



MEDICAL PROFESSIONALISM AND THE ROLE OF STATE MEDICAL BOARDS

I. INTRODUCTION

Some 2,400 years ago Plato attempted to set forth a conception of the ideal state in his dialogue known as the *Republic*. Plato uses the story of “The Shepard of Lydia” to differentiate the just citizen from the unjust.¹ In short, a Shepard comes upon a ring with the power to render its’ wearer invisible. It may seem odd to begin by invoking one of Plato’s many long-winded stories of Socrates corrupting the young. However, this allegory provides us with insight as to what it means for the medical profession to be a *profession*, and for a physician to be a *professional*.

Imagine the power that comes with the ability to render oneself invisible. The Shepard could listen to the most personal of conversations, see others in various stages of undress, and even help himself to an occasional grope of those he fancies. This power is remarkably similar to the power physicians have been granted by the American body politic.² As patients we allow our physicians, whom on many occasions are complete strangers, to probe us, poke us, look at us naked and ask deeply personal questions. We do so even though we have little idea as to our physician’s knowledge base, technical proficiency or character. We enter into this one-sided and vulnerable relationship out of trust; we trust that because physicians are professionals they will always place the interests of their patients above all others.

Trust in a physician is something that is built continually over time. Given the political and moral significance of being granted such trust, I take as a fundamental obligation that it must be continually earned.³ If this obligation is neglected, patients will not feel safe placing themselves under a physician’s care. Additionally, patients would have little reason to feel safe openly discussing deeply personal information. The goals of this article are to 1) provide state medical board members with a conceptual understanding of professionalism, and 2) recommend how board members can reassure the public that the trust it has bestowed upon the medical professional continues to be well placed.

In the next section I will provide a brief account of the meaning of a (medical) professional; or more simply, I will demonstrate the distinction between acting like a professional and being a professional. The third section consists of recommendations for how state medical boards can promote professionalism among our next generation of physicians. I will conclude by identifying two areas where state medical boards must assert their authority: clinical research and end-of-life care.

II. A BRIEF ANALYSIS OF PROFESSIONALISM

Eliot Freidson is a renowned sociologist who has written extensively on medical professionalism. In his writings he makes clear that the notion of a medical professional is a uniquely American one, belonging to a specific time and political landscape. He states that there are physicians throughout the world practicing in a variety of institutions and circumstances, yet it is the American physician who has gained the social stature and political capital necessary for acquiring a legislatively protected monopoly over the practice of medicine.⁴ This monopoly comes with gate-keeping authority to many of our social rights and benefits, including disability claims, insurance policies and employment via pre-employment physicals. Although physicians outside the U.S. possess some of this authority, none have gained such legislatively and socially demarcated power(s).

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Freidson holds a profession is an occupation that has successfully defended its' claim to possess a "special esoteric competence."⁵ Furthermore, given the nature of this special knowledge it must maintain the exclusive right to carry out this work, determine who may obtain the knowledge, determine the appropriate application of the knowledge, and have sole discretion as to whom may have access to the knowledge. Importantly, so not to think such theoretical constructs are of interest only to stuffy academics, this conception of professionalism was asserted at the outset of a recent policy statement by the American College of Physicians on medical societies' obligations to help their members understand and respond to the ethical issues raised by managed care.⁶

Determining who may acquire this particular esoteric knowledge can be expressed in terms of MCAT exam scores, undergraduate grade point averages, letters of recommendation and so forth. Determination of the appropriate application of this knowledge is carried out through the development of standards of care, treatment protocols/algorithms and through the work of state medical boards via their power to restrict, suspend or revoke a physician's license.⁷ Discretion as to who may access the knowledge is demonstrated when only physicians can admit patients to a hospital, order tests and procedures and prescribe medications.

The last necessary condition to be a profession is the establishment of a Code of Ethics. Since establishing itself in 1847 the American Medical Association (AMA) has worked tirelessly to have physicians granted a special sphere of influence.⁸ One of the most significant products coming out of this effort is the AMA's Code of Ethics, and more recently, the "Current Opinions" of the AMA's Council on Ethical and Judicial Affairs (CEJA). The Code of Ethics has undergone significant revisions in 1903, 1912, 1957 and 1980 since being introduced in 1847.⁹ The Code sets out the AMA's foundation for its members' professionalism: a physician's duty to their patient, a patient's duty to their physician, and society's duty to protect the physician-patient relationship. The Code of Ethics acknowledges the social contract between physicians and the American public; in exchange for significant benefits (e.g., self-regulation, social-economic advantages, publicly subsidized educational loans, publicly financed graduate medical education, etc.), physicians must stay current in their esoteric knowledge and skills, promote patient autonomy, alleviate pain and suffering and place the interests of their patients above all others—it is this exchange that begets a profession.

III. PROFESSIONALISM FOR THE NEXT GENERATION

Even with a growing number of bioethics departments associated with US medical schools, the medical school curriculum still does not provide enough training to prepare students for ethical issues that arise. This section provides recommendations state medical boards should pass along to medical schools and graduate medical education programs. State medical boards must make clear to these institutions and programs that they must take seriously their obligation to promote medical professionalism through curriculum revision and other changes, particularly in light of the Accreditation Council on Graduate Medical Education's (ACGME) newly required competency on professionalism.¹⁰ The following strategies are outlined in four stages representing the development from 1) prospective medical student to 2) medical student to 3) intern/resident/fellow to 4) practicing physician.

Along with college undergraduate courses in biology, calculus and organic chemistry, a philosophy course on ethics and a bioethics survey course should be required. Regarding application essays, medical schools ought to provide a case study and ask applicants to discuss the moral and social

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issues that are raised including the relevant ethical principles and theories. By using case studies schools promote the use of critical thinking skills. The goal of changing to case studies, and away from personal essays, is to promote the development of moral reasoning skills. Case studies should be given careful review and given significant weight in the admission process. Similar case studies ought to be incorporated into the MCAT exam and given similar weight. To ensure medical school applicants are well aware of the new expectations, US medical school deans should publish a joint letter discussing the new professionalism-related pre-med requirements, the kinds of virtues they are looking for in an applicant, and examples of community activities that would demonstrate such virtues.

Promoting professionalism among medical students requires incorporating ethics throughout medical school curriculum as required full-credit courses and as adjunct components to every class. Adjunct ethical components include discussing the obligation to promote dignity during anatomy labs, the issues raised by accepting meals from pharmaceutical representatives during pharmacology lectures, the protection of human research subjects during classes on research methodology, and how to promote patient decision-making skills during lectures on performing history and physicals. Other professionalism-related topics that should be addressed include communication skills, impaired colleagues, cheating in medical school, health care fraud and abuse, conflict resolution, boundaries, health care economics, and stress reduction programs.

Attending physicians and chief residents must also be provided with training in the art of pedagogy regarding professionalism. Continuing medical education (CME) programs seem to be a particularly good venue for such programs. Peer review programs ought to bring under their purview the teaching skills, clinical and ethical, of attending physicians and chief residents. In addition, state medical boards should mandate and oversee the development of model policies and procedures for house staff to report the unprofessional conduct of fellow house staff and attending physicians. This undertaking would only be of value if the process for making these reports protected the “whistle-blower” in earnest and instilled in the house staff an obligation to report unprofessional conduct. The failure to do so should be considered a form of unprofessional conduct.

In addition to requiring CME programs on bioethics, boundary violations, impaired physicians and stress coping skills, state medical boards should require sanctioned physicians to design educational programs that address the issue(s) for which they were sanctioned and provide their program to medical students and the community. A corollary issue raised by this example is the obligation of an impaired physician’s colleagues to report him. State medical boards ought to make the failure to report an impaired colleague an explicit act of unprofessional conduct.

IV. ENFORCING PROFESSIONALISM

A. Clinical Research

The safety of human research subjects must be guaranteed during all clinical research trials. This obligation is grounded in the conception of professionalism put forth in Section II of this paper, the Belmont Report, and the Council on Ethical and Judicial Affairs’ opinion on “Clinical Investigation,” which states: “In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety, and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.”¹¹ This section addresses the pervasive failure in this obligation and how state medical boards should respond.

This monopoly comes with gate-keeping authority to many of our social rights and benefits, including disability claims, insurance policies and employment via pre-employment physicals. Although physicians outside the US possess some of this authority, none have gained such legislatively and socially demarcated power(s).

Even with a growing number of bioethics departments associated with US medical schools, the medical school curriculum still does not provide enough training to prepare students for ethical issues that arise.

The failure of the medical profession to protect patient-subjects has reached such epidemic proportions it necessitated former U.S. Secretary of Health Donna Shalala¹² and former editor¹³ of the *New England Journal of Medicine* Marcia Angell to publish open letters decrying the various forms of mischief undertaken in the performance of clinical research. These letters come on the heels of the 1995 report by the Presidential Advisory Committee on Human Radiation Experiments¹⁴ and President Clinton's 1997 apology to the eight remaining survivors of the Tuskegee Syphilis study.¹⁵

More contemporary examples of mischief in clinical research includes:

- using informed consent forms that are at best too sophisticated for the average American, and at worst intentionally deceitful;
- participating in clinical trials as a physician-researcher or a voting Institutional Review Board (IRB) member, when there is a (financial) conflict of interest;
- withholding information on adverse events from subjects who have been harmed;
- enrolling subjects after it has become clear the hypothesis grounding the research is invalid;
- “using” the physician-patient relationship to enroll patients;
- allowing research sponsors to withhold negative results;
- using coercive financial inducements to enroll subjects; and
- accepting payments from sponsors for enrolling patients.

Such mischief has been thoroughly documented by the national media and in the “Determination Letters” from the U.S. Office for Human Research Protections (OHRP). Determination letters specify an institution's noncompliance with the ethical principles of the Belmont Report¹⁶ and the Common Rule¹⁷ as determined by an OHRP compliance officer. To make the expanse of this form of unprofessional conduct explicit, the following is the list of institutions that received determination letters between December 2001 and November 2002:

Walter Reed Army Medical Center, Beth Israel Deaconess Medical Center, University of Colorado Health Sciences Center, University of California (San Diego), Baylor College of Medicine, Thomas Jefferson University, North Shore University Hospital, Duke University Health System, John Hopkins University School of Medicine, Children's National Medical Center, Massachusetts General Hospital, University of Pennsylvania, Brookhaven Science Associate, LDS Hospital, University of Maryland (Baltimore), University of Washington, Vanderbilt University, Nashville Veterans Affairs Medical Center, University of Cincinnati, Yale University, Cleveland Clinic Foundation, University of California (San Francisco), University of Michigan (Ann Arbor), University of Arkansas for Medical Sciences, National Institutes of Health, Suburban Hospital, University of California (Los Angeles), Emory University, Southern Illinois University, University of Kentucky, University of Pittsburgh, University of South Florida, Case Western Reserve University, Brigham and Women's Hospital, Harvard School of Public Health, Massachusetts Mental Health Center, Indiana University, Mayo Foundation, Memorial Hospital of Rhode Island, University of Kansas Medical Center, Rush-Presbyterian-St. Luke's Medical Center, Washington University School of Medicine, University of Minnesota, Cornell University Medical Center, University of Texas Southwestern Medical Center, Boston University Medical Center, State University of New York (Stony Brook), State University of New York Health Sciences Center (Brooklyn), University of Chicago, University of California (Davis), University of California (Irvine), McLean Hospital, Mount Sinai School of Medicine, New York University School of Medicine, Columbia University College of Physicians and Surgeons, Children's Hospital of Pittsburgh, Ochsner Clinical Foundation, Parker Hughes Institute, Winifred Masterson Burke Medical Research Institute, New York University School of Medicine, Boston University Medical Center,

State medical boards must make clear to these institutions and programs that they must take seriously their obligation to promote medical professionalism through curriculum revision and other changes, particularly in light of the Accreditation Council on Graduate Medical Education's (ACGME) newly required competency on professionalism.

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New York City Department of Health, Lankenau Hospital, St. Louis University, University of Hawaii, University of Miami, University of Utah, Hawaii State Department of Health, University of Florida, Loyola University Chicago, University of Louisville, Loma Linda University, Oregon Health & Science University, Brooke Army Medical Center, Wills Eye Hospital, Memorial Medical Center (New Orleans), University of Texas Health Science Center (Houston) and Columbia University.¹⁸

In addition to requiring CME programs on bioethics, boundary violations, impaired physicians and stress coping skills, state medical boards should require sanctioned physicians to design educational programs that address the issue(s) for which they were sanctioned.

The role of state medical boards in curtailing unprofessional conduct in clinical research must be explicit and decisive, beginning with the prohibition against serving as a principal investigator while having a financial stake of any size in the clinical trial's outcome. The Human Genome project, with its ties to the technology sector, has demonstrated that the profit motive of clinical research has placed the financial interests of physician-researchers in direct conflict with the health interests of patient-subjects.¹⁹ This prohibition certainly would not preclude physicians from pursuing financial investments in general, just those that a reasonable patient-subject would believe compromises the physician's fiduciary obligation to use their esoteric knowledge first and foremost to protect the patient-subject.

Nor does this recommendation seek to prohibit physicians from working as employees of research sponsors, so long as stock options and other profit-sharing schemes are not directly tied to the outcomes of the clinical trials. Given that providing trinkets of minimal value (pens, lunches, textbooks, etc.) is considered to effect physician prescribing habits in ways not grounded in the patient's best interests, allowing physician-researchers to receive government funding while reaping stock dividends seems antithetical to a commitment of promoting the professional conduct of clinical research.²⁰

The remainder of this section provides state medical boards with recommendations for addressing unprofessional conduct in clinical research:

1. Physician-researchers should be required to personally attest to the integrity of the consent process. Attached to every consent form should be a signed statement by the physician-researcher that consent was obtained in a manner that promoted the ethical principles set forth in the Belmont Report and that the "therapeutic misconception" was thoroughly addressed. A standard "accountability" form can easily be developed.
2. State medical boards should require the deans of their state's medical schools and the directors of their graduate medical education programs to personally attest to, and submit, their policies on the protection of "whistle-blowers" in clinical research.
3. Physician-IRB members who do not recuse themselves when they have a conflict of interest with the protocol being considered should be formally sanctioned, requiring at a minimum their attendance at a CME program on research ethics. In particularly egregious situations the physician's license should be restricted, prohibiting them from serving on an IRB or from participating in clinical research.
4. Physicians serving as the IRB's chairperson should be required to personally attest to the board's compliance with the Belmont Report and federal regulations governing the clinical research.
5. Physician-researchers should be required to complete an appropriate training program in research ethics prior to their involvement in clinical research.

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6. The president of the medical staff at all institutions conducting research should be required to personally attest that all members of the medical staff who are involved in clinical research have completed the appropriate training in research ethics.
7. Physicians who withhold information from a patient-subject, or subject, who has been harmed by a research intervention, should be sanctioned for unprofessional conduct.
8. Members of state medical boards should conduct ongoing lectures to their state's medical schools and graduate medical education programs on the professional conduct of clinical research, and address related issues in their newsletter and Web site.
9. State medical boards should advocate for revisions to their state's medical practice acts necessary for ensuring the board's authority to mandate the above recommendations and sanction physicians for unprofessional conduct in clinical research.

This state of affairs is especially troubling since the central obligation of physicians has always been to care for the dying. A physician's abdication of responsibility to the dying is prima facie unprofessional conduct.

B. End-of-Life Care

There is a significant body of literature documenting the problematic nature of end-of-life care in the U.S.²¹ This state of affairs has become so pervasive that Supreme Court Justices (Sandra Day) O'Connor and (Stephen) Breyer asserted in *Washington v. Glucksberg* that if another case involving physician-assisted suicide comes before them, and appropriate pain management and palliative care has not been forthcoming from the medical profession, "...the Court might have to revisit its conclusion..." which held there is no constitutional right to physician-assisted suicide.²² To substantiate the justices' concerns, a year later a study published in the *Journal of the American Medical Association* looked at the adequacy of pain management for nursing home residents.²³ The authors found:

- 26% of those who had daily cancer-related pain received nothing for it;
- 16% received a World Health Organization (WHO) step I drug;
- a strong correlation between a lack of pain management and increasing age; and
- a strong correlation between a lack of pain management and belonging to a minority group, as minorities had a 15% higher rate of non-treatment for pain.

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1. CME programs on pain management, palliative care, advance directives and do-not-resuscitate (DNR) orders should be required for relicensure.
2. The failure to provide appropriate pain management for the dying should be considered unprofessional conduct with appropriate sanctions applied.
3. Physicians should be required to discuss advance directives with all new patients in the spirit of the Patient Self-Determination Act.
4. Notwithstanding acts of conscience, the failure to respect a patient's advance directive, or the refusal to document a patient's condition in order to prevent an advance directive from being "triggered," should be considered an explicit form of unprofessional conduct with appropriate sanctions applied.
5. Physicians should be prohibited from following policies requiring the unilateral suspension of DNR orders in the operating room.

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6. Members of state medical boards should give ongoing lectures to their state's medical schools and graduate medical education programs on professional conduct in end-of-life care, and address related issues in their newsletters and Web sites.
7. The president of the medical staff at all hospitals should be required to personally attest that all members of the medical staff have completed the required education on end-of-life care proposed in Recommendation no. 1.
8. State medical boards should advocate for revisions to their state's medical practice acts as necessary for ensuring the board's authority to mandate the above recommendations and sanction physicians for unprofessional conduct regarding end-of-life care.

CONCLUDING REMARKS

The goal of this article is to inform those involved in physician licensure and discipline as to the meaning and implications of medical professionalism. The recommendations contained in sections III and IV demonstrated the corollary obligations that arise from the privilege of self-regulation. The recommendations provided in section III are reasonable expectations. Although the recommendations in section IV may be beyond the political capital of some state medical boards, I propose that they are worth any necessary struggle. Over the past few years there has been a flurry of additions to the literature on medical professionalism. I hope this article contributes to the growing dialogue on how to honor medicine's past by promoting its integrity in the present and future.

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This paper grew out of a seminar I gave to the Alabama State Board of Medical Examiners and Medical Licensure Commission in August 2000. I am indebted to the board, commission and staff members for their feedback, and I am particularly grateful to Larry Dixon, James Hulett and Ray Murray. I am also most grateful for the support of my faculty advisors, Robert Field and Charles Rosenberg, who oversaw my independent study on medical professionalism.

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