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by John A. Robertson, Jeffrey P. Kahn, and John E. Wagner

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by Thomas H. Murray

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perspective

ON A NEW CHARTER TO DEFEND MEDICAL PROFESSIONALISM:

Whose Profession Is It Anyway?

BY STEVEN H. MILES

Medical professionalism is an inherently conservative concept, building as it does on the moral traditions of physicians in response to social changes.[1] "The Charter on Medical Professionalism," a recently published product of several years' work by its sponsoring institutions—the American Board of Internal Medicine Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federations of Internal Medicine—begins however not with a look to the past but with a look within.[2] Its opening statement: "Physicians today are experiencing frustration as changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medicine professionalism."

This is an ominous beginning and odd point of view. Why start with physicians' frustration? What threatens physicians? But the authors of the charter apparently presume their audience will immediately agree about the magnitude and nature of the threat: "meetings . . . have confirmed that physician views on professionalism are similar in quite diverse systems of health care delivery."

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(Diverse? This remarkable statement does not reflect the scant empirical data either on international views or on the views of African American physicians in the United States.[3]) It is not until the concluding paragraph that the threats are briefly outlined: "increasing disparities among the legitimate needs of patients, the resources to meet those needs," "market forces that are transforming health care," and "the temptation for physicians to forsake their traditional commitment to the primacy of patients interests."

This psychotherapeutic grounding echoes the concern raised by the American Board of Internal Medicine's "Project Professionalism"—namely, "that recent changes in the health care delivery system have resulted in 'stress surges' that can have a negative impact on the professional behavior of physicians. This concern is sharpened as physician reimbursement changes and health care is provided in a competitive environment of managed and prepaid care, threatening to reduce the status of patients to commodities rather than people with an affliction."[4]

Questions proliferate. Why is "physician frustration," rather than health or access to health care, the anchor for this new statement of medical professionalism? Why do the wealthiest nations, with the best health, best health care, best institutions of medical education, best access to the latest medical technologies, and least political repres-

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Why is "physician frustration," rather than health or access to health care, the anchor for this new statement of medical professionalism? Why do the wealthiest nations, with the best health, best health care, best institutions of medical education, best access to the latest medical technologies, and least political repression of physicians, provide the best metric for the threat to medical professionalism? In these countries, physicians are well paid, life expectancy is going up, and disability is going down. What threat?

sion of physicians, provide the best metric for the threat to medical professionalism? In these countries, physicians are well paid, life expectancy is going up, and disability is going down. What threat?

The statement of threat proceeds to directly defining the new professionalism as commitments to:

- patient confidentiality (defined in relation to electronic data systems and genetic data, with an exception to accommodate the "duty to warn" but no attempt to balance confidentiality with mechanisms for quality assurance, health systems research, insurance oversight, and so on);

- quality of care and reduction of error,

- improving access to care ("Medical professionalism requires that health care systems ensure a uniform amount of high quality services to all");

- fair distribution of finite resources ("While meeting the needs of individual patients," physicians must be cost-effective and must scrupulously avoid "superfluous tests and procedures");

- scientific knowledge (but nary a reference to the wholesale corporate corruption of sponsored research and the dissemination of this work in medical journals);

- maintaining trust by managing and disclosing conflicts of interests;

- maintaining professional competence;

- honesty with patients;

- fulfilling professional duties for the oversight of the profession and as needed to improve the quality of health care; and

- avoiding financial or sexual exploitation of patients.

The charter proposes three ethical principles to use in fulfilling these commitments: the primacy of patient welfare, patient autonomy, and social justice.

It is useful to distinguish the nature of the charter from its content and grounding. Many kinds of instruments have been proposed for asserting the nature of medical professionalism—oaths, petitionary prayers, codes, covenants, contracts, and law among them. Prayers and oaths call for each physician to perform them—to pray or to swear.[5] The Hippocratic Oath and its countless Christian-era variants are written as promises to uphold a certain sense of professionalism.[6] The Prayer of Moses Maimonides (from the twelfth century) is a petitionary prayer: "Inspire me with love for my Art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession." The Oath of Asaph and Yohanan (sixth century) has a brief oath of affirmation in response to a rabbinic interpretation of what the Torah requires of physicians.[7] Such performative statements persist. The 1998 version of the Declaration of Geneva mirrors the format of the Hippocratic oath, "I solemnly pledge myself ..."

Modern statements of medical professionalism are increasingly formatted as assertions *to* physicians rather than *by* physicians. Such statements are made by law, international accords, or professional associations. Thus the American Medical Association asserts that "A physician . . . should not be a participant in a legally authorized execution.[8] The World Medical Association's Declaration of Helsinki stipulates that "biomedical research involving human subjects must conform to generally accepted . . . principles."[9] The "Charter on Medical Professionalism" is such an assertive statement.

There are many reasons for the emergence of assertive statements of medical professionalism. First, they have a clear grounding in a world where the foundations of moral claims are undermined by the "post-modern" challenge. Who says so? The AMA says so; the law says so. Such assertions allow the author-sponsor to sidestep the debate over whether the proffered statement is grounded in tradition, deduced from the "internal morality" of the

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practice of medicine, or imposed on physicians by society. In this case, the grounding is apparently physician frustration with the market dynamics of health care.

Second, the assertive voice allows the author-sponsor to unilaterally bound the scope of medical professionalism. In one sense we are seeing the medical specialization of ethics in codes for neonatal care, for research, for work in developing countries, for prisons, and so on. Yet the same specialization that makes it easier to address the particular technical problems of medical disciplines also makes it too easy to partition moral communities. By grounding this charter in the frustration of physicians in industrialized countries, the ABIM—ACP-ASIM—EFIM charter silently tolerates the enormous and growing disparities between the health of rich and poor, white and non-white, north and south.

Unlike the performances of oaths and prayers, the assertive voice is bureaucratic. Committees do not write poetry. Consider the vast difference between "The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience," with the Hippocratic oath's, "In a pure and holy way, I will guard my life and my art and science." The charter's didactic jargon cannot be adapted to a performative statement. Whatever one thinks of its moral merit, its language cannot be cherished or read responsively. I am not aware of any research on whether the act of proclaiming or performing an ethical promise helps to internalize it to influence behavior, but this document will not be remembered in the same way as the phrases of the Prayer of Maimonides.

In a discussion of this charter on a bioethics chatline, criticisms focused on the question of whether asking a physician to be an advocate for social justice created an unacceptable conflict with advocacy on behalf of patients. I suspect that those who have and those who lack health insurance would debate this important question differently.

Certainly, the health care crisis is more profound than and better measured than by the frustration of physicians in industrialized countries. It is most intensely experienced in those nations whose health care is hobbled by poverty and intellectual property laws (annual per capita AIDS spending in Africa would buy three condoms in Uganda), in labs that are turning germs into weapons, and in countries where physicians must participate in torture or be tortured themselves. The crisis is also found in a medical-industrial complex that employs powerful tools to shape government policy and clinical judgment. Such power, as Eisenhower said of the "military-industrial complex," has "grave implications [for] our toil, resources and livelihood." These are the "stress surges" for which a new charter for health professionalism is most urgently needed. The ABIM—ACP-ASIM—EFIM charter must engage a broader authorship to speak to a bigger world.

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