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'Medical altruism in mainstream health economics: theoretical and political paradoxes' comments

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ABSTRACT

In this article, which was published in the September 2014 issue of the *Review*, Batifoulier and Da Silva examine the role of medical altruism in health economics. They argue that abandoning *homo economicus* and the mainstream practice of incorporating patient well-being in the doctor's utility function in order to explain the clinical behavior of doctors and switching from profit maximization to medical altruism both lead to a dead end. We agree but the authors leave us with no way out. We argue instead that the doctor's clinical behavior whether expressed in terms of utility or altruism is not a fit subject for economics. The way out is to restrict economics to health care issues with financial dimensions. In their article, Batifoulier and Da Silva bring their French experience to the table. We bring to the table our American experience with more than 40 years of hands-on care for patients along with the experiences of four other physicians in our extended family. The specialties include intensive care pediatrics, emergency medicine, intensive-care pulmonary medicine, dermatology, and otolaryngology. Our premise in responding to Batifoulier and Da Silva is that apart from payment for services rendered, there probably are no serious differences in the actual practice of medicine in France compared to the United States. And even if there are such differences, they are matters to be taken up by medicine not economics.

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KEYWORDS Altruism, health care, clinical behavior, maximization

1. Medical altruism

Batifoulier and Da Silva address three types of medical altruism. The first is drawn directly from mainstream economics. '… medical altruism is defined as the inclusion of the patient's welfare in the doctor's utility function' (262).

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The second asserts that:

> … medical altruism is identified with a preference that corrects the other preferences of the doctor. It acts as a constraint on self-interest and subordinates the other arguments of the utility function to respect of [*sic*] this constraint, which reduces the doctor's sovereignty of choice. (265)

The third is defined as the doctor's concern for:

> … the welfare of the ordinary, average patient … [in which she] may be more sensitive towards particular types, such as poorer patients. Models of price discrimination are then developed in which the doctor's satisfaction depends on the income of his patient. (265)

With the first definition, medical truism is incorporated in conventional economic theory when the doctor as an economic agent is represented as *homo economicus*. By incorporating the patient's welfare in the doctor's utility function, mainstream economics construes the doctor's clinical behavior in terms of the advantage to the doctor. Implicit in this perception is the notion that in terms of his own welfare, the patient is dependent on the doctor and subordinate to the doctor's professional judgment. Demand is supplier-induced.

With good reason, Batifoulier and Da Silva reject this definition because without any constraint on the doctor's self-interest '… the doctor is simply an economic agent like any other' (265). For the mainstream, the interaction between doctor and patient is simply expressed in terms of utility, satisfaction, and profit: what is gotten vs. what is given up. This interaction is no different than the interaction between a plumber and a homeowner.

The second definition introduces medical altruism as a constraint on the doctor:

> Whatever the words used and the form of the formalization of professional ethics as altruism the aim is to reject the idea of the full exercise of [the doctor's] discretionary power. Assuming that this power is not constrained leads to an absurd result whereby the doctor is simply an economic agent like any other. (265)

This constraint, according to Batifoulier and Da Silva, has the desirable effect of reducing 'the doctor's sovereignty of choice' (265). This claim is true, but it is essentially trivial. The real constraint on the doctor is the condition of the patient on presentation, the urgency of the situation at the time of presentation, and the available remedies that would successfully treat that condition. The invasive cardiologist who rushes to the emergency room to insert a stent into a patient who is suffering a heart attack is not laboring under any constraint imposed by medical altruism, but is applying her professional knowledge as to what is required under the circumstances. Indeed, it is her professional duty. The dermatologist who asks her patient to remove his shirt so she can examine his back and finds a melanoma is applying her specialized knowledge base in order to fulfill her duty to her patient.

Altruism may influence a doctor's behavior, but it is no substitute for a command of the knowledge necessary to effectively treat her patient. Put differently,

when a patient presents with a life-threatening gunshot wound to the head, it's not the altruism of the neurosurgeon that matters. It's her hands.

The third definition is even more problematical than the second. Caring for one's patients, whether poor or not, is not a matter of satisfaction. It is a duty. Not charging a patient who is unable to pay does not introduce price discrimination, with its negative connotation, into the practice. Serving the poor is *pro bono* care.

We agree in part with Batifoulier and Da Silva that a doctor:

> may be more sensitive to patients who are interesting from a clinical perspective because he prefers medicine that is more intellectually attractive or prestigious. Ethics may then be expressed as a function of disease severity. (265)

To a large extent, the patients a physician sees are determined by the specialization training program she has elected to enter toward the end of medical school. An otolaryngologist does not perform surgery on a patient with a broken leg. As a general proposition, the doctor sees first those patients with the most life-threatening symptoms. Thus, it is not ethics that is a function of disease severity. It is the doctor's response.

2. Medicine not economics governs the practicing physician

Batifoulier and Da Silva imply that in order to understand the clinical behavior of the doctor, it is necessary to move away from *homo economicus* who routinely maximizes personal net advantage. One who does not maximize utility, satisfaction, or profit. We disagree with them that mainstream health economics can be rescued by changing how we think about economic agency. Economics does not directly govern the behavior of the doctor in diagnosing and treating the patient. Medicine does.

The *homo economicus* of mainstream economics is relevant to the investment decision-making of doctors where maximizing personal net advantage is the sole objective. Even then, maximum profits may be subordinated to concerns regarding company practices on employment, environment, outsourcing, compensation of senior managers, and the like. *Homo economicus* routinely is applied by mainstream economists to work, consumption, and leisure activities though even those applications are under challenge (see O'Boyle 2011).

The doctor engages in maximizing behavior in the sense that she maximizes patient well-being as much as she is able. Thus, profit is not the objective that drives her clinical behavior but a necessary condition to continue providing health care service. Further, by acting virtuously, most especially by caring, the doctor becomes a better human being, a more trustworthy human being, and therefore better able to build confidence in the patient that what she is recommending is necessary and effective. There is no absolutely assured outcome for all patients because each one is different. For that reason, doctors typically schedule patients for at least one follow-up visit.

The physician who acts virtuously by caring and other virtues such as mercy, diligence, and honesty enhances her own personal development along a specific dimension that we choose to identify as personalist capital. The one who acts viciously by indifference, heartlessness, laziness, and deceitfulness diminishes her stock of personalist capital and her development as a person.

Thus, the typical physician acts in specific ways that enhance or diminish the well-being of her patients and at the same time enhances or diminishes her own personal development. The first is the objective aspect of her work. The second is its subjective aspect. Ideally as a professional she maximizes their well-being and her own personal development. She understands and accepts that maximum profit is not her objective. Rather, profit is a necessary condition for her to continue practicing medicine.

From this perspective, the physician engages in maximizing behavior but behavior that is almost entirely outside the domain of economics. It is possible to articulate effective policy recommendations, but they will come from the practice of medicine and not from economic theory. This means that it is necessary for mainstream economists to stop trying to rationalize the practice of medicine by imposing *homo economicus* on it. Lutz (1993: 1–12), former president of the Association for Social Economics and recipient of the Thomas Divine Award for lifetime contributions to social economics and the social economy, condemned this kind of practice as 'economic imperialism.'

3. The role of economics in health care

Economics and ethics have an important role to play in terms of payment for health care rendered especially when payment comes through private insurance companies and public health service programs. Private insurers are profit-maximizing organizations. How far are they allowed to go in refusing to pay for the care of their policyholders? How deeply can private insurers and government programs cut the reimbursement paid to doctors and hospitals for services rendered? Should private insurers be allowed to offer experience-rated premiums?

To what extent is it reasonable and justifiable that a doctor must get prior approval from a third-party payer before she can proceed with a treatment for a patient that she regards as appropriate? What is proper payment for a physician, such as an invasive cardiologist or dermatologist, who has just saved her patient's life? In terms of cost, which treatment modality offers the best outcome? From a strictly financial point of view, how does one know with some certainty that a national health care system, whether private, public, or public–private partnership, is a success or a failure?

At the present time, the doctor with an office practice has no obligation to admit into her practice a patient who is unable to pay or whose insurer or government program does not reimburse in a reasonable way. *Pro bono* may cover some patients but not all. At the same time, the hospital is required to admit everyone, even those who cannot pay or whose insurance does not reimburse

adequately. No-pay patients are well known among US health care providers as are those who file for bankruptcy protection.

Unless a patient pays in cash or by credit card, payment for services rendered is not assured. Third-party payers often reimburse providers at less than 50% of what they charge for services provided. Are they to be permitted to continue driving physicians out of practice in the interest of 'bending the cost curve' or maximizing their profits? In many instances, those doctors end up as hospital employees known as hospitalists (Nelson *et al.* 2012: 1699–1700; Schumann 2012: not paginated).

Effective policy recommendations can emerge from economics provided the analyst sticks to issues involving the financing of health care services.

4. Other issues

In the following, we address six other issues raised in the Batifoulier and Da Silva article. There are others, but we have chosen to focus on just these six.

- Batifoulier and Da Silva insist that pay-for-performance in the United States has been a 'resounding failure' (275). However, it is not clear what they mean by pay for performance. Do they mean pay in terms of patient outcomes or fee for service?
- A doctor is obliged to 'protect patients from harm and suffering' (263). This obligation inheres in the principle 'primum non nocere' – first do no harm. However, 'first' implies that more is required of the doctor than constraining her clinical behavior. In our understanding of these matters, there is the more important activating principle urging the doctor to maximize the well-being of the patient as much as possible. Nevertheless, some treatments are necessary and painful as in the case of burn patients and orthopedic patients re-establishing a full range of motion. The doctor's obligation in such circumstances is to minimize the harm and suffering.
- 'By reducing ethics to altruism, mainstream theory prevents any genuine discussion of medical ethics' (263). We are inclined to think differently. By modeling the clinical behavior of physicians in terms of *homo economicus,* mainstream economists do not have to address medical ethics and at the same time they can readily uphold their claim that economics is a value-free discipline.
- Batifoulier and Da Silva imply that a central regulator, which we take to mean a government official, is necessary to protect the patient from a sadistic doctor who has 'an interest in patient suffering' (270). In more than 40 years of practice, we have never encountered a sadistic doctor. Never. If, however, there is such a physician, protection should come from a hospital review board that can deny the doctor admitting privileges, a state licensing board that can suspend or remove her license to practice, a malpractice attorney, or prosecutor. All four are closer at hand to the problem than is a

government official and therefore more likely to be better informed as to the details of the sadistic practices.

- With regard to the 'bad rotten kid' patient, we disagree with Batifoulier and Da Silva regarding that patient's obligation.

> Patients do *not* have an obligation to collaborate with their doctors to ensure a timely and accurate diagnosis by providing honest answers to the doctors' queries, and to comply with the treatment after a diagnosis has been made. (271; emphasis added)

Unless 'not' is a typographical error, the patient has a duty to cooperate that corresponds to the duty of the doctor to provide the best care possible. Indeed, the best care possible rests on the premise of the patient who cooperates. A doctor has one effective way to deal with the 'bad rotten kid' patient. Inform him that he will have to find his health care needs met through another doctor.

- We also disagree with Batifoulier and Da Silva's conclusion.

> … if social norms were counted like economic utilities, they would have no effect. With most norms, the desired effect is obtained by seeking another objective. When applied to doctor's behavior, this reasoning brings out the fact that it is, paradoxically, only by showing his *insensibility* [bereft or incapable of feeling] to the patient's gratitude or social approval, and more generally by adopting ethical behavior in a *disinterested* manner, that the doctor will meet with the social approval or reciprocal commitment from his patient. (276; emphasis added)

We are convinced from hands-on experience that insensibility does not assure that the doctor will 'meet with the social approval or reciprocal commitment from his patient.' Quite to the contrary, such a doctor likely will experience quite different outcomes. Further, the doctor's manner must be both *personal* because every patient is different and *objective* in assessing the patient's condition and recommending a treatment regimen. 'Insensibility' and 'disinterested' will not do.

We applaud Batifoulier and Da Silva for rejecting *homo economicus* as applied by mainstream economics to health care issues. And we agree that replacing profit maximization with medical altruism is not the answer. However, we strongly recommend substituting the maximization of patient well-being for profit maximization and restricting economic theory to financial issues. This restriction offers promise for yielding worthwhile policy recommendations.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Meade P. O'Boyle MD is a graduate of Saint Louis University School of Medicine and is affiliated with the Northeast Louisiana Pediatric Clinic. She is board certified in general pediatrics and child-abuse pediatrics. Over the years, she has worked in newborn

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Edward J. O'Boyle earned his doctorate in economics at Saint Louis University. He is a senior research associate with Mayo Research Institute, specializing in personalist economics that focuses on economic agency in which the homo economicus and the individualism of orthodox economics are replaced by the person of action and personalism. He has published in the Monthly Labor Review, Review of Social Economy, Forum for Social Economics, Pediatrics, The Linacre Quarterly, International Journal of Social Economics, Business Insights, Journal of Business Ethics, Quarterly Journal of Ideology, Ethics and Information Technology, Journal of Markets and Morality, Storia del Pensiero Economico, Corporate Governance, and others. O'Boyle has authored or edited books on economics, edited journal issues, contributed chapters in books, and written an e-text for use in teaching principles of economics. He has taught economics in Poland, Ireland, and Italy. O'Boyle is a past president of the Association for Social Economics and a recipient of the Thomas Divine Award for lifetime contributions to social economics and the social economy. His website is found at www.mayoresearch.org.

References

Lutz, M. A. (1993) "Social Economics and Economics Imperialism," *Forum for Social Economics* 23(1): 1–12.

Nelson, J. R., Wellikson, L. and Wachter, R. M. (2012) "Specialty Hospitals: Analyzing an Emerging Phenomenon," *JAMA* 307(16): 1699–1700.

O'Boyle, E. J. (2011) "Meeting Human Need Through Consumption, Work, and Leisure," *International Journal of Social Economics* 38(3): 260–272.

Schumann, J. H. (2012) "The Doctor is Out: Young Talent is Turning Away from Primary Care," *The Atlantic*, March 14. Available at: http://www.theatlantic.com/health/archive/2012/03/the-doctor-is-out-young-talent-is-turning-away-from-primary-care/254221/ (accessed August 25, 2015).