

Virtual Mentor

American Medical Association Journal of Ethics
October 2001, Volume 3, Number 10: 335-338.

HISTORY OF MEDICINE

Commemorative Issue: Physicians and the Obligation to Provide Charity Care

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Physicians have long been called upon to treat the poor, regardless of the prevailing official social strategy. This duty of providing charity care has been a hallmark of the virtuous physician since the early Middle Ages², and over time was incorporated into the gentlemanly ethic of noblesse oblige. When the American Medical Association published its Code of Medical Ethics in 1847, physicians were encouraged, as a duty to the public, to provide limited, gratuitous services to the poor:

Poverty, professional brotherhood, and certain of the public duties referred to in the first section of this article, should always be recognized as presenting valid claims for gratuitous services . . . to indigent circumstances, such professional services should always be freely accorded³.

However, even by the time that the AMA formalized this duty in its code of conduct for physicians, several social factors were beginning to coalesce which would transform health care simultaneously into a commodity to be bought and sold on the market, as well as a public good--and even a right--expected by citizens from their government. Increasingly physicians would be called upon to mediate this tension between health as an expensive commodity and health as a social good. The question of how to care for the poor would land squarely in the center of this conflict, a conflict that would come to define the context of medical practice and challenge the professional obligations of physicians into the year 2001.

American medicine emerged as a profession in the wake of the euphoria and aspirations of the American Revolution. Political autonomy was in its infancy in the newly liberated colonies, and American wariness of the centralized authorities of European nations discouraged the involvement of Congress and state legislatures in the regulation of the medical profession. Instead, Americans developed a highly individualistic approach to medicine, modeled on the political philosophy of Adam Smith that promoted a specific, highly individual form of competition, with outcomes being decided by a free-market economy. Success in the American medical marketplace therefore came to depend upon the market forces of a consumer-based public.

Between the end of the Civil War in 1865 and the outbreak of World War I in 1914, improved hygienic measures and technological inventions transformed the nature, effectiveness, and cost of medical treatment. American hospitals became permanent fixtures, both in the delivery of health care to the public and in the academic and

clinical training of physicians. But unlike the hospital systems of Europe, which were largely created by religious orders or governments, the American hospital system, influenced more by a British philosophical bent and a disdain for government, developed in a distinct fashion. American physicians, eager to establish hospitals for educational and social purposes--but wary of state controls--solicited funds from private donors, who in turn became trustees and members of the board. The treatment of patients was then supported with fees charged to patients for individual services⁴.

As the century progressed, "scientific medicine" led to extremely rapid advances in clinical care. In particular, after the First World War, American medicine gained considerable prestige for its hospital-based medicine and the US witnessed a rapid growth and expansion of hospitals throughout the 1920s^{5, 6}. By then, American health care was based primarily on a fee-for-service, free-market system that was buttressed by educational standards and licensure requirements but otherwise few government controls^{7, 8}.

In the decades that followed, American hospitals required heavy capital investments for technological developments. Patient fees, which had initially been a primary source of support, were no longer enough to sustain the rapid expansion of hospitals and the technologies they used. As medical care became more effective and expensive, there was a subtle shift toward defining health care access as a social obligation. At first, American governmental involvement in providing care revolved around protecting national interests, such as the health of the Merchant Marine and the Armed Forces, and only later addressed care for the elderly, infirm, and poor. Protecting the health of the public became a major goal and, at least for some employers, maintaining a healthy workforce was also important. As effective therapies were developed that individuals could rarely afford to purchase, group hospital insurance plans were created and the concept of the third-party payer was introduced to fill the void of governmental action.

The AMA's *Code of Medical Ethics* had been re-written in the early 1920s and revised again in the 1940s to reflect the roles and obligations of physicians practicing within these emerging institutional structures. Tellingly, where the duty of charity care was once located in the Code section entitled "duties of the profession to the public," it was now shifted to a section in the Code that discussed compensation. It reflected the growing insistence that institutions, rather than individual physicians, shoulder some of the burden of caring for the poor:

The poverty of a patient and the mutual obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services⁹.

The rising costs of care and the increasing effectiveness of health care slowly led the relationships of US physicians and their patients to be mediated by a host of

private, public, and professional bodies -- insurance agencies, health care institutions, government bureaus, and professional associations¹⁰. Physicians, who have always had civic obligations to the public, are now challenged to manage-- both organizationally and professionally--the tension of health care as a commodity and health care as a basic social good in the face of patient needs, limited resources, and limited state support. As our society struggles to define and implement its most recent strategies of caring for the poor, physicians would do well to remember the fate of the itinerant wanderer, whose only misfortune was to fall ill in a community that fought more passionately for its policy than it did for its humanity^{11, 12}.

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