COMMENTS AND RESPONSES

Charter on Medical Professionalism: Putting the Charter into Practice

The following letters from the readers of *Annals* represent just the kind of debate about professional ethics we had hoped the physician charter would engender. Seven members of the Medical Professionalism Project have responded accordingly. Although we could not hope to address every issue raised, one does seem salient throughout: the apparent conflict between a patient-centered ethic of care and the commitment to a just distribution of finite resources. We recognize that compromise is necessary between these two principles, but such compromises are at the center of the liberal state's equilibrium between equality and civil rights. We believe that physicians can maintain an altruistic commitment to their patients at the bedside and still work in administrative and political contexts to develop just rules for distribution. Indeed, this tension, and our efforts to address it, is likely to define the next several decades of ethical health care practice. In that regard, the charter has been successful as a catalyst to promote an action agenda for the profession that is universal in scope and purpose. And it has furthered the collaboration of the ABIM Foundation, ACP Foundation, and European Federation of Internal Medicine in the next activity phase—to advance the charter within the context of exploring the health rights and responsibilities of patients, physicians, and society.

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TO THE EDITOR: After reading the Charter on Medical Professionalism and Dr. Sox's introduction (1), I want to point out that the vast majority of physicians throughout the United States continue to uphold the spirit of the Hippocratic Oath without the need for addendum or adjustments. The average community physician is interested in maintaining professionalism as well as professional competence and recognizes that the patient is entitled to confidentiality and excellent quality of care. The average physician has an ongoing commitment to provide access to care independent of financial considerations.

In the charter's preamble, the concept of medicine's contract with society is discussed. To a large extent, the obligations of physicians to society in that contract are nicely laid out in the subsequent discussion. Given that a contract is usually created between two parties and each party has an obligation to the other, what is society's responsibility to physicians? As highly trained, caring members of society, aren't physicians entitled to certain assurances of financial stability? Should we be expected to withstand ongoing efforts to politicize the health care industry in attempts to garner votes while balancing the federal budget? Must we continue to withstand repeated attacks from trial attorneys who have little interest in the facts of a medical case and are interested only in the payoff?

I hope not. It is my belief that if society paid more attention to upholding its end of this contract with the health care industry, there would be a lot less incentive for transgressions by physicians.

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Reference
1. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243-6. [PMID: 11827500]

IN RESPONSE: Dr. Lyons has identified an essential element in the relationship between medicine and the society it serves. In the presence of a social contract, society has every right to expect that medicine will meet societal expectations under the contract, but medicine also can rightfully expect certain actions by the society it serves. The nature of the contract has changed dramatically over the past 150 years. Up until World War II, medicine largely determined public policy, controlled the health care marketplace, exercised great authority, and was given responsibility for the health care systems in the developed world. During the past 50 years, health care has changed from a cottage industry to a complex activity consuming a substantial portion of the gross domestic product of most countries. Sociologists have noted the growth in the power of both the state and the marketplace (depending on the country and the structure of the health care system) and a concomitant weakening of medicine's influence. Thus, what society expects of medicine has not changed much, but under the contract, both the state and the marketplace began to exert authority over the structure of the system. As a result, the conditions under which physicians practice have changed. Without question, the medical profession now feels undervalued, threatened, and, at times, unable to deliver appropriate care. It wishes greater influence over public policy, and a health care system in which its expertise is recognized and used.

Along with a loss of influence has come a well-documented loss of trust in the profession. If the profession is to have significant input into public policy (the social contract), it must be trusted. The charter, *Project Professionalism* (1), and many other actions taken by medical associations, educational institutions, and licensing bodies are aimed at reestablishing trust. The charter is a statement of what medicine stands for. If physicians take note of the charter and govern themselves using it as a benchmark, one can hope that the profession will be more trusted and that the social contract will be altered in ways that answer Dr. Lyons' very justifiable concerns.

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Reference
1. Project Professionalism. Philadelphia: American Board of Internal Medicine; 1995.

TO THE EDITOR: The physician charter (1) does an excellent job of defining the role of medical professionalism in the 21st century. However, we would encourage the authors to consider the obligation of physicians to be positive role models for their students and colleagues. We agree that devotion to patients and society must be the cornerstone of our profession, but equally important should be our commitment to serve as role models. And although the charter provides a blueprint of characteristics that physicians and students can aspire to, we must make a conscious effort to inspire others to cultivate these principles.

Dr. Mike Magee once said, "Doctors are quick learners, versatile . . . and have remarkable abilities to multitask." Unfortunately, as students, we have a tendency to approach medical education with

tunnel vision. For some, this manifests as a disproportionate focus on extracurricular activities, and for others, it means to solely excel in curricular endeavors. This behavior interferes with the maturation of individuals into the competent and compassionate physicians that society expects. The charter echoes Dr. Magee's thoughts and can be further interpreted as an expectation of future physicians to pursue a more comprehensive and fulfilling medical school experience that eventually translates to higher-quality care.

Medicine is a lifestyle, complete with highs and lows. This charter holds the potential to remind students of why they entered the field, to renew their enthusiasm and love for the profession, and to provide criteria on which to base personal and professional decisions. Furthermore, at our institution, we intend to distribute the charter to all of our entering medical students during their white coat ceremony and then reexamine its principles and responsibilities at later points along the curriculum, when issues of professionalism and competence are addressed.

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Reference

1. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243-6. [PMID: 11827500]

IN RESPONSE: Mr. Quraishi and Dr. Khalid have made explicit what was clearly implicit in the minds of the authors of the physician charter: that an espousal of principles without their effective dissemination to future generations of practitioners is likely to be an empty exercise. The subsequent efforts of the sponsoring organizations of this unique collaboration have included not only practicing physicians but also residents, students, and the general public. We are not certain how much weight to assign to the forces of "tunnel vision" and careerism among students that Mr. Quraishi and Dr. Khalid warn us about, and we hesitate to conclude that these forces are to be found among students alone. In all events, however, we steadfastly regard the charter as a counterbalance to such tendencies and hope that it becomes an integral part of the education, accreditation, and certification processes at all levels of medical training, practice, and organization.

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TO THE EDITOR: The physician charter (1) is an excellent start to defining a set of ethics and principles of integrity for the new millennium, but it doesn't go far enough. For reasons reviewed elsewhere (2), physicians in the United States must go beyond this charter by knowing and adhering to good business practices as one of their many professional responsibilities. Two models illustrate this perspective. The first is the medical model of disease, which was expanded in 1977 by George Engel into the biopsychosocial model of disease (3). Today, society is increasingly concerned with health, not just disease. Health may be considered the sum total of biological, medical, psychological, social, spiritual, political, economic, and cultural factors. The integration of these variables forms the basis for a comprehensive model of health. When health is considered, the stewardship of economic resources is an important factor.

There is a parallel between evolving concepts of health and evolving concepts of ethics. In the past, medical professionalism was concerned primarily with medical ethics. Van Rensselaer Potter expanded this in 1970 to include what he termed *bioethics* (4). Today, I think it is time to think in terms of *health care ethics*. This includes compliance with health care industry standards of business integrity, especially those related to medical record documentation, coding, and billing.

It is understandable that the authors of the physician charter omitted business integrity as an issue of medical professionalism, given their premise that market forces are serving to erode the professional values of our profession. Nevertheless, I submit that this omission is shortsighted. I think it is time that we accept business integrity as a component of medical professionalism and that we start teaching this material to medical students as part of the core curriculum.

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3. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196:129-36. [PMID: 847460]
4. Potter VR. Bioethics, the science of survival. Perspectives in Biology and Medicine. 1970;14:127-53.

IN RESPONSE: Two comments are in order in response to the very apt observations on business practices brought forward by Dr. Haskell. First, in our development of the physician charter, we operated on the general conviction that a spare constitution of basic principles is preferable to one that is detailed and exhaustive. If the charter as an enunciation of principles were to be expanded, it would certainly include honesty, integrity, and efficiency in the business practices of physicians and medical organizations. Second, given our consistent stress on social and moral commitments and responsibilities, we would have highlighted the virtues of integrity and personal and organizational accountability as those aspects of business conduct that are most relevant to a charter of this type. We would certainly have included the examples given by Dr. Haskell—the husbanding of resources and meticulousness in record-keeping and billing—as integral to business integrity.

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TO THE EDITOR: The publication of the physician charter (1) is a great opportunity to ponder the meaning of the medical profession, its role in society, and the relationship between physician and patient. The principles and commitments of this charter overcome geographical and cultural borders and provide guidelines of behavior that are stimulating for a constructive dialogue, beginning from the

universally valid Hippocratic triangle (physician, patient, sickness). Starting from the debate concerning the Hippocratic Oath (2), the necessity for a physician to swear an oath has been discussed (3). On one hand, it can induce paternalistic behavior and foster self-importance; on the other, many professional societies use oaths, which give them respectability and encourage group solidarity. The Hippocratic Oath must be read as a contract. Although there is no juridical responsibility, physicians who break the contract lose their repute. Nowadays, it is generally accepted that this oath represents not the ethics that are currently common to physicians but their team spirit, which binds them to each other, as in the past (4).

The publication of this charter is extremely interesting and stresses the importance of continued medical education and professional development (5). We think that an oath can still be the ethical framework for new doctors, a datum point for physicians, but it is essential that it be integrated into a formative plan. In the Florence Medical School in Italy, we are currently evaluating the feasibility of proposing the swearing of an oath extracted from the Deontological Code, elaborated by the Italian College of General Practitioners, before inscription to the Medical College. The publication of the charter is really a great help in this regard and goes beyond the necessity of an oath.

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1. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243-6. [PMID: 11827500]

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IN RESPONSE: It is entirely appropriate for Drs. Lippi, Gensini, and Conti to highlight the Hippocratic Oath, since the members of the Medical Professionalism Project referred to it only briefly in the preamble to the physician charter. It is also important for us to clarify the role that the Oath played in our thinking. We consider the Hippocratic Oath to have much more than ritual significance, as implied by the authors' use of the terms *respectability* and *group solidarity*. We believe, on the contrary, that the Oath *does* represent the "ethics . . . currently common to physicians." However, it does so in such a general way that, while universally relevant, it provides few guidelines for applicability in historically diverse situations and within contemporary contexts. We regarded a part of our task to be the specification of guidelines that are both consistent with the substance of the Hippocratic Oath and relevant to the realities of the medical world as it confronts us at the beginning of the 21st century.

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TO THE EDITOR: I read with interest the article on medical professionalism in the new millennium (1), which proposed a new code of conduct for physicians comprising three principles and 10 responsibilities. As a proposed code of ethics, the charter is untenable for several reasons. Two of the three principles conflict. Patient welfare is predicated on individual rights while social justice is based on group rights (those of "society"). Since individual rights and group rights are mutually exclusive, the physician can follow one of these two principles but not both (2). In addition, at least 2 of the 10 responsibilities (public advocacy and just distribution of finite resources) place the interests of others ahead of those of the patient. Physicians will be less likely to subscribe to an ethical code that does not have the welfare of the patient as its highest objective.

Equality of outcome is an undesirable and unattainable vision that invariably results in the loss of patients' rights. Only under socialism (government medicine or corporate socialized medicine) are health care resources finite, so that they must be rationed or justly distributed. Under other circumstances, the provision of services—"necessary" or "unnecessary"—to one patient does not diminish the resources available for others.

The commitment to maintaining trust by managing conflicts of interest forbids physicians to pursue private gain or personal advantage. How then is it ethical for a group of physicians such as the Medical Professionalism Project to weaken our code of ethics in order to promote a political agenda (improving "the health care system for the welfare of society," promoting "the fair distribution of health care resources," or ensuring social justice)? These proposed changes in our time-honored, patient-centered ethics will worsen, not improve, the dilemma of today's physicians, who already are challenged by new technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. But even more ominous, medicine without effective, patient-centered ethics is no longer a profession but merely a trade—which was its status in ancient Greece before the Oath of Hippocrates.

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2. Vazsonyi B. America's 30 Years War: Who Is Winning? Washington, DC: Regnery; 1998:79.

IN RESPONSE: Although Dr. Arnett's points are well taken, the charter is not a code of ethics, nor is it intended to detract from or supplant the Hippocratic tradition that has long enriched medicine's history. It is a statement of contemporary responsibilities—medicine's understanding of its obligations under today's social contract. We strongly disagree that individual rights and group rights are mutually exclusive and that "the physician can follow one of these two principles but not both." We do not underestimate the difficulty of

reconciling the two sets of responsibilities but believe passionately that medicine must attempt to do so. The alternative is for someone without medical knowledge or expertise to determine the societal rights in health care and how they are to be reconciled with the rights of individual patients. Do we really wish this to occur, or do we believe that it is better for individual physicians and their organizations to use their expertise to try to achieve the proper balance? The charter suggests the latter course. It does, however, state that physicians must put the welfare of the individual patient first, thus reaffirming our traditional fiduciary responsibilities. Our duties to individual patients must be carried out with a knowledge of the impact of our own decisions on the wider society, which we also serve. We also disagree that the allocation of resources to one patient does not diminish the resources available to others under a market-driven system. The attempts at cost containment seen throughout the world, no matter what the nature or structure of the health care system, indicate that this is not true. There is no question that contemporary physicians are expected to serve both their patients and society.

A second point of some importance refers to "equality of outcome." We are not sure that equality of outcome can be termed "undesirable," as Dr. Arnett stated, but certainly such an objective is unrealistic. Nowhere does the charter advocate equality of outcome as an objective.

Dr. Arnett interprets the charter as forbidding physicians' pursuit of private gain or personal advantage. Nowhere does it so state. The conflicts of interest section states that physicians must deal with these conflicts in an open and transparent way. We cannot eliminate conflicts of interest, but we must ensure that our integrity is preserved as we cope with and manage them and recognize the consequences of our decisions.

We agree with Dr. Arnett that without effective patient-centered ethics, medicine is no longer a profession. As already mentioned, the charter is not a code of ethics but a freely given statement of medicine's commitments and responsibilities, essentially outlining where we should stand in complex times. It is aimed at restoring the feeling of pride in the profession and public trust that all observers have agreed is so essential to the proper functioning of a profession and distinguishes it from a trade.

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TO THE EDITOR: I read "Medical Professionalism in the New Millennium: A Physician Charter" (1) with great interest. Many of the goals and objectives are shared by administrative professionals such as myself. While the tendency to refashion the medical system in the United States into a business is indeed problematic to the degree that the Hippocratic Oath may require an update, the need to approach issues at the organizational level is crucial. Medical care is now provided through a complex web of physicians, facilities, and organizations, and we are all better off as a result. To meet the important goals of the new physician charter, one must look beyond the examination room and deeper into the organizations around which medical care is precariously balanced. It would be beneficial to see the charter refer to a commitment for physicians to work in partnership with administrative counterparts to improve the quality and integrity of the entire system, and to expect administrative counterparts to commit to an equivalent standard.

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Reference

1. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243-6. [PMID: 11827500]

IN RESPONSE: We certainly agree with Mr. Feldman that the medical system aspires to excellent quality. The stimuli for creating the charter, however, included the difficulty that many have in accessing that quality and the recognition that the quality can be improved. In addition, the complexity of the system has created the potential for us to lose sight of the primacy of patient welfare and the principle of social justice. Mr. Feldman also says that he would like to see the charter refer to a commitment by physicians to work in partnership with administrators to improve the integrity and quality of the system. We are under no illusion that physicians can do it alone, and indeed the body of the text of the charter makes that point. In discussing the commitments to improving quality of care and achieving a just distribution of resources, we specifically referred to working collaboratively with other professionals, hospitals, and payers. Finally, we would welcome a similar commitment from administrators and hope that the charter serves to encourage a similar document on the part of others involved in the health care system.

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Editor's Note: See the 1999 article by Smith and colleagues (Ann Intern Med. 1999;130:143-7. [PMID: 10068361]) for a set of principles that attempts to reconcile medical ethics (as reflected in the charter) and business ethics.

TO THE EDITOR: While I strongly agree with the need for a document like the physician charter (1), I believe the current document is overly simplistic in its approach and falls short of recognizing some of the complexities involved in the practice of medicine. The statement that professionalism "demands placing the interests of patients above those of the physician," while laudable, does not accurately reflect a basic tenet of human nature: namely, to act in one's self-interest. A more realistic statement would be for the physician to strive for a congruence of interest with patients. Furthermore, the "interests of patients" is a vague phrase and could include "interests" that are beyond the scope of reasonable medical practice. Perhaps the phrase "health care interests" would be more specific.

While I certainly agree with the principle of patient autonomy, I believe that patients' decisions about their care should be paramount as long as they are appropriately informed. Uninformed decisions, even when in "keeping with ethical practice," violate the principle of patient autonomy.

The commitment to honesty is essential. However, the charter as a whole is one-sided in the sense that it deals only with the physician's responsibility. The dualistic nature of the physician–patient relationship requires a concurrent set of patient responsibilities. Failure to acknowledge this limits the ability of physicians to practice in accord with the charter's precepts.

The "commitment to a just distribution of finite resources" is laudable but conflicts with the previous statement that the patient's decision must be paramount. This is an area where the charter is overly simplistic. A clearer recognition and understanding of the conflictual nature of these commitments would benefit the practice of medicine by reflecting reality. Finally, the charter does not include a statement about commitment to the art of medicine. Although this may be implied throughout the document, I believe it should be addressed specifically, with a weight equal to that of the discussion on the commitment to scientific knowledge.

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Reference

1. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243-6. [PMID: 11827500]

IN RESPONSE: Dr. Wartman's comments are precisely the kind of feedback we had hoped to stimulate by putting the physician charter forward. The essential purpose behind the effort was to provoke discussion and debate about the fundamental principles and responsibilities of physicians in our increasingly beleaguered and global profession. Our belief is that all physicians must give these matters much more attention if our contract with society is to be sustained.

Dr. Wartman suggests that altruism—placing patients' interest uppermost—is out of keeping with human nature's imperative for self-interest. To the contrary, considerable evidence shows that altruism is, in fact, an evolutionary trait of the human species. Nevertheless, no one would disagree that altruism is a difficult attribute to sustain when strong temptations to serve one's own interests are present. That is precisely why the charter posits that physicians must be conscientiously intentional about adhering to this fundamental principle.

Furthermore, Dr. Wartman's comments about the principle of patient autonomy are in perfect sync with the charter. Both assert that physicians must empower patients to make "informed decisions" but are not obliged to honor uninformed wishes that could do patients harm. We recognize that the charter defines only the physician's side of the social contract and not the patient's or, for that matter, the public's. A follow-up effort to stipulate the reciprocal responsibilities required of all parties to a valid social contract would be a worthwhile next step and, in fact, is the centerpiece of the next phase of activity by the Medical Professionalism Project.

Finally, we disagree with Dr. Wartman's assertion that the charter is "overly simplistic" in calling for a "just distribution of finite resources." The charter admonishes all physicians "to help develop guidelines for cost-effective care" and to avoid "superfluous tests and procedures." Nothing in these actions conflicts with the primacy of patients' interests.

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TO THE EDITOR: In reading the charter on medical professionalism (1), I was concerned with one aspect of these new guidelines, the "commitment to honesty with patients," which states that "physicians must ensure that patients are completely and honestly informed" before consenting to a treatment. Many cultures do not welcome the disclosure of the complete diagnosis. Some examples of such cultural differences were described in case studies published in recent issues of the *Journal of the American Medical Association*. While discussing cross-cultural issues at the end of life (2), Drs. Kagawa-Singer and Blackhall brought up examples of patients who come from countries other than the United States and who do not necessarily want to know the truth about their diseases, especially when the diagnosis involves cancer or another terminal illness. In such cases, direct discussion of prognosis is not appropriate. Another article written by Dr. McPhee on the subject of caring for Vietnamese patients (3) explained that "complete and accurate disclosure of cancer may be undesirable in such a setting," and talking about death directly "would bring bad luck."

Given that all physicians are strongly encouraged to respect the commitments in the charter as professional standards, how can a physician be culturally sensitive and respect the wishes of a patient who doesn't want to be completely informed without violating the new charter? Do the authors of the charter believe that it is sometimes acceptable to deviate from the specific principles and commitments, or is every physician expected to follow them as stated?

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3. McPhee SJ. Caring for a 70-year-old Vietnamese woman. JAMA. 2002;287:495-504. [PMID: 11798372]

IN RESPONSE: We thank Ms. Nusinovich for the opportunity to clarify and comment on an important issue in our increasingly multicultural societies. The charter emphasizes two principles that are relevant to the question she raised: the primacy of patient welfare and patient autonomy. Both principles guide the physician to be patient-centered in providing medical care to the patient; this is intrinsic to both understanding and respect for the patient's culture. The language quoted from both the principles and professional responsibilities commands the physician to empower the patient to participate in decisions and to respect the patient's autonomy. Implied in these statements, albeit not explicitly stated, is having respect for a patient's request to be relieved of the specifics of medical decision making. Empowering patients to participate in decisions does not mean forcing them to do so. Rather, in this context, it means permitting the patient to exercise his or her autonomy. Consistent with preserving autonomy, a patient's clear preference to have decisions made by someone else, whether that person is the physician or family members, should be honored as long as the request is not for inappropriate care.

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