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Commemorating Virtual Mentor's First Two Years

Commemorative Issue

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FROM THE EDITOR
Commemorative Issue: Random Acts of Kindness - Sustaining the Morale and Morals of Professionalism
Audiey Kao, MD, PhD

Countless stories about the experiences of those working, learning, and living within medicine's crucible are recounted and passed down from one generation of physicians to another. This crucible, otherwise known as internship, has often been characterized in military terms. Interns are seen as privates in boot camp, where their physical, mental, and emotional skills are pushed to the limits. Food rations and bunks are basic if not occasionally substandard. Many of the skirmishes and battles fought by interns are chronicled like wartime reports from the front lines. And, as in the military, a certain bond is established among physicians who live through the ordeal together.

While many of these boot camp analogies are right on target, the goals or ends of the 2 systems--one designed to train individuals who, in the act of defense, must sometimes do enormous harm, and the other designed to educate those who are expected to treat the sick with competency and compassion--differ greatly. The similarity of their means, however, creates circumstances in which the ends of medical education and training are oftentimes a casualty. Therefore, leaders in medical education and attending physicians (including myself) have a duty as teachers and mentors to address this system failure, even if it calls for random acts of kindness.

Though internship is now many years behind me, I still reflect on my experiences as an intern and wonder how things would have been different (or how I would have been different) if greater attention had been placed on sustaining the morale of interns, residents, and those around them. Many physician-educators have said that the toughening up process--being on call for 36 hours straight and seeing the course of disease through its initial acute phase--is a requirement of internship. Without it, these educators claim, one's ability to cope with the anxiety, frustration, and seeming chaos is undermined. While there may be some truth to that practical reasoning, many of the experiences of internship are unnecessarily exhausting and demoralizing. I would argue that the training and education of the next generation of physicians could be improved by giving greater consideration to the pivotal role that attending physicians play in setting the tone, spirit, and morale of the "troops" under their direction.

I am not suggesting that individual attending physicians can address all of the problems, especially the structural challenges, that confront academic medical centers in our changing health care marketplace[1, 2, 3]. But I firmly believe that attending physicians must be keenly aware that their values and actions serve as powerful signals to others on the medical team. Our conduct at all times--and this includes the actions we take to bolster (or undermine) the morale of our students--sets important examples. I'm talking about simple, commonplace actions such as providing food for the team post call, something I make a point to do consistently. I have not yet had occasion to draw blood or insert an IV, but if my team needed an extra hand, I hope I would do it. At this point, I'm sure some of my colleagues are muttering to themselves, "Get a reality check."

Whether one considers such actions as placing an IV or offering food to be random acts of kindness is not the issue. The relevant issue is that, as teachers and mentors for the next generation of physicians, we must find our own practical ways to sustain the morale of our students. The why, what, and how is up to each attending physician, as random opportunities to act kindly present themselves. Sustaining sufficient morale among interns and residents strengthens the moral basis of professionalism and our ability to educate and train future physicians (some of whom may be taking care of us when we get older and sick) in the practice of ethical and compassionate medicine.

I would like to conclude by briefly touching on the "golden rule." As children, most of us learned about right and wrong, good and bad, and what constitutes proper conduct by reciting the golden rule: do unto others as you would have others do unto you. For many faiths and religions around the world, this ethic of reciprocity serves as the basis for moral and ethical conduct. In reflecting on the value of morale, all of us who are teachers of medicine should ask ourselves: If I were an intern again, how would I want to be treated by my attending? The teacher inspired by the ethic of reciprocity is not motivated by personal benefit. Those who will benefit will be the generation of students who have as their attending physicians the students we are now guiding and teaching. Ultimately, and more importantly, the beneficiaries of our attention to the morale of the learning environment will be the current and future patients of our students. I firmly believe the simple wisdom of this ethic of reciprocity is a key to educating for professionalism.

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Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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VIEWPOINT
Commemorative Issue: Lessons from 30 Years of Teaching Clinical Ethics
Mark Siegler, MD

The best clinical medicine, Plato tells us, is practiced when the scientific and technical aspects of care are placed in the context of a personal and professional relationship in which the physician strives to win the patient's support and trust[1].

In this regard, the professional and ethical values described by Plato and those expected of contemporary physicians are remarkably similar. Both are based on a medical relationship with the patient in which the physician's core ethical and professional values are the foundation of good clinical care.

Although disagreements persist among experts about what aspects of medical practice are captured by the term "medical professionalism," wide agreement has nevertheless emerged in recent years within academic medicine that it is essential to try to teach the concept of professionalism to medical students and residents[2]. Based on 30 years of experience in teaching clinical medical ethics, I believe that any such educational endeavor must address the following 4 questions: Why teach it? Who should teach it? What should be taught? How and when should it be taught?

Why Teach Medical Ethics?
The fundamental justification for teaching clinical medical ethics (or, for that matter, any other medical school or residency subject) is based on its contribution to the care of patients. Therefore, the principal goal of teaching clinical ethics is to improve the quality of patient care in terms of both the process and outcome of care. If young physicians are equipped with the skills required to reach ethical decisions with their patients, their patients' dignity will be protected. This means that in educating young physicians, emphasis must be placed not only on the ethics of the actual decision but also on the ethics of the decision-making process. The skills of ethical analysis are part of the competence-set of young physicians and are a necessary complement to the scientific and technical aspects of clinical medicine.

Who Should Teach Clinical Medical Ethics?
Medical ethics should be taught by those who do it well and who have the capacity to motivate students and residents to improve the quality of both patient outcomes and their patient-physician interactions. These teachers could be either practicing physicians who have received training in ethics or bioethicists who have clinical experience. Physician teachers are especially desirable because they can teach

ethics in the clinical setting by reference to actual clinical cases, which is similar to the way most other effective clinical teaching is done. Physicians are responsible for resolving, rather than just analyzing, clinical-ethical problems in order to reach good decisions with their patients. Lastly, physicians also demonstrate ethically appropriate professional attitudes and values to students so that students learn both from the formal teaching of clinical ethics and from their teachers' modeling of ethical behavior and professional conduct.

However, it must be noted that an unfriendly institutional culture can easily undermine the well-intentioned efforts of those trying to impart professionalism by means of the curriculum. The greatest challenge in teaching professionalism is to modify the internal culture of the academic health center so that it better reinforces the values that medical educators wish to impart. Recently, I supervised a particularly empathic and compassionate resident who had admitted 10 patients in the previous 12 hours. She was tired, irritable, and overwhelmed by her clinical responsibilities. I tried to serve as her teacher and mentor but I now find myself with less time to teach because I am forced to document patient records in order to prove that I am not engaged in fraud and abuse. Also, many of the patients we care for are uninsured in our health system and are often neglected medically between acute in-patient hospitalizations. Further, our teaching hospital faces serious financial constraints, some of which have required firing nurses and other patient care personnel. Many of their tasks now fall to the overworked resident. As physician-historian Kenneth Ludmerer suggests, it is not easy to model and teach medical professionalism in such a commercial atmosphere which "does little to validate the altruism and idealism that students typically bring with them to the study of medicine"[3].

What Should Be Taught?

The teaching of clinical medical ethics should include 3 dimensions: cognitive knowledge, behavioral skills, and character development.

Cognitive Knowledge. Students should be introduced to the literature of clinical ethics, to the research methodologies used in ethics, and to a practical approach for ethical analysis. The specific curriculum should reflect the incidence and prevalence of clinical situations that are encountered in the students' or residents' work. Curriculum design also can be based upon published studies of the epidemiology of ethical dilemmas that are seen in inpatient settings[4], outpatient settings[5], or consultation settings[6, 7]. Another approach to curriculum design is to target teaching to the perceived needs and preferences of students, a list of which will be different for students and residents at different levels of training and in different specialties[8, 9 10].

Behavioral Skills. The assimilation and mastery of cognitive knowledge is not an end in itself for clinicians. To be effective in caring for patients, clinicians must have the behavioral skills necessary to put their knowledge to work in everyday clinical encounters[3]. A physician who knows the legal and ethical requirements of

writing an order not to resuscitate should also be expected to know how and when to approach patients and families in a thoughtful and sensitive way to initiate discussions about DNR status. Instruction in the behavioral skills of clinical ethics requires teaching and role modeling by experienced clinicians who can demonstrate the skills in practice. It further requires that students have the opportunity to practice these skills while being supervised by experienced clinicians.

Character Development. In *Meno*, Plato asks Socrates, "Is virtue something that can be taught? Or, does it come by practice? Or, is it neither teaching nor practice that gives it to a man but natural aptitude or something else"[11]? This ancient question defies an easy answer. In my view, medical education and training provides students not only with a new vocabulary and a new knowledge base, but also serves as a moral pilgrimage in which character and attitudes are molded by the experience of caring for sick patients. While most students will change during training, not every student will emerge from the training pilgrimage with a set of character traits that insure that ethical and professional standards are always maintained. This, in turn, places a heavy burden on those who help select medical students for admission to medical school. Medical school admissions committees do very well, but sadly, there is no gold standard to identify with precision those students whose character flaws may prevent them from developing the kind of ethical and professional attitudes that society wants and demands of its physicians. Left to myself, I always would select positive character traits (if I could identify them) over GPAs or MCAT scores, but I acknowledge that such a selection process is an art, not a science.

How and when should clinical medical ethics be taught?

At the University of Chicago, we emphasize 6 principles (the 6 C's) in teaching clinical medical ethics. (1) Clinically-based: Teaching should center around a clinically oriented situation. (2) Case-based: Real patient or clinical cases should serve as the teaching focus. (3) Continuously reinforced in class: Teaching clinical ethics should be continuously integrated throughout the 4 years of medical school and residency training. Whenever possible, ethics teaching should be linked with students' other learning objectives. For example, an ideal time to teach about brain death and the vegetative state is during a basic science course on neuroanatomy and neurophysiology. Similarly, the introductory anatomy course offers a unique opportunity to deal with issues of death, dying, and respect for the dead body. The course on history taking and physical diagnosis is the optimal time to engage students on topics such as the doctor-patient relationship, truth-telling, confidentiality, and informed consent. (4) Coordinated with clinical clerkships: Clinical teaching about ethics and professionalism is best accomplished by integrating teaching into each of the students' clinical clerkships. Coordination disrupts the pattern of clinical education least, takes advantage of student involvement with actual cases, and eliminates the problem of designing a course to cover all the major ethical and professional issues encountered in all major specialties. (5) Clean: Clinical medical ethics teaching should be clean (ie, simple). Our model for teaching clinical medical ethics includes cognitive training in the fundamentals of ethics with a core set of lectures on 8-10 important topic areas, a

recommended text that is clinically oriented, a basic approach to ethical decision making[12], and a bibliography of accessible articles and reference materials for further reading. This cognitive information is supplemented by providing students with opportunities to develop behavioral skills in their clinical work ("See one, do one, teach one"). For example, after reading about the core elements of informed consent, a student observes a skilled clinician negotiating consent with a patient and the student is then given an opportunity to elicit informed consent while the instructor observes the student-patient interaction. (6) Clinicians as instructors: Clinicians should participate actively in the teaching effort both as instructors and as role models for the students.

Although medical ethics has been taught in most American medical schools since the 1970s, there is little data to document whether such ethics training has been successful in improving the process of patient care or patient outcomes, strengthening the doctor-patient relationship, or improving the way medical decisions are reached. Very few studies, if any, have examined the impact of medical ethics teaching or of medical ethics generally on the quality of patient care. For example, one major study showed that despite medical ethics' 30-year preoccupation with end-of-life issues, the care dying patients received in American hospitals is inadequate both clinically (in terms of failing to provide sufficient pain medication) and ethically (in failing to respect the wishes of dying patient)[13]. Professor Leon Kass, one of the pioneers of the American bioethics movement, recently commented critically about the achievements of bioethics: "Though originally intended to improve our deeds, the practice of ethics, if truth be told, has at best improved our speech"[14]. As we move forward to develop and implement a national effort to teach medical professionalism, one lesson to be learned from teaching medical ethics relates to the failure of medical ethics to document its achievements. This suggests that in developing teaching in medical professionalism, it is essential to specify the goals of such new teaching, to demonstrate how such teaching improves the process and outcome of patient care, and to develop from the outset methods to evaluate its impact on students[15].

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Mark Siegler, MD is the director of the MacLean Center for Clinical Medical Ethics.

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CASE AND COMMENTARY
Commemorative Issue: Renewing a Prescription for a Relative
Commentary by Audiey Kao, MD, PhD

Case
Ann is completing her internship year at a major teaching hospital. Her brother Michael, who lives 100 miles away in a rural setting in the same state, has been seeing a psychiatrist for anxiety disorder and depression and has been taking medication for his illness. Without the medication, he would have severe panic attacks that would force him to avoid most social situations and to experience episodic bouts of severe depression. Michael is almost at the end of his medication and learns that his psychiatrist is out of town on vacation. He telephones his sister and asks her to call in a prescription refill. Ann readily complies, believing that her brother's circumstances warrant her to use her status and authorize the prescription refill.

Questions for Discussion
1. What do you think of Ann's reasoning? What other options does she have? Is she putting her brother Michael in any danger by refilling his prescription?
2. Would the situation be different if Michael were Ann's friend? Does the type of illness or medication make a difference?
3. Why is it considered unethical for physicians to treat their immediate family members?

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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FROM THE EDITOR
Commemorative Issue: A Physician by Any Other Name
Audiey Kao, MD, PhD

What's in a name? In Act II, scene ii of Romeo and Juliet, William Shakespeare's young hero says: "That which we call a rose/ By any other name would smell as sweet." It didn't matter to Romeo that Juliet bore the surname "Capulet," a name despised by his own Montague family. He loved her for who she was. In affairs of the heart, lovers may be both blind and "illiterate" to the connotations of names and titles, but as Shakespeare's most famous tale demonstrates, the consequences of their "illiteracy" can be fatal.

In the medical realm as with other social ecosystems, the names we use to identify various participants matter a great deal; they reflect and shape the identities, obligations, and expectations of those in relationship. Until recently, terms used to refer to those we seek out when we are sick have changed very little. The term "physician" has been around since the days of Hippocrates, and derives from "physik," an ancient Greek word for "nature." Hippocratic physicians understood illness as part of the natural order (as contrasted with those healers who believed that illness was part of the supernatural order--punishment from the gods) and sought explanations for illness in the physical world.

The term "doctor" came into usage in the Middle Ages (13th - 15th centuries) when the education of physicians shifted to the university setting. "Doctor" signified a physician who had received formal university training, usually with a heavy emphasis on the teachings of Aristotle and Aristotelian logic. Thus if one wanted to be technically correct in applying the terms "physician" and "doctor," one would say that Hippocrates was not a doctor, although he was a physician.

Beyond etymology, an individual who is sick and seeks the care of a doctor has certain expectations about this interaction and the professional obligations of the physician. Patients expect their interests will be put above those of the physician. Patients rely on their doctors to keep sensitive information private and confidential. Patients count on their physicians to treat them with empathy and compassion, especially when that is all that can be offered. And patients expect their doctors to act as caregivers, not as purveyors of a health care service. In essence, patients must trust that when they seek the care of a doctor at a time of illness and thus vulnerability, the physician will employ his or her specialized expertise and educated judgment on behalf of the patient 's health and well-being.

Today's lexicon is increasingly muddled. Physicians are commonly referred to as health care providers, a name change that is anything but benign. In our increasingly market-driven health care system, the use of such terms as "health care provider" supports the notion that the interaction between patient and doctor is no different than an economic transaction between a buyer and seller. In this commodity model of medicine, health care providers are guided by a market ethic; they are not bound to the professional ideals and obligations that have defined medicine for centuries. To those (perhaps chiefly the young and healthy) who say that our traditional lexicon is outdated, its professional model unnecessary, and that "health care providers" are interchangeable with physicians, I can only reply, "Caveat emptor."

In addition to the profound impact of a market ethic on medicine, other changes with potential to undermine the integrity of the therapeutic relationship confront patients and physicians. The explosion and proliferation of medical information, while empowering the lay person, can erode trust in the judgment and authority that has traditionally resided with the learned professional. Advances in the biomedical sciences, especially the possibility for new treatments and cures opened by unlocking the human genome, are welcome. But they can also redefine our concepts of disease and affliction and ultimately alter whom we choose to treat. Our growing diversity forces us to confront personal differences and individual biases, and the patient-physician relationship is not immune to these changing norms, styles of conduct, and trends in society at large. Each of the changes in the evolving medical landscape challenges the integrity of the patient-physician relationship, the trust that has been at the foundation of this therapeutic dyad for centuries. What will future participants in this special encounter expect from each other when they come together?

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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VIEWPOINT

Commemorative Issue: The Trend Toward Casual Dress and Address in the Medical Profession

Sara Taub, MA and Kayhan Parsi, JD, PhD

Your brand-new family doctor walks into the waiting room, spots you, and hurries over to introduce himself. He slaps you cheerfully on the shoulder and then booms: "Hiya, Bob! I'm Dr. Hotchkiss! What's up"[1]?

One of the more enduring changes of the "dotcom" revolution of the 1990s is the movement toward casual dress in the workplace. Suits and ties are out. Polo shirts and khakis are in. Ninety percent of US companies allow some form of casual dress, up from 62 percent in 1992[2]. Traditionally staid employers such as law firms and banks are enthusiastically jumping on the casual bandwagon, though some still require formal attire for interactions with clients. Employers argue that it is a perk that improves worker morale, yet costs nothing.

This "casualization" in the workforce is but one component of a larger cultural trend in which social relations and forms of address are less formal than they were a generation ago. Adult peers typically dispense with formal titles of address (eg, Mr. or Ms.) and move directly to a more familiar first-name basis. This may reflect a certain democratization. It also may reflect the influence of youth culture, where informality and spontaneity are greatly prized.

Is society better off with more formal or informal styles of dress and address? Is this an ethical issue or one of mere etiquette? Does what we think of as "mere etiquette" have some ethical significance? Consider the opening scenario. Is the physician's etiquette likely to affect the therapeutic relationship?

Casualization has indeed influenced dress and behavior within the health care arena. Nurses long ago shed the white uniform and cap for more practical and comfortable garb. Certain television shows, such as ER, have helped popularize the loose-fitting surgical scrub as the uniform de rigueur in medicine. Some places, however, attempt to draw the line in casualization. One academic medical center reinforces the notion that casual dress may not be in the best interest of the patient-physician relationship:

> A physician's appearance serves as a powerful, nonverbal symbol that affects communication between doctor and patient. Patients react negatively to jeans, athletic shoes and socks, scrub suits, clogs, prominent ruffles, dangling earrings, and excessive aftershave lotion or perfume. Patients express preference for well-trimmed hairstyles[3].

Physicians have mixed responses to these matters, as exemplified in an exchange of letters in the *Newsletter for the American Society of Anesthesiologists*[4]. One physician claimed, "You have to 'talk the talk,' 'walk the walk' and 'dress the dress' if you want to be recognized as a physician." Another stated, "When it comes to our attire, anesthesiologists need to stop being so egocentric: we dress for our patients and for the professionals with whom we work, not for ourselves." And a third added, "How many times has the perception that we are slobs affected interactions with the public, other physicians, hospital administrators and health care organizations?" But a dissenting voice felt that "[n]o amount of gaudy, expensive dress will ever make some anesthesiologists professional. . . . [A] physician can act professionally regardless of what he or she is wearing."

The effect of dress on patients has even been studied by physician researchers at West Virginia University. Dr. Dorian Williams, associate professor in the Department of Family Medicine, led a study in which they surveyed 209 patients, 62 medical students, 63 residents and 109 faculty members. Dr. Williams hypothesized that patients wanted a more professional look among residents, and his study tended to prove him right. Even more interesting, physicians and patients alike favored white coats and name tags. Nonetheless, Dr. Williams argues that a physician's specialty and the length of the patient-physician relationship matter. "In psychiatry you can overdo it too. In anesthesiology . . . a scrub suit works fine. If you are a community-based doctor and your patients know you, casual dress may be OK. But certainly if you don't have an established relationship with the patient and you are working for someone else, representing their institution, the patients want the doctor to look professional," he said[4].

The range of perspectives represented in these comments points to the larger question: Does casualization compromise the therapeutic relationship? There are those who argue that physicians' professional attire and behavior play an instrumental role in their communication with patients, inspiring confidence and credulity and indicating respect and a desire to please. If this is indeed the case, casualization may indicate a significant change in how physicians choose to relate to their patients--one that could have consequences for patient care and deserves to be studied further. On the other side of the debate are individuals who claim appearance and attitude are mere matters of social etiquette. They insist that a physician's medical abilities are what really matters; questions of dress and address are frivolous criteria by which to judge a professional responsible for promoting medical well-being.

Whether casualization in the doctor-patient interaction is one-sided or reciprocal may color general reactions to the trend. If the relaxing of social etiquette norms is exercised only by physicians, it could reinforce the power differential that already exists between patient and physician, rather than foster a more comfortable environment for all. Although the white coat worn by physicians has long been criticized as a symbol of power that skews the medical encounter, Williams' study seems to suggest that patients appreciate seeing physicians wearing it. This reflects

the fact that non-professionals expect professionals to don certain kinds of uniforms in order to contextualize the relationship and give it the gravity and respect it deserves. For instance, seeing a judge in street clothes rather than judicial robes would probably send the wrong message to litigants--that the judge is just another person who does not have special duties with regard to the proceedings. These social expectations and psychological responses are evoked by other professional uniforms, whether they are worn by police officers, members of the military, or clergy. The style and formality of the dress set the relationship apart from ordinary business encounters, reminding physicians of their professional obligation and reinforcing the patient's confidence in the individual clinician who, as denoted by his or her attire, is a designated representative of a trusted profession.

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Sara Taub, MA is a research associate in the AMA Ethics Standards Group.
Kayhan Parsi, JD, PhD is a fellow in the AMA Ethics Standards Group.

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ART OF MEDICINE
Commemorative Issue: Mona, Is That You?
Audiey Kao, MD, PhD

Mona is a 24-year-old, olive-skinned female with a diagnosis of thaasophobia, complicated by severe geliophobia.

How effective are conventional means for protecting patient privacy and confidentiality, the foundations for trust between patient and physician?

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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PERSONAL NARRATIVE
Commemorative Issue: Through the Student's Eyes: "But I Don't Eat Sweets"
Michael Bevins

Nowadays, a large part of primary care medicine involves the treatment of chronic diseases like hypertension, diabetes, and high cholesterol. Such conditions can be very difficult to manage, especially when they cause their bearers no sensible burden. A seemingly simple plan, some slight diet modification, and a couple of pills a day, for example, can prove nearly impossible to carry through, hence the ubiquity of what is somewhat condescendingly referred to as patient non-compliance. Unfortunately, we have yet to find a way to make ourselves do what we know we should, let alone the key to making others do what we believe they should. Nevertheless, the blame for medical sins of omission, such as failing to take medication or to quit smoking, is most easily placed on the patient..

Anyone who spends time in a Family Medicine clinic will become acquainted with this problem, even a second-year medical student like myself. One day, I met Mrs. Gracia, a friendly Hispanic woman in her mid-50s with a history of diabetes and hypertension, for which she took medication. According to her records, the hypertension was well controlled. The diabetes was another story, however. For as far back as her records went, which was about two years, blood test results monitoring her diabetes had elevated significantly. Not surprisingly, on that day her blood glucose was more than double what it should have been. After looking at the records, I recalled some of the complications of diabetes: neuropathy, heart disease, vision problems, kidney damage, and I rehearsed some pertinent interview questions before introducing myself and asking Mrs. Gracia how I could help her.

Well, she just needed to refill this medicine here and other than that everything was good. She told me she felt great, was active, had been taking her medicine, and had no problems. But good health is so unsatisfying for an eager medical student; perhaps I'd just have to get specific. Fatigue? No. Weight changes? No. Chest pain? No. Numbness or tingling in her hands or feet? No. Vision problems? No. Urinary problems? Infections? Appetite changes? No, no, no. We continued in this manner until I had exhausted every avenue I could think of to uncover a sign of ill health. But she would not budge. In fact, if not for her persistently sky-high lab values, you'd never know Mrs. Gracia had diabetes.

Measuring your blood pressure at home? No. How about your blood sugars? No, she didn't like needles. "But I really don't eat sugar," she added, "You know, that's why I don't get why I have sugar diabetes: I've never been one to eat sweets." At

this point, I explained to Mrs. Gracia that she could have too much sugar in her blood even if she didn't eat a lot of sweets, and that people didn't get diabetes from eating too much sugar. She seemed surprised to learn this, but she said she understood. Nevertheless, I remained unsatisfied, and I sensed that the issue had not been settled for Mrs. Gracia either. Surely, I thought, this had all been explained before, probably many times. But then why didn't she get it? And why did I get the feeling that she didn't believe what I had just told her?

Demonstrating the generosity of most patients who participate in medical education, Mrs. Gracia did not object to being seen twice more: once by the resident and myself, and once with the addition of the attending physician. But when questioned the second and third time, both in Spanish, her story remained the same: no problems. She again admitted to not measuring her blood sugar at home, although she claimed to be taking her medications. The physicians were concerned about her lab values, however, and they tried to stress the importance of home monitoring. Mrs. Gracia nodded along and said, "Okay," when told she would have to stick her finger every day to measure her blood sugar. Was she acquiescing or just being polite?

During the third interview, she repeated her puzzlement at the diagnosis of sugar diabetes since she didn't eat much sugar. Again it was explained, this time by the attending physician, that her diabetes was not caused by eating lots of sweets. Surely she understood now. Surely everything would fall into place now that she had been offered this fact with the endorsement of 2-1/2 white coats. But she seemed as surprised to hear it as she had been when I told her the same thing not 20 minutes earlier. Had I not been clear? Or did she just need to hear it from a doctor? Either way, she said she understood.

Perhaps because of my mediocre Spanish skills, my wandering mind, or something else, I'm not exactly sure what happened next, but Mrs. Gracia became angry. It seems the attending physician implied that Mrs. Gracia had been remiss in her treatment. Perhaps she hadn't been taking her diabetes medication or sticking to her diet, because her lab values should not be so high if she were doing as she was supposed to. Her response was surprising. This previously soft-spoken, pleasant woman shouted, "Believe me or don't. But I do not eat sweets!"

I understood this much: that she could have high blood sugar, despite not eating a lot of sweets, had not reached Mrs. Gracia. But how could that be? She said she understood. Maybe she hadn't after all, or maybe she just didn't believe it. Either way, I could practically see that simple fact gasping for life at Mrs. Gracia's feet, lying on the floor between her and the attending physician. For some reason, it simply could not find a place among her worries over meals, work, family, laundry, prayers, bills, etc.

The attending physician reassured Mrs. Gracia that he believed her, but that he was very concerned about her high blood sugar. It was no use. There was no getting

beyond the wall that had gone up between the patient and the doctor. Despite the unusually large amount of time spent with her, Mrs. Gracia was not convinced, and now she was angry. She was going to continue with her daily activities as she had before: not eating sweets, not sticking her finger, maybe taking her medication, still not understanding why she had sugar diabetes. Nevertheless, a respectable effort had been made, and the effort would be made again. Meanwhile, other patients were waiting.

Granted, many people manage their chronic conditions very well. But the ones that don't should concern us. As a student, I have been assigned to physicians who seem not to have even one non-compliant patient, while others have more than their fair share. Nevertheless, the key to success remains elusive. Perhaps it lies in a place we are unlikely to look. Most of us are inclined to locate the blame with the burden, that is with the patient, who after all must take the medicine, eat the vegetables, do the exercise, etc. But this is too facile, just as is blaming the physician. In those difficult situations in which it works, managing chronic conditions seems to depend on what exists between the patient and doctor, on a relationship of mutual understanding and reciprocal responsibility. Successfully managing diabetes, hypertension and the like is far more than a simple set of instructions that a patient must follow. It is a process in which both patient and physician are mutually engaged and from which both benefit. In short, the responsibility for managing chronic disease is a shared responsibility. Unfortunately, these are often the hardest responsibilities to fulfill.

Questions for Discussion

Mrs. Gracia does not understand her diabetes, need for treatment, or dietary restrictions. How might a medical student raise concerns about this patient's lack of understanding to her physician, who is also the medical student's preceptor? Given their time constraints, how can physicians make better use of their patients' social support networks and the expertise of other health care professionals in situations such as this?

Michael Bevins is a research assistant in the AMA Ethics Standards Group.

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MEDICINE AND SOCIETY
Commemorative Issue: Patients at the Margins
Sam Huber

Awareness entails the consistent effort to be mindful of the needs of individual patients and how effectively we might be meeting those needs, as well as our own. Vulnerability is inherent in the medical encounter, and learning to manage the needs and abilities of both patient and physician can be a central part of professional development. There is a tremendous amount of information which physicians must marshal during any one clinical encounter. Maintaining medical awareness is complex in its own right, and adding additional perspectives on informational, cultural, social, or spiritual needs may seem a daunting task, but the results are more effective and efficient care.

The idea of physicians as advocates for their patients or for groups of patients is not new, nor is the notion of physicians as instruments of social change anything radical. Still, the physician remains a potential source of effective support for the social needs of patients. Being a voice for awareness or for proper distribution of resources with respect to needs and responsibilities is an important part of both an individual and institutional commitment to the health of society. While activism in medicine is essential, care should be taken that zealous advocacy not become paternalism and that autonomy remains protected. We can advocate for access, increased medical literacy, and better quality of care, but patients must still be left to participate in their own health and their own health care.

While the category of professional responsibility is broad and multifaceted, it may be in part simply viewed as a call to citizenship and a duty to provide competent and compassionate care. If each patient is seen as having certain needs and vulnerabilities, then developing awareness of them and managing resources around the best mutually derived treatment plan comes close to what might be described as standard of care. In this light, there is a professional duty not only to provide care for populations who might be considered marginalized but also to cultivate an awareness of specific or individual vulnerabilities and to advocate for appropriate awareness and allocation of resources. Just as poverty and vulnerability extend through the biopsychosocial spectrum, so does professional responsibility apply to individuals, institutions, and professional societies, and the profession as a whole. The physician as social activist need not only be a personal battle or grassroots effort, but may also be an institutional, educational, or social position. None of these are mutually exclusive or isolated but rather are points on a continuum of commitment.

With these considerations, classroom discussion of a hypothetical Mrs. Jones who can't afford her diabetes medications can move beyond the dilemma of whether or not to support her on free samples. A perspective utilizing awareness, advocacy, and responsibility includes the difficult questions of distributive justice, and also allows for the exploration of whether or not Mrs. Jones understands about her disease and how to take her medication, whether the television commercials she is watching support or erode her dietary and exercise regimen, and how one might work as an individual or part of an institution to make changes at the biological, social, corporate, or political levels to make Mrs. Jones' participation in her own health care more effective. Mindfulness of these ideas can be part of daily practice if encouraged as part of the practice of good medicine.

Sam Huber is a research assistant in the AMA Ethics Standards Group.

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HISTORY OF MEDICINE

Commemorative Issue: Physicians and the Obligation to Provide Charity Care

Karen Geraghty

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 Ages[2], 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 accorded[3].

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 services[4].

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 services[9].

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 associations[10]. 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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Karen Geraghty is a fellow in the AMA Ethics Standards Group.

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PERSONAL NARRATIVE
Commemorative Issue: "Please Help Me. My Baby Is Sick and Needs Medicine."
Robert C. Davidson, MD, MPH

The neighborhood has very nice homes, many of which are owned and occupied by Asian Kenyans. These folk are third- or fourth-generation Kenyans who culturally continue to relate to India. They are the descendants from the Indian railroad workers brought into Kenya during the British colonial rule. They have prospered in Kenya financially, and "Asians" own many of the larger Kenyan companies. It seems curious that after 3 or 4 generations they still do not identify themselves as Kenyan. We have enjoyed our conversations with our Asian Kenyan neighbors, and they have frequently given us advice, particularly on how to interact with "Kenyans." It has been more difficult than we thought to relate to "African Kenyans." We have a great relationship with the Kenyan staff at work, both the professional and clerical staff. We have had some wonderful discussions about America. At our Fourth of July party we all toasted our common heritage of rebellion against British rule. However, the rest of the Kenyans with whom we have daily interaction are at such a different income level that it is difficult to be friends or even friendly.

The level of poverty and unemployment in Nairobi is so high that we are constantly made aware of the disparity of resources. "Please help me. My baby is sick and needs medicine." This plea came from a woman in rags sitting on the street outside our home with a baby asleep on the dirt. Perhaps the easiest thing to do would be to give her some shillings, which might make me at least feel a little less guilty. However, we are repeatedly warned by other expatriates and our Asian Kenyan neighbors to give nothing to beggars. They will return tenfold the next day, we are told, if the word gets out that the "daktari" gives money. Perhaps some examples will help portray the dilemma.

We interviewed for a man to help with housework and driving. "Lucas" was selected. He had a pleasant personality and came with good references. However, problems quickly began to arise. Lucas was repeatedly absent for several days at a time due to illness. He came to see me at home on a weekend and asked me to get him some medicine to cure him. I asked if he had seen a doctor. Of course, the answer was that he could not afford it. He then proceeded to take off his shirt to show me a rash that was bothering him. As I gazed at an emaciated body with a typical Herpes Zoster rash, I immediately suspected the problem. This man was in the later stages of AIDS. The physician part of me began to race through options.

How could I help? I knew I could not be his physician. I did not even have a Kenyan medical license. He could never afford retro-viral drugs or even lab tests and preventive therapy such as Sulfamethoxa-zole/trimethoprim. I began to worry that his cough might be more than a simple problem. Could he be spewing mycobacterium on my wife as he drove her around in the car? My mind returned to an incident the previous week when he had presumably fallen asleep while driving and almost went off the road. I of course knew he could no longer work for us. I was not worried about his infectivity, but rather his capacity to do the job. We sat on the porch and talked for a long time. He seemed to understand that he could not work any more for me but began bargaining for some money so he could go to the doctor, get cured and find another job. I simply could not say no. I gave him one month's salary as terminal pay and some extra money to go see a doctor. We left on good terms.

The next day he was back with his daughter in her school uniform. "Please, I need some money to pay my daughter's school tuition or they will kick her out. She wants to be a doctor like you." As hard as it was, I held the line on what I had already given him and assumed this ended the saga. The next day his wife showed up toting a small baby. "Please, daktari, Lucas is very sick and will die if you do not give him some money for medicine." My heart went out to this woman. Was she also HIV+? Was the baby? How could I justify sitting on the porch of this beautiful home saying no to her? On the other hand, where would it stop? This is one of the dilemmas of "giving" in Kenya.

Recently, I visited a mission hospital outside of Nairobi, staffed by rotating American physicians under the auspices of their church. The chief surgeon, an orthopod from Atlanta, immediately took hold of me and urged, "Come with me. You have to see something." He led me to the bedside of a precious 10-year-old Kenyan girl. She had been brought to the hospital following a snakebite. He had operated to remove necrotic tissue from the area of the bite and relieve the tremendous pressure from swelling. However, she was showing increasing systemic manifestations of the venom. In his opinion, if she did not receive anti-toxin within the next 24 hours, she would probably die. Did the Peace Corps have any? How about the US Embassy? Could I help him? My mind began to race. Yes, I knew that we stocked a shared supply of anti-venom with the US Embassy medical office. It was for use on Embassy personnel or dependants or Peace Corps volunteers. The words from my orientation sessions came ringing back. "Under no circumstances are you to treat or give medicine to any person other than authorized US personnel." This was the General Counsel for the Peace Corps speaking. My boss, the director of clinical services for Peace Corps and a general surgeon, leaned over and whispered, "You better listen to this, as you will be tempted." The speaker went on to outline the dire consequences which could ensue if we "misused" US property. OK! I can handle this, I mused. However, standing in a mission hospital a world away from Washington, looking at a little girl that I could probably help from dying, was not part of the bargain. The US spent millions in aid to Kenya. How could I justify not "giving" to this little girl and this caring and dedicated physician?

The harambe is a long-standing cultural custom in eastern Africa. It has been explained to me that it comes from the tribal custom of helping other members of the tribe in times of need. During my first week in Nairobi, one of the staff said there was a harambe for one of the secretaries and I was invited. Great, I thought. It is nice to be included. It turned out that it was not a gathering at all. Rather, it was a memo to all participants telling them how much they "owed." I have always been supportive of the graduated income tax, but wow, this was a pretty hefty bill. I paid the money, mainly because I was new in country and did not know what else to do. I did not have a very good feeling about it. Sure enough, the next week I was invited to another harambe. Was this the spirit of giving I wanted? Where would it end? Was I being selfish for wanting a bit more personal involvement and control over my gifts? Would I be culturally insensitive if I did not join in this "long standing Kenyan tradition"?

I could cite more examples, but I think these give a good picture of the dilemmas faced by an American physician in eastern Africa. I purposely did not say how I decided to respond in these situations. The issues are more important than my responses. I do not view my working here as a "gift" to anyone. I am supported well by the US Government through the Peace Corps, and I am gaining much more than I am able to give through my work as a physician. I do feel a desire to "give" in the face of the huge need I see in this country. We are slowly finding what works for us, but if you are faced with the same situation, expect the decisions to be harder than you think.

Robert C. Davidson, MD, MPH is professor in the Department of Family and Community Medicine at University of California, Davis, where his interests include both rural health and the organization and financing of health care systems. In the past few years, he has served as both the director of Rural Health and earlier as the medical director of Managed Care for the UC Davis Health System. *Out of Africa* is an on-line journal of his odyssey in the US Peace Corps as the area Medical Officer in Eastern Africa.

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PERSONAL NARRATIVE
Commemorative Issue: Through the Student's Eyes: Keeping the Trust
Sam Huber

There is a responsibility for a student to engage in the process of making medicine. It may seem ridiculous, but the deans mean it when they say that we are (at least in part) the future of American medicine. To take on those seemingly lofty goals and try to become them is part of the tuition of medical education.

There is a history of apprentice-style learning in medicine. Part of being an apprentice is taking on the goals and dreams of the instructor. When one learns to think in a particular way, one learns to dream that way too.

Just as medicine happens between a patient and a physician in a human relationship, so does the personal relationship of education happen between a student and a teacher. Medical education, like medicine itself, is more than a product or a commodity. It is an experience and a relationship. The goals and reasons for going to medical school, one's own personal manifesto, allow one to enter into the educational relationship. From there, it is a matter of continually reevaluating one's direction. Professional education is not about youthful collegiate theory or idealism coming into contact and conflict with the harsh pragmatic reality of gloomy contemporary medicine. It is about incorporating other ways of thinking into one's personal schema and using them to gain and make new knowledge as well as to make medicine. The instructor has a duty to impart medical information and methods of thinking in the most genuine way possible. The apprentice has the difficult job of trusting the instructor while simultaneously questioning the sources of knowledge and remaining mindful of which systems should be internalized and propagated, and which should be rejected. As an experience and a relationship, medicine does not pass like a textbook from one to the next, but rather grows and changes along with the needs and personalities of its practitioners and its patients. Maintaining an authentic core recognizable to all physicians is the special task of the educational relationship.

At stake is more than a lifestyle or an occupation. As one of only a few categories of legitimation, medicine is linked to the operation of society, the sanctioning of cultural perceptions and explaining behavior. As a method of understanding, medicine is one way we make sense of a confusing world. Beyond the social contract to provide care, the educational relationship is responsible for perpetuating the role that medicine can play in society. The efficacy of medicine is based on sustaining the trust between medicine and society.

The boundary between the exam room and polite society is infused with and maintained by a powerful trust. It is well understood that language, behavior, and expectations are all different in medical encounter than they would be in a social call. Being seen as trustworthy is essential to establishing and maintaining a therapeutic relationship (or an educational relationship). There is an important power in the boundary between things that are kept separate, where rules change. Working on the cusp of that boundary is where the novice physician constructs and reconstructs the future of medicine one patient relationship at a time. It seems that the profession passes from one practitioner to another on a personal basis, and it is the trainee's job to make those rules, techniques, and ideas manifest in practice. There is power in a kept confidence, in a physical exam or in a procedure, because of the trust invested in the therapeutic relationship.

I decided to go to medical school because I felt a duty to social responsibility and effecting tangible change in the world. This was an idea implicit in my upbringing and discovered and unfolded in college. The fractal, biopsychosocial nature of medicine allows the effecting of social change on several levels at the same time. In this way, medicine is allowing me to work out my ideals and principles. Preparing for conscientious action in combination with physical action and tangible endpoints generate feedback from the daily bread and butter of individual patient contact to the amalgamation of dedication and outcomes over a career. I am not interested in paternalistically "helping people," but rather living as a person with other people, and working toward recognizing, expanding, and realizing goals that are already there, even if they are difficult to vocalize. I am interested in the therapeutic relationship, not that of a puppeteer.

The reasons that I have remained in medical school are more important than the reasons that brought me to its door. I have become fascinated by the fragile yet resilient qualities of human beings. Disaster, psychosis, and pressure ulcers are all just minutes away, but humans can react, relate, and renew themselves as well. Nowhere is the balance between fragility and resilience more poignant than in the study of and participation in the end of life.

I have argued that exploring new perspectives and thinking styles is an important part of medical education. I have internalized 3 of these schemata as I have applied them to questions and interactions outside of my curriculum. First, I have been fascinated by the essential pragmatism at the heart of medicine. It is more than an interesting coincidence that William James, a physician, is considered part of the school of philosophical pragmatism. All of the knowledge and technique is about doing something. Secondly, an interesting line has emerged between pedagogy and epistemology. Pathology and the extremes of disease have been presented as a route to learning things, but a randomized, controlled trial is necessary in order to know something. Finally, categories of function and dysfunction have been taught as descriptive points on a spectrum of behavior. This distinction offers a fluid link between the sick and the well that preserves the humanity and similarity between patient and physician.

I came to medicine because of a mission. I have stayed here because of a fascination. To unite the two into a career while staying authentic to both is my daily goal.

Questions for Discussion
Are there right and wrong reasons for going into medicine? Are the motivations for pursuing a career in medicine actually reasons, or are they more like personality or character traits? How might the admissions process be designed to take motivations and character into account?

Sam Huber is a research assistant in the AMA Ethics Standards Group.

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PERSONAL NARRATIVE
Commemorative Issue: "You're Doing What?"
Robert Davidson, MD, MPH

The "why" question was and continues to be the hardest for me to answer. I had a great job at UC Davis. I enjoyed teaching medical students and residents, and my practice through the Family Medicine center was successful and interesting. However, I had a growing feeling that I had lost, or was losing, the desires which pushed me into medicine as a profession in the first place. I was just a bit too comfortable. I missed the feeling of commitment and job satisfaction that I had when I started my career working in an Office of Economic Opportunity neighborhood health center in a barrio section of Los Angeles. I needed a challenge.

For you to better understand my comments, I need to tell you a bit about what I am doing. On February 1, 2000, I began working for the US Peace Corps as the Area Medical Officer for eastern Africa. I am a hired employee of the US government and need to emphasize that the real heroes of the Peace Corps are the volunteers who dedicate 2 to 3 years of their lives to working in countries where they are needed.

My primary responsibility is the health of the volunteers who are working in eastern Africa. I cover an ever-changing area that currently includes five countries: Kenya, Tanzania, Malawi, Madagascar, and Uganda. The area expands or contracts as the political climate changes in the nations of eastern Africa. Ethiopia, for example, had one of the larger Peace Corps activities before the recent political unrest and destabilization resulting from its conflict with Eritrea, another previous Peace Corps country. When the safety of its volunteers can no longer be reasonably assured, the Peace Corps closes down in that country until things settle a bit.

Each Peace Corps country has a medical office as part of the core support for volunteers. For the most part, advance-trained nurses and/or physician assistants staff these. The area physician serves as consultant, mentor, and quality assurance person, and fulfills a host of other duties for the country medical staff. There are 4 area physicians in Africa, their areas roughly determined by dividing the continent by the 4 points of the compass. We use regional hubs such as Johannesburg, South Africa and Nairobi, Kenya for treating volunteers who need levels of care greater than that available in their countries. We can, and do, send volunteers back to the US on med-evacs when they need levels of care not readily available in Africa.

The clinical aspects of the job are fascinating. A misguided and somewhat cynical colleague said before I came that all I would see would be healthy 20-year-olds with sexually transmitted diseases. He could not have been more wrong. I have seen more pathology and challenging health problems in the first 6 months than I would see in years back in the States, even at a major medical center like the UC Davis Medical Center. The majority of problems can be roughly divided into 3 categories: stress-related disorders, infectious diseases including tropical diseases, and trauma. Much time and effort are spent in preparing the volunteers to avoid health problems "in country" and stay healthy. For the most part this preparation is effective.

However, I have seen a number of unexpected health problems that are initially diagnostic dilemmas, especially without the ready availability of modern imaging techniques now standard in the United States. One such dilemma concerned a 40-year-old woman volunteer whose disorder was ultimately diagnosed at George Washington University Medical Center as a pericardial thymoma. Another case involved a 62-year-old man with cancer at the esophageal-gastric junction. In a recent case, a young volunteer complained that his "belly button" hurt and was pushing out. Examination showed a huge peri-umbilical abscess, which drained 200 cc of foul smelling, probably anaerobic, pus. He responded well to incision, draining and antibiotics. My impression is that the base problem is a congenital non-closure of the embryologic vitello intestinal duct that has been asymptomatic up to now. He is winging his way to Washington, and I am sure the surgery residents will enjoy and learn from caring for him.

The Peace Corps volunteers today are far different demographically from their counterparts in the early days of the Corps. The age of the volunteers in my area ranges from 24 to 74, with a large number in their 50s. They bring with them the usual diseases for their age cohort. No longer is a diagnosis of type II diabetes, asthma, or hypertension a cause for rejection from Peace Corps service. What has not changed is the wonderful sense of dedication and challenge that has always motivated volunteers to select Peace Corps service. I have enjoyed all the patients I have cared for, but the sense of dedication and commitment I find in the volunteers makes them special.

Before I make this job sound like Nirvana, I need to put our living situation in perspective. The eastern Africa hub is Nairobi, Kenya. This is where we live. Nairobi is no longer an easy place to live. Many people who lived here in the past speak fondly of the "good old days" when Nairobi was considered a great place to live. Certainly the weather is wonderful and the scenery is spectacular. Nairobi is a cosmopolitan city with fine restaurants and modern shopping centers and supermarkets. However, the constant threat of robbery makes it difficult to relax. United States nationals live in virtual fortresses complete with iron bars on the windows, wrought iron security gates on all doors, a wrought iron security grate to isolate our sleeping quarters from the rest of the house, perimeter security lights, and 24-hour security guards at each compound. We carry a radio link to the US Embassy at all times for use in an emergency. Home invasion robberies, street

muggings, and the current trend of carjackings detract considerably from enjoyment of the city.

More recently, the 2-year drought has produced severe water and, therefore, electricity shortages. On alternating days, we have no electricity from 6:00 AM to 6:00 PM or from noon to midnight. Water availability is variable. Most homes have plastic tanks to store water, but to be of much value these require electric pumps and electricity. One becomes so dependant on modern appliances in the US that the transition to kerosene lamps and 2-burner gas ranges for cooking seems like a hardship. But it certainly offers the opportunity to return to a simpler way of life. I have found it fun to do puzzles by lamplight, and easy to adjust to a sleep schedule from 8:30 PM to 4:00 AM, so I can have a couple of hours of electricity in the morning.

I am not quite sure how my reflections on working as a physician in Africa will be received by my colleagues and students. My experiences are far different from those of the many US physicians who give of their time and talents in the many mission hospitals in Africa. Yet it is certainly helpful to me to reflect on this experience, and perhaps by sharing it with you I can help you contemplate why you chose medicine and what you want from you career. I would like to talk more about my impressions of the health problems in the host countries and of the medical care systems and physicians in eastern Africa, but I need to sign off before the electric.i.t.y.. g.o.e.s... o.u...

Robert Davidson, MD, MPH is a member of the core faculty and is the research director for the Department of Emergency Medicine at Lincoln Medical and Mental Health Center in the Bronx, New York. He is board certified in both pediatrics and pediatric emergency medicine with a special interest in teaching and medical writing.

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FROM THE EDITOR
Commemorative Issue: All WoMen are Created Equal
Audiey Kao, MD, PhD

Based on the video history, the medical students were asked how they would assess and manage these cases. No significant differences in diagnostic decisions and recommended management were related to patient weight, except for medically indicated differences, such as blood glucose monitoring and dietary counseling. However, the study revealed that medical students were less confident that obese patients would be able to comply with the nutritional and exercise recommendations, and they were less likely to want obese patients in their medical practice.

Despite its methodological limitations (such as convenience sampling and the hypothetical nature of the clinical encounter), this study sheds light on the complex and challenging issue of physician bias and its impact on medical decision making. More importantly, this study is part of a much larger inquiry into the seemingly intractable social, economic, legal, and political barriers that create a vicious cycle of health disparity that not only affects individuals but leads to a concretization of poor health across generations and geography[4, 5, 6, 7, 8].

In the US, for example, the number of individuals and families living below the federal poverty line has decreased significantly over the past decade. Yet, over this same period, as the nation enjoyed unprecedented economic growth, the number of those without health insurance has reached epidemic proportions, with more than 16 percent of the US population unable to afford health insurance and millions more who have inadequate coverage. Inequities in health care on the global stage are staggering. More than 17 million Africans have died from AIDS and many millions more are infected with HIV. The impoverished nations of sub-Saharan Africa are crumbling under the weight of this modern plague. Without rapid and sustained assistance from the rest of the world, some of the most threatened countries may not survive as nation-states.

In both circumstances, the primary contributor to disparity in health is not medical but social, involving poverty and inequitable distribution of whatever wealth and resources exist. Addressing the medical consequences of social conditions such as poverty demands participation and leadership from physicians in their roles as citizens of a civil society. As physician-citizens, we can give of our expertise to those in need, support charitable organizations, endorse those who advocate for effective social policy, donate blood, register in a bone marrow bank, and always

vote. Of course, this level of citizenry takes time, money, and effort, but, inasmuch as we are among society's most affluent members, we must strive to live up to these obligations. How the medical profession mobilizes to address the national and global crisis of disparity in health and other challenges to the welfare of humanity will largely determine the vitality and robustness of medicine's social contract with civil society.

In many respects, the social contract between medicine and society is embodied in the codes of ethics that establish the standards for professional conduct for members of the profession. The world's first national code of professional ethics was created more than 150 years ago at the founding of the American Medical Association. At the time, the AMA's *Code of Medical Ethics* was considered comparable in its revolutionary stance to the Declaration of Independence[9], another social contract that forever redefined the terms of our human existence by proclaiming that all men (and women) are created equal.

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Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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AMA CODE SAYS
Commemorative Issue: The Code as Expert Witness
Karen Geraghty

In the last 2 decades, there has been a dramatic increase in the use of the American Medical Association's *Code of Medical Ethics*[1] in judicial rulings concerning the medical profession. Of the 225 legal citations of the *Code* since 1943, 181 occurred between the years 1980 and 1999. These statistics underscore 2 trends of significance for the medical profession--the societal trend of increased medical litigation and the judicial trend of relying on professional statements of conduct as standards of legal evaluation and judgment. In effect, the *Code* is evolving into an expert witness for professional conduct and as such is essential knowledge for practicing physicians.

When the American Medical Association was founded in 1847, the *Code of Ethics* was a brief pamphlet articulating the ideals of professional education and practice[1]. Over the last 100 years this small volume has developed into a 2-part code which distinguishes medical ethics from matters of etiquette.

The *Code* itself makes no claim to legal authority. Amid the reorganization of the American Medical Association in 1903, physicians, as a matter of professional duty, were encouraged to join a local or county medical society. The AMA was to function as a federation of state organizations and, as such, put forth "a suggestive and advisory document" in the form of the "Principles of Medical Ethics"[2]. It was explicitly left up to the state associations, and not to the AMA, to establish regulations and penalties for the practice of medicine in their local or specialty areas, based on the guiding principles set forth by the national association.

Throughout the 20th century, the AMA's *Code* underwent continuous refinement, expanding to address the innovations of scientific medicine and the institutional issues of health care delivery. Today, incorporating the concepts of the original *Code*, the contemporary *Code of Medical Ethics* now articulates 7 fundamental "Principles of Medical Ethics," which "are not laws, but standards of conduct which define the essentials of honorable behavior for the physician"[3]. In addition, there is a statement of 6 fundamental "Elements of the Patient-Physician Relationship," which define the rights that best contribute to the "collaborative effort between physician and patient" for the health and well-being of the patient[4]. Opinions of the Council on Ethical and Judicial Affairs, approved by the House of Delegates, accompany the *Code*, providing practical applications of the "Principles of Medical Ethics" to the numerous ethical issues in medicine. Annotations following the Opinions highlight the judicial rulings that have made use of the *Code*.

The Opinions, which are derived from the "Principles," have been significant in shaping judicial precedents in health care law. They have been cited in landmark judicial decisions such as *Cruzan, Bouvia, Tarasoff and Roe v Wade* to name but a few of the more publicly known cases.

In the *Bouvia* case[5], for example, a mentally competent, physically disabled woman requested cessation of forced feeding through a nasogastric tube. Quoting Opinion 2.18 (1986) [now Opinion 2.20], the court held that a competent adult patient has the legal right to refuse medical treatment, despite the fact that such a refusal will hasten the patient's death:

> The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. . . . Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis[6].

In the *Tarasoff* case[7], the court, citing Opinion 5.05, noted that it is permissible for a physician to violate the confidential nature of the patient-physician communication when disclosure is necessary to protect an individual or community from harm:

> The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities[8].

In its brief 154-year history, the AMA's *Code of Medical Ethics* has developed from a handbook of professional guidelines to a comprehensive document that addresses all aspects of professional behavior in the medical setting. As the *Code* continues to evolve in the legal arena as an expression of the medical profession's standard of conduct in addressing new challenges in health care such as those listed in the *Bouvia* and *Tarasoff* cases, knowledge of the *Code* is, now more than ever, an urgent and necessary aspect of every physician's practice.

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Karen Geraghty is a research associate in the AMA Ethics Standards Group.

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VIEWPOINT

Commemorative Issue: Through the Physician's Eyes: AMA President's Inaugural Address, 2001

Richard F. Corlin, MD

With the preponderance of weapons these days, it comes as no surprise that gun violence--both self-inflicted and against others--is now a serious public health crisis. No one can avoid its brutal and ugly presence. No one. Not physicians. Not the public. And most certainly not the politicians--no matter how much they might want to.

Now my speech today is not a polemic. It is not an attack on the politics or the profits or the personalities associated with guns in our society. It isn't even about gun control. I want to talk to you about the public health crisis itself and how we can work to address it, in the same way we have worked to address other public health crises such as polio, tobacco, and drunk driving.

At the AMA, we acknowledged the epidemic of gun violence when, in 1987, our House of Delegates first set policy on firearms. The House recognized the irrefutable truth that "uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and death." In 1993 and 1994, we resolved that the AMA would, among other actions, "support scientific research and objective discussion aimed at identifying causes of and solutions to the crime and violence problem." Scientific research and objective discussion because we as physicians are--first and foremost--scientists. We need to look at the science of the subject, the data, and--if you will--the micro-data, before we make a diagnosis. Not until then can we agree upon the prognosis or decide upon a course of treatment. First, let's go straight to the science that we do know. How does this disease present itself? Since 1962, more than a million Americans have died in firearm suicides, homicides and unintentional injuries. In 1998 alone, 30,708 Americans died by gunfire.

Now, we don't regulate guns in America. We do regulate other dangerous products like cars and prescription drugs and tobacco and alcohol--but not guns. No federal agency is allowed to exercise oversight over the gun industry to ensure consumer safety. In fact, no other consumer industry in the United States--not even the tobacco industry--has been allowed to so totally evade accountability for the harm their products cause to human beings. Just the gun industry. In a similar pattern to the marketing of tobacco, which kills its best customers in the United States at a

rate of 430,000 per year, the spread of gun-related injuries and death is especially tragic when it involves our children. Like young lungs and tar and nicotine, young minds are especially responsive to the deadliness of gun violence.

I want you to imagine with me a computer game called "Puppy Shoot." In this game puppies run across the screen. Using a joystick, the game player aims a gun that shoots the puppies. The player is awarded 1 point for a flesh wound, 3 points for a body shot, and 10 points for a head shot. Blood spurts out each time a puppy is hit, and brain tissue splatters all over whenever there's a head shot. The dead puppies pile up at the bottom of the screen. When the shooter gets to 1000 points, he gets to exchange his pistol for an Uzi, and the point values go up.

If a game as disgusting as that were to be developed, every animal rights group in the country, along with a lot of other organizations, would protest, and there would be all sorts of attempts made to get the game taken off the market. Yet, if you just change puppies to people in the game I described, there are dozens of them already on the market, sold under such names as "Blood Bath," "Psycho Toxic," "Redneck Rampage," and "Soldier of Fortune." These games are not only doing a very good business, they are also supported by their own Web sites. Web sites that offer strategy tips, showing players how to get to hidden features like unlimited ammunition, access more weapons, and something called "first shot kill," which enables you to kill your opponent with a single shot.

We do not let the children who play these games drive because they are too young. We do not let them drink because they are too young. We do not let them smoke because they are too young. But we do let them be trained to be shooters at an age when they have not yet developed their impulse control and have none of the maturity and discipline to safely use the weapons they are playing with. Perhaps worst of all, they do this in an environment in which violence has no consequences. These kids shoot people for an hour, turn off the computer, then go down for dinner and do their homework.

If this was a virus--or a defective car seat or an undercooked hamburger--killing our children, there would be a massive uproar within a week. Instead, our capacity to feel a sense of national shame has been diminished by the pervasiveness and numbing effect of all this violence. We all are well aware of the extent of this threat to the nation's health. So why doesn't someone do something about it? Fortunately, people are. People we know, people we don't know, and people we have only heard about are working hard to abolish the menace of gun violence--of all forms of violence--from the American scene.

The question remains: what are we, the physician community, going to do about it? I can tell you first what we're not going to do. We're not going to advocate changing or abolishing the Second Amendment to the Constitution. We really don't have to, to make our point. The gun lobby loves to use the Second Amendment as a smokescreen to hide the reality of the damage that guns do and to prevent our

looking any deeper into the facts and statistics of that damage. We've all heard that tired old statement: guns don't kill people--people kill people. But how does that explain these facts? A gun kept in the home for self-defense is 22 times more likely to be used to kill a family member or a friend than an intruder. The presence of a gun in the home triples the risk of homicide and increases the risk of suicide fivefold. We, the American Medical Association, are going to take a different route--not just calls for advocacy, but for diplomacy and for statesmanship and for research as well. And make no mistake about this: We will not be co-opted by either the rhetoric or the agendas of the public policy "left" or "right" in this national debate about the safety and health of our citizens. One of the ways we will do this is to help assemble the data. Current, consistent, credible data are at the heart of epidemiology. What we don't know about violence--and guns--is literally killing us. And yet, very little is spent on researching gun-related injuries and deaths. A recent study shows that for every year of life lost to heart disease, we spend $441 on research. For every year of life lost to cancer, we spend $794 on research. Yet for every year of life lost to gun violence, we spend only $31 on research--less than the cost of a taxi ride here from the airport.

That's bad public policy. It's bad fiscal policy. And it certainly is bad medical policy. If we are to fight this epidemic of violence, the Centers for Disease Control must have the budget and the authority to gather the data we need. The CDC is intent on doing its job and is now heading up the planning for a National Violent Death Reporting System--coordinated and funded at the federal level--and collecting data at the state level. Because knowing more about the who, what, when, where, why and how of violent homicides, suicides, and deaths will help public health officials, law enforcement, and policy makers prevent unnecessary deaths.

We will not advocate any changes at all based on urban legend, anecdote or hunch. We will only base our conclusions on evidence-based data and facts. It's just good, common sense--the kind of solid epidemiology that has been brought to bear on other public health hazards, from Legionnaire's Disease to food-borne illnesses to exposure to dioxin or DDT. Trustworthy science that can help us prevent harm before it happens.

For, as we physicians know, prevention is usually the best cure. One of the giants of American medicine, Dr. William Osler, proposed using preventive medicine against serious public health threats like malaria and yellow fever. And the tools he advocated--education, organization and cooperation--sound like a pretty good definition of diplomacy to me. We will put these same tools to use in removing the threat of gun violence from our society.

People have told me that this is a dangerous path to follow. That I am crazy to do it. That I am putting our organization in jeopardy. They say we'll lose members. They say we'll be the target of smear campaigns. They say that the most extremist of the

gun supporters will seek to destroy us. But I believe that this is a battle we cannot not take on.

While there are indeed risks, the far greater risk for the health of the public, for us in this room, and for the AMA, is to do nothing. We, as physicians and as the American Medical Association, have an ethical and moral responsibility to do this, as our mission statement says, "to promote the science and art of medicine and the betterment of public health." If removing the scourge of gun violence isn't bettering the public health--what is? As physicians, we are accustomed to doing what is right for our patients and not worrying about our comfort, ease or popularity. Our goal is to help cure an epidemic, not to win a victory over some real or imagined political enemy. Anyone who helps us in this fight is an ally--anyone.

We don't pretend to have all the answers. Nor do we expect the solution to be quick, and we certainly don't expect it to be easy. In fact, I am certain that we will not reach the solution during my term as your president. But together as the American Medical Association--guided by our stated mission--we recognize our obligation to contribute our voice, our effort and our moral imperative to this battle. And we will.

Almost a century ago, in his book *Confessio Medici*, Stephen Paget, the British physician and author, referred to medicine as a divine vocation. This is part of what he said:

> Every year young people enter the medical profession . . . and they stick to it . . . not only from necessity, but from pride, honor, and conviction. And Heaven, sooner or later, lets them know what it thinks of them. This information comes quite as a surprise to them . . . that they were indeed called to be doctors. . . . Surely a diploma . . . obtained by hard work . . . cannot be a summons from Heaven. But it may be. For, if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine[2].

We are here today as the guardians of that divine vocation and as such are dedicated to do what is right, whether or not it is comfortable, whether or not it is easy, and whether or not it is popular.

Stephen Paget, you can rest well tonight. Your divine vocation is in good hands. We will guard it well. We will live up to our mission--we will do what is right.

Questions for Discussion

1. In the face of a serious threat to the health of the public, is the individual physician obligated to support the position taken by his or her professional association?
2. Are professional responsibilities acts that we "must do" or acts that we should "try to do?"

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Richard F. Corlin, MD is president of the American Medical Association.