

Panel Discussion

Issues in Medical Ethics

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Question:

After six years of medical training I am about to become a professional, and I realize that I have no understanding of the business end of medicine. I wonder if you can address the professionalism of the business of medicine. No one has trained me to deal with patients who are underserved — should I charge them or not charge them, and so forth? Should our training include something about this?

Dr. Mark Siegler:

Historically, medical students, residents and fellows have been protected from this kind of knowledge. Even clinical faculty was protected from a lot of the business aspects of medicine, so we were not well prepared to teach this. I think that it would be dishonest these days if we don't educate our trainees about the world that they are about to enter. I certainly do not think it should dominate medical education, but I think it is crucial that graduates of our programs understand the world that they are going to be entering, so that they can be best prepared for it.

Dr. Samuel Bloom:

As a longtime medical educator and observer of the medical profession, I think that medical schools and medical educators generally have made the decision that it is essential for the training period to concentrate on the science and clinical practice of medicine. And that only by an immersion in modern medicine can you produce a doctor. I disagree with this intellectually, but I have great respect for the fact that the medical profession has chosen this method. There should be preparation for the world of medical practice as well as the world of medical science and clinical decisions and judgment. But I seem to be a minority voice among medical educators and am often told that I don't understand because I am not a physician. It is not very sensible to turn anyone loose without

preparation for the realities in which they are going to work.

Audience:

What behaviors get medical students and residents called to the dean's office the quickest? Are they breeches of professionalism or something else?

Dr. Fred Hafferty:

What gets you in the most trouble is disrespecting, questioning a higher authority, failing to do something that you should have done, and general laziness. I don't think that it is failure in ethical and moral issues that gets you into trouble.

Jennifer Fehser:

I'd add cheating and dishonesty to that. I am a fourth-year medical student and from what I have seen, that is what gets people into the most trouble.

Dr. Roger Cornwall:

What gets you in trouble and into the chairman's office the fastest on my service is failure to answer a page — that is considered a breach of professionalism. Unfortunately, the residents who get called in for that don't see it as a breach of professional conduct but rather as disobedience to the hierarchy.

Dr. Rhodes:

What about the virtue of responsiveness and the importance of presence, showing up, calling, and spending time talking to patients?

Dr. Edmund Pellegrino:

I wonder if we wouldn't advance a little further in this conversation if we dropped the term "professionalism." What you are talking about is a moral obligation — to respond to a call is a moral obligation. When you are called on the carpet for a failure of ethical obligations, that relates to professionalism, but that is secondary.

Ethics is at the heart of the matter. I think that too much concentration on “professionalism” gets us off the major factor, which is that we have major obligations which go with being a physician because of the nature of what we do! I don’t think there is any way of getting off that hook. You can try to get off it by saying that because the chief wants this, it is a hierarchy issue. No, it is your duty as a physician!

Dr. Cornwall:

I think this point is sadly lost on our residents. For the most part, residents think that they have a professional duty to their superiors to follow the rules. They miss the whole point that those rules are to help us face our moral responsibilities.

Dr. David Neirman:

That’s exactly right. Ethics is the job of the director of the residency program or the director of the service. One of my problems is that today the directors of clinical services really don’t run the service. Often they are not present and they are not commenting on the ethical issues.

Audience:

How do we get medicine, as a profession, as a collective, back to making ethical and moral arguments against managed care requirements? How do we get the profession to address policies that are preventing us from practicing medicine properly, instead of arguing about pennies?

Dr. Stephen Latham:

You are right on that matter. As far as I’m concerned, our professional organizations have failed totally. They have become corporate entities. They have become unionized. They have become a guild. They have become loyal to each other rather than concerned with representing us as a moral community. I think the existing organizations today have lost their capacity to convince the public that they are acting in their interest. I don’t know how to bring back the concern for the public interest, but I don’t think we can do it with existing organizations.

Audience:

Dr. Pellegrino’s talk persuaded me that professionalism is tied up with unions and with trade activities. It is a reality constructed by organizations. Instead of using the word “professionalism,” we should talk about professional virtues. That phrase “virtue” gives a very clear signal.

Dr. Pellegrino:

I think the word “professionalism” is out there and a lot of people have rallied around it. It is not going to be so easy to get rid of it. We may need clarification of its fundamental basis.

Dr. Latham:

There are some areas where we have options and some areas where we don’t. Professionalism is entrenched in our law, in our culture, in our society. It is part of the tradition of medicine. We can’t get rid of the word. In the sociology literature, someone could write forty pages saying how bad the word is and that we shouldn’t use it. But we really don’t have any choice. We are stuck with the word “professionalism.” Since we are stuck with it, we had better define it properly, teach it properly and convince the public that it has a positive, and not a negative, impact. I also want to say that many existing associations are doing their very best to promote a positive professionalism.

Audience:

Dr. Pellegrino expressed many deep concerns about the ability of the current organizational structure to lead significant reform of behavior. Another speaker raised the issue that the application of antitrust law and the development of Medicare in the United States may have caused the profession to significantly lose the ability to police itself and, in essence, to reform itself. I would like to hear what is happening in Europe in terms of the medical profession’s ability to police and reform itself.

Dr. Thomas Rütten [panelist]:

In an authoritarian system, as medicine tends to be, I think that if reform is possible it has to come from those who practice the profession. We can’t expect reform to come from the top. In Europe, people have been talking about reform of the health care system for decades without changing the everyday practice of physicians, aside from some financial changes for certain groups of practicing physicians.

What has been said about authority is crucial both for medical ethics and for professionalism. We cannot rely on authorities exclusively, even if these authorities are role models in the best sense of the word. As long as we do, we are at risk of picking the wrong ones. Those who follow the wrong role models can turn from moral

physicians into criminals without understanding their transformation. We have to educate students, and ourselves, to be independent thinkers and to maintain a critical attitude toward whatever tests they confront, whatever structures, institutions, professional practices they encounter. Reason should be the prime authority for the physician's behavior.

Dr. Cornwall:

I would like to echo the comment that change probably cannot come from the top. I say that as somebody who is close to the bottom. We need to work on the inclusion of the young generations of doctors, including medical students and residents, in these discussions. A lot of attention needs to be paid to the opinions of these people.

Dr. Neirman:

Why wait to be included? Why not do something — I'm serious about that. You may not be invited to the party, but if you feel as you do and have a very fundamental understanding of the questions, you can challenge the older generations. Students can do something. Waiting to be invited is not the way to go about it.

Dr. Hafferty:

The request for reform from the bottom up is very sound, but it also makes me think of a paradox. We are living in a period of medical education reform that is dominated by the principle of activating the student, student-centered learning, problem-based learning. While there is a lot that can be done from the bottom up, it is very difficult to change the feeling of being at the bottom. Students and residents are at the bottom because of the social structure of medicine and the organization of the medical school. There is a hierarchy of status, and we retain the boundaries of the uppers and the lowers. So the paradox is that we encourage the people at the bottom to be active, to learn, to participate, to be part of the team. But at the same time, we remind them that they are still at the bottom and they are supposed to mind their p's and q's. We do this and we have no awareness of the duplicity of it. When students leave the medical school, they are going to encounter the same kinds of organizations — power driven and hierarchical — in which there are status boundaries. You have to smash your way from one level to the other. I do not believe that professionalism, in itself, can overcome these status and structural barriers.