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1. Introduction to the debate and its application to the Chilean context

In a recent opinion piece published in the influential British Medical Journal entitled “Private practice is unethical—and doctors should give it up,” [1] English cardiologist John Dean has encouraged a debate about an uncomfortable yet important issue for reflection about the medical profession and its social role. From his perspective, private medicine is not ethical since it is organised in terms of money rather than the needs of patients or society. In this article, we evaluate Dean’s arguments and their applicability to the Chilean context in order to examine whether doctors have obligations which make it questionable to develop their practice in the private sector, and whether a moral duty to work in the health public sector can be derived from this.

It is important to note that said comment is made within the context of the English health system, which like other developed countries has high levels of performance regarding the quality of care, access, efficiency and equity. [2] By contrast, the Chilean public health system (represented by the National Health Fund, FONASA), despite its wide coverage, has poor equity indicators, and it is particularly striking that doctors are unequally distributed between the public and private sectors. Chile has a relatively low proportion of doctors in relation to other OECD countries. The availability of medical specialists in the public sector is 46.6% [3]. This situation leads to inequality since the public sector covers around 80% of the population and concentrates those with the highest need of medical care (the poorest, senior adults, and women of reproductive age) [4], [5].

Another feature of the Chilean case is that the private sector offers incentives, such as better income, facilities, and favourable conditions for professional development. Without a doubt, this partly explains why doctors migrate to the private sector, which is estimated to be 50% two years after finishing their speciality training [6]. While in societies with a liberal approach, such as Chile, doctors have the right to choose where they can work professionally, they are not exempted from the ethical responsibility of deciding to work in one health system or the other. We think that given the reality of the Chilean health system, it is especially relevant to reflect on this decision and its implications.

2. In search of the internal good of the medical profession

The main argument posited by Dean questions the association between medicine and business, since it would encourage doctors to favour profit over their patient's health. This point makes sense when considering the proposition that medicine, as any practice, seeks an internal good that defines its identity and standard of excellence [7]. Since Hippocrates, this internal good has been the restoration of health and the relief of the suffering occasioned by illness. Thus it is argued that when external goods are sought, such as money, professional prestige or fame, physicians corrupt their professional practice and even forget the meaning of their profession and cease to be good doctors, subsequently losing social legitimacy [8].

It is interesting to note that if the goods internal to medicine are formulated around virtues specific to the doctor-patient relation, private practice could be seen as compatible and even more favourable for the professional fulfilment. This would be the case of physicians who despite concentrating on people with more resources and less needs treat their patients with genuine interest and high quality standards [9]. This leads us to the question about whether the good internal to medicine is limited to ensure well-being of the patient or includes a more ample social commitment, directed to the general good of the population.

Although it is widely recognized that the good internal of medicine is mainly aimed at patients, authors such as Pellegrino and Thomasma [10] incorporate virtues with social orientation, such as justice, compassion and self-effacement. In this sense, Pellegrino says "for the virtuous physician in pursuit of excellence in the moral life, medical knowledge, however, is not proprietary. It is held in stewardship for those who need it and not just for those who can pay" [10, p. 170]. These ideas are reflected in the interdisciplinary project "The goals of medicine" by the renowned Hastings Center, a document warning that "the hazards of the market include the introduction of an alien set of economical values into the institution to medicine, whose inherent ends have been historically been philanthropic and altruist, not commercial" [11, p.43].

Other joint statements of organizations and groups of physicians have shown a more explicit commitment with social justice in health. For example, in 2002 the international initiative "Project for the medical professionalism" issued a document establishing a "principle of social justice" among the three fundamental principles of the profession, which requires the physician to actively participate promoting a fairer and more egalitarian health system [12]. Even with more emphasis, the Manual of Ethics of the World Medical Association posits the need of a more social approach

when allocating resources, according to which the “physicians are responsible not just for their own patients but, to a certain extent, for others as well” [13, p. 72]. It should be highlighted that these documents can be considered binding for physicians in Chile, since they have been incorporated as appendices in the last issue of the Code of Ethics of the Chilean Medical Association [14].

3. The physician and the private practice.

Another argument put forward by Dean suggests that the development of the private health sector hinders the public sector since valuable recourses are diverted from it. This idea can be extrapolated to the Chilean case, where we have seen that there is a disproportionate concentration of medical specialists in the private sector. However, it could be replied that this argument is not convincing since it presumes, without justification, that the public system is more valuable than the private health system. After all, the migration of physicians to the private sector is not negative per se, since it could be possible that the privatization of health services could have favourable results for the general population, as according to some would be the case after the privatization of other public services in Chile [15]. In fact, after the economic liberalization process began in Chile in the 80’s, important health indicators (such as, life expectancy and maternal and infant mortality) have maintained good levels in comparison with other countries with similar GDP [16].

However, more than resulting from privatization processes, these indicators would be explained by the high levels of coverage and strength of the public sector, as well as improvements in other social health determinants [17], [18]. It can be said that the dominant view in the literature suggests that the health system privatization in Chile has resulted in an inefficient and unequal distribution of health resources [19], [20], [21]. From a global point of view, according to two recent systematic revisions, there is no evidence to support that the private health service is more efficient in the use of economic resources or that it gets better health results than the public sector [22], [23]. Although private health can be associated to improvements in the access and service quality, this takes place in a population with higher income and is detrimental to those more deprived [17], [24]. In fact, the users of the National Health Fund report to be more vulnerable and unsatisfied with the health system than their counterparts in the private sector.

In short, the evidence does not support the thesis that the expansion of the private health has globally benefited people’s health. It is derived from this assertion that it is unethical to work in the private sector? This consequence can be avoided if it is contended that the responsibility to share the health services fairly does not lie on the individual physicians, but on those managing the health

systems. This idea is compatible with the function assigned by Rawls to social institutions of distributing rights and fundamental duties for individuals [26]. However, it is questionable to place the virtue of justice on a merely institutional level, since it is individuals who endow institutions with justice [27]. In addition, if there is evidence that the institutions are not ensuring certain minimal requirements of justice, it would be the individuals who are responsible to restructure the institutions in order to perform their function adequately [28].

However, it is possible to assert that the social obligations of the physicians are more important than those required by the other members of the society, since the concept of profession supposes the adoption of obligations towards others which are higher than those possessed by any individual by virtue of their participation in a social framework [29]. Similarly, unlike the obligations assumed by other members of the society, such as the commitment to pay a debt to a third party, the obligations of health professions are inherent to their exclusive position as expert professionals and providers of essential services for the community in which they are part. It is this community which entrusts the physician the role of providing these services, which entails a higher degree of commitment than other activities [30].

4. Conclusions

As a summary, we can say that although the main duty of a physician is to pursue the highest satisfaction of the needs of a patient, it is also important to assume commitments and responsibilities related to an efficient and just administration of the health services in the population, services of which the physician plays an indispensable part. How to link these responsibilities is still controversial [31]. However, in any case it is preferable to avoid delegating this type of decision to professionals who do not have the technical competence nor share the interests of medicine [32]. As noted by Weinstein [33], the medical community should participate in collective actions of social agreement, aimed at defining common goals regarding the management and allocation of resources. These agreements can give rise to policies and clinical guidelines allowing physicians to perform their role responsibly as agents and advocates of patients.

Even though it is possible to assert that the internal good of medicine can flourish both in the public and private systems, the professional performance exclusively in the private sector risks of disconnecting the physician from social obligations inherent to their profession, among which to ensure an adequate distribution of the medical care hours according to the needs of the community is included. In any case, these obligations are not strict norms, but ethical guidelines that must be

balanced in view of other obligations, similarly to what happens with the *prima facie* principles of medical ethics [34]. In this regard, there is some flexibility to recognise that private sector physicians can create spaces to develop their social obligations through, for example, self-regulating organizations of the professional career or contributing to the education of future physicians.

Finally, given that the social character of the medical profession can be taught and integrated through experience, we join other calls to incorporate contents and practices in the training of future physicians that allow the development of social virtues and professional responsibility extended to the society as a whole [35], [36], [37].

References

1. Dean J. Private practice in unethical—and doctors should give it up. *BMJ*: 2012; 350:h2299. DOI: 10.1136/bmj.h2299 Link: <http://www.bmj.com/content/350/bmj.h2299.full> PubMed (ID): 25944061
2. Davis K, Stremikis K, Schoen C, Squires D. Mirror, mirror on the wall, 2014 update: how the US health care system compares internationally. *The Commonwealth Fund*. 2014 Jun;16:1-31. Link: <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>
3. MINSAL. Informe sobre brechas de personal de salud por servicio de salud. 2016. Link: http://web.minsal.cl/wp-content/uploads/2015/08/Informe-Brechas-RHS-en-Sector-P%C3%BAblico_Marzo2016.pdf.
4. Herrera T. Desafíos para la reforma del financiamiento del sistema de salud en Chile. *Medwave* 2014;14(4):e5958 DOI: 10.5867/medwave.2014.04.5958
5. Goyenechea M, Sinclair D. Propuesta para una salud pública gratuita y de calidad. CIPER Chile. 2014. Link: <http://ciperchile.cl/2013/06/03/propuesta-para-una-salud-publica-gratuita-y-de-calidad/>.
6. Albert, C., Jara, M. Crisis de médicos especialistas en la salud pública: las causas de un tumor de larga data. CIPER Chile. 2015. Link: <http://ciperchile.cl/2015/09/01/crisis-de-medicos-especialistas-en-la-salud-publica-las-causas-de-un-tumor-de-larga-data/>.
7. MacIntyre A. *After virtue: A study in moral theory*. Notre Dame, Indiana: University of Notre Dame Press; 1981.
8. Cortina A. *Ética de la empresa: claves para una nueva cultura empresarial*. Madrid, España: Editorial Trotta; 1994.
9. Altman K. Patient's right to choose private medicine. *BMJ* 2015; 350:h2810. DOI: 10.1136/bmj.h2810 PubMed (ID): 26036662
10. Pellegrino E, Thomasma D. *The Virtues in Medical Practice*. New York, USA: Oxford University Press; 1993.
11. The Hastings Center. *The Goals of Medicine: The Forgotten Issues in Health Care Reform*. Washington, USA: Georgetown University Press; 2000.
12. Project MP. Medical professionalism in the new millennium: a physicians' charter. *The Lancet*. 2002 Feb 9;359(9305):520-2. Link: <http://annals.org/aim/article/474090/medical-professionalism-new-millennium-physician-charter> PubMed (ID): 11827500
13. Medical Ethics Manual. World Medical Association. 2015. Link: https://www.wma.net/wp-content/uploads/2016/11/Ethics_manual_3rd_Nov2015_en.pdf.
14. Código de Ética del Colegio Médico de Chile. 2013. Link: <http://www.colegiomedico.cl/wp-content/uploads/2016/09/Codigo-de-Etica-Colegio-Medico-Chile->

2013.pdf.

15. Fisher R, Serra P. Efectos de la privatización de servicios públicos en Chile. *Cono Sur. Serie de Estudios Económicos y Sociales* 2007; 2-4 Link: <https://publications.iadb.org/bitstream/handle/11319/3904/Efectos%20de%20la%20privatizaci%C3%B3n%20de%20servicios%20p%C3%BAblicos%20en%20Chile.pdf?sequence=1&isAllowed=y>
16. González R, Requejo JH, Nien JK et al. Tackling Health Inequities in Chile: Maternal, Newborn, Infant and Child Mortality between 1990-2004. *Am J Public Health*. 2009; 99(7): 1220-1226 DOI: 10.2105/AJPH.2008.143578 Link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696659/> PubMed (ID): 19443831
17. Unger J-P, De Paepe P, Solímáno G, Arteaga O. Chile's neoliberal health reform: An assessment and a critique. *PLoS Med* 2008; 5(4): e79. DOI: 10.1371/journal.pmed.0050079 Link: <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0050079> PubMed (ID): 18384231
18. Jiménez J, Romero M. Reducing Infant Mortality In Chile: Success In Two Phases. *Health Aff March* 2007; 26(2): 458-465. DOI: 10.1377/hlthaff.26.2.458 Link: <http://content.healthaffairs.org/content/26/2/458.full> PubMed (ID): 17339674
19. Goic A. El Sistema de Salud de Chile: una tarea pendiente. *Rev Med Chile* 2015; 143: 774-786. DOI: 10.4067/S0034-98872015000600011. Link: http://www.scielo.cl/scielo.php?script=sci_arttext&pid=S0034-98872015000600011&lng=en&nrm=iso&tlng=en PubMed (ID): 26230561
20. Cid C. Problemas y desafíos del seguro de salud en Chile: el cuestionamiento a las ISAPRE y la solución funcional. *Temas de la Agenda Pública, Centro de Políticas Públicas PUC* 2011; 49. Link: <http://politicaspUBLICAS.uc.cl/wp-content/uploads/2015/02/problemas-y-desafios-del-seguro-de-salud-y-su-financiamiento-en-chile.pdf>
21. Serra, I., Román, O., Orellana, M. Román, A., Correa, J. Chile, indicadores de mortalidad estancados y deteriorados. ¿Consecuencia del modelo de mercado impuesto? Análisis y corrección urgentes, un imperativo ético. *Cuad Méd Soc (Chile)* 2016, 56 (1 y 2): 5-31. Link: http://cms.colegiomedico.cl/Magazine/2016/56/1/56_1_3.pdf
22. Wouters OJ, McKee M. Private Financing of Health Care in Times of Economic Crisis: a Review of the Evidence. *Glob Policy* 2017; 8: 23–29. Link: <http://onlinelibrary.wiley.com/doi/10.1111/1758-5899.12211/pdf>
23. Herrera CA, Rada G, Kuhn-Barrientos L, Barrios X. Does Ownership Matter? An Overview of Systematic Reviews of the Performance of Private For-Profit, Private Not-For-Profit and Public Healthcare Providers. *PLoS ONE* 2014; 9(12): e93456 DOI: 10.1371/journal.pone.0093456 Link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249790/> PubMed (ID): 25437212
24. Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. Comparative Performance of Private

and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review. *PLoS Medicine* 2012; 9(6): e1001244. DOI: 10.1371/journal.pmed.1001244

Link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3378609/> PMID: 22723748

25. Superintendencia de Salud. Estudio de opinión a usuarios del sistema de salud, reforma y posicionamiento de la superintendencia de salud. 2015. Link:

http://www.supersalud.gob.cl/documentacion/666/articulos-12432_recurso_1.pdf.

26. Rawls, J. Teoría de la justicia. México D. F., México: Fondo de Cultura Económica; 1995.

27. Wiggins, D. Neo-Aristotelian Reflections on Justice. *Mind* 2004; 113(451), 489.

28. Quong J. "Public Reason", *The Stanford Encyclopedia of Philosophy*. 2013. Link:

<https://plato.stanford.edu/archives/sum2013/entries/public-reason/>.

29. Hortal Alonso A. Ética general de las profesiones. Bilbao, Desclée De Brouwer. 2002.

30. Ozar D. The Social Obligations of Health Care Practitioners. *Medical Ethics*. 275.

31. McKneally M, Dickens B, Meslin E, Singer P. Bioethics for clinicians: 13. Resource allocation. *Can Med Assoc J* 1997; 157(2): 163–7. Link:

<http://www.cmaj.ca/content/157/2/163.full.pdf+html>

32. Ortiz A. Gestión clínica y conflicto de intereses. *Acta bioethica* 2009; 15 (2): 157-164.

DOI: 10.4067/S1726-569X2009000200005 Link: http://www.scielo.cl/scielo.php?pid=S1726-569X2009000200005&script=sci_arttext

33. Weinstein M. Should physicians be gatekeepers of medical resources? *J Med Ethics* 2001; 27: 268–274. DOI: 10.1136/jme.27.4.268 Link:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1733427/pdf/v027p00268.pdf> PubMed (ID): 11479359

34. Beauchamp L, Childress J. Principios de Bioética. Ed. Mason SA. Barcelona. España. 1999.

35. Goic A. El fin de la Medicina. *Santiago*, Chile: Editorial Mediterráneo Ltda.; 2000.

36. Dharamsi S, Ho A, Spadafora S, Woollard R. The Physician as Health Advocate: Translating the Quest for Social Responsibility Into Medical Education and Practice. *Acad Med* 2011; 86(9): 1108-13. DOI: 10.1097/ACM.0b013e318226b43b Link:

http://journals.lww.com/academicmedicine/fulltext/2011/09000/The_Physician_as_Health_Advocate__Translating_the.21.aspx PMID: 21785306

37. Boelen.Ch, Woollard R. Consenso Global sobre la Responsabilidad Social de las Facultades de Medicina. *Educ Med* 2011; 14(1): 7-14. Link:

http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1575-18132011000100004