or a marketing ploy using the business concept of customer satisfaction for greater profit.

Measures of performance, quality improvement, and patient satisfaction can be positive. However, they can also mask

other agendas. For example, the results look better when seriously ill or risky patients are de-insured from the system, or when the sickest people are dropped by physician panels and hospitals. This approach may be good business, but it violates the precepts of justice and beneficence. Financial incentives motivate performance for the good or for the bad; therefore, they can also undermine efforts geared toward clinical excellence and altruism. Pay-for-performance encourages the actions it measures but underemphasizes important aspects of care that are not measured. It puts at a disadvantage the physician who cares for the sickest, poorest, and least compliant patients.

The call for a re-evaluation of the role of physicians in this post-modern world of health care is no hollow cry. Physician burnout is increasing, and studies show that the leading causes are performing too many bureaucratic procedures, feeling like a cog in the medical industry, and the computerization of medical practice. Physicians in the 1990s began to talk about “the hassle factor.” Accordingly, a disturbing number of physicians would discourage their children, or any young person, from entering medicine.

My bookshelves sag with books that decry the losses of modern medicine, while a distressingly small number contain practical solutions. Eiser challenges us to think about how consumerism, the pursuit of profit, computerized protocols, Internet doctor ratings, blogs, and multiple stakeholders affect the patient-physician relationship. He is not so naive as to suggest we can roll back the cultural revolution that is under way, and he questions whether the humanistic era really ever existed. However, he does strive to preserve a meaningful individualized patient-physician relationship amidst rapid change. Realizing that corporate forces are hard to reverse, he calls for a “not-so-profitable healthcare organization that embraces an ethical value in addition to profitability.”

The Ethos of Medicine in Postmodern America is a thoughtful, informative book by an experienced clinician, educator, and ethicist. It introduces a broad view of a complex system about which we may previously have had simplistic opinions. This is primarily an American story, but similar changes are afoot in Canada and elsewhere.