BLACK MARKET MEDICINE

An Ethical Alternative To State Control

By Alphonse Crespo MD

STATE INTERVENTION AND UNDERGROUND ECONOMY

Black markets do not exist in a free society. They are the stigmata of interference with the voluntary exchange of goods and services. The road to an underground economy is paved with state planning, regulation and intervention. Politically tuned redistribution of resources invariably disrupts market harmony. Market disruptions in state controlled economies sooner or later lead to price controls, restrictions and rationing. Standard bureaucratic cures for collateral effects of state intrusion hurt both producers and consumers. In mixed economies, imperiled industries react by lobbying for protection, while consumer groups press for price control. If powerful enough, both succeed in steering parliamentary action. Protectionism and over-regulation run rife and stifle incentives for efficient production. More and more intervention is called for, which ultimately climaxes in crisis situations: marginal producers are phased out of official markets by unrealistic price freezing; over-regulated outlets fail to meet demand; the more adventurous amongst unprotected entrepreneurs turn for survival towards informal distribution channels, whilst impatient consumers look for ways to jump the queues. At this point, the economy is ripe for the black market.

Most economists are familiar with the above scenario. Recent history has indeed shown that, if unopposed, the intervention cycles of state controlled economies always result in (1) falls in production (2) inefficient distribution (3) rampant corruption and (4) flourishing black markets.

Medical services are not immune from this process. Black market medicine is not a theoretical concept. Although it has now dissapeared from former communist states of Eastern Europe where it was long considered as an institution, it remains a reality in many parts of the world. This paper proposes to dwell on the ethical questions raised by the underground practice of medicine.

DEFINING BLACK MARKET MEDICINE

Black market medicine can be defined as the practice of medicine outside existing legal frameworks. These frameworks vary from one country to another. Thus when a Madras surgeon grafts a kidney bought from a living donor, he is accomplishing a legal, socially useful and lifesaving action. A Harley Street doctor performing the same type of curative organ transfer in a London hospital is party to an illegal transaction. If found out he will be spared no ignominy.

When Manchester born Doctor Jack Preger set up his medical tent in the sidewalks of Calcutta, as he stubbornly did every morning in breach of Indian laws, he knew he may have to spend more time at the police station or in court before the day is over, than in attending to the sufferings of his needy patients. A Swiss Red Cross team engaged in similar humanitarian action near the Afghan border will be offered near diplomat status and a warm welcome from Pakistani officials. Bare-hand surgeons from the Philippines command some measure of respect in their native island. Their craft, alas, is not easily exportable. Some years ago, two elusive Philippino healers ingloriously ended their Alpine career in jail after several months of highly successful albeit illegal practice of their art in the rooms of otherwise sedate Swiss

hotels. As these examples suggest, the forms underground medicine can take from one country to another, depend qualitatively on the sectors of state involvement in health matters and quantitatively on the degree of bureaucratic regulation of medical services.

HEALTH CONTRACTING UNDERGROUND

For the sake of clarity some kind of classification is necessary. Four main types of services or commodities are potentially available in an underground health market:

1. The patient contracts for standard medical care outside public health laws with a practitioner trained in medical school, holder of a University degree in medicine and bound by the Hippocratic Oath or some equivalent ethical covenant. This can be called standard black market medicine. Such a service usually thrives wherever the public health systems boast a legal monopoly over heavily rationed medical services.

2. The patient contracts for forms of health care not available otherwise, with practitioners not trained in medical schools and not licensed by law to deliver medical care. Health healers, bare-hand Philippino surgeons, naturopaths, etc. are in this category, which can be defined as underground alternative health care wherever such practices are banned.

3. The patient contracts with healthy individuals on a commercial basis for specific health related services such as surrogate pregnancies or organ transfers whenever these are restricted or forbidden by existing law. We can name this the underground bio-transaction market. One cannot doubt that if the present trend towards political regulation and curtailment of human gene technology continues, we will soon be faced with a specific black bio-market for gene surgery.

4. There is of course a black market for pharmaceutical products. This encompasses both addictive, recreational or performance enhancing drugs, as well as curative drugs either restricted by rationing of imports (e.g. antibiotics in Eastern Europe) or unavailable because of bureaucratic regulations governing the introduction of new drugs (e.g. those of the FDA in the US).

There is a strong case against laws, which force healers outside regular markets. These laws violate freedom of contract as blatantly as those that would imprison doctors and patients within closed bureaucratically regulated markets. Much could also be said on the perverse side effects of "the moral equivalent of war" governments have launched against drug black marketeers. Such issues, however, lie somewhat beyond the scope of a study meant to focus on the relationship between the underground market and the medical ethic. Only those types of black market services that involve the professional group bound by the Hippocratic code of conduct (i.e. medical practitioners) will therefore be dealt with here.

THE HIPPOCRATIC LEGACY VERSUS STATE LEGITIMACY

The Hippocratic covenant is at the core of medical ethics. The Oath is basically a moral contract between the graduating physician and his teachers tacitly binding him to all his future patients. This contract is specific to medical practice and constitutes the common ethical denominator that traditionally governs the conduct of the medical profession. The Hippocratic code rests on two basic principles known to all medical doctors. The first obligation being of course "to treat patients to the best of one's ability and judgment and above all not to harm them or do them wrong." The second precept stresses the confidential nature of the contract between patient and physician: "I will keep silence on whatever I see or hear concerning the life of men in my attendance of the sick..."

Much has been written on the political control of medicine and its effects on medical ethics. Ernest Truffer, a Swiss ENT surgeon, was the first to expose, in 1981, the emergence of a "veterinary ethic" whenever and wherever intrusion from third parties led to a breach of the Hippocratic contract. Indeed few are the doctors today who do not have to face, in their everyday practices, the moral dilemmas and ethical compromises which plague the delivery of healthcare in a bureaucratically regulated environment.

If, as it clearly appears, state intervention is leading to a gradual erosion of medical ethics, two questions must be answered before the medical profession can consider withdrawing its cooperation with the state on ethical grounds: does government intervention proceed from an ethical postulate morally superior to Hippocratic values? If this were so, the shortcomings of state medicine can be denounced, but there is no point in opposing, at least on moral grounds, the legitimacy of state control. Assuming on the other hand that we find no clear cut ethical justification for government action, a second question follows: is a Hippocratic ethic at lesser risk in the black market than within current legal frameworks

Let us deal with the first question. Is today's government control of medicine - a heritage from Bismarck's Prussian socialism - morally justified whatever the losses incurred in terms of our Hippocratic legacy? The moral code of a single well-defined professional group is of course easier to identify and to defend than that of a complex institution such as government

Taken outside its medical context, the Hippocratic ethic is after all nothing but an expression of natural law. It sets the guidelines by which the ailing, the wounded and the weakened members of a thinking species can be looked after and cared for. The very terms of the Hippocratic covenant are designed to safeguard the fundamental interests of the weaker of two contractants. It ensures that patient and doctor contract as equals. The Hippocratic contract is attuned to the fundamental axiom of self-ownership: each human being belongs to himself and not to others. Whether he is ailing or not does not alter this basic truth. The doctor is not the owner of his patient's body, neither is the health administrator nor the politician.

The reverse is also true. The patient cannot own the doctor, he can only contract for his services. The health administrator can regulate the doctor's work only if both doctor and patient voluntarily consent to regulations. Slavery is never far when contracts are tainted with coercion.

The Hippocratic legacy cannot possibly clash with any legal framework that respects the axiom of self-ownership and its corollary that one must not do harm to others. As long as all parties respect the property rights all individuals have over their own minds and bodies, and over the product of their work, there can be fundamental moral conflict between the medical doctor, and a law enforcing agency, whether it call itself the State in an open system or the Mafia in an underground system. Looking at the past history of these two powerful institutions one may see that neither can claim a spotless record when it comes to elementary respect for property rights.

THE MORALITY OF INTERVENTION

We have so far established that medical actions are morally acceptable insofar as they are founded on the *primum nihil nocere* principle, the obligation, above all else, to do no harm. We must now take a closer look at the state and try to find a common denominator for all of its actions. We must find a moral hallmark which would be as specific to state agents as the "first do no harm" principle is to the medical profession.

We are of course all familiar with the forms taken by state intervention in everyday life. The day we are born, our parents register us in state administrative files. They are punished if they fail to do so. Compulsory education comes next, on grounds of the commendable goal to fight illiteracy (although Mormon parents are known to have been shot to death by US agents for attempting to school their offspring outside official institutions). Then we have military service, seldom voluntary… as soon as we start working for a living, the inevitable taxation of our income comes next. Now, what is it that distinguishes state intervention in our lives from that of other benevolent institutions such as the churches, the Salvation Army, the Diners' Club, our family doctor or our favorite aunt? The answer comes in one word: coercion! We cannot refuse to pay taxes or do military service without dire consequences: in the best of cases some of our property will be forcefully seized by the tax collector, or we will be bodily taken away from our homes and imprisoned. If we happen to refuse armed cooperation with government when it engages in that murderous rampage known as war, our lack of compliance is tantamount to "treason" and can cost us dearly. In every one of these cases the property rights individuals have over their own bodies and over the product of their work, are violated. We should be cautious about the moral code of an institution so readily prepared to resort to violence in order to implement its goals.

Let us assume, however, that wicked as the state may be when it tramples the rights of young men who refuse to be trained as cannon fodder or when it compels working citizens to feed its indolent bueaucracies with part of the product of their toils, it may after all be redeemingly moral when it comes to interventions in medical matters. As stressed before, it is an instinctive notion of our species that those in direct need of care must be helped in some way. One could argue that if an organization such as the state is the best agent for the realization of this end, it could be logical and moral that the medical profession, which after all follows the same goal, should be subordinated to the state in its delivery of care. However, is the state, when it intervenes in health care, truly guided by the principle that "all in direct need must be taken care of"?

Bismarck was probably the first modern ruler to implement a coherent national system of state controlled health care delivery. That such social endeavors were dictated by political expediency, rather than by moral considerations, can be suspected of a man who professed that: "... History's great problems must be solved by blood and iron." Bismarck understood that only a strong German society structured in a Prussian military way would efficiently furnish both the iron and the blood needed for present and future power games.

The social security scheme was the glue for this design. Some early socialists saw Bismarck's project as a bribe, intended to divert the working class from true socialist revolution. The prospect of outflanking rival socialist orators may indeed have proved a powerful prod for a consummate political strategist such as Bismarck. Whatever the ulterior motives, Bismarck's social security turned out to be a far more radical and pioneering step towards socialist control of society than inefficient programs such as Soviet five-year plans or ephemeral experiments such as the Paris Commune. From its inception, state control over medicine has had at best an ambiguous relationship with ethics. It will on the other hand remain intricately related to power politics. The mechanics of present day state intervention in health matters tend to corroborate this perception.

ETHICS IN DEMOCRATIC DECISION MECHANISMS

In all fairness, it is not possible to pass a moral judgment on state intervention in medical matters without looking at the decision making process which commands such action. One cannot determine whether decisions implemented by state agents in the medical field are dictated by ethical or moral considerations, without first identifying the decision

makers. Politicians and civil servants will generally answer that the ultimate decisions are taken by "the people". This could theoretically be true in countries where the rule of civil servants and politicians over citizens at large is checked by the principles of direct democracy. Even in such model democracies as Switzerland however, one could quote innumerable instances where those in power manipulate the democratic decision making process to suit their own ideological or political pursuits.

Let us make, for the sake of argument, the very hypothetical assumptions that there exists an ideal democracy where decisions taken by the people are untainted by previous manipulation by politicians and where civil servants comply with these decisions and implement them scrupulously. In such a system citizens will tend to vote according to emotions or to immediate interests. Many will enter the polling booth without full information on the issues put to ballot (and may even unwittingly undermine their own interests by their vote). Some may let their moral principles guide them in their choice but it is not certain this group would command a majority. Even if, against all odds, a majority of fully briefed citizens, overcoming emotions and egoisms, did occasionally attune their ballot to moral principles, the moral priorities of citizen A and B will not necessarily match those of citizen C, nor will they take into account the egoistical interests of citizen D. In fact, every democratic vote ultimately does some violence to the interests and aspirations of the defeated minority. Is such violence truly moral?

Doctors and patients everywhere constitute a minority with respect to citizens at large. The potential dangers they face even in a utopian democracy are evident: a process that escapes their direct control can determine their fate. In a planned society the funding of the health system is in competition with that of the armed forces, of education, of leisure, etc. The diversion of public funds towards the construction of sports facilities often meets with more popular support than the equipping of public hospitals with magnetic resonance scans. From the very earliest times, ruling politicians have acknowledged the importance of the *circenses* even if they have sometimes tended to forego the *panem*. Ceaucescu starved the Rumanians, but did not fail to offer them a Nadia Comaneci.

The issue of "people power" is theoretical. If one breaks down the state as an institution into its different components, one can see that, whatever the political regime, final decisions are made by politicians and implemented by civil servants. They are the ones who must answer for the course of action taken by the institution. They cannot disown personal responsibility for their actions by claiming to be the agents of a superior power. The moral legitimacy of the state must be examined in the light of the moral standards of its agents. Politicians and civil servants respond to various motivations. The former might enjoy the taste of popularity, power and honors whilst the latter will often be guided by an understandable desire for a safe career in an environment free from the risks of the market place. Except for party loyalty, dutiful repayment of political debts and equitable balancing of lobby pressures (more important than balancing budgets), ethical imperatives seldom get past the rhetoric state in the political market. The public political discourse is rarely in tune with the true intentions of the politicians nor is it consistent with the end results of their actions.

It is no secret that today's government actions in health matters are dictated by economic considerations, not immune to the pressures of conflicting health lobbies. Medical doctors' lobbies are overpowered by those of other interest groups. The sick and the lame and the wounded have other battles to fight than those of the political arena: except for AIDS activists, few have had the stamina to build resilient influence lobbies. In fact if one goes beyond the rhetoric of welfare, one can see that practically everywhere today, public health policies have come to reflect the interests of the stronger members of society! It logically follows that if one puts the Hippocratic ethic on one side and that of government intervention on the other, the moral balance unquestionably tilts in favor of the medical ethic. This brings

us to the obvious conclusion. There is no moral justification for state control of medicine. We can go further and positively state than any action by state agents that interferes with the Hippocratic covenant is clearly immoral. The fact that there may be laws or decrees that condone such intrusion is irrelevant.

MEDICAL ETHICS UNDERGROUND

Having established that the Hippocratic ethic is not safe in a state controlled health system; one has yet to demonstrate whether its survival in an underground market is possible. Let us examine in turn different forms taken by black market medicine and try to establish if they meet the ethical criteria defined at the outset, namely: is the "self ownership" axiom respected, is the *primum nihil nocere* principle safe and can the confidentiality of the medical contract be safeguarded? The last point is the easiest to demonstrate. Insofar as black market medicine is by definition an unlawful activity, secrecy is an essential condition of its existence. There is little room for third parties. It is therefore obvious that the confidentiality of the medical contract is safer in the black market than it would be even in an open market free from state intrusion.

Let us now look at the underground fate of the *primum nihil nocere* precept. The patient who resorts to underground medical services has in fact made a voluntary choice. After assessing the quality of treatment he would be getting at low cost in the public sector and that which he expects to receive in the black market at a cost, he has opted for the latter. His freedom of choice does not stop there: in an underground system he is free to choose his doctor. Practitioners competing for black market patients have a potent incentive to deliver the best possible treatment. A dissatisfied customer can land his doctor in jail! The accountability of the physician is greater in the black market: he cannot dilute his personal responsibility when things go wrong or hide behind the heavily protected legal environment of state medicine. It is easier for a doctor to treat his patient "to the best of his ability and judgment" in the black market than in a state controlled system that constantly pressures him to ration his time and care.

How does the self-ownership axiom fare in the black market? Publicly financed medical care fosters a peculiar relationship between patients and political health planners. Sooner or later, the latter tend to act as the owners of the former. Patients loose their freedom of choice whilst doctors forfeit their professional independence. In the black market, the patient pays directly for his medical care. His contract with the physician subordinates him to no one. He is and remains the owner of himself.

The notion of self-ownership in the black market can also be studied from another angle. Defending the morality of the black market by approaching the emotionally charged issue of the brokerage and sale of organ transplants may seem a perilous course. Yet this controversial topic best highlights the relationship between the "self ownership" and market. The shortage of "legal" donors and the risks linked to prolonged hemodyalisis has led to an active black market in the sphere of kidney transplants in countries where organ sales are banned. Doctors partaking in such transactions have been accused of unethical conduct and have suffered heavy legal and professional sanctions. Lawmakers who condone the bureaucratic rationing of medical technology are not necessarily in the best moral position to condemn kidney brokers whose transactions, letting aside emotional reactions, objectively diminish the number of victims of dialysis quota fixing. As long as the biological transaction is done fairly, with a consenting, fully informed and healthy donor, the fact that an individual should part with one of his organs for altruistic reasons or in exchange for money, is his prerogative. In giving or selling an organ for transplantation, he is exercising in full the ownership rights he has over his own body. If one must at all costs find a villain in

commercial bio-transactions one should not point at the risk taking broker nor at the ailing receiver but rather turn one's eyes to the welfare planner whose tamperings with the market breed such dire situations in which the destitute find it more expedient to sell their organs in black markets than to sell ordinary goods in ordinary markets.

CONCLUSION

What conclusions can we draw from these considerations? The first is that a complex collective institution whose entire action ultimately rests on coercion cannot be expected to follow a consistent moral code. The second is that when such an institution is empowered with total control of medical care, it becomes easier for the physician to stand by his own ethics in an underground environment than within the institution's monopoly. The ethical doctor in the black market can neither be goaded nor coerced into forsaking his principles. Doctors willing to overlook the Hippocratic covenant will find many opportunities for fulfillment as state employees: the difficult environment of the black market is not for them.

Defying the law can sometimes be the only course left for the doctor faced with legislation contrary to his ethics. In so doing he is guilty of no crime other than that of non-cooperation with a morally empty institution. By thus refusing violence to his conscience, not only does he act as a worthy disciple of Hippocrates: he also demonstrates his will to live as a free man in a free world.

BIBLIOGRAPHY

1. Peter H. Aranson, "Rational Ignorance in Politics, Economics and Law", Journal des Economistes et des Etudes Humaines, vol. 1, no. 1, 1960, pp. 43-59.
2. Lewis Albert Alesen M.D., "The Physician's Responsibility as a Leader", The Caxton Printers., Caldwell Idaho, 1953.
3. Frank Chodorov, "The Income Tax: Root of All Evil", Devin Adair, New York, 1954.
4. Bertrand De Jouvenel, "The Ethics of Redistribution", Cambridge University Press, 1951.
5. Hernando De Soto, "El Otro Sendero", Instituto Libertad y Democracia, Lima, Peru, Editorial Printer Colombiana, Bogota, 1986.
6. Wendy McElroy, "Demystifying the State", The Voluntaryists, Baltimore, Maryland, 1982.
7. Elizabeth Pflanz, "Aspects éthiques, juridiques et commerciaux des transplantation d'organes", Panorama Medical, 1990/I, Berne.
8. Murray Rothbard, "Power and Market", Sheed Andrews and McMeel, Mission, Kansas, 1970.
9. Ernest Truffer, "Independent Medicine, Hippocratic Medicine", Paper delivered to First Iatros Congress, Sydney, 1981.
10. Ludwig Von Mises," Socialism", Liberty Classics, Liberty Fund, Indianapolis, 1981.
11. Carl Watner, "Towards a Proprietary Theory of Justice", C. Watner, Baltimore, 1976.