Editorials

Health Care Reform As A Moral Imperative

Brody's[1] interpretive and generally favorable summary (pp 236-41) of the report from Working Group #17 of the Clinton Health Care Reform Task Force (to which he was a consultant) gives us an unusual insider's look at the moral justifications for the President's plan, as well as his (Brody's) optimistic opinions that it will be good for family practice, and family physicians should take the lead in supporting it.

It is heartening to learn that the Task Force took moral values into account formally and early in its planning. Perhaps that approach will shape the debate so that each of the principal contending interest groups will have to make the same effort to convince the nation that it, too, is claiming the moral high ground. A moral aim will not insure a moral outcome, but it might temper what can be argued publicly.

American (read USA) politicians are old hands at moral superiority games in both domestic and foreign policy, as illustrated by our historic battles over abolition, prohibition, the Vietnam war, and now abortion and gun control. Unfortunately, the legislation that emerges from such battles rarely realizes the best moral ideals, but that is no reason for cynicism. The devil is in the details of the compromises that have to be negotiated, and the best legislation can be subverted. Even so, it seems appropriate that we debate the morality of health care reform.

Proponents of reform, as represented by the Clinton Task Force, assume that reform has become a self-evident moral imperative. If that belief is an accurate assessment of the nation's temper, it is already a partial victory, because the debate then moves from whether anything can and should be done to what to do.

One of the most distressing features of our thinking about health care during the last couple of decades is our lack of confidence in the possibility of change and lack of conviction about the reasons for it. The optimism of the 1960s, when Medicare and Medicaid were enacted, began to peter out in the face of harsh economic realities in the 1970s and hardening social policies in the 1980s. An aura of inevitability and intractability came to surround the problems of health care. It is like a melodrama without villains. We complain bitterly about costs but absorb each new round of price escalations, because sellers of services and products have been able to convince us that they are inevitable and necessary, even that they grow out of the essential goodness of the system.

Brody hints that the consensus around the moral imperative for change might not be entirely solid. He mentions that the insecurity of the middle class and threats to US international competitiveness are the most potent stimuli for change,[1] neither of which seem to be of the same moral order as achieving fairness and equity for all citizens. One can imagine solutions to economic and political problems that would leave the moral problems untouched. For instance, the 14 moral values endorsed by the Task Force do not raise questions about what might be the biggest problem, namely, whether a moral health care system can be founded on profitmaking and entrusted to corporate capitalism to manage. Surely a system that shows no inclination or power to correct its own flaws cannot escape moral censure. Not only has our health care system contributed to inequities against those who cannot afford it, but almost equally it has exploited those who can. Sooner or later we all are likely to be gored by this ox.

Brody appeals for family physicians to back the Clinton proposals enthusiastically, thereby defining ourselves as progressive, open to the future, and ready to collaborate with policy makers and other reformers. We should do this because we are already committed to the values of primary care — the centerpiece of the Clinton proposal — and prepared by training and experience to make primary care work. There is a good deal of truth in this argument.

Family physicians, on the whole, have a verifiable record of public trust, working hard, living among and knowing our patients, and serving our communities; and we have not been fingered as

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the culprits of extravagant costs, excessive testing, inhumaneness, and other forms of exploitation. On the other hand, we have not yet practiced in a system of care that depends for its economic viability on maximizing, standardizing, and monitoring these virtues. As a practical, unspectacular specialty, we have not been in the spotlight of public accountability in the way we might become under the Clinton reforms. We will lose our charms if we forget our roots, take on airs, and see reform as our chance to grab for power.

Brody calls attention to two potential conflicts, which are part of the same thing, namely, better utilization of expensive and scarce resources. One is the shifting of funds toward primary outpatient care and away from expensive tertiary and subspecialty care. The other is gatekeeping. In both instances the moral task is to divest secondary personal gain from individual clinical decisions. Whatever gains accrue from better utilization must be used to improve services and enhance the functional integrity of the system. I cannot imagine this happening in a climate of conflict and suspicion among family physicians, consultants, and patients, so our commitment to reform ought to include transparency of financial arrangements at all levels of care.

Gatekeeping is like walking a gymnast's balance beam; it's much harder when the beam is elevated. Brody draws a fine distinction between protecting patients from the potential harm of overtreatment and denying them potential beneficial treatment. Because iatrogenic harm is already built into the present system of care, and only a fraction of it ever comes to litigation, my guess is that denying potentially beneficial treatment will continue to be felt by physicians as the greater risk.

There is a third element of gatekeeping that might become more important in a reformed system; that is, when the primary physician goes to bat as an advocate for a patient to get what is needed from the system. My recent conversations with about 50 family physicians working in one of the established managed care systems suggest that the advocate role takes on more importance as the managed care entity "matures."

Already the shape of opposition to the Clinton reforms is becoming visible. Some will deny the reality of the crisis; that position has already reached the "letter-to-the-editor" stage in Alabama. The major opponents, however, will concede the injustice of the uninsured, avow that they have always favored universal coverage, then oppose the changes that could remedy the problem. They will fight a skillful retreat under the banner of "freedom of choice" and conjure visions of long lines of sick people waiting interminably to be treated.

What feels different to me now than when Medicare and Medicaid were debated in the mid-1960s is that the old "socialized medicine" rhetoric has become hollow. There is nothing left to be feared from big government than has already been experienced from big business. It's way past time for a change, and I, for one, support Brody's call.

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References

1. Brody H. Moral values in health care reform: implications for family practice. J Am Board Fam Pract 1994; 7:236-41.

Family Physicians As Researchers In Their Own Practices

The resurgence of interest in practice-based research[1] provides special impetus to consider carefully the report in this issue of *JABFP* by Slatkoff, Curtis, and Coker.[2] Beginning with the apparently innocent request to provide a control group for an investigation that required only an additional cervical specimen to be taken at the time of the Papanicolaou smear and a willingness of the patient to talk with an investigator, they report unanticipated difficulties that emerged, affecting both providers and patients. This article is not about theoretical possibilities; it is about the practical consequences of fear, distrust, additional unplanned work, and unnecessary interventions that resulted from their efforts to improve medicine through research about problems important

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