

Virtual Mentor
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FROM THE EDITOR

The Physician as an Evolving Moral Actor

“Trust me, I’m a doctor!” concludes Gene Simmons, of the classic hard rock band Kiss, in a television advertisement for the soft drink Cherry Dr. Pepper [1]. In this 2010 commercial, Simmons, Doctor Love himself, taps a deep-seated public sentiment concerning the prescriptive authority of physicians; the 30-second spot is amusing because an aging, steel-and-leather-clad musician would otherwise have no such claims to this kind of respect.

Physicians have long been held in high respect. The earliest shamans and witch doctors derived authority from local deities, the practitioners themselves often undergoing ritual initiations to distinguish themselves from the rest of their communities as minor prophets [2]. As medical science evolved, so did the status of the physician. The seventeenth-century story of a man’s selling his soul to the devil was raised to tragic proportions because that man was *Doctor Faustus*. This fall, tens of thousands of American medical students will take part in white coat ceremonies that symbolize their initiation into the select group of modern healers. Medicine remains an august profession, but the source of the knowledge from which its authority springs has since shifted completely from god-given providence to technocratic excellence.

But what of the physician’s moral status in this more secular system—the trustworthiness the Dr. Pepper commercial references? Are we to assume that with education automatically comes moral excellence? There must be more than the respect afforded to those who have obtained advanced degrees; after all, there are no rock stars on television hawking products by claiming to be lawyers, or even PhD-level marine biologists. Perhaps it’s that medicine is the business of helping people. But absent the presumed necessary association of medicine with moral authority, is it now possible for a bad person to be a good doctor?

In this month’s issue of *Virtual Mentor*, we remove physicians from the clinic to explore their moral influence—while members of society, doctors are no ordinary citizens. In 11 articles, we address the additional responsibilities of physicians need to earn and maintain a position of moral authority in our contemporary society.

The reality is that physicians, like all people, aren’t perfect, and more than 2 percent smoke cigarettes despite a preponderance of evidence against doing so. Sonja Boone, MD, notes in her case commentary that a physician’s responsibility begins with personal behavior because they serve as powerful role models, particularly to impressionable children. Citing the Hippocratic maxim “*primum non tacere*”—first

do not be silent—Stephanie Toth, MD, suggests that physicians should tactfully intervene if they recognize that a colleague’s personal habits apply this normative power in harmful ways. This month’s excerpt from the American Medical Association’s *Code of Medical Ethics* pertains to physicians’ responsibility to maintain their own health and to intervene when they observe impaired colleagues.

Sometimes, interventions by colleagues are not enough to correct personal transgressions. Valarie Blake, JD, MA, looks at cases in which medical boards have been challenged for taking action against physicians for their conduct. In our policy piece, Herbert Rakatansky, MD, explores the rationale of medical boards in their evaluation of physician behavior. He notes that with respect to artists and composers, for examples, we can love the art while disliking the producer. Medicine is different. Doctors do not create products; rather, the patient-doctor relationship is itself the product. If trust is lost, all is lost.

Once a physician acquires moral authority through deeds and work, how should this goodwill be employed? In our second clinical case discussion, Grayson Armstrong describes the power of physician advocacy as participatory citizens of influence, even on issues not immediately relevant to medicine. Thomas Bledsoe, MD, describes the limits of this advocacy and offers suggestions on how to act within those limits without forfeiting the trust of patients who may oppose a particular political view.

In an op-ed, Ford Vox, MD, describes what happens when the limits of advocacy are breached, offering the participation of University of Wisconsin family medicine physicians in pro-labor protests against state-level changes in February 2011 as a recent example. By writing dubious “sick notes” for protesters, the physicians themselves became the story, thereby deflecting public opinion from their cause. Acts of aggressive advocacy by physicians, he explains, require particular contemplation, lest we lose control of our narrative and prescriptive powers granted by society.

That doesn’t mean doctors should shy away from social or political advocacy. Steven Rivoli, a second-year student of osteopathic medicine and alternate delegate to the AMA House of Delegates, argues in an op-ed that advocating to end discrimination is part and parcel of medicine’s duty to further the best interests of the public. Despite its being a divisive issue, he notes, the denial of civil marriage to GLBT couples has adverse effects on their health; for physicians to stay silent about it would not be in keeping with the way we approach other social determinants of health.

In a journal review of “Expectation and Obligations: professionalism and medicine’s social contract with society,” by Cruess and Cruess (2008), medical and law student Michael S. Sinha identifies four obligations physicians derive from their contract with society. He suggests that the physician assumes a civic duty greater than that of the average citizen, with a responsibility to take action to improve the community.

After all, he notes, society subsidizes medical education, then pays the big bucks, because it “expects a greater return on investment.”

Examining further society’s implied contract with medicine in *VM*’s medicine and society section, Nadia N. Sawicki, JD, MBe, asks why society seems to feel justified in imposing such high standards of personal conduct on physicians. If we value them for clinical competence and their fiduciary ethic of care toward patients, Swicki says, then we should judge physicians on those grounds alone.

As is often the case in medical practice, issues that arise outside the clinic do not necessarily stay there. Janice Miller, MD, describes the challenges of professional practice when the physician’s simultaneous status as neighbor bleeds into the clinical sphere. But even in the setting of urban academic medicine, external forces shape the way physicians view themselves as professionals. In a narrative, Diane Plantz, MD, explores job satisfaction and burnout among employed physicians and housestaff who have increasingly found themselves to be paid cogs in biomedical behemoths. Despite the changes in practice models and work restrictions, she notes, satisfaction remains in actively helping patients—a part of medicine that will never change.

In sum, through historical precedent and continued efforts from the body of medicine, today’s physicians maintain a level of moral authority in interpersonal and social contexts. As practice models and science continue to change, it is important that physicians protect that which makes us special. We hope you learn from and enjoy this issue of *Virtual Mentor*.

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CLINICAL CASE

“...Not as I Do”

Commentary by Stephanie Toth, MD, and Sonja Boone, MD

It was a hot August afternoon. After a long day of dialysis assessments at a large academic medical center, Dr. Jones, an attending-level nephrologist, stopped at a nearby convenience store on his way home to make a last-minute purchase. A group of teenagers was in the store buying snacks. Dr. Jones also noticed a new cardiology fellow who was wearing his white coat and scrubs, probably on his way home after a day in the cardiac cath lab. In full view of the teenagers, the young cardiologist purchased two packs of cigarettes and lit one up in a nonchalant manner on his way out the door. Watching the receding figure through the store windows, the teenagers began holding their throats and coughing theatrically. The nephrologist, a lifelong nonsmoker, was taken aback by the fellow’s behavior.

Commentary 1

by Stephanie Toth, MD

As if physicians don’t have enough to worry about. Do they really have to concern themselves with how they behave in public after working hours? To whom does it matter what physicians do with their own time, as long as they provide appropriate care to their patients? Are they any different from individuals who work outside of the health care environment? Or, does the physician’s profession hold a certain sanctity in the community that may preclude them from partaking in certain activities? Is the ironic saying, “Do as I say, not as I do,” a convenient phrase to hide behind, or is it quite simply, hypocrisy?

It is a moral question that has been raised before and has regularly riled up proponents on each side. Moralists trumpet physicians as exemplars of responsibility, leaders of a superhuman life who set an example for their community and patients. Others argue that physicians are human too; they are as fallible as the next person, and they too experience stress, death, and emotional hardship. Since physicians are not immune to the daily stresses of life, it is reasonable that they too may succumb to the vices that entice all of us.

In response to an article in the *British Medical Journal* entitled, “Doctors Who Smoke” [1], one reader satirically wrote that, in addition to weeding out doctors who smoke, we should consider barring doctors from practice if they are “obese and sexually reckless.” In a later issue of the journal, a letter writer responded to the article:

On cardiovascular grounds,... we should also discourage those with a sedentary lifestyle; those with diets containing over 30 percent fat; those with a type A or “coronary prone” personality (that probably gets rid of most surgeons); those who drink more than 21-30 units of alcohol a week.... We should also discourage those doctors who parade their suntans, as sunbathing is a reckless and irresponsible activity. They should be allowed laboratory work only [2].

The point is well taken. Physicians are none other than mortal beings. They are not superhuman, and they are most definitely not impervious to the multitude of vices that surround us, be they tobacco, alcohol, or gluttony. More likely, physicians smoke for the same reason nonphysicians smoke: they are addicted. Does this mean that physicians’ actions, flawed though they may be, can be excused as ordinary, inherent human fallibility?

Let us examine the situation our cardiology fellow finds himself in. It is late. He has just finished another grueling day in the cath lab. He may have even had his first adverse event in the lab. Maybe he doesn’t want to be late for dinner with his wife, again. Or perhaps he is just anxious to get home so he can turn the television on and his mind off. Whatever the case may be, it is not his first experience with stress, and it certainly won’t be his last. So he decides to go to the local convenience store to pick up a pack of cigarettes. It could have just as easily been a six-pack of beer, a bag of potato chips, or even a 30-minute detour on the gym’s elliptical. To each his own.

What raises the moral stakes of his situation, however, is that not only does he purchase cigarettes in front of adolescents, he does so in his hospital attire. The irony that a budding *cardiologist* is buying cigarettes is likely to be lost on the group of youths, so let us also forgo it and tackle the more obvious problem: the physician sets a poor example in front of the next generation by purchasing a product with a label that reads, “Smoking kills.” Naturally, the teens would think smoking must be less harmful if they witnessed a physician partaking in the habit. Wouldn’t anybody be inclined to think that the consequences of smoking are less dire if a physician is willing to smoke? The young cardiologist is setting a bad example not only for the youth, but also for the community he serves. Whether physicians like it or not, their profession has been highly revered, both internationally and historically, and, just because today’s practice of medicine has moved away from a paternalistic model, it does not mean that patients no longer look to their physicians for advice. More importantly, advice need not always be spoken. Leading by example can be as simple as taking the stairs, wearing a bicycle helmet, or not smoking.

Suppose the physician counsels patients against smoking and doesn’t condone the habit even though he has fallen victim to it. Has the patient been wronged? After all, smoking is an individual’s choice, is it not? Unfortunately, this cannot be the case for physicians. It is not enough to say simply, “Do as I say, not as I do.” If physicians cannot lead the way against tobacco, nobody can. The field of medicine is one of the

few witnesses to the myriad effects tobacco has on the body. Physicians are often the only advocates patients have against their smoking habit. Every branch of medicine is touched by tobacco—pediatrics, primary care, psychiatry, obstetrics, gynecology, surgery, urology, otolaryngology, pathology—just as every region of the body is touched by the consequences of smoking. A physician, knowing all of this, should feel a moral obligation to quit smoking, if not for society, at least on behalf of his health.

Let us get back to the second, more glaring offense of our young cardiologist: he is wearing his physician's white coat while purchasing cigarettes. It is possible that he was so dazed from his day of cardiac catheterizations that he simply forgot to take his coat off. Possibly so, but whatever the case, he is wearing the universally iconic attire of the medical profession, the white coat. Just as one wouldn't wear it for a night out on the town, one shouldn't wear one into a convenience store to purchase cigarettes. His actions are a sore misrepresentation of physicians as a whole. The white coat demands responsibility and professionalism, and hence the young physician's actions are unacceptable. While it is understandable that one's white coat may feel like a second skin to some, it is important to remember that when donning one in public, the nameless wearer represents all physicians.

Finally, as the teenagers in the scenario thankfully show distaste toward smoking, we will instead focus on the character who has quietly observed the scene unfold before him: the nephrology attending. What role, if any, should the more experienced doctor play in this setting? Do the two physicians know each other? Do they work at the same institution? Should the nephrologist simply speak with the fellow directly? Perhaps direct his concern to the fellow's attending physician? Is it his place to say anything at all? With no obviously correct answer in sight, it is apparent that this scenario could play out a number of ways. Each physician placed in the attending physician's shoes will bring his or her own moral code and comfort level to the situation. Unfortunately, whereas physicians are well versed in the Hippocratic adage "primum non nocere"—first do no harm—they are more reluctant to employ a lesser known Socratic maxim, "primum non tacere," first do not be silent [3]. Approaching the young physician and alerting him to morally reprehensible actions should not make experienced physicians uncomfortable; they are simply counseling another person in a long line of colleagues and patients. It is not enough to wait until medical ethicists redirect our moral weathervanes. Veteran physicians should feel comfortable enough to speak with a young physician, especially when they witness a public display that sheds negative light on the field of medicine as a whole.

Fortunately, the above situation is not very common; only 2 percent of physicians in the United States smoke tobacco [4]. Nevertheless, the scenario raises the question of whether a physician's actions outside of the workplace should be held morally reprehensible if they contradict medical advice. It is impossible to claim that the 2 percent of physicians who smoke tobacco products lack integrity as medical professionals. Though a personal choice, it is not the only one. Perhaps they chose to start smoking years earlier and have been unable to gain control of the addictive

habit. As elucidated in the most recent amendment of the physician's oath, "my colleagues will be my sisters and brothers," physicians have a moral obligation to help not only their patients, but also each other [5]. While it may seem rude or intrusive, what is the long-term harm in asking: "Have you thought about quitting?"

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Commentary 2

by Sonja Boone, MD

It might be surprising to learn that 2.3 percent of physicians in the U.S. smoke cigarettes [1]. It is even harder to believe that in 1946 there was a Camel cigarette ad with the headline "More Doctors Smoke Camels Than Any Other Cigarette!" and citing a nation-wide survey of doctors as support [2]. As the nation attempts to focus efforts on disease prevention, it is imperative that we understand why even the 2.3 percent of physicians who smoke remain addicted, knowing what they know about biochemistry of nicotine.

While this case seems to be straightforward, there are several factors to consider. The smoker is a physician colleague who is addicted to nicotine and willing to ignore the standards of professionalism in order to have a cigarette. How would one approach such a colleague?

There are at least four perspectives to consider:

1. A "purist" perspective (No one should smoke; smoking is bad for one's health.)
2. A professionalism perspective (Doctors, especially, should not smoke, and those who do should not smoke in public where they are likely to be recognized as doctors.)
3. A beneficence view (The individual's inability to quit smoking must be due to excessive stress; the smoker may need help.)

4. A respect for autonomy view (The individual has a right to make his or her own life decisions, be it smoking, not eating well, not exercising, as long as he or she is not directly harming others.)

The view or perspective one adopts determines the extent to which one feels justified in intervening in the cigarette-buying cardiologist's affairs.

If one adopts the purist, professionalism, or beneficence view, one is likely to intervene. Only the radical respect for autonomy view supports nonintervention. I believe that intervention is justified in this instance and that an approach that entails empathy for the cardiology fellow's tobacco addiction is best—a hybrid of the professionalism and beneficence views. Still, one does not simply walk up and inform the cardiology fellow that smoking in front of others while wearing scrubs represents less-than-desirable professional behavior. The nephrologist could, however, walk up and mention that they both work at the same hospital and ask what sort of day the cardiologist had. This could lead to further questions about work and life.

Studies have shown that physicians are powerful role models for patients and that physicians who engage in healthy behaviors are more likely to counsel their patients on such behavior [3]. Given this information, the fact that the cardiologist was smoking in front of “tweens” further argues for intervention. Children from age 12 years into their early 20s are highly impressionable, and they are particularly vulnerable to exposure to addictive substances such as tobacco and alcohol [4]. The cardiology fellow has actually exposed these young “tweens” to a harmful substance and set a bad example as a professional.

Overall, an intervention in this case will require compassion, empathy, and establishing rapport and therefore trust in order to convey a message that smoking is harmful to self and others and is less-than-professional behavior.

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CLINICAL CASE

Physicians and Political Advocacy

Commentary by Thomas A. Bledsoe, MD, and Grayson W. Armstrong

It is October in the American Southwest, and Mrs. Feldman is watching playoff baseball on TV. Between innings, she notices her gynecologist, a well-respected professional who delivered both of her children as well as those of her sister, in a political advertisement.

This is an election year, and, in the 30-second spot, the physician speaks on behalf of a state proposition that would curtail public services, including education benefits, to illegal immigrants and their noncitizen dependents. His name appears under the image of a graying man dressed in a sharp polo shirt and khakis.

“Hi, I’m Dr. Seligman. I’m a lifelong resident who has been practicing medicine in this state for 20 years, and we need your support in saving American tax dollars,” he says.

Mrs. Feldman, who strongly disagrees with the proposition, is upset to see the doctor she likes and respects taking this view. The next week, she goes to Dr. Seligman’s office for a routine exam. The office’s walls are decorated with artistic renditions of the fetal stages of pregnancy; there are no posters or campaign literature visible. After she grumbles her protests of the doctor’s television appearance to the admitting nurse, who commiserates, Dr. Seligman arrives. There is no discussion of political topics, but she remains disconcerted by Dr. Seligman’s using his position and the respect people have for him to promote this political action.

Commentary 1

by **Thomas A. Bledsoe, MD**

This case raises questions about the public activities of physicians outside of the practice of medicine. When and how is it appropriate to use one’s status as a physician in nonmedical affairs?

In this case, Dr. Seligman is presented as a “well-respected professional” and his patient is disturbed by his use of that respect (presumably both for him as an individual and for the profession to which he belongs) to further aims not related to the practice of medicine. I would like to start analyzing the case by considering *why* he is well-respected. What has Dr. Seligman (or his profession) done to earn that respect? The code of professionalism endorsed by the American Board of Internal Medicine, the American College of Physicians and the European Federation of Internal Medicine defines professionalism as

the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health [1].

The profession *earns* respect as a result of the knowledge base accumulated by members of the profession over time and its commitment to use it for the good of society. The “well-earned respect” may stem from Dr. Seligman's scientific approach to the practice of medicine, to his contributions to the field or to his ability to put the interests of his patients before his own interests.

While one could certainly imagine the good doctor having applied the scientific method to his personal study of the issues around funding education and other services to illegal immigrants and his having made significant contributions to our understanding of these issues, none of this is presented in the vignette. By contrast, Dr. Seligman seems to be simply trading off his well-earned high standing in the community *in the practice of medicine* to attempt to speak with authority in areas outside of medicine. His use of the honorific “doctor” in his self-introduction appears to be an attempt to present himself as an authority figure in this area as well, perhaps fraudulently.

In this respect, Mrs. Feldman would be right to question the authority of the physician as spokesperson for a political cause. At the same time, a desire to view him with skepticism *as a physician* would be misplaced. Why should his desire to speak outside of his area of highest expertise and credibility call into question the respect she has for him within his scope of practice? It certainly would be within her rights to accept care only from physicians with whom she shares political opinions, but this would be foolhardy.

The second issue in this case relates to a possible *obligation*, arising from the precepts of professionalism, to speak out, even on topics not directly related to the practice of medicine. In addition to the privileges granted to members of the profession, there are also responsibilities and obligations. As physicians, we have privileged access to information, both at a personal level and at a systems or societal level. With that privilege comes responsibility, and sometimes that responsibility involves actions not traditionally related to the practice of medicine, even in the broader “professional” sense. Dr. Seligman may be aware, to an extent that few others in his community might be, of the degree to which services to various groups of legal residents are being curtailed as a result of efforts to provide these or other services to residents who are not in the community legally. Dr. Seligman may think it is *wrong to keep silent* in the face of his knowledge of these situations. (In the words of James Dwyer, “*primum non tacere*”—first, be not silent [2].)

In sum, there are many perspectives to consider. Dr. Seligman must first consider whether *his experience as a physician* gives him some insight on policy that others

do not have. If so, it would seem defensible at least to mention his experience as part of his credentials. If not, then it would seem inappropriate and perhaps even paternalistic in the old-fashioned sense, now generally seen as negative, to try to make the case that “doctor knows best,” especially if the issue is not related to the profession.

Finally, if he considers himself an expert, then he must weigh carefully the positive and negative effects his political activity will have on his relations with his patients. Some, like Mrs. Feldman, may find that the therapeutic relationship she has had with her physicians over the years is compromised by his advocacy. Others may seek out this doctor *because* of his political positions. Either way, the relationship becomes more complicated and perhaps less *therapeutic*.

In the end, I am reassured by Dr. Seligman’s apparent separation of practice and political positions—no pamphlets in the office—but am discomfited by his presenting himself as both an expert and maybe even as a representative of the profession in the political advertisement, especially as the issue seems distinct from medicine.

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Commentary 2

by **Grayson W. Armstrong**

Should a physician use his credentials as a doctor to support explicit political viewpoints even though this may generate ill feelings among his patients? Physicians have a long history of involvement in politics. Doctors were a part of the push against socialized medicine in the 1940s just as they are currently voicing their diverse opinions on health care reform. Mrs. Feldman’s negative reaction to Dr. Seligman’s ad illustrates the importance of paying attention to political involvement by physicians.

There are many points to consider: whether or not it is acceptable for physicians to publicly support legislation; whether or not the content of the legislation plays a role in that acceptability; when, if ever, physicians should discuss political matters with their patients; who, if anybody, should be responsible for deciding whether legislation is appropriate for physicians to support; whether anyone should intervene if physicians' political stances are perceived to exceed boundaries for professional involvement; and whether the legislation in this case falls in line with Dr. Seligman's ethical responsibilities.

Physicians' Civic and Professional Rights and Responsibilities

Dr. Seligman explicitly supports the measure he speaks out for, and, as a citizen of the United States, he enjoys the rights and privileges of political free speech that allow him to do so. Political free speech includes, but is not limited to, lobbying public officials, running for political office, and supporting political candidates and legislation. Political stances of any kind may take the form of public endorsements, such as Dr. Seligman's appearance in the television ad, or private endorsements. Physicians may exercise these political rights as individuals, through political action committees, or through local, state, or national medical and non-medical associations. In light of this, Dr. Seligman's support of political legislation is well within his constitutional rights as a citizen.

According to the American Medical Association *Code of Medical Ethics*, Dr. Seligman as a physician also has a professional responsibility to improve his community, advance public health, and encourage access to medical care for all individuals [1]. So, while, as a citizen, Dr. Seligman has the right to support any legislative mandate he chooses, as a professional, he also has the obligation to ensure that the legislation he supports does not infringe upon the advancement of public health, the betterment of community, or access to medical care for all.

Individual physicians often have differing views about whether or not specific legislation meets these professional guidelines, and, indeed, they are entitled to their own political viewpoints. One timely example is the debate over whether legislation mandating that individual Americans buy health insurance will increase patient access to health care services. Who, then, is responsible for deciding whether legislation satisfies a physician's professional responsibilities? Ultimately, Dr. Seligman is. In order to form an educated political opinion, however, he must keep up to date on political and health care issues. He may also seek input from his colleagues, professional medical societies at the local, state, and national level, or from legal and political professionals.

Is anyone besides Dr. Seligman responsible for judging whether or not his political stance accords with his professional imperatives? In general, physicians should be cognizant of the views of patients, co-workers, colleagues, and medical and non-medical organizations in order to enhance their ability to make an informed decision. At the same time, physicians must weigh their political rights with their ethical responsibility when deciding on political stances and, ultimately, make this decision

for themselves. Once Dr. Seligman is convinced that his stance is aligned with his professional ethics, he has the right to free political speech and should not succumb to undue pressure by any party, nor should he accept punishment for his stance.

Analysis of Legislation

Is the legislation supported by Dr. Seligman, which limits educational resources provided to illegal immigrants and their dependents, concordant with his ethical responsibility as a physician? Specifically, does the legislation limit or promote access to medical care, negatively or positively impact public health, or disrupt or enhance community?

It could be argued that the legislation does not directly limit access to health care, as no mention is made about specifically limiting health care resources to illegal immigrants or their dependents. However, one could also argue that illegal immigrants and their dependents indirectly lose access to health care through the restriction of educational resources. Not having access to education limits both employment opportunities and earning potential and would make it less likely that those affected would obtain either employer-offered health insurance or sufficient earnings to purchase their own health care services. Conversely, this decrease in resources for the illegal immigrant population could translate into more available health care resources for documented residents.

The legislation's impact on both public health and community are also important points to address. One could argue that restricted educational resources may result in a decline in the education of the illegal immigrant population on public health issues. Those affected may need more urgent or emergency health and social interventions for preventable problems, which ultimately require more community resources.

It can also be argued that the legislation disempowers illegal immigrants and sets up a divide between this population and documented residents, which could encourage discrimination. Conversely, limiting illegal immigrant educational resources may release funds that could then be devoted specifically to public health issues or to education of the entire community, leading to a positive public health impact. The resources freed up might also be reallocated to legal residents for education, health care, or other means of building community.

Despite the multitude of conflicting arguments about the appropriateness of this legislation, one hopes that Dr. Seligman weighed all of the potential consequences, keeping in mind his ethical responsibility as a physician and subsequently came to his conclusion that the legislation was appropriate. After coming to such a conclusion, Dr. Seligman could have publicly justified his political stance using such arguments in the television ad, but it appears from the information provided in the case that this did not take place. Outlining health care-related arguments should not be a requirement of physicians when publicly supporting legislation.

Politics and Patient Care

Irrespective of the content of the legislation, ethical dilemmas are bound to arise when politics comes into the medical context. Mrs. Feldman, as a patient, may worry that the quality of care Dr. Seligman offers her could be diminished if she argues with him, making her less likely to bring up her concerns about his politics. Medical students and residents may feel that their grades or training will suffer if they voice disagreement with a senior physician's political views. (Physicians can make an effort to refer vulnerable parties to forums, such as public sessions sponsored by independent institutions, where they can voice dissent without fear of retribution).

Physicians should be mindful to discuss political matters with patients only in settings where patients and families are not emotionally pressured by health care concerns. The television ad featuring Dr. Seligman airs in nonmedical settings. Additionally, Dr. Seligman does not touch on political topics during his patient's medical visit. Political discussions should not occur during the clinical portion of a medical visit. If patients introduce such discussions after the clinical encounter has concluded and the patient is not in emotional distress, the physician can state his views. He must, however, keep political discussions with patients respectful and reassure them that their political beliefs will have no effect on their treatment. Physicians should use their best judgment in deciding when medical issues or concerns make such political discussion inappropriate.

Is it possible that Dr. Seligman's political advocacy will compromise patient care? When physicians consider political advocacy methods, they should avoid collective actions such as strikes, which may limit access to care or delay imperative care. Additionally, formal unionization or workplace alliances may tether the physician to other workers who do not share in the physician's professional responsibility to treat patients. Dr. Seligman's television ad, however, does not limit his patients' access to care, does not align him with workers who don't share his professional responsibility to treat patients, nor does it by any direct mechanism compromise the delivery of high-quality patient care.

Conclusion

Physicians have the same political rights and freedoms as every other U.S. citizen, but they must balance these freedoms with their ethical responsibilities to patients. Physicians should make every effort to arrive at educated decisions and should remain open to new ideas. Ultimately physicians are responsible for choosing their own political stances. Physicians should make sure to formulate and communicate political opinions without compromising their responsibility to care for their patients.

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Virtual Mentor

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CLINICAL CASE

When Patients Worry about the Doctor

Commentary by Jan Miller, MD

Dr. Weller, a pediatrician in a one-stoplight town, arrives at her practice earlier than usual, avoiding the eye of the office manager, who is sitting at the front desk. No doubt Alex is aware of what much of the town now knows—that Dr. Weller’s 16-year-old son was arrested the night before, after drunkenly driving into a shop front not far from the office Dr. Weller is standing in at the moment.

“Morning, Doc,” Alex calls to Dr. Weller’s retreating back.

“Morning, Alex,” she mutters, busying herself with her coat, bag, and mail. She looks forward to immersing herself in patient visits—any break from the loop of worry, anger, recrimination, and embarrassment that she’s been in since the call came from the county jail.

But work provides little respite. A couple of well-child checkups are canceled; Dr. Weller wonders if there’s a connection. Are her patients doubting her or trying to give her space? Or is it just a coincidence? And a number of patients’ families express condolences and offer parenting advice during their visits, despite her best efforts to redirect conversation to the patients’ condition. Dr. Weller ends the day exasperated and embarrassed.

Commentary

On the island where I live, there’s a sign that hangs in our police station. It reads: “The nice part of living in a small town is that when I don’t know what I’m doing someone else does.” Living in a small community can be an incredibly rich experience. Living and working in that same community can also be a tremendous challenge.

My family and I live on a small island 12 miles from mainland America. Access is by boat or plane. In bad weather we can be cut off for days. There is one medical center, one doctor on duty at a time. Everyone knows who drives which car, and who has been where. A 5-minute trip to the store becomes a 45-minute outing as you stop to talk. Though it’s a sign of respect, I sometimes feel like my given name is really “Doc.” Patients have long conversations in the waiting room about many topics, including their medical problems (and probably *me*) and often discuss their diagnoses on the way out the door. They do not have to abide by HIPAA; we do. And patients know that what they discuss with me goes no further.

Being a keeper of secrets can be emotionally difficult. And what happens when the focus is turned back onto you? If you choose to become a part of a small community, you give up all chance of anonymity. It is really nearly impossible to keep your private life private and still be a part of the community without appearing aloof and superior. Your patients are also your friends, neighbors, and colleagues. Advice is freely given, even if unwanted, and presumably the givers mean well. The trick is to acknowledge it, then gently steer the conversation back to patients' own concerns. When parents offer Dr. Weller their condolences on her son's arrest during an office visit, a simple "thank you" is all she needs to say before resuming the previous topic. This should convey the message that the sentiments are appreciated but the subject is not open to discussion. If parents ignore the message and continue with advice, Dr. Weller may have to be more direct: "I'm sorry but we're here to talk about your son (or daughter), and I'd like to hear more about the reason for your visit today."

Damage control, too, is difficult. But if Dr. Weller is truly part of the community, has been at the library and school fairs, the church dinners, the town meetings, the birthday parties and funerals, she will be respected and supported by most. If office visits continue to be lighter than usual, Dr. Weller has a couple of choices. She may just be patient. If she continues to treat everyone professionally and to the best of her ability, avoiding as much discussion of her personal life as possible while being interested in all aspects of her patients' lives, then her patients will return when they need care.

If waiting patiently and doing nothing is not part of Dr. Weller's character, she could consider writing a letter to the editor that is brief and to the point, apologizes for any harm her son's behavior has caused, and emphasizes that the experience has strengthened her understanding of troubled kids and her compassion for parents.

Will a private scandal hurt patient care? Chances are that it will not, as long as Dr. Weller's competence as a pediatrician and focus on her patients' needs does not diminish. The good news is that it probably won't be long before another controversy replaces this one, and Dr. Weller's son's misdeeds take a back seat.

Despite what some doctors might like to think, we are all human. No one is perfect. As long as Dr. Weller's work isn't the issue, she should shake off the embarrassment, work out the problems with her kids, listen to others' opinions without anger, and get on with her life in a special place. Chances are the people in that small town will respect her more for maintaining her professional demeanor and moving on.

Jan Miller, MD, is the medical director of the Block Island Medical Center in Rhode Island.

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THE CODE SAYS

American Medical Association *Code of Medical Ethics*' Opinions on Physicians' Health and Conduct

Opinion 9.0305 - Physician Health and Wellness

To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired.

In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing. Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed.

The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by: promoting health and wellness among physicians; supporting peers in identifying physicians in need of help; intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program; establishing physician health programs that provide a supportive environment to maintain and restore health and wellness; establishing mechanisms to assure that impaired physicians promptly cease practice; assisting recovered colleagues when they resume patient care; reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority.

Issued June 2004, based on the report ["Physician Health and Wellness."](#)

Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues

Physicians have an ethical obligation to report impaired, incompetent, and/or unethical colleagues in accordance with the legal requirements in each state and assisted by the following guidelines:

Impairment. Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (see Opinion E-9.0305, "Physician Health and Wellness"). Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority.

Incompetence. Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate. Incompetence that poses an immediate threat to the health and safety of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board.

Unethical conduct. With the exception of incompetence or impairment, unethical behavior should be reported in accordance with the following guidelines and, considering, as necessary, the right to privacy of any patients involved:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization.

When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved.

Issued March 1992, based on the report “[Reporting Impaired, Incompetent, or Unethical Colleagues.](#)” Last updated June 2004, based on the report “[Physician Health and Wellness.](#)”

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[“...Not As I Do.”](#) October 2011

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JOURNAL DISCUSSION

Rousseau at the Roundtable—The Social Contract and the Physician’s Responsibility to Society

Michael S. Sinha

Cruess RL, Cruess SR. Expectation and obligations: professionalism and medicine’s social contract with society. *Perspect Biol Med.* 2008;51(4):579-598.

“Temperance and labor are the two best physicians of man; labor sharpens the appetite, and temperance prevents from indulging to excess.”

Jean-Jacques Rousseau, Emile, or Treatise on Education

In “Expectations and Obligations: Professionalism and Medicine’s Social Contract with Society,” Richard L. and Sylvia R. Cruess consider medicine’s implicit duties to society [1]. The authors note that, although well-accepted as an appropriate model, the “social contract” in health care is a “mixture of implicit and explicit, written and unwritten” [2]. To clarify, the authors subdivide “medicine” into individual physicians and the institutions of medicine. “Society” is divided into individual patients, the general public, and the government. In the triangulation among medicine, government, and society, the balance of power and influence shifts from time to time, and, as society evolves, so must the social contract.

The authors use a schematic diagram to show the relationships between medicine and society [3]. In this diagram, the individual physician has obligations to (1) the individual patient, (2) the profession of medicine, (3) the general public, and (4) the government. Under contract theory, each party has expectations of the other and relies upon the fulfillment of those expectations, to benefit or detriment [4]. The specifics of that contract have evolved over time to fit emerging societal trends. The authors assert that the “social contract,” at its root, forms the foundation for medical professionalism and clarifies both the roles and expectations of medicine from government and society at large.

Though the authors do not rank these four obligations, I have ordered them purposefully. Much has been said about the first two obligations, those of a physician to the individual patient and to the profession of medicine. For this reason, medicine is often regarded as a calling; the interests of the patient and the profession are supposed to outweigh personal interests. The principles of beneficence, nonmaleficence, autonomy, and justice govern a physician’s duty to the individual patient [5]. The Hippocratic Oath symbolizes the physician’s obligation to both patients and the profession of medicine [6].

What the second two obligations—to the general public and the government—have in common is, as Cruess and Cruess put it, a duty to engage in “promotion of the public good” [7]. In general terms, this means that a physician accepts, and is held to, higher expectations and a more prominent social role than the average citizen. As such, a physician who ignores his or her implied responsibilities as a public servant is breaching the social contract. Many physicians fill the role of public servant nobly and admirably, but many fall short.

How should the medical profession fulfill these obligations? Consider philosopher Jean-Jacques Rousseau’s thoughts in *The Social Contract*, published in 1762. He boils the concept down to the following: “Each one of us puts into the community his person and all his powers under the supreme direction of the general will; and as a body, we incorporate every member as an indivisible part of the whole” [8]. As a member of a learned profession, a physician has more “powers” to put toward the general will, and ought to do so. Part of the reason our society rewards physicians with more pay is because it, justifiably, expects a greater return on investment.

One important component of the physician’s obligation to the general public is in the realm of public health. As physicians, we have a wealth of knowledge to share. For instance, the importance of smoking cessation, proper diet and exercise, and vaccination should be shared with the public as a whole. Why should we settle for counseling the individual patient when so many in the community need this advice? Physician outreach beyond the walls of a clinic or operating room should be a fundamental means of fulfilling that civic duty.

We have an integral role in public health and prevention to promote change that benefits society and improves health outcomes, even when those changes do not directly benefit us as physicians. Improving access to clean water, for instance, prevents millions of cases of water-borne illness in developed countries. An infectious diseases specialist in a country with insufficient access to clean water may have a satisfyingly large patient load, but the greater societal good demands the eradication of preventable illness wherever possible. Physicians should strive to reduce their patient load as much as possible by focusing on prevention, even though a healthier population makes fewer office visits.

Prevention also makes sense economically; a healthier population requires less health care spending per capita. Health care financing is another essential element of the public good that doctors must work toward. As in the exam room, this entails putting the general good above one’s own interests—something doctors do not always do. This has played out recently in the passage of the Affordable Care Act. Recognizing that the health care system in the United States is broken and unsustainable, physicians had to choose whether to resist change or to advocate for improving the delivery of medical care, for physicians and patients alike, in future generations. Some physicians, so adamant about maintaining the status quo and the quality of life it provides them, have favored those individual interests at the expense of the social contract.

It should be noted, however, that health care costs are not rising exponentially because physicians are too well-paid. They rise due to the lack of emphasis on primary care, the increasing burden of preventable disease, and the misallocation of health care resources. These are all areas in which physicians have expertise. The need for a gastric bypass reflects a failure of primary care and prevention in communicating the importance of diet and exercise. Dialysis for end-stage renal disease may reflect a failure in the management of diabetes, hypertension, or both. Specialists may stay in business treating these patients, but also have an excellent understanding of the course of disease and means of prevention. Physicians can and should get involved in their communities, helping to develop programs that promote healthier lifestyles and disease prevention. This is just one example; there are numerous opportunities for physicians to engage in community-building.

What about at the state and federal level? If physicians are unhappy about Medicaid payments, the Medicare Sustainable Growth Rate, or individual state issues such as medical malpractice reform, they can make their voices heard, either by communicating with their elected officials or by running for public office. The same is true of federal laws such as the Affordable Care Act. Rather than decrying the law and demanding its repeal, physicians should look at benefits the law provides and lobby for improvements that further the public good. Altering a system, such as health care, that badly needs reforming is a lengthy process and does not end with the passage of a single law, no matter how “comprehensive” it purports to be. We, as physicians, have an ongoing responsibility to shape the future of our profession for the benefit of our patients and for society as a whole. No single political party represents the spectrum of needs of the medical profession, and, therefore, physicians must continue the health care reform movement, even if it requires a partisan tug-of-war to succeed.

Physicians must remember that their social contract with society extends beyond that of the individual patient and the medical profession and into the realms of the general public and the government. As public servants, physicians should heed Rousseau’s warning:

Every individual as a man may have a private will contrary to, or different from, the general will that he has as a citizen. His private interest may speak with a very different voice from that of the public interest; his absolute and naturally independent interest may make him regard what he owes to the common cause as a gratuitous contribution, the loss of which would be less painful for others than the payment is onerous for him [9].

In the calling of medicine, at least, the opposite is true—the loss of a physician’s contributions to the public good is far more onerous than the benefit to a physician’s quality of life. To the contrary, contributing to the public good is likely to improve the physician’s quality of life by instilling a sense of accomplishment and personal satisfaction. The task is its own reward.

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HEALTH LAW

Home or Hospital—Your Medical Board Is Watching

Valarie Blake, JD, MA

Giving an alcoholic beverage to a 17-year-old, stashing counterfeit money, unlawfully possessing an automatic weapon, evading your taxes—if this sounds like a just another Friday night to you, then reconsider the profession of medicine [1-4]. A physician's public image is often as important as his or her professional one, particularly to medical licensing boards. All of the above are activities that have caused physicians' medical licenses to be challenged by state boards, whose jurisdiction can extend beyond the physician's practice of medicine to his or her private actions.

State medical boards giveth and they taketh away. Granted their powers by state law, these boards are charged with dispensing and revoking medical licenses, investigating complaints, and monitoring rehabilitation of physicians when appropriate [5]. They were conceived to "give the public a way to enforce...competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession" [5].

Deviations from the standard of care are the most common cause of complaints to medical boards. These include overprescribing or prescribing the wrong medications, failing to diagnose an illness, neglecting to provide postoperative care, providing test results in a less-than-timely manner, and not responding to trauma calls [6].

Some states only discipline physicians for actions related to the practice of medicine. Examples of disciplinary causes related to practice include professional incompetence, wrongful or excessive prescription of drugs, improper sexual conduct toward patients, and alcohol or narcotics addiction [7-10]. Other states' boards discipline for conduct outside of professional duties. In these states, personal conduct can warrant disciplinary action if it demonstrates "moral turpitude," meaning that the act reflects "on the character, integrity, and honesty" of the physician [11]. Examples include tax evasion, mail fraud, and sexual offenses outside of work [4, 12, 13].

A careful balance must be struck to avoid over- or underdisciplining physicians. A state medical board that is perceived as going easy on physicians may face public critique and legal liability. A board that disciplines a physician, however, risks a suit brought by the doctor, charging it with wrongfully jeopardizing his or her license. Hence, it is important that boards follow consistent and equitable procedures when reviewing licenses to avoid legal challenges.

Failure-to-Discipline Claims against Medical Boards

In 2010, the Federation of State Medical Boards reported a total of 1,815 losses of license or privileges and 1,296 restrictions on licenses (e.g., probations) nationwide [14]. Public Citizen, a national nonprofit consumer advocacy organization, publicly critiqued medical license boards in March 2011 for underdisciplining physicians. Examining data between 1990 and 2009, Public Citizen concluded that over 55 percent of physicians who got in trouble with their local hospitals were never disciplined by their state licensing boards [15]. Of these physicians, 35 percent were charged with a serious violation such as immediate threat to health and safety, sexual misconduct, fraud, incompetence and negligence, narcotics violations, or defrauding health care programs [15]. Similar concerns were raised recently by the same organization about California's medical board [16].

In one failure-to-discipline case, a patient sued the state medical board over complications of her pregnancy, claiming the board was negligent in failing to discipline her ob-gyn, who had past complaints about his performance [17]. The state's highest court held that the medical board was immune from suit, just as a state prosecutor is immune with respect to which criminals to sue [17]. They reasoned that, without such immunity, a board's fear of liability might prompt it to pursue more cases, leading, presumably, to a higher number of wrongful claims against physicians' licenses.

In some instances, state governments are stepping in to ensure adequate disciplining of physicians. In Illinois, a recently passed law permanently strips licenses from health care workers found guilty of sex crimes, forcible felonies, and battery of a patient—taking the decision out of medical boards' hands [18].

Legal Claims by Physicians against Medical Boards

State medical boards also face suits from physicians who claim they have had their licenses unfairly acted against.

When a court accepts a case against a medical board for review, the level of deference with which it examines the medical board's judgment varies from state to state. In Maryland, the state "review[s] an agency's decision 'in the light most favorable to the agency,' since their decisions...carry with them the presumption of validity" [19]. In Florida, while it is acknowledged that a medical board should have wide latitude, the court also urges caution where revocation of a professional license is at stake, requiring that "any ambiguity [be] interpreted in favor of the licensee" [20].

Physicians can make a number of legal claims against a medical board including arguments that the board did not follow proper due process in its proceedings, that the physician was not treated like others in a similar situation, that the claim constitutes double jeopardy (or punishment for the same infraction twice), or that the medical board was in some way biased or incompetent.

Due process and equal protection arguments. Physicians can make claims that their treatment by the medical boards was unconstitutional either because due process was not followed or because they were not granted equal protection. The right to equal protection “requires the law to treat those similarly situated equally” unless different treatment is justified [21].

One physician sued a medical board, claiming its treatment of him violated his right to equal protection because he had his license suspended after pleading guilty to two different counts of reckless driving while under the influence of alcohol. He argued that he had received treatment unequal to that given to licensed nonmedical professionals, because his board had not had to prove that his actions harmed a client or patient as other professional boards had been made to prove. The court was very deferent to the judgment of medical boards, stating that the board’s purpose was to protect the public, and a medical board’s decisions should only be overruled if they were “palpably arbitrary” [22].

In the same case, the physician argued that his right to due process (a fair trial) had been violated in his medical board hearing, claiming that his guilty plea should not be presumed as conclusive evidence of unprofessional conduct warranting licensure action [23]. Again presuming the appropriateness of the board’s actions, the court stated that the practice of accepting a guilty plea as conclusive evidence of unprofessional conduct could not be deemed unconstitutional “if any basis reasonably justifies it” and held that “it is not necessary to wait until a member of the public is harmed to take steps to prevent such harm from occurring” [24].

Double jeopardy. In another case, a physician was convicted of kidnapping and sexually abusing an employee. The board suspended his license to practice medicine for 1 year [25]. The physician claimed a violation of the Constitution’s double jeopardy clause, arguing that he was punished twice—once with 5 years of probation and community service and a second time with the suspension of his medical license [25]. The court acknowledged that the license suspension may “carry the sting of punishment” but emphasized that the purpose for it was distinct—the probation was to protect the public from criminal behavior, and the license suspension was to protect the public from unfit physicians [26]. Thus both punishments were permissible.

Competency. Another possible complaint is that the board in question is not competent to revoke or suspend a license. A pediatrician convicted of child molestation argued that her 6-year license suspension was invalid because the board’s decisions were inconsistent, it impermissibly viewed facts outside of the case record, and it made no effort to keep track of past cases and use them as guideposts for future ones [27]. The court likened the process of medical boards to that of a court, and was reluctant to pass judgment on the board’s proceedings. Although a board has “a different development and pursues somewhat different ways from those of courts, they are to be deemed collaborative instrumentalities of justice and the appropriate independence of each should be respected by the other” [28].

Bias. A physician in the Virgin Islands whose license was suspended challenged a medical board with the claim that it was biased against him [29]. Specifically, he argued that one member of the board was in direct competition with him and that the rest of the board ignored this and permitted that person to participate in disciplinary proceedings [29]. The court held that the physician had not provided adequate proof of the board member's bias, but did not suggest that such a claim would be untenable if better evidence existed [29].

Physicians are often perceived as public figures in their communities, so professional and private wrongdoings can be equally troublesome. Medical boards continue to pursue the task of protecting the public through careful issuing, suspension, and revocation of medical licenses. They face critiques (and sometimes legal liability) on both ends. Some argue that they are too proscriptive, and physicians have fought back by claiming violation of their equal protection, due process, or double jeopardy rights, as well as making claims of incompetency or bias against the board, when their licenses were in peril. However, medical boards also may face suit and public outcry for failure to discipline doctors who are hazardous. As boards continue to walk that fine line, physicians must continue to remember what is at stake in how they behave, whether at home or at the hospital.

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POLICY FORUM

Criminal Convictions and Medical Licensure

Herbert Rakatansky, MD

In 1992 an Ohio physician failed to file one of his employee's quarterly federal tax returns (a misdemeanor); in 1995 he failed to pay estimated taxes of about \$160,000 (a felony). This occurred during a time when he was managing his own business affairs. In 1998 he pled guilty in federal court and paid, in addition to restitution, a \$2,000 fine and served 6 months of monitored home confinement. In 2000, the Ohio board of licensure suspended his license for 90 days based on the interpretation of the law that the misdemeanor crime involved "moral turpitude."

The physician took the medical board to court, but the court affirmed the board's license suspension. Immediately, the physician appealed the trial court's decision, and, in 2002, an Ohio court of appeals reversed the trial court's decision, stating, "We believe appellant's misdemeanor offense under the circumstances of the present case did not rise to the level of baseness, vileness, or the depravity in private and social duties which man owes to his fellow man, or to society in general" [1]. The appeals court asked the licensing board to review the case again based upon only the felony, and the board reaffirmed the suspension, which was subsequently upheld by the Ohio Supreme court in 1994.

This case asks whether a doctor's behavior outside the professional arena should be considered by a regulatory authority as a factor in deciding the doctor's fitness to practice. There is general agreement that competence and behavior occurring within the practice of medicine are proper criteria to consider.

Seemingly similar questions have been asked about other endeavors. Can a bad person be a good artist, actor, and so on? Should we exhibit Picasso's paintings of women even if he is known to have treated them badly? Should we listen to or perform the music of Richard Wagner, knowing he was an outspoken anti-Semite? These questions may seem analogous but they are not. In these examples we may choose to admire and enjoy the creations of the artists and simultaneously dislike the artist as a person. When encountering the art (visual, aural, or performance) we need not and actually often *do* not interact personally with the artist. We are experiencing and evaluating the artistic product, not the artist, and, significantly, we do not consider the transgressions of one artist a reflection on the total universe of artists.

Doctors are different. Patients almost always interact personally with their doctors (only a few specialties such as radiology and pathology have little direct patient

contact). Patients do not interact with the products produced by doctors; the patient-doctor relationship is the product.

The unwritten social contract doctors have with patients is based on trust. Each patient trusts that his doctor will act only in his or her best interests. Trust in medical institutions is generated by extension of the trust one has in one's individual physicians and by the reputation of the institution itself. In many circumstances the patient does not choose the specific doctor and, even if he or she does choose, there may be little objective basis for that choice. Rather, patients "trust" that their welfare and best interests will be the paramount factors in the decisions made by the medical system and the doctors who treat them. The loss of trust in doctors, individually and collectively, is a patient safety issue. Without trust, persons in need of care will not be forthcoming with accurate health information, are unlikely to be compliant with medical treatments, and in some cases may not utilize the health care system at all.

So it is important to consider the effect of aberrant extraprofessional behavior on the trust the patient has in her personal doctor and consequently in the profession as a whole. We must also question whether the identified behavior puts patient safety at risk.

Social policy as expressed in U.S. law designates "moral turpitude" as a valid reason to restrict the licensing of professionals, including but not limited to, doctors and lawyers, and also as a criterion for admission to the U.S. (as a visitor or immigrant). Moral turpitude is defined by state law and specifically in our index case as: "an act (of) baseness, vileness, or the depravity contrary to accepted and customary rule of right and duty between human beings" [1]. Other states have definitions very much the same. The societal view of what constitutes such behavior has varied over time; note, for example, the changing view of behaviors associated with same-sex romantic relationships.

The Federation of State Licensing Boards, in its model legislation for state medical license boards, lists many grounds for sanctioning medical licenses including "the commission or conviction of a misdemeanor involving moral turpitude or a felony, whether or not related to the practice of medicine, or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) to a misdemeanor involving moral turpitude or a felony charge" [2]. The U.S. State Department, however, lists a number of specific crimes as examples of moral turpitude. The list includes "tax evasion (willful)," "an intent to defraud," and "fraud against revenue or other government functions" [3].

A law enacted in Illinois in 2011 mandates permanent revocation without a hearing of the license of a health care worker convicted of forcible felony or criminal battery against a patient "including any offense based on sexual conduct or sexual penetration" or one who is required to register as a sex offender [4]. No discretion to the board is allowed.

It seems highly likely that a search of state laws would confirm that the right of a medical licensing board to restrict a doctor's license for behavior involving moral turpitude is either enshrined in law or accepted in practice. It is critical to note that *any* felony or a misdemeanor involving moral turpitude may be the offense.

We depend on the criminal justice system to punish illegal behavior and deter others from committing it, both by preventing the perpetrator from continuing bad behavior and by meting out retribution for what has already been done. The license to practice medicine is granted to ensure competency and protect patient safety. Ideally, restriction of the license should be invoked only for reasons related to competence and patient safety and not used as a punishment per se. As a matter of policy, however, it is clear that the connection between "moral turpitude" outside the practice of medicine and the ability to practice medicine safely has been accepted as social policy.

This connection was clearly stated in 1956 by the attorney general in the state of Washington in an advisory opinion as follows:

"Has a person who is licensed to practice medicine and surgery in the state of Washington, and who has been convicted in a Federal court of the offense of income tax evasion, been convicted of a crime involving moral turpitude as defined in our statute, RCW 18.72.030 (1)?"

Our answer is in the affirmative [5].

Why this is so and whether it is true in all cases is worth discussing. We can consider four qualities or types of behavior to illuminate the question.

Honesty. Patients assume that doctors are honest, that they will not misrepresent findings or diagnoses during the course of the patient-doctor relationship. Patients assume that their doctors will honestly recognize and deal with conflicts of interest. Not only do patients make this assumption, but this principle is also a basic ethical imperative. It is explicitly stated as one of the nine AMA Principles of Medical Ethics [6]. Patients trust the entire universe of doctors to adhere to this standard. Dishonesty in the context of medical treatment is an obvious breach of professionalism.

It is likewise reasonable to believe that dishonesty outside the professional arena may extend into the doctor's dealings with patients. Why should a doctor who lies about his income tax, an action that has well known and predictable consequences, not behave dishonestly in the medical sphere, an area over which he exerts far more control and in which the consequences, if any, are less predictable and likely to be less consequential? A pattern of dishonesty in any area of a doctor's life may be damaging to patient trust in the doctor and by extension in the profession and detrimental to the best interests and safety of that doctor's patients.

Criminal behavior. Conviction of a crime generally has a pejorative influence on one's reputation. Public trust in the convicted doctor and the entire profession is eroded. Should a doctor convicted of a crime outside the medical arena have restrictions (temporary or permanent) imposed on his or her practice of medicine? The licensing board restricts practice to protect patients. The licensing board should not mete out retribution, as the state does; it should strive to protect patients by preventing further criminal behavior that affects competence or patient safety. If the licensing authority has reason to believe that the commission of a crime or the presence of "moral turpitude," however defined, may affect competency or safety, then restriction of practice is justified.

Health. It is the responsibility of each doctor to be physically and emotionally healthy so his or her function is not impaired while treating patients. In considering the case of the Ohio physician, one could ask the question: Did an underlying illness contribute to the dishonest behavior? Does the doctor have bipolar disorder and did he in a manic phase accumulate debt and imperil his financial status? Was his judgment about cheating on his tax return influenced by an illness such as depression or addiction? The doctor must pay the legal penalty for breaking the law, as must any person. As a part of its deliberations about the restriction of privileges to practice, the licensure board should consider referring the doctor for medical and psychiatric evaluation. The finding of a treatable illness should be a factor in the decision of the licensure board. The best resource for this is a physician health program (PHP). Most states have such programs associated to different degrees with local licensure boards and state medical societies [7].

Boundary violations with patients. Patients trust that information and the access to physical and the emotional closeness granted to doctors in the course of the patient-physician relationship will be used only for therapeutic purposes. The use of such information or access to satisfy the physical or emotional needs of the doctor constitutes a boundary violation. It is important to emphasize that the responsibility for understanding and enforcing this obligation rests 100 percent with the doctor. The universally accepted prohibition against a sexual relationship with a patient dates back to the time of Hippocrates. Criminal sexual behavior outside the medical arena (e.g., exhibitionism, child pornography, rape) may be especially destructive of the trust patients have in the doctor and the profession. We must also ask whether these behaviors outside the professional arena put patients at risk of boundary violations. Criminal behaviors involving sexual boundaries occurring outside the practice environment may be indicators of a risk for such behaviors to occur in the professional sphere and thus constitute a risk to patients whether or not the patients are aware of these behaviors.

The American Medical Association's *Code of Medical Ethics* is the generally accepted standard of professional behavior. In addition to the AMA ethics code, medical professional organizations, medical staffs, and institutions frequently have their own codes and standards of behavior. Professional organizations and institutions should evaluate members' behavior in accordance with these established

ethical standards and take action about membership and clinical privileges to protect patients and enhance trust in the profession. Ultimately it is the responsibility of the state licensing board to protect the public by adjudicating individual cases, taking into account any possible underlying illness, utilizing appropriate due process, and relying on review by the court as allowed by law.

We can conclude that, to the extent that morally intolerable or illegal behavior outside the medical arena is construed as posing a danger to patients due either to the specific behavior or potential loss of trust in the doctor or the entire profession, regulatory or judicial sanctions on the practice of medicine are appropriate. This conclusion is supported both by our ethical imperatives and by our legal system.

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MEDICINE AND SOCIETY

Judging Doctors—The Person and the Professional

Nadia N. Sawicki, JD, MBe

Joe turns to see Doc Wilson swigging from his flask.

JOE: Aren't you supposed to set an example for people?

DOC WILSON: Nope. I'm just supposed to hold people's hands while they die [1].

As a scholar of bioethics and health law, I often find myself reflecting on this scene from David Mamet's *State and Main*. For physicians, one drawback to being part of a profession society holds in such high regard is the expectation that their decision making, both inside and outside the clinical sphere, be beyond reproach. Whether implicit or explicit, this expectation is one that few other professions face. Attorneys may be gamblers, plumbers may be tax frauds, and corporate managers may solicit sex for money without facing professional discipline or public censure.

This phenomenon provokes two lines of inquiry. First, what is it about the medical profession that inspires such idealistic (and, many would argue, unrealistic) expectations? And second, why is it necessary to impose such high standards of conduct on physicians when the rest of us are free to make poor personal choices without suffering significant professional repercussions?

Why Doctors?

Atul Gawande describes Western medical practice as “dominated by a single imperative—the quest for machinelike perfection in the delivery of care” [2]. Its mission is to strive for success at all costs, despite the fact that medicine is an inherently imperfect science. Patients die. Treatments stop working. Medical personnel make errors. And yet, every death still seems like a failure—at least to the first-year medical resident, and certainly to the patient's family.

These ambitious standards for medical practice, while impossible to satisfy, often seem to bleed over into the expectations for physician behavior beyond the clinical realm. State medical licensing laws authorize professional discipline on the basis of “unprofessional” or “unethical” conduct; as a result of medical boards' broad interpretation of these laws, physicians have faced disciplinary actions for conduct as varied as assaulting someone at a car wash, soliciting sex in a public restroom, possessing marijuana for personal use, and failing to disclose information relevant to child-support payments. Moreover, even setting aside legal obligations, society often judges medical professionals on the basis of personal characteristics unrelated to

clinical competence. For example, a reasonable patient might be unwilling to rely on the guidance provided by an obese cardiologist, a nurse who verbally abuses her colleagues, or a family physician, like Doc Wilson, who takes a tippie from a flask in broad daylight.

Why, then, does the medical community and society as a whole impose such high standards on its physicians and nurses? Unlike politicians and public officials, who are often held to similarly ambitious standards of personal conduct [3], most medical professionals are not routinely in the public eye and do not expressly hold themselves out as paragons of civic responsibility. One explanation for the difference in attitude towards physicians may be that their practice deals with intimate matters of life, death, and bodily integrity. However, this justification is unsatisfying, as the same considerations apply to the attorney defending his client against a death penalty sentence, the engineer whose calculations ensure the safety of the general population, and the tattoo artist who makes permanent alterations to a person's body.

Perhaps the best explanation may be that physicians and nurses are members of a profession whose primary goal is understood to be the care and protection of vulnerable individuals, and society looks askance at any conduct that calls into question this ethic of care and respect. It is easy to highlight examples that support this interpretation. Recent public debates about how best to limit the growth of health care spending treat with repugnance any proposal that hints at bedside rationing. Recommendations that physicians initiate discussions of end-of-life planning with their patients are criticized as paving the way for "death panels." More importantly, the expectation remains that, when payors and policymakers push to limit treatment in an effort to control costs, physicians will not only put their patients' interests first but also defend these interests against public intrusion. We expect doctors to practice medicine because they care about patients and want to do good in the world, not as a means to achieving fortune and fame.

In short, the medical profession is expected to be guided by the principle of fiduciary duty, even when doing so conflicts with its political or financial interests. And perhaps we hope that physicians will exhibit supererogatory personal conduct because we believe that such conduct reflects positively on what "kind of people" they are, and, therefore, their professional motives. Indeed, many consumers do seem to expect similar character traits from other service professionals who work with vulnerable populations, including teachers, day care providers, and social workers.

Should We Expect So Much?

It is impossible for any individual, regardless of profession, to possess every human virtue and refrain from poor decisions in all areas of life. Much as the "reasonable person" standard in tort law is criticized as looking to a "mythical figure" who is "devoid ...of any human weakness, with not one single saving vice, sans prejudice, procrastination, ill-nature, avarice, and absence of mind" [4], a standard that imposes higher expectations of personal character on medical professionals is similarly untenable. Indeed, the fact that a number of professional and legal mechanisms

acknowledge the occurrence of mistakes in medical practice—morbidity and mortality rounds, apology policies, and medical malpractice suits, among them—is a testament to this.

One of the most common justifications offered for imposing character requirements on physicians is that patients, reasonably or not, simply will not trust a medical professional who exhibits vices in his personal life. This justification, however, is unsatisfying. Requiring physicians to uphold the highest standards of personal conduct because patients expect it says nothing about the normative reasons for why such conduct ought to be required [5].

A better place to begin this inquiry may be to first ask why we value physicians. Do we value them because they are trained in clinical methodology, or because they are, so to speak, “good people”? I believe that the primary reason society values medical professionals is because of their clinical competence and expertise. Consider, for example, a patient recently diagnosed with inoperable brain cancer—is she more likely to seek treatment from her primary care physician, with whom she has a decades-long relationship of trust, or pursue a more innovative treatment being provided by a specialist with a reputation as a boor? Judging by the lengths many patients go to enroll in clinical trials and visit specialists with whom they have no preexisting relationship and about whose personal characteristics they know nothing, clinical competence seems to be the driving factor. Good character is, of course, a plus; but it is the rare patient who, in a time of crisis, would decline care from an expert with a reputation for poor personal character. This attitude is reflected in the law’s treatment of professional licensure and discipline, which merely sets a floor for minimum physician competence; it does not require perfection [6].

One challenge to this perspective might be that judging medical professionals on the basis of clinical competence alone does not speak to another valued characteristic—namely, their adherence to the principle of fiduciary duty. It is one thing for a patient to prefer a skilled but reproachable specialist over a kind-hearted generalist, but many would argue that no reasonable patient would prefer the specialist if he demonstrated an unwillingness to put his patients’ interests before his own. Indeed, imagine a surgeon whose knowledge of medicine is unparalleled and who performs the most delicate procedures with care and precision—despite his technical qualifications, it would be difficult to consider him a competent practitioner if he performed a procedure without consent, in direct violation of his patient’s right to personal autonomy.

If, indeed, our judgment of medical professionals is dependent in part on their respect for the principle of fiduciary duty, there can be no reason to expect supererogatory “after-hours” behavior from them unless we first demonstrate that such behavior is demonstrative or predictive of their attitudes towards patients. Many have argued, for example, that a physician who submits fraudulent documents to the government is perhaps more likely to be dishonest with his patients [7]. As an empirical matter, however, this assumption may not be defensible. Social science

research on the consistency of moral behavior has reached no clear consensus on whether character traits are generally consistent across various domains. Scholars of psychology have long debated whether human behavior is primarily dispositional (grounded in consistent character traits) or situational (dependent on context and environment). Situational behaviorists believe that, at heart, context matters: a tendency towards deceit in one's personal life does not necessarily predispose a person to fraud in his professional life [8, 9]. Most contemporary theorists conclude that behavior is generally driven by both dispositional and situational factors [10, 11], though the balance between the two may vary depending on context. For example, dispositional or trait-based factors often have less predictive value in "strong situations," like workplaces, where personal behavior is narrowly prescribed and often dictated by norms, scripts, and routines [12, 13]. To put it in simpler terms, someone who routinely leaves dirty dishes in the sink at home may nevertheless have an impeccably organized office.

Moreover, even if personal characteristics were predictive of professional behavior, this would not serve as a normative justification for evaluating physicians on the basis of those characteristics. Imagine, for example, that a retrospective study demonstrates that physicians who wear bow ties are eighty percent more likely to commit medical malpractice. Surely, this predictive link alone would not justify social reproach or professional discipline, absent a separate finding that the physician lacks the intrinsic characteristics of education, training, and character that form the foundation of competent medical practice.

In sum, if the reason society values medical professionals is that they possess valuable clinical skills and exercise those skills with a fiduciary ethic of care towards their patients, we ought to be evaluating physicians on those grounds directly, rather than looking to their behavior "after hours." It is simply inefficient to look at a physician's propensity to get into bar fights as an indicator of how well he or she will perform in a professional role. Of course, individual patients are free to set their own expectations for physician behavior—when choosing a primary care physician, for example, I might seek out a physician who regularly attends religious services. Such preferences, however, are personal in nature, and ought not factor into societal, professional, or legal expectations of physician behavior. Demanding that medical professionals exhibit virtues that the rest of the population regularly struggles to maintain is not only unrealistic, but a poor substitute for requiring care and skill in their interactions with patients.

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MEDICAL NARRATIVE

Reconnecting to the Moral Core of the Profession

Diane Plantz, MD

While leading a recent ethics discussion with pediatric resident physicians, one participant made the comment, “I don’t feel like I do anything for my patients. I am just a person who writes admission orders and notes. Where is the doctoring?” My heart sank. Do residents really feel this way? Do they not recognize their value? Who else is seeing that patient in the middle of the night, obtaining a history, doing a physical and inputting the orders to begin the medical care that is necessary to improve the patient’s health and well being? At teaching hospitals all over the United States, it is the residents who care for patients in the wee hours of the morning.

We discussed this as a group and I tried to impart an awareness of their value to their patients and society. Afterwards, I reflected on how I had felt as a resident. Do I feel this way as an attending physician? Do other physicians? And if so, why—what causes us to devalue our work? Is it the changes in the medical system, in culture, in society? Is it our patients’ impression of our role in their lives? Or is it our perception of our role? Could physicians’ low valuation of their role in patients’ well-being be the reason why we have low job satisfaction, a high burnout rate, and an increased risk of suicide?

Physician job satisfaction has come to the attention of the media as well as being documented in the medical literature. In the past, physicians were well-respected professionals with high levels of job satisfaction. Their jobs were challenging and stressful, but also intellectually stimulating and socially useful. Physicians have become progressively more dissatisfied with their careers; a recent poll of young physicians found that 40 percent would not choose medicine as a career if they could make that choice over again [1]. And an internet survey of 865 physicians found that 70 percent of those responding would not encourage their children to become doctors [2].

Why are physicians so dissatisfied with their careers? Many blame the ever-changing medical system. Today it is electronic medical records and the “Big Brother” feel of the federal government pushing accountable care organizations (ACOs). In the past, it was technological advancements that distanced us from the patient, managed-care organizations, and insurance companies, all of which seemed to limit independent and unbiased medical decision making. And let us not forget the pervasive fear of malpractice lawsuits in a culture that seems to promote the idea that physicians should be able to cure all disease and magically reverse death—at least that is what happens on popular TV medical shows.

What I think we fail to realize as a profession is that change is not only limited to the last 70 years. The practice of medicine is a dynamic one. In the distant past—and, in some societies, today—demons and witchcraft are blamed for illness. Shamans and herbalists are sought after to cure illness. Today, most graduating medical students recite a version of the Hippocratic Oath, which originally stated, “I will not cut for stone,” meaning they wouldn’t do surgery to remove stones in the body, a practice in the time of Hippocrates that led to much suffering. In modern medicine, we frequently do surgical interventions for gallstones or kidney stones—so this prohibition isn’t relevant anymore. If medicine is always changing, maybe it is not the changes themselves that cause physicians to become dissatisfied and disheartened; perhaps it is, rather, that physicians allow these changes to obscure their reasons for practicing medicine.

The purpose of medicine as defined by Aristotle is the healing of the patient [3]. Albeit simplistic, this has not changed. This does not mean only restoring a patient to his or her previous level of health, but also helping those who will not return to a healthy state maintain the best quality of life possible, with the least amount of pain, discomfort, and disability. No matter how the medical system changes, this purpose—the physician caring for the patient—does not.

Today, it seems that neither society nor physicians recognize this value. Some physicians think society and the medical system have failed them by not “support[ing] their inner sense of dedication” [4]. Others have failed to hold true to their purpose. The physician does not value the privilege of caring for the sick, and in response society does not make physicians feel valued. Only physicians can break this cycle; we must focus on the purpose of medicine.

Like many other physicians, I too have contemplated quitting medicine. After finishing my pediatric emergency medicine fellowship. I wanted to quit because of the stress and risk of malpractice. For about 7 years I struggled with this decision. I went back and forth working part-time to full-time, trying to balance my family life with my work life. I went back to school to obtain different degrees, trying to figure out a way to find happiness in my career. What was lacking was an appreciation of the purpose of medicine. Although I could not save the life of every patient, I did provide something of value for almost every patient. While emergency care is critical for patients with life-threatening emergencies, the provision of nonurgent care—the colicky infant, for example, that first-time parents could not calm at home—is just as valuable not only to them, but to me as a physician. In providing care and comfort in both the urgent and nonurgent cases, I have reconnected with the value of practicing medicine.

No matter how medicine changes, physicians who want to find satisfaction in their work must keep the purpose of their profession—to heal and comfort—alive in their minds and spirits.

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OP-ED

The Risks of Professional Protest

Ford Vox, MD

The United States began with acts of civil disobedience. What dwindling moral footing the nation holds in the world today stems in large part from its beating back an axis of fascist and totalitarian regimes 65 years ago, followed two decades later by its now hallowed civil rights protests that tore away a layer of domestic injustice. Yet because this great tradition exists does not mean that physicians are free to fully engage in it. Our profession is a civil construct, an invention created by a patchwork of state and federal laws. When we engage in acts of civil disobedience we must realize that we challenge the government and the society which grants us our right to practice medicine. Whether a physician fancies herself a member of the Green Party or the Tea Party, she must obey our government's rules, and be extremely diligent in those increasingly rare instances when she feels herself compelled not to do so.

When we do not choose our battles carefully, disaster can ensue, for the profession as a whole and for ourselves very personally. In February 2011 the Wisconsin state capitol was convulsed by massive protests staged by government employees, most notably its public school teachers, who were outraged over the governor's push to revoke certain collective bargaining rights, including their power to negotiate for better health insurance. Members of the University of Wisconsin's Department of Family Medicine, including both residents and attending physicians, felt compassion for the educators' cause, and wanted to participate in the display, but rather than symbolically protest in the streets alongside the teachers, they decided to perform an act of civil disobedience: the doctors wrote out fake sick notes for the teachers, many of whom were falsely using illness as an excuse to attend the protests, and risked firing by doing so.

The execution of this particular act of civil disobedience was telling—and typical of the problems physicians face when they venture into public protest. When made public, civil disobedience is in fact a media act: reporting is the primary venue through which communication of meaning occurs. Engagement with the fourth estate is a skill for which most physicians will find themselves ill-prepared. While in the midst of writing their excuses, the Wisconsin family medicine doctors appeared caught off-guard when peppered with questions by everyone from the Associated Press to freelance videographers. Associate Professor Lou Sanner implausibly claimed his prescriptions were for “stress” that he diagnosed only after forming an adequate doctor-patient relationship in the midst of all the hustle and bustle. Another doctor said she was writing the excuses to support the teachers' mental health. The messages and the acts didn't mesh. It doesn't take an MD to know these doctors

were playing the system in service of ulterior motives, and not a single reporter present missed the red flags of incredulity.

While acknowledging the motivations of the physicians concerned as generally wholesome, the Wisconsin Medical Society had no choice but to condemn these public acts as violating a sacred trust between society and doctors. Referencing Dr. Sanner's comments in particular, the society stated that the patient-physician relationship is a cornerstone of high-quality health care and that "important elements of that relationship, such as conducting proper medical evaluations of patients, should not be taken lightly" [1]. The Wisconsin Medical Society understood what the protesting physicians did not: the high regard with which the public holds the medical profession is not a given. It can be lowered.

Why is the medical profession respected? Why is it intrinsically meaningful when doctors have something to say? What is that added meaning? Understanding the answers to these questions is essential to gaining an accurate sense of the boundaries of our behaviors within social and political spheres, including public protest. Public regard for the medical profession is the residuum of daily patient-physician encounters, especially in those times when a patient trusts in our integrity, is soothed by our knowledge, and accepts our honest, calm, and methodical approach when we reach our individual professional limitations.

The Wisconsin doctors' actions threatened this standing, and the profession is punishing them for their breach. To date the University of Wisconsin School of Medicine has privately censured at least 12 of the doctors they employ, and the Wisconsin Medical Examining Board may take further action when it reviews the results of formal investigations into eight of the physicians undertaken by the state's Department of Safety and Professional Services [2]. The doctors' best defense may be the fact that we cannot practice good medicine without taking into account social factors beyond a diagnosis; I would not condemn the considered decision of a fellow physician made in the privacy of her own clinic room, who decided to grant a single work excuse for a preponderance of social needs. Our social welfare and our health are inextricably linked. But the same transaction, carried out in public view, time and again, without any plausible doctor-physician relationship necessary to make such a determination, deserves no such collegial deference. Indeed I criticized the Wisconsin doctors before a national audience on the website of *The Atlantic* magazine [3].

We have the right to be political actors in this country; doctors are citizens too, but we must understand that the profession is itself a legal construct created for the purpose of improving public well-being. There are other ways to maintain the collective health than by authorizing a single profession with all the rights and privileges physicians still enjoy in today's health care system. We will see our profession erode away through the democratic process if we undermine its standing. The quickest way to that end is abusing the public's understanding of the physician narrative. The physician narrative is the default credibility we are given by doing

nothing more than entering the profession— it is that collection of concepts, generally positive, that people think they know about us the moment they learn that we are doctors. We trade on it to do our jobs. We also trade on it in when we advocate for any issue we believe in.

With a medical degree comes the fact that whatever you have to say in the domain of public discourse will be interpreted through the lens of your connection to the medical profession. This truth applies to medical students as well. In my early 20s I took my tendency to speak my mind to a new level when I started evangelizing my personal spiritual views on a web site I designed about philosophy and religion. While in medical school I decided to try my hand at sparking local discussion groups about my ideas around the country, beginning with a group in my own city. While my activities had nothing to do with my chosen career, my medical identity, such as it was, proved too powerful a narrative for journalists to resist. Headlines like “Medical student prescribes a religion,” which appeared in *The San Diego Union-Tribune*, reflected how little control I had over my own message [4]. I desperately wanted to create a movement that stood on its own, but just as interesting to the people who wrote about my work was the fact that the man at the center was about to be a doctor. My career path made a rather eccentric extracurricular activity seem less fringe, more legitimate, and more worthy of the continued attention of the reporters who kept on writing for the 3 years my little escapade lasted.

Whenever we do something for the consumption of reporters, we are trading on the same factor that makes that headline “Doctor Arrested for DUI” of interest to the local paper. Mr. Smith probably would not have earned the headline, but Dr. Smith did. When we engage with the media, we are tangling with a force that does not share our professional interests. Is what you have to say worth the loss of dignity to your profession? What do you hope to achieve? If your goal is important enough, and if you intend to pursue it at great personal cost, your activities will likely also pose a risk to the mission of medicine and the work of physicians. In that case you should consider leaving medicine behind to pursue your cause.

What about the committed doctor who intends to remain in the profession but advocate for a change, perhaps one related to the practice of medicine or the needs of patients? Understand that public protests are a general venue open to all, but doctors can never expect to be nameless faces in the crowd. They are always subject to being singled out and having their participation analyzed for its relationship to medicine. When Hollywood celebrities fly out to African refugee camps, or get themselves arrested in domestic protests, they lose their own narrative as well. They routinely insist they want the focus of attention to be on their cause, but their public identity as an actor or musician routinely proves too powerful for reporters to ignore: questions of motivation always follow. Were they seeking publicity? Were they trying to shape their own image by attaching their persona to a humanitarian cause? Doctors will similarly find their motivations questioned: the public, and the reporters who keep them informed, will always attempt to comprehend your actions in the context of the greater medical narrative.

The Wisconsin doctors weren't smart about managing the narrative: their actions conflicted with the concepts of trust and integrity, exposing them to the charge that they used their professional power and privilege to support personal political interests. When the matter prompting protest is explicitly in a doctor's personal financial interest, public protest is never the appropriate venue. Back in 2003, malpractice insurance rate spikes scared a group of surgeons at a Maryland public hospital who responded with threats of a work slowdown, prompting governor to meet with them [5]. The work slowdown never happened, and the state established a temporary fund to offset the rate increases by the state's major malpractice insurer. Those rate hikes have since leveled off, and the political process of malpractice reform continues in the state through the usual channels. The state's physicians did not need to threaten a work slowdown in order to get the governor's attention—they were well capable of lobbying and petitioning political leaders en masse, advocating for the issue in ways that did not threaten patients [6]. They violated the medical narrative, and opened themselves to demeaning remarks like those delivered by the Maryland House Speaker, who said "It shouldn't be about doctors. It shouldn't be about lawyers. It should be about patients" [7].

Doctors in New Jersey actually went through with planned walkouts that year. The result? Eight years later malpractice reform is still working its way through the Garden State's traditional channels. Not only does public protest (especially over issues of self-interest) threaten the standing of the medical profession, it's typically an ineffective last-ditch strategy. Just ask Wisconsin teachers who are now working their first semester without a union contract and already paying more for health insurance [8]. Change in Wisconsin will happen at the ballot box, not in the streets.

Doctors have achieved their standing in society through the delivery of highly skilled services to those in dire need. When we engage in hotheaded public protest and civil disobedience, we must have a reason that rises to the level of endangering our ability to practice medicine at all, and a clear explanation for how our actions fit into the medical narrative we all share. If we do not manage our messages well, others will interpret our actions for us, and we cannot expect their version to be favorable.

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OP-ED

Doctors' Responsibility to Reduce Discrimination against Gay, Lesbian, Bisexual, and Transgender People

Stephen Rivoli, MPH, MA, CPHQ

At this moment, medicine and health care in America are at a crossroads. In this time of transition, individual physicians and physician groups, like the American Medical Association and various state and specialty medical societies, are voicing their perspectives about how best to improve our system and bring health to our patients. As the scope of this conversation grows, it includes social determinants of health like socioeconomic status, race or ethnicity, and sexual orientation. Differences in how people are treated by their society can lead to significant health disparities. We physicians and physicians-in-training need to take a hard look at what our real obligation is to our society.

Do physicians, individually and together in organized medicine, have a responsibility to act to improve the health of those we serve? And, if so, how far does that responsibility extend? One bit of insight comes from the Hippocratic Oath many physicians have taken throughout the centuries, which includes the following lines:

I will prevent disease whenever I can, for prevention is preferable to cure; I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm [1].

The oath is explicit about a duty to prevent disease in even the healthy members of our society without a single specific exception. In life and practice, though, the doctors who speak that oath are often left wrestling with its meaning in the context of modern science, personal moral ethical beliefs, and practical concerns about finite resources.

Same-Sex Marriage Rights in the United States

In June 2011, the American Medical Association passed a resolution advocating that same-sex couples no longer be denied civil marriage [2]. To understand why a medical organization, ostensibly a nonpolitical entity, would take on such an issue, the first question must be: is there science to suggest that social factors negatively affect the health of GLBT Americans? According to several studies, there are real and significant disparities between the health of GLBT Americans and that of their heterosexual counterparts, as is so eloquently stated by Anne Dohrenwend, PhD, in "Perspective: A Grand Challenge to Academic Medicine: Speak Out on Gay Rights" [3]:

We know that GLBT adolescents are at risk of harassment, injury secondary to bullying, withdrawing from school because of safety fears, and suicide attempts [4-6]. Antigay discrimination is a common experience for GLBT adults as well, and it is associated with negative mental health outcomes [7]. Although a lack of research on the GLBT population has made it difficult to evaluate disparities, current data suggest that the GLBT community is at elevated risk of anxiety, mood, and substance use disorders; suicidal thoughts and plans; smoking; and unsafe sex [8-10].

We know that marriage, which provides a substantial range of psychological, social, and health benefits, is an important aspect of social context [11]. In fact, evidence suggests that legal and social recognition of GLBT relationships may reduce discrimination and lead to better physical and mental health for gays and lesbians [12].

I would argue that marriage is the single most important right denied to GLBT individuals. In fact, the Human Rights Campaign has identified 1,000 legal rights associated with marriage, such as hospital visitation, visa rights, tax-related inheritance advantages, medical decision-making rights, and pension benefits, but it is the less obvious, more social “soft benefits” of marriage that are most easily taken for granted. Some of these benefits are spousal support groups; acknowledgment of spouses at graduations and retirements; offers of prayer for sick spouses; emotional, psychological, and monetary support in times of natural crisis or disaster (e.g., Red Cross and government support for married partners of 9/11 victims); and the presentation of a U.S. flag at the death of a spouse in military service [3].

While there is clearly room for further research, the published science substantiates that the social standing of GLBT people has negative effects on their health. Accordingly, the AMA’s policy on this matter reads:

Our AMA: (1) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (2) will work to reduce health care disparities among members of same-sex households including minor children; and (3) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households [13].

Beyond the science, though, sit the personal ethical and moral beliefs of the men and women who make up the American Medical Association and the profession of medicine. In a pluralistic society, should any group of physicians, let alone an

organization representing the profession, take a rigid stance on issues as socially divisive as those of GLBT health disparities or GLBT equality? The answer is yes. It is incumbent upon physicians to accurately represent the results of research and to act on what these findings tell us about improving health. Today's medicine is based on evidence, and the profession is duty-bound to further the best interests of the public; whatever our individual moral views on sexual orientation or issues like the nature of marriage, the profession must evolve as our body of knowledge evolves, regardless of personal bias.

Finally, some argue that advocating for GLBT Americans, who make up about 2-5 percent of the U.S. population [14], is a less efficient use of resources than speaking out about social determinants of health affecting larger groups of people. Some types of advocacy, such as employment nondiscrimination protections, cut across demographic boundaries and perhaps appear to be more "efficient." It is a false choice, though, to say that we need to be selective about who to stick up for and which wrongs to mend. It is not our standard of practice to choose between diagnosing and treating hypertension and high cholesterol in our individual patients; why should we treat a society that way? Taking strong positions is our work, just as treating patients to the best of our understanding is our work. Moreover, prominent organizations like the American Medical Association can raise the profile of social issues significantly, at little cost.

The health of gay, lesbian, bisexual, and transgender Americans is clearly affected by social determinants, from intimidation to discrimination and legal nonparity with straight Americans. That evidence confers on physicians an obligation to act according to the Hippocratic Oath and the standard of practice, which compel us to promote proven methods of restoring and maintaining health. Even in the context of limited resources, in which we practice medicine every day, we are compelled to maintain that high professional standard. Physicians, individually and collectively, have an ability to impact health unlike that of any other group. The sooner we take strong action to reduce the negative social factors affecting GLBT Americans, like adolescent bullying, insufficient access to competent and sensitive care, and the lack of legal rights, the closer we bring America to better health and well-being overall.

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CORRESPONDENCE

The Role of Retail Clinics in Today's Medical Care

A Response to [Medical Ethics and Retail Clinics](#)

The thoughtfulness evident in abundance in Thomas Heyne's Bander contest essay by itself makes it worthy of the 2011 prize. We cannot, however, escape its pervasive elegiac tone, infused through Mr. Heyne's peculiarly dated examples of ways in which physicians might respond to patients' failure to abide by their doctors' advice to "have a regular medical home." Mr. Heyne suggests in one prominent example that such a contrary patient might, here in the twenty-first century, "maintain a portable record...documenting the retail visits, or (*better*) that the patient have the retail clinic *fax* all documentation from each visit (as recommended by the AAP)...."

Space prevents me from suitably elucidating the problems I have with this or other specific examples. Lacking such constraints, I might digress on the central role of EHR in retail clinics' business propositions and processes and then contrast it with the diffident attitude of many physicians' professional organizations towards this class of emerging tools for accumulating, assessing, and appropriately sharing actionable health care information with patients and those who care for them.

Happily, I can instead summarize my disbelief and dismay thus:

Really?

Early in his essay, Mr. Heyne reminds his reader about the primacy Osler placed on knowing "what sort of patient has a disease." He thereby stresses the importance of a fine appreciation of context to the eventual value of a physician's ministrations. Later, Mr. Heyne seems to disregard that reminder, himself; he appears uninformed about the context of contemporary practice that, according to the Bander scenario, has to contend with the ethical "disease" posed by retail clinics. In a world where soon over 80 percent of physicians will possess a smartphone (the better, presumably, to access the latest medication and clinical references—but not to improve their processes for managing and distributing information to patients), we should be ready to forgive those doctors who cock a quizzical eyebrow at one or more of Mr. Heyne's ethical prescriptions.

Gregory Judd

benefits information group

Publisher, Healthcare 311, a web-based, smartphone-friendly utility for locating retail and other convenient care clinics

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Suggested Readings and Resources

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