

From the Editor

- When Must Physicians Assume Public Advocacy Roles?** 773
Robert E. Burke

Clinical Cases

- Media Attention to End-of-Life Cases** 775
Commentary by Ware G. Kuschner and John J. Paris

- Lead Paint Dangers and Physician Advocacy** 783
Commentary by Lisa J. Chamberlain and Timothy Hoff

- New York Super-AIDS Case: Physician as
Public Health Officer** 790
Commentary by LaVera M. Crawley

Journal Discussion

- Protecting the Vulnerable: A Call for
Pediatrician Advocates** 794
Philip Perry

Clinical Pearl

- Diagnosing Pediatric Lead Toxicity** 798
Jennifer Reenan

Health Law

- Kevorkian: When Physicians Take Controversial Public Stands** 803
Sunil Nair

Policy Forum

- Physician Members of the President's Council
on Bioethics** 808
VM interviews with Daniel W. Foster and William B. Hurlbut

**Physician-Advocate: Deciding What To Fight
for and When** 813
VM interview with Philip A. Pizzo

Medicine and Society

**Physicians as Public Advocates: Setting
Achievable Goals for Every Physician** 816
Clarence Braddock

**Physicians as Reporters in the Media:
Meeting the Challenge of Patients' Needs
for Better Information** 819
VM interview with Sanjay Gupta

**On Being a Physician and a Member of
Congress** 823
Donna M. Christensen

A Doctor in the House 826
Dave Weldon

Assessing Physician Legislators 828
Allison Grady

Op-Ed

Citizen MD 836
Paul Costello

Upcoming Issues of *Virtual Mentor*

January: Ethical Issues in Screening
February: Expertise in Medicine
March: Cost of Care

Virtual Mentor

Ethics Journal of the American Medical Association
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From the Editor

Who Are Physicians Supposed to Be?

It's a question that every medical student, resident, and physician grapples with at one time or another, and one that became important to me almost as soon as I entered medical school. What role should I have in my patient's lives? As a physician, what role should I play in my family, my community, and my society?

Few would claim that choosing these roles is easy or intuitive. There are expectations at my institution (and I think generally) that physicians should be: competent clinicians, ethical decision makers, cost controllers, nurturing caretakers, creative researchers and scientists, teachers to students and patients, avid followers of current health-related events, counselors, businessmen and women, and advocates for their patients. Fulfilling any of these roles requires reflection and effort, but the one I find I have the most interest in and the least guidance for is the last. The importance of physician involvement in the local and national community is taught in my classes; indeed, planning and executing a community health project in partnership with an organization in our local community is a required part of the curriculum. However, there seems to be little real consensus among physicians or the public at large that every physician should have a significant public advocacy role beyond the individual patient-physician encounter. When should physicians choose this role?

The central question of this issue of *Virtual Mentor* is: when does medicine's social contract with society require an ethical physician to take a public role (defined as a role beyond the patient-physician encounter) in advocating for the health of his or her community? Conversely, are there times when this is inappropriate or ought to be avoided? If physicians take public roles, what ethical values should guide their public involvement?

These questions are of crucial importance for 2 reasons: the public realm is increasingly influencing the individual patient-physician encounter, and physicians are uniquely equipped to advise their communities on pressing public health issues.

Contemporary society influences every aspect of physicians' lives, whether they choose to participate in public advocacy or not. Patients come with questions about pharmaceuticals they've heard about through direct-to-consumer advertising. Medical ethics cases like that of Terri Schiavo permeate the news. Patients can find medical advice that may or may not be sound from a variety of popular media. Insurance companies and employers can impose pressure to keep patient visits short and broadly curtail health care costs. How ought we as individuals and as a profession to respond?

Recent history has given rise to more pressing public health concerns. Society seems to be asking physicians for answers to social problems that lie within their purview:

how ought we to prepare for bioterrorism or an infectious epidemic? How should the problem of the uninsured and underinsured in the United States be solved? What are we to do about the epidemics in our midst: obesity, diabetes, and heart disease? Are stem cells going to live up to their promise? Should intelligent design be taught in schools alongside evolution? These are questions individual physicians will be asked in their offices and social settings, and “expert” physicians or professional medical organizations will be asked in a public setting.

Where can one turn for guidance? We looked to members of the President’s Council on Bioethics, the senior health correspondent at CNN, physician members of Congress, medical school deans, bioethicists, medical sociologists, American Medical Association staff, and of course, physicians who struggle to maintain professional and public advocacy roles. I am very grateful for their time and their willingness to share their ideas with me and now with you, the reader. Their ideas are sure to elicit even more questions, but perhaps the best way to try to define our public role as physicians is to begin the dialogue and see where it leads us.

Robert E. Burke

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Clinical Case

Media Attention to End-of-Life Cases

Commentaries by Ware G. Kuschner, MD, and John J. Paris, SJ, PhD

George Whitlock has lived in rural Georgia for all of his life, third in a family of 7 siblings. He started his own business building houses in his community. George is something of a legend for his kind manner and generosity—“pay us when you can” is a sentence frequently out of his mouth. A portly, balding man of 50, now he supervises more than works on the construction site and presides over his family of 2 daughters and his wife.

One day, George was walking on the frame of the second floor of a large house he was building for people from the city. As foreman Jim White tells it, “I turned around and George was gone.” Jim recalls a horrifying moment when he finally saw George lying prone 2 floors below. Jim sent someone for the doctor and tended to George until help arrived.

Dr Shirley Wolcott, an internist and longtime resident of the community, was the first to arrive, and an ambulance came soon after. She accompanied George to the hospital where tests showed that George had suffered a heart attack and subsequent head trauma from the fall with brain swelling due to an intracranial hemorrhage. George was taken by helicopter to a regional trauma center where he was stabilized and put on a ventilator. Later a feeding tube was inserted.

After a week went by, George’s family and Dr Wolcott requested a transfer to their community hospital, so they could be near to George and Dr Wolcott could monitor his recovery. Dr Wolcott initially assured them that once the swelling receded, George would recover consciousness, based on what she was told at the hospital by the neurologist who examined George’s brain scans.

As the weeks turned into months, however, Dr Wolcott became more and more convinced that George would not make the recovery she was hoping for and requested a second consult by another neurologist from the city hospital. After fully examining George, the neurologist found that the damage to his brain was more extensive than previously thought and told Dr Wolcott that George was in a persistent vegetative state (PVS) and unlikely to regain consciousness. Dr Wolcott broke the difficult news to George’s family and counseled them through the process of deciding how to proceed. They agreed with Dr Wolcott that if George wasn’t going to recover consciousness he wouldn’t want to be kept alive indefinitely, which he would view as being a burden to his family.

The Whitlock family were also members of an influential church community. They asked that the community pray for them and the difficult decision they were making to remove George's life support, a plea that provoked both sympathy and outrage among the large congregation. One member went so far as to contact local television stations about the case, resulting in national media attention. Another, an emergency physician, saw George on television and concluded that the consulting neurologist's findings had to be mistaken. He lobbied the media and the Whitlocks to get more specialists to examine George. The Whitlocks were left somewhere in the middle, relentlessly tugged by those who wanted them to let George go and those who thought this action was unethical at the least and possibly tantamount to murder.

Dr Wolcott was unwittingly caught in the public limelight, being asked whether she had advised the Whitlocks to "pull the plug."

Commentary 1

by Ware G. Kuschner, MD

Let's begin by identifying the stakeholders and the other influential actors in this case. Their comments, actions, and beliefs drive the conflict that is pitting community against family and physician against physician. First, and above all, there is George. It bears emphasis that George's welfare and any of his previously expressed beliefs about life support in the setting of grave illness must remain central to any discussion about what constitutes appropriate medical care. Next, there are George's family and Dr Wolcott; the people in George's life who are now obligated to make medical decisions in concert for George, since he has lost decisional capacity. Finally, there is the community, or, more precisely, 2 communities. There is the intimate, face-to-face community in which George and his family live, which includes the members of their church. There is also the "community" of the general public created by media attention that has taken an interest in this case.

Central Tensions

There are 2 central tensions in this case. First, there is conflict over who is speaking for George's best interest. Dr Wolcott and George's family have the legal authority to determine what constitutes appropriate medical care for George, and they have an ethical duty to abide by George's treatment preferences as expressed prior to his injury. They have developed a plan to withdraw life support that is predicated on: (1) the consulting neurologist's diagnosis of persistent vegetative state and the prognosis that George is not likely to regain consciousness, and (2) the family's understanding of George's treatment preferences. Tension has evolved because some members of the local faith community and general public have expressed strongly held beliefs that conflict with the family's and physician's plan. Members of the community have challenged both the premise for the decision to withdraw life support and the act itself, arguing that Dr Wolcott and the family are developing a plan that is based on incorrect information ("the neurologist's findings had to be mistaken") and that it is not ethical to withdraw life support.

A second central tension in this case is uncertainty about the physician's role in the public conflict. What are Dr Wolcott's obligations, if any, to become embroiled in the public debate about George and to attempt to defuse the conflict?

Dr Wolcott's Roles

Legal obligations. Dr Wolcott's principal obligation is to George. She has a contractual obligation to provide standard medical care consistent with her patient's treatment preferences. Although George did not prepare an advance directive detailing his treatment preferences in the setting of grave illness, he did provide cues to his family and physician that if he were irreversibly gravely ill he would not want to be kept alive indefinitely. George did not appoint a durable power of attorney for health care before his injury; but he does have engaged family members who are empowered legally and ethically to act as his surrogates for medical decisions [1, 2]. In this setting, it is the responsibility of the patient's surrogates to make decisions, in concert with the treating physician, by the method of substituted judgment. The standard of substituted judgment dictates that the surrogate must act in accordance with the patient's known or likely preferences. The decisions need not be in agreement with either the proxy's personal preferences nor those of the physician. Dr Wolcott must abide by these treatment preferences, unless they are in conflict with her own values, in which case she would be obligated to assist the family in finding another physician for George [3, 4].

Family-centered care. Does Dr Wolcott have obligations beyond those to George? There are evolving expectations that the health care team should attend to the needs of the family in end-of-life care [4-6]. Principles of family-centered care include showing dignity and respect for patient and family, information sharing, family participation in case management, and collaborative decision making.

The family's announcement to the community of its decision to withdraw life support has created special tensions and conflict for the family. The principle of family-centered end-of-life care compels Dr Wolcott to provide the family with emotional support that should include displays of empathy for the criticism and ostracism the family may be experiencing and also for the ambivalence, guilt, and fear they may be feeling as a consequence of their decision.

Dr Wolcott should provide continuing assurance that the family's decision is what George would have wanted and, therefore, is ethically sound, as well as legal. Dr Wolcott should assure the family that she and they have done everything possible to bring comfort and dignity to George, including respecting his autonomy by adhering to all of his treatment preferences. Dr Wolcott's support of the family's emotional well-being will help the family find solace in their decisions and reach emotional closure when George dies.

Addressing conflict in the community. It should come as no surprise that members of both the local community and larger public have different opinions as to what constitutes ethical care of George or of any person in a persistent vegetative state. Dr Wolcott has several options in addressing conflict in the community. These include empowering

the family to educate critics of the basis for their decision to withdraw life support. Specifically, Dr Wolcott can advise the family to communicate: (1) The treatment preferences that George expressed prior to the injury, (2) the thoughtful deliberation that preceded the decision to withdraw life support, (3) the extended time period over which events have unfolded and (4) George's lack of progress over this period of time, and (5) the concurrent opinions of qualified physicians including a neurologist, who have examined George, that there can be no expectation of meaningful recovery as George would want.

With permission of George's family, Dr Wolcott could volunteer to speak to a church leader (eg, minister) about the care George has received and the basis for the plan to withdraw life support. She can communicate essential information to the church leader about George's status, prognosis, and wishes. This, in turn, may empower church leaders to address conflict within the faith community about the family's difficult decision. The church leader's moral authority within the church may facilitate "getting the message out" that George is being treated with dignity, respect, and in accordance with his wishes.

Finally, there is the larger community of the general public, including the television audience. If the family wishes to address this audience, Dr Wolcott may extend her support through a public announcement that reviews the challenges of the case and the decision-making rationale.

The Emergency Physician's Opinion and Behavior

The emergency physician's judgment and motivations can be questioned. He has displayed prejudicial behavior, literally prejudging George's status based on the incomplete information of a television report, thereby undermining his credibility and moral standing in this case. Absent a professional or personal relationship with George that trumps that of other physicians or family members, he lacks both legal and ethical authority to make decisions about the next best course of care. His behavior has contributed to family tension, which is in conflict with the principles of family-centered care. Even if the emergency physician had special expertise in traumatic brain injury, the above mitigating factors constrain him from rendering a definitive conclusion about the quality of health care George is receiving.

Finally, physicians have an ethical obligation not to undermine the reputation and professional standing of another physician without cause. The emergency physician's public criticism of the neurologist's assessment is inconsistent with this precept.

Physician commentary on diagnosis, prognosis, and treatment of disorders should be limited to areas of expertise. Medical expertise is predicated on sufficient education, training, and experience in a medical discipline. Opinions about ethical matters and articulation of personal values and beliefs should be distinguished from commentary on the medical facts of a case. A physician is entitled to discuss an ethical matter outside of his or her specialty, provided a clear distinction is made between the ethical issue being discussed and the medical facts and opinions of a case.

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The views and opinions of the author do not necessarily reflect those of the Veterans Affairs Palo Alto Health Care System or those of the United States Department of Veterans Affairs.

Commentary 2

by John J. Paris, SJ, PhD

The hypothetical Whitlock case raises several questions concerning the medical treatment for a patient in a persistent vegetative state. One of these issues—must such a patient undergo life-prolonging interventions—was first raised in the landmark 1973 case of Karen Ann Quinlan. There, the New Jersey Supreme Court ruled, "No external interest could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life" [1]. The court's rationale for its ruling was that the constitutional right to privacy was "broad enough to encompass a patient's decision to decline [unwanted] medical treatment" [1].

While a competent patient can readily exercise that right, the issue is more complex for the incompetent patient. In such cases, as the *Quinlan* court noted, the only practical way to prevent destruction of the right is to permit the patient's family to render their best judgment as to what the patient would want. If the choice would be to withdraw a life-prolonging intervention, that decision, the Court declared, "should be accepted by a society, the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them" [1].

Other jurisdictions have articulated variations on that standard. The Massachusetts Supreme Judicial Court in *Saikewicz* utilized "substituted judgment" to determine the

idiosyncratic values of an individual patient [2]. Under that rule the decision maker's task is, in the Court's words, "to don the mental mantle of the incompetent" to discern what the patient would choose if able to do so. New York and Missouri adopted the much more rigid requirement of "clear and convincing" evidence of what the once-competent person would want before authorizing the withdrawal of life-sustaining interventions [3]. That requirement necessarily precludes the withdrawal of medical interventions from minors, the never-competent and all of those who for whatever reasons have never formally articulated their preferences on the use of life-prolonging treatments [4].

Interventions or Basic Care?

A second issue in George Whitlock's situation, one that roiled the nation in the recent Terri Schiavo case, is whether artificial nutrition and fluids are medical interventions to be evaluated like any other medical treatment, or basic care that may not be withheld or withdrawn so long as the patient is physically able to process nutritional support. For those who subscribe to the latter position, the removal of artificial nutrition and fluids is tantamount to "starving the patient to death." Such an action would be criminal negligence or deliberate homicide. The AMA's Council on Ethical and Judicial Affairs rejected that view in an Opinion issued in 1984 [5]. There the Council defined artificial nutrition and fluids as life-sustaining medical treatments, which are no different from other life-prolonging interventions such as mechanical ventilators or dialysis machines. Further, it held that it is not unethical to remove such interventions from patients who are terminally ill or who are in persistent vegetative conditions provided such a decision is made in accordance with the patient's values or "best interests."

That position was subsequently adopted by every state court of final jurisdiction that has ruled on the status of artificial nutrition and hydration. The legal issue was definitively resolved in the United States in the Supreme Court's 1990 *Cruzan* decision where the Court recognized that under our Constitution a person has "a constitutionally protected right to refuse even potentially life-prolonging artificial nutrition and fluids" [3]. Justices O'Connor and Brennan specifically cited the AMA's opinion for the proposition that artificial feeding cannot be distinguished from other forms of medical treatment.

No Breach of Duty

With this legal and medical background we have the context for assessing the charges of "murder" in the Whitlock case. As the California Court of Appeals put it in *Barber v Superior Court*, a case in which 2 Los Angeles physicians were indicted for first-degree murder for, at the family's request, removing an intravenous feeding tube from a patient diagnosed as irreversibly unconscious: "The patient has no obligation to undergo the intervention, and therefore the physician no duty to provide it" [6]. Since there was no breach of duty by the physician in withdrawing the IV, there was no criminal act. What occurred rather, was the recognition by the family and physicians that there is no need to utilize medical interventions to prolong the life of a patient who is dying or one for whom there is no realistic expectation of return to a functioning, cognitive existence.

Another issue raised in the Whitlock case is the accuracy of the diagnosis of persistent vegetative state. Any diagnosis is, of course, subject to the standards within the profession for adequacy and accuracy. Those standards require a trained diagnostician making the assessment based on the evidence. That standard was met in this case.

Nothing would justify an uninvolved physician's making a diagnosis on a patient whom he has not examined and whose records he has not reviewed, nor for publicly challenging the findings of a well-qualified neurologist's "full examination." This is particularly true of the due diligence that would accompany a neurological examination done for a second opinion.

An outside physician, if asked by the patient's family, might advise that they ought to have the diagnosis "confirmed" by another well-qualified neurologist. If in the extreme case it appears to someone, including one licensed to practice medicine, that the treating doctor's actions are a violation of the law, the proper recourse, as the Florida State Supreme Court made clear in *In re Dubreuil*, is for that party to inform the local prosecutor [7]. To otherwise thrust oneself uninvited into a case is to be—in the description the New York Court of Appeals used to characterize the right-to-life attorney who brought the *Baby Jane Doe* case into the judicial system—an "interloper," ie, one with no relationship to the patient, no personal knowledge of the facts in the case, and no standing to challenge the family's decision [8].

Nor is there any ethical justification for an outside physician to speak to the media about an individual case other than to explain how a diagnosis is made for a particular condition and to educate the public as to what the literature says about such a diagnosis. This might be done, for example, if there were an interest in the medical condition of someone who was a prominent public figure. Illness itself, however, does not transform a patient into a public person subject to media scrutiny.

For the treating physician, Dr Shirley Wolcott, the patient's privacy rights, HIPAA regulations [9], and the physician's commitment to confidentiality with regard to what she has learned in her interactions with her patient preclude her making any public comments on the case —other than in the face of a "serious and imminent threat to the health and safety of a person or the public" —without the permission of the patient or the patient's proxy.

The license to practice medicine gives one the awesome responsibility of acting for the best interests of his or her patient. It does not transform the individual into society's Don Quixote. Physicians might well heed the words of Justice Benjamin Cardozo in *The Nature of the Judicial Process* where, writing on the role of a judge, Cardozo notes, "[The judge] is not to be a knight-errant, roaming at will in pursuit of his own idea of beauty or of goodness...He is not to yield to spasmodic sentiment, or to vague and unregulated benevolence" [10].

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Clinical Case

Lead Paint Dangers and Physician Advocacy

Commentaries by Lisa J. Chamberlain, MD, MPH, and Timothy Hoff, PhD

Dr Tim Jones, a family medicine physician, practices in a community health clinic outside of Oakland, California, in a low-income neighborhood. Dr Jones works long days seeing patients from the community with illnesses prevalent in groups of low socioeconomic status: tuberculosis, HIV, and metabolic syndrome, among others. He has a wife and one child, both of whom are healthy. He spends part of every weekend making house calls, helping patients get prescription medications, assisting his elderly parents with their needs, and meeting with community and school leaders about health projects. Dr Jones has become something of an expert in diagnosing and treating lead exposure in children, since many of the housing options in his community are not adequate. Given early diagnosis and treatment, including counseling of the family to try to limit exposure, many children experience minimal symptoms. This week, Dr Jones saw another child who had symptoms of lead exposure. He would like to help his community correct the root causes of this threat to its children, but, after caring for his family and his individual patients, he is exhausted.

Commentary 1

by Lisa J. Chamberlain, MD, MPH

The case of Dr Jones elicits feelings of both admiration and concern. While we admire his deeply felt commitment to his patients and their community, we are concurrently concerned that his mode of practice is unsustainable, that his present course will negatively impact his family, and that he will suffer from exhaustion, undermining his career. This case raises many questions: What is the physician's obligation to the patient? What is the difference between a physician's obligation and a physician's aspiration to improve health? And finally, how can one practice and not overextend?

Increasingly, medical professionals are engaging in community and health policy arenas [1-3]. This involvement is in direct response to a heightened awareness that many health issues, such as lead poisoning, have their roots in the community. Aspects of modern culture that give rise to these diseases, such as environmental contamination, represent the new vectors of disease [4]. To address them one must practice both inside and outside of the clinic walls, and physician advocacy is one approach. One definition from the *Lancet* states "Advocacy only means taking the problems that one faces day to day and pursuing their resolution outside their usual place of presentation" [5].

What Is the Physician's Obligation to the Patient?

Physicians have an obligation to work within their own practices and communities to ensure that patients have access to high-quality preventive, urgent, and specialty care that is geographically, linguistically, culturally, and financially accessible [6]. These noble ambitions frequently clash with the financial realities of a growing uninsured and underinsured population [7]. Practicing physicians are caught in the debate between the utilitarian notion of distributive justice, which acknowledges finite resources, and the notion of justice as equity where all patients are guaranteed equitable access. This is a crucial debate, and one in which doctors must be heard.

The strength of the link between the policy and the health outcome can guide physicians in distinguishing their obligations from their aspirations when advocating for patients [6]. For instance, Gruen et al suggest that it is the physician's *obligation* to work with individual patients and in the larger realm to reduce tobacco use because the health implications of tobacco use are well established. They suggest that physicians may *aspire* to address factors such as poor educational opportunities and neighborhood safety, since the impact on health outcomes is suggestive but not conclusive. Determining the strength of the scientific evidence can help a physician prioritize his obligations over his aspirations.

How Can One Practice and Not Overextend?

Where does this leave Dr Jones? He is exhausted—and who wouldn't be—after making house calls, helping his parents, and partnering with community leaders on health projects. He would appear to have 3 jobs and be doing them all in isolation. Let's examine each activity to ascertain where obligations end and aspirations begin and then consider where different advocacy approaches would strengthen his work but lighten his load.

Dr Jones is exceeding his obligation to see that his patients have access to high quality care. Instead of making house calls, might he look upstream to assess why patients can't get to the clinic? Maybe the clinic is too far away, and he could establish a satellite clinic in a location closer to the need. Alternatively, if the practice values house calls, perhaps he could be given time during the work week to make those visits.

Dr Jones spends time assisting his patients in filling their prescriptions, which is a perennial challenge for many Americans. Luckily Dr Jones practices in California where a new prescription drug recycling program has recently been signed into law. This surplus medication collection and distribution law approved by Governor Schwarzenegger on September 30, 2005, creates a "...program for purposes of distributing surplus unused medications, as defined, to persons in need of financial assistance to ensure access to necessary pharmaceutical therapies" [8]. It is possible that Dr Jones is unaware of such recent legislation with all that he is doing. One easy way to stay abreast of such important issues is participation in local organized medicine, where short frequent e-mails alert members to legislative activity. A compelling part of the story behind this legislation is that it was the direct result of medical students' advocacy for patients just like Dr Jones's. In 2004 a group of Stanford medical students approached one of California's elected officials with the

idea of introducing legislation allowing indigent seniors to obtain medications that would otherwise be thrown away. With this legislation now law, countless California seniors will receive medications where before they would not. Medical students can clearly be extremely effective and unique advocates.

Finally, Dr Jones aspires to improve the health of the community through various projects with local community groups and schools. Self-care is important, and it appears that he is overextended in his aspirations. One approach to focus his activities would be to examine where his passion and expertise intersect: childhood lead poisoning. This is an area where the scientific evidence for prevention is very strong, thus it is a health topic where a physician is all the more obligated to act.

Regarding his clinic patients, Dr Jones should recognize that he is one member of a public health team available to address lead poisoning. His role is to provide medical treatment where indicated and then to refer these patients to the Alameda County Public Health Department. He should advocate at the county or state level in favor of lead abatement programs or legislation. As a physician who witnesses the effects of lead, he has a unique and powerful voice to bring to this process. When the next new patient comes in with symptoms of lead exposure he will be heartened with the knowledge of all that he is doing to prevent future cases. By focusing on lead issues he limits his efforts to an area where his impact will be greatest. He must not attempt to solve all of his patients' problems. At some point in the future his advocacy endeavors may shift to address obesity, or any one of myriad topics, but at this point in his career he has one issue and should remain focused. This will prevent overextension and burnout.

No epidemic has ever been halted by focusing on the individual patient, and many of the health issues facing our nation and world today are the same sort of challenges. As physicians learn to advocate for individual patients and beyond, they will improve the lives of many while they improve the quality and enjoyment of their work.

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Commentary 2

by Timothy Hoff, PhD

Physicians have fallen far short in terms of using their power and influence to advance the public's health in the United States. The balkanization of medicine through specialization [1], the inability of doctors to view themselves as a united group of workers as well as highly educated professionals [2], the narrowly focused training and economic agendas of professional associations [3], and the increasingly unappealing aspects of practicing medicine as both a job and profession [4], conspire to render medicine a weak force for change or improvement in relation to the social and economic conditions that bear directly on health care in this country. Ironically, juxtaposed to this reality is another in which individual doctors, armed with technological gadgets and sophisticated understanding of disease processes, grow more effective at keeping people alive longer—newborns and the elderly alike—and improving the quality of life for select groups, in particular the insured, middle-class citizens in our country.

Citizen Jones and the Power of a Profession

Dr Tim Jones will probably end his medical career frustrated at his inability to do much more than his job as a competent clinician. He could be the best clinician in the world. Chances are, however, that the lead poisoning diagnoses, the poverty-induced chronic diseases, and the preventable, life-shortening afflictions will keep arriving at his doorstep until he takes down his shingle or restricts his practice to some affluent American suburb where those problems are less visible. Certainly, being a competent doctor is enough for any one individual in his or her lifetime. But is Dr Jones required to do any more than what he can as a clinician to improve health in his practice community?

I believe the answer to this question is yes, but it involves Dr Jones's becoming an active part of a larger and potentially imposing collective persona—one that is in the best position to realize fully the social contract between medicine and the general public. This persona exists in the organizations that represent doctors. Such organizations have long been successful in gaining economic autonomy and clinical decision-making discretion for their members. But they have been less effective in bringing down the full measure of their influence on solving the problems that undermine people's ability to be healthy.

As a sociologist who studies medicine, I see a profession that has difficulty assuming an identity with respect to the larger purposes it serves for assuring the health of populations. In studying why doctors belong to organizations like professional associations, for example, I found that economic and instrumental interests, ie, the self-interest motivation, far outweighed concerns about achieving social justice in health care or using the power of the collective to lobby for and shape the kinds of changes needed to improve people's lives enough to make them healthier [3].

There are so many professional organizations competing with each other now for the attention and business of individual physicians that these organizations must focus on bread-and-butter issues like income and reimbursement, continuing medical education, and the advancement of legislation that furthers the interests of medicine. Improving the health of disadvantaged populations is simply not important enough in the mind of the average doctor to succeed as a marketing pitch for membership. Just getting physicians to join more than their little specialty organization is a major task these days. The professional associations know this; they know that the world of managed care presents challenges that affect the individual doctor's work life, and they know that doctors want to see these challenges solved by their membership group.

An Inward-Looking Profession

It seems that everyone, individual physician and collective organization alike, are fixated on the local, everyday economic and clinical worlds of medical practice settings. The problem is that this myopic focus results in an almost exclusively inward-looking group of professionals. This is a group whose major journals and mouthpieces can talk about issues of health care inequality, the uninsured, or health care access, but that has little collective will, experience, or perspective to actually do anything about those problems at a policy level. In an ironic way, the attention paid to protecting physician autonomy—economic and clinical—from the onslaughts of managed care, insurance, technology, lawyers, and the government, has forged a situation in which the medical profession has difficulty breaking away from its more parochial, grassroots interests to attend to the larger societal interests that shape health and illness in our country. Just look at what happened during this country's last foray into a universal health care debate in the early 1990s. Medical specialties lobbied against each other. All of them lobbied to protect physician interests first and foremost. And "health care coverage for everyone" remained a noble idea few disagreed about, but few could actually stand being implemented.

Medicine: a Tough Calling

For many in the profession, being a doctor is a tough calling these days. Becoming a clinician creates massive personal debt. Most need intensive advance preparation even to qualify for entrance into medical school and residency. The unique challenges faced by an increasingly diverse profession (eg, female physicians) in the workplace, the likely reality of salaried worker status once practicing, and the dizzying pace of knowledge change within some areas of medicine conspire to make the modern-day physician more prone to career dissatisfaction. At the least, these challenges create a life where the everyday work of patient care drains the energy and enthusiasm needed to tackle bigger-picture issues [4]. We cannot expect, nor should we, that the Dr

Joneses of this world will become individual crusaders, spending 10-20 hours per week trying to help solve the health problems brought on by persistent poverty, substandard living and nutritional conditions, lack of health care insurance coverage, and inadequate access to care. It is unrealistic, given how demanding and personally testing the life of the average doctor is these days.

Join Professional Organizations

What we should expect, and what Dr Jones is obligated to do, is to engage his professional organizations actively to serve as change agents and work to correct the adverse conditions within which many people toil and which contribute to poor health. This means Dr Jones has to take several simple but crucial actions. First, he needs to join professional organizations, not steer away from them like his colleagues have in droves over the past couple of decades. He should not simply pay dues for his specialty association but should join the local county medical society, the larger American Medical Association, and one or more of the myriad grassroots physician interest groups dedicated exclusively to the bigger-picture health care issues, like the uninsured problem.

Dr Jones must take a small chunk of his salary and invest financially in those particular groups that can advocate for solving the problems that produce many of the sick patients who come to see him on a daily basis. Once a member of these different organizations, Dr Jones must devote a small amount of time to them, not 10-20 hours per week but a few hours per week. This involvement does not mean simply going to the annual meeting to hear presentations but serving as an officer or delegate or grassroots promoter. Dr Jones can interact with other colleagues in these groups over time and build constituencies to raise issues and bring them to the forefront of his association's agenda. This kind of involvement, performed by thousands of doctors across the country simultaneously, would quickly turn organizations such as the American Medical Association, often criticized for being "out of touch" and narrowly focused on a small subset of the profession, into broadly representative bodies that must be responsive to their membership.

Work for Change

Dr Jones does not have to think about his role in grandiose terms. That will only disappoint and paralyze him. Nor does he have to burn himself out pursuing causes in relative isolation from his colleagues. What he needs to do, however, is get with it, recognize that real improvements in our population's health are made at the level of social and economic policy, and at the very least align himself formally with the professional organizations which, for better or worse, still command some level of respect and power in the political and social arenas. Then he needs to work with his colleagues to make those professional organizations the change agents for societal problems that impact the public's health. As an individual physician acting alone, Dr Jones will likely have little impact on population health. As part of an active, aggressive professional association or organization, one that is not allowed simply to serve medicine's interests but is pushed by people like him to force policy change on a grander and less self-interested scale, he stands the best chance of making a difference.

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Clinical Case

New York Super-AIDS Case: Physician as Public Health Officer

Commentary by LaVera M. Crawley, MD, MPH

In February of 2005, Dr Thomas Frieden, the health commissioner of New York City, publicized the case of a man who seemed to have a strain of HIV resistant to all known drug therapy and one that progressed more rapidly from HIV infection to full-blown AIDS than any other strain known. Dr Frieden's office specified that the man in question was a male methamphetamine drug user who had unprotected sex with multiple male partners. In Dr Frieden's words, "This case is a wake-up call. First, it's a wake-up call to men who have sex with men, particularly those who may use crystal methamphetamine" [1]. The stakes are not small regarding HIV infection in New York City. It is known that 88 000 New Yorkers are infected with HIV, and it is estimated that another 20 000 are infected and do not know. If a new "super-AIDS" strain were developing, it would have ominous consequences for the New York community.

Experts were split on whether the case truly represented a new strain of AIDS or rather a man whose increased susceptibility to the virus made it appear more virulent, though some did speculate that a new strain was inevitable. The New York Community HIV/AIDS Mobilization Project reacted strongly to Dr Frieden's public statements, saying, "Rather than 'increasing awareness of the risks of unsafe sex and crystal use,' the Health Department risks stigmatizing gay men as crazed drug addicts carelessly or wantonly spreading a killer bug" [2].

Commentary

Was Dr Frieden's statement unduly alarmist? Frieden's office, the New York City Department of Health and Mental Hygiene, considers the city as ground zero of the HIV epidemic in the US [3]. Given the severity of the AIDS crisis in New York, what would be an appropriate public health action upon discovering the possibility of a new, drug-resistant HIV strain in the population? Frieden's news conference and alert to medical providers and hospitals followed the discovery of, not a cluster, but only 1 case of an infection with a drug-resistant strain of HIV that progressed rapidly to AIDS [1]. Was the warning of an impending outbreak of a "super bug" premature? Should the health commissioner's office have waited until an outbreak of this new infection was certain—that is, more cases reported in the New York area—before making an announcement?

Going Public: Contextual Issues

It should be pointed out that this incident—the potential of a super-AIDS epidemic—

presented itself in a new era of emergency preparedness. Although the issuing of Frieden's wake-up call was never thought to be a response to an act of terrorism, we may do well to consider this case in the context of a post-9/11 New York. Dr Frieden assumed his post of commissioner for the health of New York not long after the 2001 attacks on the World Trade Center. Of the tragedy, Frieden was quoted as saying, "It has changed the face...[and] character of our city. The trauma is significant. I think our responsibility to the public is to be honest" [4]. Indeed, providing communities with honest information and acting on that information in a timely manner are important functions of public health officials.

A Super-AIDS Virus in New York?

The public's right to be informed, educated, and empowered about specific health issues is one of the key principles of the ethical practice of public health, yet an underlying assumption of that principle acknowledges that in some instances "action is required in the absence of all the information one would like" [5]. Given that there was incomplete knowledge of the virus in question at the time of the announcement, should more studies on this strain have been conducted prior to alerting the public? Early on it was unclear whether or not this was indeed a novel "super bug" or whether there was something unique in the case of this particular individual that increased his risk of becoming sick. The patient was known to have engaged in high-risk anonymous sex along with the use of crystal methamphetamine, a substance known to reduce inhibitions and increase the likelihood of engaging in unsafe sex practices. Frieden's office may have used the case as an opportunity to address a growing health risk that affected a subpopulation of New Yorkers with the hopes of decreasing the incidence of these behaviors. With regards to the HIV/AIDS epidemic, Frieden is on record as having said earlier, "We have to be blunt and forthright with our public education" [4]. But was such bluntness justified? Although his announcement had the potential to stigmatize gay men, it is unlikely that it was intended as such and equally unlikely to have had such an impact. On the other hand, the continuing investigation has suggested that the announcement has not had the anticipated effect of reducing high-risk behaviors within the social network surrounding the case. The New York City Health Department reports that "unsafe sex, especially among men who have sex with men, continues at unacceptably high levels" [6].

Balancing Acts: Moral Considerations

This case illustrates a conflict among basic principles within the Public Health Code of Ethics. Dr Frieden's office chose to honor its duty to provide information necessary for decisions on policies and programs and to act in a timely manner on the information it had. This may have conflicted with the duty to "achieve community health in a way that respects the rights of individuals" (or in this case the rights of a segment of the population) as well as to "advocate and work for the empowerment of disenfranchised community members" [5].

Justificatory Conditions for Moral Decisions

If Frieden does indeed privilege forthright information sharing over protecting a group's rights, then how are we to judge the morality of his acts? In mapping the terrain of public health ethics, Childress et al identify 5 "justificatory conditions" to

consider when attempting to resolve moral conflicts [7]. For one, an act must be effective, or thought to be so, to justify infringing on other moral considerations. In this case, the outcome to be judged was whether or not the announcement increased medical provider vigilance in surveillance of all HIV-positive patients to detect other cases, if they existed. In hindsight, we may question the effectiveness of this act, given that few cases have been detected since the announcement. However, the question we must address is whether or not Dr Frieden's actions were appropriate, given the facts he had at the time.

A second consideration is that of necessity: an act must meet the criterion of a prima facie obligation. If there are alternative approaches that are less morally conflicted, then they should be pursued. There was no intention in this act to encroach upon the rights of others. An alternative was to delay the announcement until there was clearer evidence of a cluster or more was known about the virus. However this might have jeopardized the health department's ability to get out in front of the predicted outbreak.

A third justificatory condition, proportionality, states that the benefits of an act must outweigh the benefits of not acting or acting differently. If there was evidence that the announcement would serve to drive a marginalized population further underground through stigmatization or discriminatory actions against them, then one could argue against the announcement. Although this did not seem to be the case, it is an important consideration given the power of the health care system to reinforce stigma associated with HIV/AIDS [8].

Further moral questions are raised considering the fourth and fifth conditions—least infringement and public justification—which must be considered together. The former states that “public health agents should seek to minimize the infringement of general moral considerations” [7]. The latter condition, public justification, states that if an action, practice, or policy infringes on another moral principle then the public health agent must be accountable to the individuals or communities affected by that action. The outcome of potential stigmatization of any group might be an infringement upon that group's rights for autonomy or a compromise of the principle of nonmaleficence on their behalf. Were effective discussions with that community held in the spirit of collaboration prior to the announcement? If yes, then we can presume or hope that Frieden's message was presented in a way that simultaneously informed the public and protected the gay community's rights. If not, then we may be left to question whether his actions were justified under these conditions.

In summary, Frieden's acts would most likely withstand scrutiny under the 5 justificatory conditions described above. However, it is perhaps Frieden's style of bluntness—or at least the media's portrayal of his message—and not his moral stance, that has led to the questions raised here. Had the same media message been tempered with a consideration of its impact on the gay community, the moral conflicts addressed here might not have arisen.

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Journal Discussion

Protecting the Vulnerable: A Call for Pediatrician Advocates

by Philip A. Perry, MSJ

Satcher D, Kaczorowski J, Topa D. The expanding role of the pediatrician in improving child health in the 21st century.

***Pediatrics*.2005;115(4 suppl):1124-1128.**

David Satcher, MD, the 16th surgeon general of the United States, and his co-authors have written a call to action and a survey of what can be done toward health reform in the field of pediatrics. The success of child health initiatives in capturing public attention stands in contrast to other efforts at health reform. Building on this, Satcher et al address the many serious concerns that remain to be acted upon. They offer examples of what physicians can do through community health initiatives. Attempting to revive interest in the Healthy People 2010 framework for child health, they undergird their arguments with rights-based ideas from the United Nations and the World Health Organization (WHO). They stress how essential it is for pediatricians to be involved not only in patient encounters but also in social and community-wide projects on behalf of children.

The undeniable core of the argument for improving childhood health care is that children are among the most vulnerable of people and patients. As Satcher, Kaczorowski, and Topa characterize our 21st century world, “We live in a society that claims to cherish childhood while allowing the abuse, molestation, incarceration, subjugation, segregation, and exploitation of children” [1]. Despite historic success in addressing childhood diseases through immunization, many problems remain that can be solved only at the social level. In the United States and the developed world, “new morbidities” and “millennial morbidity” now threaten children. Environmental problems specific to industrialized societies are a good example of a new morbidity, eg, children growing up in decaying “Rust Belt” surroundings. Other social problems that affect “post-industrial” children include the effects of mass media on behavior, fast food that feeds obesity, and social inequalities that widen the economic gap. All these health problems either start or get worse because of social, community, and environmental factors [2].

The first section of the article describes the problems in detail. Poverty and ill health go together, as Satcher et al persuasively show. And the US statistics still have the power to shock: a ranking of 28th among developed countries for infant mortality; 900 000 children neglected or abused, resulting in 4 deaths a day; poor environmental quality that can be blamed for 25 percent of preventable illness. Thus, the authors are drawn toward the conclusion that “it now seems that the next major advances in

decreasing pediatric morbidity and mortality will require social and public health policy changes as well as continued scientific innovation” [3].

This is where the authors will strike a nerve, of course. Their critique is the medical equivalent of a legal resort to a class action suit. The role of the pediatrician will have to expand, they say, to advocacy “not just for the individual but for the population of children as a whole” [4]. If you’re with them this far, they direct your attention to the Healthy People 2010 framework as a means to address the most serious problems. The Healthy People 2010 report had its genesis in the Clinton administration, of which Satcher was a part (as surgeon general). It pulls together research and social policy and develops a unified solution. If pediatricians joined to achieve the goals presented in the Health People plan, the whole population of children, and their environment would be encompassed in the care of the medical community. The 10 indicators of child health status—5 health system indicators and 5 lifestyle indicators—would become measures by which progress could be judged. It’s advocated here that physicians choose one indicator and work on it as it affects children [5].

Indicators

Health System

- Immunizations
- Mental health
- Violence and injury prevention
- Access to health care
- Environmental quality

Lifestyle

- Overweight and obesity
- Physical inactivity
- Irresponsible sexual behavior
- Substance abuse
- Tobacco use

Where does this leave the individual pediatrician? Not without a public role. If none of *these* indicators are motivators, the authors suggest that pediatricians discover an issue on their own—the most urgent problem in their local community—and take it on as a personal cause.

The authors adduce several examples of individuals who have made huge differences in their communities’ overall health. O. Marion Burton is cited for his work with impoverished patients in South Carolina. They were, as he found, “medically disenfranchised,” when he began treating them in a county public health clinic in 1989. As time went on more and more children came into the clinic with no medical ties at all. “It was unusual for these children to have seen any 1 physician more than once” [6]. This lack of continuity in care shocked Dr Burton into action. Not content just to see more patients in his practice, and realizing that others elsewhere in the state were

similarly underserved, he approached other pediatricians from around the state. In conversation with the state health commissioner they agreed that the public health clinics were becoming the sole health providers for 80 000 children in South Carolina. A study resulted from that meeting and the findings led to action. Partnerships of public health professionals and primary care physicians were formalized to improve care in every district of the state's public health system. From a low of 45 percent, the well-child visits of infants from birth to 3 years of age rose to 84 percent in a 4-year period [7].

Other successes that began with one or a few pediatricians concerned about their communities give weight to the imperative for individual action. In Rochester, New York, Diana Kudes, MD, a pediatric resident at Golisano Children's Hospital, found mental health resources wholly inadequate and gained the support of civic organizations to improve support for families with mental illnesses [8]. She did it by allocating and protecting one half day a month to devote solely to her cause. With time a major constraint for any physician, that step proved important, and her superior's agreement was crucial to her ability to carry through her plan.

Dr Satcher himself, as director of the National Center for Primary Care at his academic home, Morehouse School of Medicine in Atlanta, works on health problems at a national level.

Other strategies are recommended to practitioners:

- Outreach to educators and politicians
- Study of international examples, such as the United Kingdom, where pediatric successes have been achieved
- Partnerships between academic health centers and community organizations to promote child health
- Resource-sharing by universities and national health agencies [9]

If there's no political will for a classic liberal solution, such as a national or tax-funded health program, then an alternative must be offered. Ethically, the authors imply, the work ought to begin immediately at the local level. It would be hard to argue against their contention that the stakes are high. The moral arguments that "children are the future" and that every child "deserves a chance for a healthy start in life" cannot be easily denied. Their persuasiveness has contributed to the success of pediatric health care reform legislation [10].

The UN and WHO statements are appealing to those who see a right to health. They support Satcher's argument for extending pediatricians' reach, not only into the public arena to seek legislative or financial support, but into the further reaches of health care beyond illness. The WHO defines health broadly, as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" [11]

which is also a good description of what all parents, rich or poor, would want for their children.

If agreement can be reached that universal childhood health care is what we want as a society, then Satcher et al provide a good road map for getting there. Pediatricians are positioned to give the process a good push in the right direction. However, the expansion of the physician's role would demand an expansion in the physician workforce and a diversion of resources to accomplish the tasks. The pediatrician's job description, under this plan, would come to include closer cooperation with public health personnel, community action for environmental quality, and even improving the economic viability of their communities, all to help their young patients toward better health in a changing world.

Discussion Questions

1. Why do you think the United States ranks so low (28th) in child mortality?
2. What changes in the health system would be required to achieve the authors' goals: eg, through expansion of the physician work force or legislation to achieve the desired improvements in childhood health?

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Clinical Pearl

Diagnosing Pediatric Lead Toxicity

by Jennifer Reenan, MD

An extraordinarily abundant though toxic element, lead has proven useful to humanity since ancient times and continues to be a key component of many products and industries. Cosmetics, food flavoring, fiber optics, pottery, batteries, paints, radiation shields, glass, and, of course, plumbing (the Latin for lead is *plumbum*) are just some of the many historical and present-day examples of the diverse applications of this metal. However practical, the “widespread dissemination of lead in the human environment” negatively impacts our health and well-being as the ubiquitous substance is (often unknowingly) ingested, inhaled, or absorbed transcutaneously [1]. Acute and chronic lead poisoning, sometimes called plumbism, are associated with significant medical morbidities, adversely affecting the renal, hepatic, hematologic, gastrointestinal, and neurologic systems. Unfortunately, the pediatric population is particularly susceptible to the neurological damage caused by acute and chronic lead poisoning [2].

One of the more alarming findings of the National Health and Nutrition Examination Survey II (1976-1980) was evidence that more than 85 percent of American preschoolers had elevated levels of lead in their blood [1]. Significant regulatory actions have since succeeded in decreasing the incidence of elevated blood lead levels in the US population. The overall prevalence of elevated blood levels (defined as >10 µg/dL) for all ages was 0.7 percent in 1999-2002 [3]. The decline in lead poisoning during the last 3 decades has been attributed to the passage and enforcement of federal legislation that effectively eliminated lead from its 3 major environmental sources: gasoline, food and beverage cans, and paint [4]. However, lead prevention must remain a public health priority. Some 24 million homes in the United States reportedly “still contain substantial lead paint hazards, with 1.2 million of these units occupied by low-income families with small children” [5]. This and other data from surveys conducted in 2000 by the Centers for Disease Control and Prevention (CDC) suggest that primary care and emergency physicians who work with children, particularly the disadvantaged, must continue to be vigilant about screening for and assisting families affected by lead poisoning [4].

National Recommendations for Pediatric Lead Screening

Two large, national medical institutions, the Centers for Disease Control and Prevention and the American Academy of Pediatrics (AAP) have developed comprehensive guidelines for physicians and health care workers engaged in pediatric lead screening [4, 6]. Physicians should also refer to state- or locale- specific screening recommendations. These targeted recommendations may be based on epidemiologic data (often organized by zip code using geographic information systems and models)

that are more relevant to the patient population immediately served. Also, the CDC web site provides links to state-specific strategic elimination and local childhood lead poisoning prevention programs. Physicians hoping to be effective advocates for lead prevention in their communities may find it useful to review these plans.

Recommendations encouraging the universal screening of all toddlers (prevalent during the 1990s) have given way to calls for more targeted screening of at-risk children based on such criteria as residence in a high-risk neighborhood or red-flag responses to personal-risk questionnaires. Currently both the CDC and the AAP advise screening all Medicaid-eligible children as well as children who are enrolled in other assistance programs like WIC (women, infants, children).

In March 2000, a 2-year-old girl living in a New Hampshire apartment complex constructed before 1920 became the first victim of fatal pediatric lead encephalopathy in over 10 years. She died 3 weeks after emigrating from Egypt with her Sudanese refugee family. According to the CDC report, “a wall in a sibling’s bedroom had multiple holes from which the patient had been seen removing and ingesting plaster” [7]. This case calls attention to the special risk that children who are refugees, adoptees, or recent immigrants face in terms of lead exposure (related primarily to poor housing conditions here in the US). Venous blood tests taken from 96 immigrant children at 90 days and then again at 3-6 months after arrival in the US demonstrated a dramatic increase (40 percent) in elevated blood lead levels [8]. The CDC therefore recommends that all refugee children between the ages of 6 months and 16 years be screened both at the time of arrival and then 3-6 months after placement in a permanent housing situation [8].

Signs and Symptoms

Mild lead poisoning (10 to 25 $\mu\text{g}/\text{dL}$) caused by repeated exposure over a period of time can be insidious. There may not be any obvious or specific physical signs or symptoms. One pediatric text advises that “plumbism should be included in the differential diagnosis of anemia; seizure disorders; severe behavioral disorders; mental retardation; colicky abdominal pain; and the arthralgia, bone pain, and cerebral and abdominal crises of sickle cell disease” [9]. In confirmed cases, lead poisoning must be taken seriously. Though the mechanism of its toxicity is not yet known, even mild exposure is capable of causing great developmental and psychological harm including cognitive impairment with lower IQ scores, impulsiveness, difficulty with concentration and attention, irritability, hearing loss, and speech delays. Indeed, a recent study identified a 7-point IQ loss in association with the first, initial 10 $\mu\text{g}/\text{dL}$ of elevated blood lead concentration during the lifetime of the patients studied [10]. This new data suggests that exposure at levels (<10 $\mu\text{g}/\text{dL}$) currently considered “safe” may in fact be dangerous with possible permanent neurologic consequences.

With more significant lead exposure (>40 $\mu\text{g}/\text{dL}$), a child may experience abdominal pain, anorexia, constipation, headaches, emesis, confusion, muscle weakness, seizures, alopecia, and anemia (classically with basophilic stippling).

At levels $>70 \mu\text{g/dL}$, there should be emergent concern about nephropathy and encephalopathy with increased intracranial pressure, impaired consciousness, bradycardia, hypertension, papilledema, respiratory depression, and coma [3].

Labs and Other Tests

Suspicion of lead poisoning is confirmed by measurement of the blood lead levels using venous samples. Hemoglobin, hematocrit, and iron studies may be ordered for evaluation of iron deficiency and anemia, conditions that are often associated with lead poisoning. An abdominal radiograph is done when there is concern about ingestion of larger lead-contaminated materials. Finally, follow-up blood monitoring is a critical, though often neglected, component of ongoing treatment and prevention [11].

It is also important to do a detailed environmental, nutritional, and developmental assessment for children with elevated blood lead levels. The goal of the environmental assessment is to identify the sources of lead exposure (eg, lead paint, lead in water, lead in imported goods, lead related to caregiver's activities) [see Table 1].

Table 1: Key Questions to Ask Regarding Lead Exposure in a Child's Environmental History

I. Paint and Soil Exposure

- Age and general condition of the primary residence and other relevant sites
- Duration of child's habitation at residence and other relevant sites
- Evidence of chewed or peeling paint on woodwork, furniture, or toys
- Recent repairs or renovations
- Outdoor soil exposure (soil contamination)

II. Relevant Behavioral Characteristics of the Child

- Hand-to-mouth activity
- Pica (unusual appetites, eg, for clay, dried paint)
- Hand washing before meals and snacks

III. Exposures to and Behaviors of Household Members

- Occupations and hobbies of adult household members

IV. Miscellaneous Questions

- Access to imported foods, cosmetics or folk remedies
- Food storage in imported pottery or metal vessels
- Presence of vinyl mini-blinds manufactured overseas before 1997
- Well water usage

Source: Centers for Disease Control and Prevention, Atlanta, GA. [12]

Prevention and Treatment

The first goal of lead poisoning treatment is to identify and then avoid or remove

(when possible) the source of lead exposure. Residential investigation and testing may include evaluating samples of house dust, paints, tap water, and bare soil. Caregiver education about the sources of lead and the neurodevelopmental hazards of lead exposure is critical to prevention [2]. Toys, pacifiers, and hands should be washed frequently. Unfortunately, the relative efficacies of most environmental lead removal techniques are less than ideal [13]. Specialized cleaning methods like high-efficiency particulate air (HEPA) vacuuming and interior dust abatement must be done frequently in order to be effective at reducing lead levels [14]. Residential paint hazard remediation is efficacious when pre-abatement blood levels are greater than 35 µg/dL [13]. This intervention entails either removing the lead paint (by such methods as sanding, heat stripping, or wire brushing) or covering the lead paint with a new surface or a binding material. Permanent removal and decontamination of environmental sources of lead can be time-consuming, costly, and inconvenient and may even require temporary relocation while the work is being done.

The National Advisory Committee on Childhood Lead Poisoning Prevention has developed an evidence-based series of recommendations for managing elevated blood lead levels [12]. According to this monograph, chelation therapy should commence at blood lead levels >45 µg/dL. Oral succimer may be used, or, if the patient is hospitalized, calcium disodium edentate (calcium EDTA) can be delivered intravenously.

At extremely high blood lead levels (>70 µg/dL) or in children with symptoms of serious lead poisoning, the appropriate treatment is parenteral therapy with EDTA and hospitalization [4]. Another agent, dimercaprol (or BAL) forms a nonpolar compound with lead that is excreted in bile and urine [2]. Because dimercaprol is water-soluble and therefore readily crosses the blood-brain-barrier, it may be particularly useful in treating acute lead encephalopathy (in conjunction with EDTA).

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Health Law

Kevorkian: When Physicians Take Controversial Public Stands

by Sunil Nair

The respect America accords to its physicians lends weight to the public opinions of these professionals. But physicians' comments reflect not only societal or medical situations that deserve praise or need remediation; they also reflect on the integrity of the medical profession itself. Society continues to defer to physicians' opinions so long as physicians retain the respect of the public by their words and deeds. Depending on how one views his crusade in favor of physician-assisted suicide, Dr Jack Kevorkian either tarnished (or polished) society's respect for the medical profession, and harmed (or augmented) the significance accorded physicians' public viewpoints.

"I want to be convicted!" said Dr Jack Kevorkian during his 1994 Michigan trial for second-degree murder; Dr Kevorkian went on to state: "I should walk up to the bench just like in the movie *Gandhi* and say, I have violated your law and if you have any respect for your system you will give me the harshest penalty possible" [1].

While not found guilty in that case, Dr Kevorkian was eventually convicted on March 26, 1999 for the murder of Thomas Yourk, an ALS sufferer, to whom Dr Kevorkian had administered a lethal injection of potassium chloride [2, 3]. In April 1999, Dr Kevorkian was sentenced to 10–25 years in prison for second-degree murder, and another 3–7 years for illegal use of a controlled substance, with the sentences to run concurrently; he is, however, eligible for parole in 2007 [3, 4].

Legal Background

Physician-assisted suicide (PAS) remains a contested issue in the United States. As recently as October 2005, the Supreme Court heard oral arguments in the case of *Gonzalez v Oregon*, initiated in November of 2001 when then-Attorney General John Ashcroft declared that PAS was not a "legitimate medical purpose" and suggested that any doctor who participated in an assisted suicide would be in violation of the US Controlled Substances Act and would lose his or her federal drug license. On November 7, 2001, Oregon sued John Ashcroft and the Justice Department, claiming Mr Ashcroft had unconstitutionally pre-empted the Oregon Death with Dignity Act, passed in 1994, which permits PAS in the state of Oregon. (Oregon won both in district court and on appeal; the decision of the Supreme Court is expected in June 2006) [5, 6].

The Supreme Court had previously considered the issue of PAS in 1997, when in the cases of *Washington v Glucksberg* and *Vacco v Quill* (considered together) it unanimously decided that the average American has no constitutional right to physician-assisted

suicide and states could therefore bar the practice. The Court's ruling implied, though, that states could constitutionally pass laws permitting PAS, bringing the question back to the state legislatures (at least until Attorney General Ashcroft's announcement in 2001) [7, 8].

At the state level, 54 euthanasia or PAS measures were introduced in 21 state legislatures between 1994 and 2004, all of which were defeated. There have been, in addition to Oregon's ballot initiative, other referenda in Washington (1991), California (1992), Michigan (1998), and Maine (2000). So far, Oregon remains the only state where PAS is legal [8].

Physician-Assisted Suicide: Definition and Controversy

In the practice of PAS, a physician provides the patient with a lethal dose of medication, which the patient then uses to end his or her life. PAS should be differentiated from other end-of-life practices, such as euthanasia, terminal sedation, withholding/withdrawal of lifesaving treatments, and palliative sedation.

Euthanasia is the direct termination of a patient's life *by a physician*, through lethal injection for example; this is the practice for which Dr Kevorkian was tried and convicted. Terminal sedation refers to the sedation of a terminally ill patient to the point of unconsciousness, with all life-support and nutritional systems subsequently withdrawn. Competent patients, or medically incompetent patients with advance directives, may decide to forgo further medical care for their illnesses or injuries, a decision which both states and physicians universally recognize as legitimate even if the end result will be the death of the patient [9]. Palliative sedation is the administration of high doses of pain medication—doses that might inadvertently result in death—to relieve extreme suffering. The intent of palliative sedation, however, is to provide comfort to patients suffering from diseases in their end stages [10].

Proponents of physician-assisted suicide argue that the law ought to recognize the autonomy of patients and permit them to make end-of-life decisions, including the choice to terminate their own lives. They argue that mentally competent patients are allowed to hasten death by refusing medical treatment; those patients who cannot hasten death by refusing treatment (those with long-term, degenerative diseases) ought to have the same right to end their lives. Proponents suggest, too, that there is an element of compassion in PAS, which could be viewed as a legitimate alleviation of unbearable suffering that will only get worse over time. Finally, there are some who argue that assisted suicides already occur in the United States—legalizing the practice would allow for an open discussion of the standards and procedures to be used in PAS [9].

Opponents of PAS, on the other hand, argue that the practice is a violation of the sanctity of life and runs contrary to religious and secular traditions against the taking of human life. PAS, unlike refusal or withdrawal of treatment, is a positive act of life-termination and therefore cannot be justified. Opponents further contend that there is the potential for abuse of the practice—they suggest PAS might be used as a cost-containment strategy in end-of-life care; patients who may not have (or who may not

be provided with) adequate access to health care or support personnel might be “pushed” toward an assisted suicide to alleviate familial financial or emotional burdens. There are also concerns that physicians might make mistakes in diagnosing illness or providing care, thereby encouraging a patient to undertake PAS when there is no need for it. Professional organizations, such as the American Medical Association, worry that legalizing PAS might undermine traditional medical ethics [9].

Position of the Medical Profession

The American Medical Association has taken a firm stance against physician-assisted suicide. In Opinion 2.211 of the *Code of Medical Ethics*, the AMA’s Council on Ethical and Judicial Affairs decided in 1994 (and reaffirmed in 1996) that:

...allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks [11].

The opinion goes on to suggest that physicians should seek to respond to a patient’s end-of-life requirements through:

...specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect...and good communication [11].

The American Medical Association is not alone among professional organizations in opposing PAS: in 1997, the AMA was joined by the American Psychiatric Association, the American Nurses Association, and nearly 50 other health care-related organizations when it filed an amicus curiae (“friend of the court”) brief with the Supreme Court opposing PAS [12, 13]. As recently as 2002, the American Geriatric Association renewed its position against PAS, citing many of the same concerns listed above [14].

Not all physicians share the opinion of the AMA or other health professions organizations, however: Dr Kevorkian obviously dissented when he assisted in the deaths of over 100 individuals during the 1990s. Dr Timothy Quill, currently director of the Palliative Care Program at the University of Rochester Medical Center, shocked the medical profession when he publicly admitted that he had prescribed barbiturates to a patient with the knowledge that she would use them to end her life [15, 16]. In fact, a 1996 survey on PAS by the *New England Journal of Medicine* found that of the 1902 participating physicians, 36 percent said they would be willing to participate in PAS if it were made legal. The study also found that, even under current legal conditions, 3.3 percent of respondents had assisted in at least one suicide by prescribing life-ending drug dosages. (More of the respondents, 4.7 percent, had euthanized a patient by directly administering at least one lethal injection [17].)

The ongoing PAS controversy, while unresolved, has at least had the affect of bringing to light issues of end-of-life care that are often overlooked or otherwise ignored. While physicians may differ on the specifics, all can agree that they have a duty of care to their patients which persists unto death—care that may include referrals to counseling experts (psychiatrists, clergy), palliative sedation, and withdrawal of life-maintaining treatment (if requested by the patient or the patient’s surrogate). These practices are consistent with medical professional ethics and current legal norms.

Physicians, as well-educated community leaders, can encourage their patients and the general public to consider the topics surrounding end-of-life treatment, including emotional preparation for the loss of loved one, cost and quality of care, and preparation of a will. Physicians should encourage the adoption of advance directives and—for individuals who do not want to be revived should they experience cardiac arrest—do-not-resuscitate (DNR) orders to make patients’ wishes clear prior to the final stages of terminal illness when the ability to communicate effectively is lost. Many end-of-life debates are so acrimonious precisely because the participants do not know what the terminally ill patient would want.

Physicians should continue to advance the discourse on end-of-life issues responsibly through the media and membership-based organizations to ensure that patients receive the best care possible consistent with medical ethics and the law. No persons better understand the full personal and medical implications of terminal illness than physicians; consequently, physicians should be proactive in maintaining adequate patient care for the grievously ill, while being personally prepared to face end-of-life cases in the course of their medical careers.

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Policy Forum

Interviews with Physician Members of the President's Council on Bioethics
Daniel W. Foster, MD, and William B. Hurlbut, MD

Q. Do you know anything about the nomination/selection process by which you were selected?

A. Foster: They get nominations from many people. President Bush first selected Dr Leon Kass as chairman of the council. I do not know how much Kass's input counted. I did not know I was being considered until the White House Personnel Office called me to ask me if I would serve. I was considered, I think, because I was chairman of a large Department of Internal Medicine in a medical school (University of Texas Southwestern Medical School) that had 4 Nobel Prize winners, because I was a physician scientist who had been continually funded by the NIH, and because I was a member of the Institute of Medicine of the National Academies. Although I doubt that they knew this, I had also been a trustee of a bioethical think tank called the Park Ridge Center for Health, Faith, and Ethics for a number of years.

This is a council, not a commission. A council is the highest advisory body of the federal government. The parchment of my appointment is signed by both President Bush and Colin Powell, who was then Secretary of State. The Secretary of State has to sign for members of councils. Another characteristic of the council is that all meetings have to be open; there can be no executive sessions.

A. Hurlbut: I had hints because a few people told me they were going to put my name forward. It's interesting that these were people from both the liberal side and the conservative side. I assume they believed, as I also intend, that my positions would be earnest, well-grounded in science, and sensitive to the concerns of both sides.

Q. What do you think is the specific role of physicians on the bioethics council in contrast to the roles of other scientists and professionals on the panel?

A. Foster: It is interesting that, despite its name, the council has only a few professional bioethicists. In addition to physicians, there are lawyers, sociologists, political scientists. The physicians are important because they treat real people with real diseases and face real ethical questions all the time. The council's latest volume, to be released this week, is about the care of the aged with dementia. In the last 4 weeks I presided over the deaths of the president emeritus of University of Texas Southwestern Medical School and another professor emeritus who was the founding father of academic rheumatology. Real-life decisions had to be made on whether to intubate, carry out further chemotherapy, etc. In addition, physicians have insight into the diseases potentially approachable by stem cell therapy.

A. Hurlbut: There are 5 physicians, and with Edward Pellegrino there will be another one, and a very distinguished physician, by the way. The root of your question is, what does a physician bring to a council like this, and I think it's plain that it's a very important role. For questions as difficult as these, we need a range of perspectives—one human being cannot know enough to make pronouncements about the full range of questions with which we are faced.

But I would say that priority must go to medicine. If you don't know the science, forget it, you won't get the questions right. I don't think there should be a professional track called bioethics. About 90 percent of the bioethical literature frets over problems that will never emerge since they are beyond the range of realistic scientific possibility—that's especially true with genetics and neuroscience. Now, one might say about the physician that, even though he knows the problem, he may not have a clue as to how to deal with it, and that is sometimes the case. But, having said that, I think a well-rounded, liberally educated physician is generally better qualified to comment on these questions than a research scientist, a lawyer, a philosopher, or a bioethicist. But no one has the full perspective. What we hope for is to have conversations with a lot of diverse perspectives. And as the process of the council has unfolded, the physicians have made many comments along the line that have been crucial, I think, to making the deliberations realistic, meaningful, and certainly scientifically well grounded.

Q: *[asked of Dr Hurlbut only]* **What considerations do you think are most of important for selecting people for the council?**

Hurlbut: Well, I'm not a political appointee. When I talked to White House staff for the interview no one asked me how I voted. I basically said I'd be comfortable serving my country under this administration and that I wasn't interested in being political—I told them I'd vote for anybody who was against telemarketing.

I don't think the council selected with politics as the primary concern. When we met with the President, he was earnest about the fact that, as a collective society, our country needed help in addressing these issues. He said that these biotechnology dilemmas would define his administration more than any other issues, including terrorism, and he may have been right on that. Cloning, transforming human nature—these are truly serious considerations with deep significance for our civilization and even our species—significance that goes beyond matters of immediate political alignments. I didn't go in with a preset view one way or another toward the President, but I was impressed by him. He spoke with a sensitivity and an honesty that I thought were highly meaningful in a president. He told us he wanted us to present the best arguments on both sides, and that's what we've consistently done. He also told us he wanted us to help engage and educate the public; in other words, that we weren't some kind of intellectual oligarchy that was going to decide the issues on our own. Rather we were invited to stimulate the national process of discussion. He said he wanted our advice, but that these issues were so profound and central to our being that only deliberation through a truly democratic process would suffice to decide them.

Q. Council members do not represent any constituency. What, then, guides your position-taking on the council?

A. Foster: Council members do get characterized from their previous writings. That might be pro-life, pro-science, pro-stem cell research, anti-stem cell research, etc. Our government is based on the view that its representatives (whether in the Congress or a council or as president) act for the general good. They are influenced by their philosophies and their theology (if any), but decisions are supposed to be reasoned judgments for the good of the people. In the 4 years of the council, it was clear that this process was operating in the members. Discussions have been scholarly, not shrill.

Hurlbut: That's an important point. I have a biographical perspective here. I got to Washington on the day after I was appointed to the council, and, as I do every day, I went running. I remember going by the Washington monument, the Lincoln monument, and it was one of those moments in my life I'll never forget, running along there and thinking about the opportunity given to me. It was very humbling because I knew the magnitude of the topics we were going to deliberate, and I knew how ill-equipped most people in society and even in medicine are for dealing with them. And I knew that we wouldn't have major-league hitting power—this kind of council never ends up immediately changing the world. But I also knew that, with Leon Kass at the helm, this would be a productive, deep deliberation, and, frankly, that has held up. I feel privileged to be invited to be part of the inner circle in these discussions, and what I mean by that is that I feel an enormous responsibility to our entire national heritage, ranging back to George Washington and the very sense of who we are as a nation and our place in history as a uniquely open and democratic system. I feel a great responsibility to be as earnest as I can in search of the truth—a truth that is as universal as possible.

In any governmental body, you cannot escape the fact that people will bring their personal assumptions to the table. But, to the degree that you can find people who are well experienced in intellectual dialogue, you can find people who are neither ethnocentric nor narrow-minded, and I can say that of my colleagues on the council. I myself have traveled to half the countries of the world and seen their realities. This has helped me to realize that there are cultural ways of expressing differences that are very important, but there are also universals. I can see that people all over the world are looking for many of the same things and are going to be vulnerable to some of the same dangers of biotechnology. I also bring some familiarity with a variety of religions, and have sympathy for opposing ideologies. Yet I bring an earnest desire to serve the truth and not anyone's private agenda. I feel zero degree of obligation to side with the President's specific position, and he made it plain that he didn't want us to feel those obligations.

Q. You are physician-educators as well as members of the council. Do you see any conflicts in fulfilling these 2 roles?

A. Foster: I felt no conflicts in being either a physician-educator or a physician-scientist. I have insights from these 2 roles that I believe are, from time to time, informative. In general, fellow members found these insights helpful, I think.

Hurlbut: Until my appointment to the council my students found me somewhat inscrutable with regard to my opinions on specific issues. A teacher is always caught between talking deeply about the things he or she believes in and over-influencing students by doing so. In my classes I open the questions rather than start with a bunch of assumptions, and my students respond to that. When we talk about evolution, we need to ask, “How did *we* get here?” And is there anything about the way the world is constructed that would give you any basis for taking a moral position in the first place? That automatically opens questions about the origin and ultimate destiny of the cosmos.

Those are important questions that underlie ethics, and I don’t claim to have the answers, but I engage my students in discussing them. And, again, on the President’s Council I bring the same search for root sources and values.

Q. Do you think physicians have an obligation to be active in public life?

A. Foster: When asked to carry out any communitarian function, the physician should consider whether sufficient time is available, whether his or her interest level is high, and whether the duty is an important one to take on. The Bioethics Council was very intensive from time to time, especially when we were all working on the production of volumes for publication.

Physicians are generally very gifted. In America, for example, they have the gift of citizenship and a repertoire of identities available to them, something that someone born in sub-Saharan Africa does not. They are sufficiently gifted intellectually (credit to their genes, not to themselves) that they may go to medical school and practice medicine. Even in times like these, when there is considerable distress in the medical community about reimbursement schedules, malpractice, and diminished incomes, all physicians are in a tiny minority of our citizens in terms of blessings. They will always have discretionary income, even as reimbursement rates fall. I do believe there is an ethical payback requirement to society and to the Universe, if I may put it that way. I have done several communitarian functions in addition to my service on the council. For example, I was elected as a trustee of the Dallas Independent School District and served during the desegregation case that led to our busing order. That was both important and tense. I did medical television on PBS, including 4 seasons where each week I invited an outstanding academician to talk about a medical problem. This series was sold to BBC and shown also in Europe. I have been active in the peer review and other systems of the NIH almost throughout my career: Study Section, NIDDK Council (National Institute of Diabetes and Digestive and Kidney Diseases), search committees, and 10 years on the Board of Scientific Counselors of the NIH Clinical Center. Another requirement, in my mind, for academic physician-scientists, is that they serve as editors, reviewers, and writers of textbooks.

Hurlbut: I've always been ambivalent about physicians in public life. I certainly think that they need to bring their scientific expertise and medical experience into the conversation. But as a physician I'm trained to be a caregiver on an individual basis. And in a strange sort of way there's almost a conflict in social policy. You know you have a patient who is potentially dangerous or is harboring a dangerous disease, and you can't take him and lock him up or advocate to have him committed. As physicians we are rigorous advocates at the level of individual patients; we are not sociologists, or social theorists, or economists, or people weighing these issues on the scales of politics and legislation. I find myself involved in the political process now, not really in a partisan way but in trying to promote a solution to what I think is a partisan conflict. I'm learning a lot about the political process, some of which is discouraging indeed (you know that old saying, never ask what goes into making sausages or laws) but also conceptually important. I've had conversations on stem cell biology with Orrin Hatch, George Allen, Senator Brownback, and Senator Frist, who, I think, have thoughtful, earnest intentions to seek solutions. And as a physician I feel comfortable doing that because I'm not telling them what to decide. I'm a resource of information.

Now, I have to pause and answer your question by saying something different than what I just said, because I think that biology is becoming so important that we do need specific legislators to work on science and medicine, and I think that there's a place for physicians with good experience and a talent for public policy to step out and leave their practices behind in the service of the nation. I think we'll probably be at a point soon where we would benefit from a president who is also a physician. Maybe not, I don't know for sure, but I think it helps to have senators and representatives who are physicians. I think physicians should not use what you termed "advocacy" so much as really sincere understanding of the issues and leadership. I would say the best way to serve is by keeping the dialogue realistic, and physicians can do a great job of that. If physicians become like an advocacy community, or a lobbying group, or a labor leader, that would be unfortunate. As physicians we are dedicated to the social good and should promote that and not ourselves.

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Drs Daniel W. Foster and William B. Hurlbut were appointed to serve on the President's Council on Bioethics in 2002

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Virtual Mentor

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Policy Forum

Physician-Advocate: Deciding What to Fight for and When

An interview with Philip A. Pizzo, MD,
Dean of the School of Medicine, Stanford University, Palo Alto, California.

Q. What led you to become active in advocacy for causes in medicine and pediatrics? You have had a complicated relationship with the federal government: you worked for the government at the National Institutes of Health, interacted with it both as the dean of a major medical school and in an advisory capacity in the Institute for Medicine, and now as director of the California Stem Cell Initiative. Can you tell me a little bit about these experiences and how they have shaped your thinking about your role as a physician and now a public figure?

A. I was influenced by the dramatic changes in social welfare as well as discord that characterized the 1960s. I became immersed in the great debates of those times—civil rights, health and welfare, peace versus war. My wife, who was an advocate for children, demonstrated the importance of taking a stand. For me, the opportunity to change the lives of individuals—or a society—was compelling and galvanizing. So too was the sense of idealism that one's efforts could transform our world.

The issues were directly related to the personal experiences I have had—as a student, trainee, physician, scientist, administrator, and leader. A common underlying theme for me has always been to put the importance of helping people or society first—even if that has personal costs. Patients have been the starting point for most of my advocacy—but I have tried to couple advocacy with scientific or at least evidence-based underpinnings.

My earliest public foray was in supporting children with cancer or bone marrow failure who needed advanced technologies or medications that may not have been readily available. This took on a larger context as HIV infection and AIDS became prevalent in children during the mid-1980s. The fact that drugs were not being developed—or were not even available—for children prompted me to take on drug companies and the FDA, as well as state and federal governments, to overcome these barriers. This required confronting the FDA's regulatory posture and mobilizing public attention in a manner that compelled that agency to change its decision and make a drug, AZT, more available to children with AIDS. Over time these activities have contributed not only to immediate changes in drugs for children but also to sweeping legislation that has resulted in new federal regulatory policies. More recently, these same issues have had to be addressed in a number of developing nations where access to AIDS drugs has been drastically limited and national infrastructure, drastically lacking. In these latter efforts I have worked with nonprofit organizations, like the Elizabeth Glaser Pediatric AIDS Foundation, to drive change.

I clearly recognize that over the years my responsibilities and activism have assumed greater magnitude. As this has happened, I have always tried to remember that my personal role needs to be sublimated to a higher cause and that neither the desire for personal credit nor the fear of discredit can play any role. I recognized that in taking on issues which confront the norm or which challenge organizations—especially organizations with financial resources or power— it is imperative to sustain one’s personal integrity and do everything possible to stand above reproach. That has meant making specific decisions that have personal costs.

Q. This issue of *Virtual Mentor* discusses where politics and medicine meet. Where have you noticed that intersection in your career? Could a physician ignore politics and be successful?

A. It is hard for me to separate the role of the physician from that of advocate— although I recognize that this relationship may be more seamless in pediatrics. As a physician it is important to advocate for one’s patients at a fundamental level—for their health and welfare and for their safety and well-being in a community. In some ways, the huge advantage and success that the US has had in biomedical research is a consequence of political and governmental decisions, especially in supporting the National Institutes of Health. Conversely, the dysfunctional health care system in the US (which is not really a system) is also the consequence of political decisions or indecisions. Many of these extend back decades, in the case of health care to President Woodrow Wilson’s inability to launch an organized health care system—a failure that was replicated during the Truman, Johnson, Nixon, and Clinton administrations. The policies of local, state, and federal government on decisions of health care (eg, state support for Medicaid and medical education) or national policies on research (eg, stem cell or contraceptive research), and matters of public safety and the public good (state or federal policies on science, gender, marriage, abortion) all have tremendous consequences on individuals. While a physician can stay focused on simply delivering medical care, it is hard for me to imagine that our rapidly changing economic environment and evolving global community will leave anyone immune to involvement in societal or political problems.

Q. In your opinion, how should the federal and state governments and medicine interact?

A. The dynamic interaction between the state and federal governments has been both positive and negative. For example, when a positive social care program—like Medicaid—was passed on the federal level, states had the right to determine their level of funding, and some choose to do so quite minimally, perhaps driven by social and even racial perspectives. More recently, when the federal government decided to block stem cell research, certain states— California most notably—challenged that decision and established separate state funding mechanisms to support it through Proposition 71, the 2004 ballot initiative that established the California Institute for Regenerative Medicine. In contrast, other states (eg, Kansas, Missouri) are moving to ban such research with all the consequences therein. On another level, some states (Oregon, Vermont) have introduced novel initiatives in health care whereas others have made health care a lower priority.

I believe there is a benefit to having areas of state and federal separation as well as unison. It depends on the issue and the availability of resources. For example, we need a health care revolution in this nation, but I am not sure that it can occur at a national level first, given past history. It may require state development and experimentation to create opportunities for success.

Q. Do you find that serving on a committee of medical experts appointed to advise the federal government is useful, and how do you think those experts should be chosen?

A. A committee's usefulness clearly depends on its purpose, on how it is chosen and appointed, what authority it is given, and whether it is advisory or driven by political agendas. In recent years a number of national advisory committees have been contaminated by ideology, religion, and politics. Individuals have been appointed to committees at the FDA and in HHS, for example, because they had a certain point of view (eg, regarding abortion or faith). When the committees in question are medical and scientific, appointments on such grounds make a mockery of the scientific advisory process. Most recently, this circumstance has been evident in the President's Council on Bioethics as well as committees on reproductive health at the FDA. It is notable that the appointment of leaders to major federal institutions has been politically motivated or influenced by "litmus tests" of alignment with the administration. Again, this is a most unfortunate development and impacts negatively on the success and credibility of the committee. Further, committees can be negatively affected when members have conflicts of interest that are either unexpressed or that influence their decisions—as may have recently happened in some FDA advisory committees. In my opinion, each of these is an example of the function or integrity of a committee being negated or compromised.

Q. When did you decide that seeing patients or doing research was not enough and that it was necessary for you to take on some sort of public role? I'd be especially interested in your decision process regarding the California Stem Cell Initiative.

A. My more public roles have never been replacements for patient care or research—they have been extensions of those activities. Before I came to Stanford 4 years ago, I spent the prior 3 decades in patient care, research, and education. As for the stem cell research initiatives, the major motivation on my part was to do everything I could to not have ideological points of view impede vital research that could improve the lives of adults and children. While I am respectful of individuals who have moral or religious objections to stem cell research, I do not agree that such a point of view should negate the ability of individuals who don't share those objections to carry out this type of research; nor should it prohibit our nation from supporting it.

I have long believed that it was important for me to help remove whatever impediments stood in the way of patients' benefiting from new discoveries or receiving access to health care or programs that promote social justice. Accordingly, some of the problems I have confronted include funding for research, such as the stem cell research we are discussing, support for training future pediatric investigators,

the responsible conduct of clinical trials including the role of the pharmaceutical industry and National Institutes of Health in conflicts of interest, and, even more broadly, the emerging antiscience mood in the US and the future of health care.

One must be judicious in taking on campaigns that can challenge one's own institution, and there are times when one must make clear that he or she is speaking personally and not on behalf of an organization. Taking public stands on stem cell research or the need for fundamental change in our health care system can be tightropes to walk along. Finally, as one gets more publicly active, it is not beyond possibility that one's own career opportunities—or even employment—can be put at risk. But, if at the center of one's motivations is improving the lives of patients and people, such risks seem worthwhile—at least they have to me to date.

Q. Do you think physicians ought to be more in the public eye? How do you think medicine as a profession is doing with its public relations? Any personal insights from positive or negative public relations experiences?

A. Physicians are in the public eye—and, sadly, I think the public perception about profession of medicine has suffered during the past few decades. A number of factors contribute to this—including the avarice of some physicians about their own financial gain, the negative impact of managed care and its conversion of medicine from a service to a business, the role of big pharma in driving up drug costs or in eroding public confidence in the way drug companies conduct clinical trials and assure public safety, and the negative effects of the activities of some physicians with conflicts of interest. So, while members of the public usually feel positive about their own doctors, they have less respect for the profession of medicine. I believe this is a situation we all need to deal with; we need to win the public trust. We do not have viable, trustworthy organizations to speak on our behalf. I do not believe that the AMA has succeeded in that regard, and others have not stepped into the fray in a meaningful way. So we will need to create and develop other vehicles and mechanisms to do this. And the heart of this will be the role of physicians, one by one or in their communities, interacting more successfully and honestly with the public and regaining trust and respect for medicine as a caring profession.

Q. What would you say to an individual physician who wants to get involved in public advocacy but does not know how?

A. First that this is a serious decision that should be guided by motivations to help others and not oneself. Second, the issues should be those that the individual cares deeply about and for which she or he is willing to accept the responsibility and accountability that come from being engaged.

In medical schools and residency training programs there are organizations, individuals, or groups that are involved in advocacy. It could be worth beginning there, if possible. At Stanford there are a number of student groups, possibilities through scholarly concentrations, and specific programs (eg, in pediatrics) that create avenues for engagement.

If conditions don't exist for one's own issue, I think it might be best to find a mentor or guide and then develop one's own path—with the hope that others will follow.

Q. Regarding your role as dean, do you think medicine should be educating doctors to be effective public advocates?

A. I take my role as a leader in academic medicine very seriously. I have believed it imperative that I set an agenda and blueprint for Stanford—which I have tried to do since my arrival here. I have also believed that I need to address public policy questions that are important to me and to the future of medicine and science. By doing so, in the most honest and forthright way that I can, I hope that I am modeling and educating students and others to take an active interest in these matters.

This interview was conducted by Robert E. Burke, theme issue editor for December.

Philip A. Pizzo, MD, is dean of the School of Medicine, Stanford University, Palo Alto, California. Before joining Stanford, he was the physician-in-chief at the Children's Hospital in Boston and chair of the Department of Pediatrics at Harvard Medical School, specializing in childhood cancers and pediatric AIDs. He is a member of the Institute of Medicine of the National Academy of Sciences.

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Medicine and Society

Physicians as Public Advocates:

Setting Achievable Goals for *Every* Physician

by Clarence H. Braddock III, MD, MPH

Since the earliest existence of the medical profession, physicians have accepted a host of ethical responsibilities. Physicians should be truthful, compassionate, and hold confidences. The idea that physicians should be patient advocates doing everything within reason to help their individual patients is also an idea that is woven into the fabric of medical practice. Contemporary medical practice, however, has thrust the profession into some new territory and forced medicine to confront a new range of potential roles and responsibilities, including those of gatekeeper, steward of limited health care resources, administrator, and manager.

Many physicians have indulged the temptation to get involved in more prominent ways, individually or collectively engaging in public debate about how health care is delivered and practiced. Some have argued that medical professionalism includes a component of public engagement [1]. Others go further, claiming that the social contract between the medical profession and society imposes on physicians a responsibility to provide leadership in matters involving the health of the public.

The “Medical Professionalism Charter,” a document endorsed by virtually every medical specialty society, embraces the principle of social justice as a value fundamental to medical practice [2]. It further endorses several specific responsibilities for physicians, such as demonstrating commitment to improving the quality of care, access to care, and just distribution of finite resources. These are realms that are, by their nature, public—not individual—hence the charter constitutes a formidable argument for a broad public role for physicians.

But what does the professional imperative implied in these analyses mean for the individual clinician? Beyond joining a professional organization and participating in its internal policy deliberations, must each individual physician take on a public role? Do I need to run for Congress or set up a hospital in another country to fulfill my professional obligations to society? How do I do this while simultaneously fulfilling my primary obligations to care for my own patients and maintain excellence in the provision of clinical care?

Gruen and colleagues have recently articulated an affirmative answer to these questions of physician advocacy [3]. These authors link a public advocacy role to the physician’s responsibility to individual patients. The boundaries of the wider responsibilities, they argue, can be understood as a series of concentric circles with

obligation at the center and aspiration at the periphery. Those community issues and influences that impact the health of *their* patients serve to separate the inner from the outer circles—obligation from aspiration. As examples, Gruen and colleagues argue that a dermatologist, in addition to treating skin cancer, should actively endorse programs to prevent skin cancer [3]. Trauma surgeons should advocate for seat belts and bicycle helmets. For these authors, activities at the outer reaches of national and international health influences remain “above and beyond” the call of duty.

What are some tangible ways that physicians can meet these public responsibilities? There are many well-known physician advocates whose work seems laudable but out of reach for most physicians. Even the examples of physician advocacy in this issue of *Virtual Mentor*, while exemplary, should not be expected of *every* physician. Many achievable activities, however, fall within the concept of the “physician citizen” and represent the kind of activities that *any and every physician* should be undertaking [3]. These achievable goals resemble those of active lay citizens who remain informed about issues of importance to their community and join the community dialogue about them. Ask yourself, as a citizen, *Do I go to PTA meetings? School board meetings? Community town hall meetings on homelessness? Do I participate in volunteer work?*

Beyond their involvement as lay citizens, physicians should strive to bring their knowledge, experience, and community standing to bear as voices for change. So, for instance, when the PTA is confronting proposed cuts to after-school sports programs, a family physician can offer evidence of the impact of physical activity on childhood and adolescent obesity. When the school board is discussing the school’s vending machine policy, a pediatrician can speak from experience and knowledge about the effect of nutrition on the health of children in the community. When the city council takes on homelessness, an internist can uniquely give voice to the public health and social justice dimensions of this urban problem, advocating for solutions that consider these complexities.

If we acknowledge this public role for physicians, we must also recognize that their education and training must clearly communicate this responsibility, providing students with the knowledge and skills that will enhance their effectiveness in advocacy. Examples include curriculum that addresses contemporary models of health care delivery and core principles of public health, as well as practical experiences in public advocate roles, such as participation in service learning activities. A curriculum of this type, coupled with an acceptance of a broad responsibility of contemporary practice, can help individual physicians and the profession fulfill an important role as agents for change.

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Medicine and Society

Physicians as Reporters in the Media:

Meeting the Challenge of Patients' Needs for Better Information

An Interview with Dr. Sanjay Gupta, MD,
Senior Medical Correspondent for CNN

Q. How did you decide that taking a formal public role was necessary for you or what went into that decision?

A. I did a lot of public policy in college and became interested in, for example, how people get their health care information, how you preserve the Medicare and Medicaid federal entitlements. It's not just health care policy people; everybody's really stuck on this stuff. I went to work at the White House for a while as a fellow, and there I did all sorts of things, and I worked on projects related to health care as well. I got a sense of the sort of awkward dance between people who are in public roles and a public that wants information about their health and health care. I talked to people about jobs in 1997 that involved television and decided it wasn't really a match for me at all, so I didn't do anything about it. Years later I received an invitation from the chairman of this company [CNN], and when I worked at the White House he was very interested in health and in medicine and the media; we talked, and he offered me a job with CNN and I accepted, and also took a job as faculty neurosurgeon at Emory, so there was no specific moment; it was just an evolution.

Q. How do you decide what to talk about and how to portray it to the public? Is there a threshold of knowledge you have to have about something before you broadcast it?

A. How we portray topics to the public—that's easier to answer, because one of the things that journalists have to do, and I think it's their primary responsibility, is *not* to think about how we're going to portray it—we portray it as what it is. Right? We don't want to bias somebody by how we portray it. There are things that certainly demand more attention, for example, hurricane coverage, tsunami coverage. Those things obviously affect a lot of people and are significant world events. To take another example, if Lipitor has some significant impact on reducing your chances of getting glaucoma, then that's a story we'll do, and we'll show somebody who had that significant improvement or benefit from Lipitor.

You asked how we choose, that's a more challenging question. We're working with a 24-hour news network. If we cover something, we raise its level of importance, just by virtue of covering it. Not everything deserves to be covered because it just doesn't; because when the public sees it on CNN they're going to think it's something that might affect them. It might worry them. And in particular, they take what physicians say very seriously. But for the most part, "newsworthy" means it's affecting a lot of

people, or it's a significant development, a new treatment or prevention that both affects people and is novel. We talked a lot recently about this vaccine for cervical cancer. Cervical cancer affects maybe 10 000 women, but this is the first time we've ever had a vaccine for prevention of a cancer. Which is amazing, really, if you think about it. So that's one type of story that comes up on the news.

The other type of story is something that's called an enterprise story, meaning that it's not necessarily in the news but we think it's an opportunity to use the medium to educate people about something. For example, an operation called a pallidotomy is sometimes used to try to treat Parkinson's disease. There was nothing particularly newsworthy about that story when we decided to air it but we wanted to educate people about the alternatives for a very debilitating neurological disease. I think people got a lot out of it. So I'd conclude this by saying that medical journalism is a little bit different than other types of journalism because we also have a public health role as well, and I think we have to deal with both of those things—news and public health service—that's what drives our story production.

Q. Have you ever faced a situation where you weren't sure what to say about the state of research for a certain condition or disagreed with the network's take on a medical issue (if it has one)?

A. There's always going to be 2 sides to an issue no matter how clear-cut it seems. In an ideal world, we'd have an hour for each story. Then we could have experts both for and against come on and talk about it. To give you an example, think of the cervical cancer vaccine; now that's a pretty hard one to argue against because it's a vaccine against cancer. You get a shot when you're teenager and you won't get this type of cancer. Pretty great. The problem is who do you give it to? Do you give it to all women? It's a sexually transmitted virus that causes this cancer, so do you have to have a discussion about sexual education with the women who are getting this? Should the parents be involved? There are nuances in this if you look hard enough. I don't think there's a clear, absolute answer to how you decide exactly what you're going to say. I think the public trusts CNN because we exercise good judgment about the situation. We can't get into every single detail in a 3- or 4-minute piece on television, but what we do is just put the story out there and let the public know that there are issues they should be thinking about beyond the obvious.

Q. Who and what do you rely on for your knowledge of medicine outside your specialty?

A. I'm a neurosurgeon and there are areas outside my expertise. I'm fortunate in that I probably have one of the best networks of doctors now in the country that I can call in my rolodex. Someone is always willing to help me understand or get perspective on it.

And he or she will say, "I'd stay away from this and here's why," or "I really think that people aren't paying enough attention to this and here's why." It's a constant process of getting feedback. I don't pretend for one second to be an expert in every area; my own opinion is formed by people around me. I'd also say that here at CNN we have 15 producers, one of whom has a health background, and they are very, very diligent

in the work that they do. They probably could have gone to medical school themselves and they're very talented. I'm fortunate in having the support structure that I have.

Q. Can you comment on how health information is given to the public and how you would change it? Are physicians doing an adequate job of representing themselves publicly? How do you think individual physicians should respond to the increasing wealth of health information (correct or not) available to the general public?

A. I still come from an idealistic world. I'd like to think that the public for the most part gets their medical information from their doctors. You know, you go to the doctor's office and fill out a form, and a doctor studies it, asks you questions, examines you, and then tells you what he or she thinks should be done about it. That's the way it should work, the way it has worked so well. A couple things have changed that. One is that our society has gotten technologically much more sophisticated. A lot of information is suddenly available to the average person on the Internet, on the television, in all sorts of different media. So this availability makes it inevitable that patients are going to get their information from places other than their doctor's office.

What I think, and people are starting to agree with me on this, is that doctors and health care providers should be the ones controlling the public flow of medical and health information. It should be people who are trained in the field, have the background, and are taking care of patients; people who know how hospitals run and how the medical establishment works should be stepping outside their role a bit from the one-on-one patient conference and assuming a larger public role, whether on television, or in magazines, or whatever. If patients are seeking this information, they should get it from the best sources possible. And I think that we are definitely heading in that direction. I don't know that physicians are doing a good job of controlling that information flow yet. I mean, you walk into a bookstore today, and you want to buy a book on breast cancer. You'll find a book by Susan M. Love, MD, who's a fantastic breast cancer surgeon out of Southern California, and she is great, right next to a book by somebody who is not a physician, has never seen anybody with breast cancer, and doesn't know any of the basic information about breast cancer, someone who is basically hawking books.

I think there is not enough of a sort of scrutiny, a vetting process, which should be there for all the public, if you could do it. Now, it's an American process, so you don't want to ever limit access to the information out there, but when it comes to health, when it comes to people's well-being, there needs to be some sort of vetting process. I think the challenge is getting really smart, good, educated doctors to be a part of this process, so they make sure there's sound content available if people are looking for it.

Q. When do physicians need to take a public advocacy role? When are they ethically obligated to do so?

A. I don't think there's ever a point when someone says they have to do it. First of all, let me just say that taking care of patients in and of itself is a noble, time-consuming, and worthy thing, and I don't want to pretend for one second that being a doctor is not an incredibly rewarding and important profession. Beyond that there are a certain

number of people who are good at communicating their profession and some of the nuances of their profession to large masses of people. And if it's something they want to do, then I think they should. I think that as a medical community we need to realize that patients are getting their information in nonconventional ways and we need to oversee that, but I don't think that anyone has some sort of obligation to get involved in public advocacy in addition to a medical practice. It is a lot to ask of anybody, and I think the community, the AMA, or organized medicine as a whole can speak to that responsibility.

Q. Would you comment on the AMA in particular—their public relations arm, and whether you think that's doing a good of representing physicians, and if it's effective or not in moving public policy and public health forward?

A. Well, the AMA is a powerful organization—they accomplish a lot on behalf of doctors in this country. I'm always amazed when I hear some of the breadth of the responsibilities of the American Medical Association—they're organized, they have good leadership, they're a good model I think for all sorts of professional societies to follow. There is also the AMA/National Association of Medical Communicators conference, that is training communicators who are doctors or health care professionals to do some of the work that you and I have been talking about. I think the AMA has risen to that challenge. I think that what's driving it now is the public thirst and appetite for this information and we just have to keep up and we're doing a pretty good job of it.

This interview was conducted by Robert E. Burke, theme issue editor for December.

Sanjay Gupta, MD, is senior medical correspondent for CNN, assistant professor of neurosurgery at Emory University School of Medicine, Atlanta, Georgia, and associate chief of the neurosurgery service at Grady Memorial Hospital, Atlanta.

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Medicine and Society

On Being a Physician and a Member of Congress

by The Honorable Donna M. Christensen, MD

I have been blessed to have had 2 rewarding careers—family physician and member of the US Congress—that I truly love and enjoy. Most importantly they are jobs where I have had the opportunity to make a real difference in people's lives and well-being.

I practiced medicine on my home island of St Croix for 21 years. Although my original intention when I began residency was to go into adolescent medicine, I had a family practice instead, in the full sense of the phrase. About a third of my patients were seniors.

I also had the privilege of serving as a community health physician and emergency room doctor, and as director of maternity, child health, and family planning and a community health center, as well as being a hospital medical director and assistant (for a while, acting) Commissioner of Health, all while continuing my primary practice.

During that time I was also active in community affairs and the Democratic Party. I served as a high school PTA president, an elected school board member, and as Democratic National Committeewoman for 12 years. So prior to coming to Congress, although I never served in an elected legislative body, I would say I led a life which balanced medicine and politics.

Nevertheless, the decision to leave my practice was a difficult one. There is no way for a solo practitioner like I was to serve in the House of Representatives and continue to see patients from so far away as Washington. The rules of the House do not allow it in any case.

My elderly patients were of special concern to me, so when they said, "Dr Green (my name then), you have served us well for all these years, if this is something you feel you have to do, we will support you." So they released me to make the decision to run for the office I now hold. My pledge to them was that, if elected, I would continue to look out for the needs of all of my patients and that of my entire community from this broader platform.

I was first elected in 1996, after losing a previous bid for this office 2 years earlier. As the representative from the US Virgin Islands, I am a nonvoting delegate to Congress, which means that while I have a vote in committee and all other privileges afforded members, I cannot vote on the floor of the House. Being a physician and the first woman physician to have served in the Congress were key for me, providing visibility and a voice on issues of national concern. Particularly instrumental was being appointed to lead the Health Braintrust of the Congressional Black Caucus (CBC),

whose goal it is to eliminate disparities in health and health care for African Americans and other people of color. It is through this influential post that I have been able to take my practice to the larger national office and also help address the social and economic determinants of health that were as much a part of my practice in St Croix as were disease and illness.

Beyond bringing my medical experience and knowledge to Capitol Hill, I feel that I have also brought some of the art and the ethics of the practice of medicine to the process and approach to legislating and shaping policy.

The skills honed through the diagnostic process help me to get to the heart of an issue. My scientific background and the practice of evidenced-based medicine have enabled me to apply the same principles to deciding my positions on a given issue—not just in health but on every bill or policy before us. It is most disconcerting to observe that far too often legislation and policy are set in direct conflict with what science has informed.

As a family doctor, I learned how to listen to my patients and to hear what they were saying and what they were not. Sometimes, I wonder if my colleagues listen at all.

My public health background has taught me the principle of prevention—especially primary prevention—which can be applied to almost all health problems we can think of.

During my 21 years as a physician I have been sensitized to the issues that affect the well-being of people, and it is that sensitivity, more than politics or my own personal ideology, that becomes the yardstick by which I measure what I do.

On such issues as affordable drugs, universal coverage, health disparities, global health, stem cell research, needle exchange, and many others I do not have trouble deciding which side I must support—the ethics of medicine and the imperative to do no harm and to respect, preserve, and protect life remain my guide.

I am proud that, as a member of Congress, I have been able to be at the forefront of groundbreaking legislation in minority health. The Minority AIDS Initiative was the first funding designed to build the capacity of the frontline minority community health and faith-based organizations to address the HIV/AIDS epidemic.

In 1999, my CBC colleagues and I were able to make a direct appeal to the Advisory Committee on Immunization Practices which advises the Centers for Disease Control to recommend the extended use of vaccines in children aged 2 to 5, a critical age for minority children. It has been proven to have made a dramatic difference in their health.

Another accomplishment of which I am proud is my association with the creation of the National Center on Minority Health and Health Disparities in the National Institutes of Health which is important to the support and coordination of minority health research.

In order to address minority health disparities, the Tri-Caucus, (the CBC, the Hispanic Caucus and the Asian Pacific Islander Caucus) with support from the Democratic leadership has introduced the Health Care Equality and Accountability Act of 2005. It addresses improving access to health care, ensuring culturally competent care, and encouraging minorities to enter the health professions.

It is not my intention to remain a member of Congress for life. At some point, I plan to return to some aspect of public health. I do manage to get a few continuing medical education credits every year, but medicine has changed so much that to go back into practice would require at least an intense refresher course.

Finally, I am very distressed by the disregard for physicians and our training, skill, and art and the low esteem and value placed on what we do. We have become a low-paid pawn in the corporate profit-driven, rather than care-driven, system. I hope I can play a part in changing that, but making that happen will require all of us to become more politically savvy and active.

I have much concern for the future health of our nation, and I hope that my medical colleagues who have the same skills I have brought to politics will use them to influence and help shape that future. No one group has more to bring to that debate. No one group can do it better.

Donna M. Christensen, MD, is serving her fifth term in Congress as delegate from the United States Virgin Islands. She practiced family medicine from 1975 to 1996 when she was elected to the House of Representatives. She was medical director of the Nesbitt Clinic in Frederiksted, VI, and medical director of the St Croix Hospital, as well as Territorial Assistant Commissioner of Health and Acting Commissioner of Health.

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Virtual Mentor

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Medicine and Society A Doctor in the House

by US Representative Dave Weldon, MD

In the summer of 1994, just 5 months before the general election, I decided to enter the race for the open US House seat in Florida's 15th Congressional District. I was motivated by serious concerns over the direction of our nation, particularly the efforts by then first lady, now Senator, Hillary Clinton to dramatically expand the federal role in health care delivery. Our system then and now has several serious problems. But the solution then being proposed, which would have driven most Americans into government-run healthcare, seemed unacceptable.

When I was first running, I was torn regarding the notion of leaving my patients if I won the election. I had spent many years in medical training and serving in the Army and had only been in private practice 8 years. I was successful, I enjoyed what I was doing, and had some mixed feelings about possible success at the ballot box and a sudden change of career.

Nonetheless, I ran for Congress enthusiastically, compelled by the belief that the values and policies I was fighting for were right for the nation and the community I lived in. I took advantage of my slight misgivings about victory by deciding from the outset that I would not compromise my moral beliefs and the public interest for the purpose of victory. I believe that philosophy has served me well through 5 re-elections.

Arriving in Congress in January 1995, I found myself in a sea of lawyers and businessmen. There were only 4 physicians among the 435 members of the House. I expected to be asked frequently to provide input on medical issues, and I have. Being an internist not only allowed me to speak with authority, it also gave me the opportunity to establish relationships with members across the political spectrum. House members have often approached me not only with policy questions but with medical questions involving themselves, their family members, and friends. This has opened lines of communication and friendships across the aisle that might otherwise not have been established.

One challenge I have faced is keeping up to date on the latest in internal medicine. The rules of the US House of Representatives required that I give up private practice, so I volunteer at a veterans clinic where I provide medical services on a monthly basis. Being a veteran myself, I especially enjoy this. It allows me to keep my hand in medicine and serve those who have given so much to protect the freedoms that we enjoy today. Staying current is difficult. So before heading to the airport each week, I often grab a handful of medical journals to read on the flights between Florida and Washington, DC.

Over the years I have drawn on my medical knowledge and background for a host of health care debates such as those involving Medicare reform and solvency, prescription drug costs, medical malpractice reform, and health care inflation, to name a few.

My background and knowledge in medicine have also led me to play a role in a number of policy debates involving medical ethics. This has included debates about physician-assisted suicide, the use of medical marijuana, judicial orders for the withdrawal of life-sustaining care, abstinence education and parental consent regarding juvenile access to contraception and abortion services.

What I was not expecting when I first ran for Congress was the degree of involvement I would have on a number of bioethical issues. These include the criminalization of attempts at human cloning and the use of taxpayer dollars to fund research that will involve the creation, use, and ultimate destruction of human embryos. Related to the debate is a medical ethics component. Human cloning and human embryonic stem cell research will require human eggs in large numbers and, therefore, women donors. If we say human cloning and embryo research is okay, have we just turned women into a commodity for their eggs?

Bioethical and medical ethics debates seem to arise continually. In recent years the Congress has been funding research in the field of nanotechnology. Nanotechnology has the potential to lead to breakthroughs in a host of areas such as electronics, material science, and medical care. Today, however, some are discussing the potential for nanotechnologies to be applied as “human enhancements.” We all would love to see nanotechnology emerge as a tool to extend sight to the blind or heal people with neurological disabilities. But, what about more subjective applications or trans-humanistic goals?

It is critical that we begin asking these questions and start having this discussion now. A thorough public policy debate is critical but it must be based on science, substance, and standards (ethics). Leave out any one of these components and you have a recipe for failure. Let us learn from the past as we press on to the future.

Dave Weldon, MD, of Melbourne, Florida, is an Army veteran and physician who was first elected in 1994 to represent Florida's 15th Congressional District. Dr Weldon's medical degree is from the State University of New York's Buffalo School of Medicine, where he was accepted into the Alpha Omega Alpha Medical Honor Society. He completed his residency in internal medicine at the Letterman Army Medical Center in San Francisco.

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Medicine and Society

Assessing Physician Legislators

by Allison Grady

The 109th Congress comprises an impressive variety of people. Between the House of Representatives and the Senate there are 82 women, 43 African Americans (only 1 in the Senate, however), 28 Hispanics, and 141 with records of military service [1]. Overwhelmingly, most of those serving in the federal legislature have had previous careers as state legislators, congressional staffers, or public servants [1]. There is also a small but outstanding group of Congress members who share a past different from all others: these 17 legislators have medical degrees. As physicians, these men and women have the ability to understand the bedside issues of health and health care better than their congressional peers, and they can more easily grasp the interconnectedness that these intimate situations have with politics and policy making. In their roles as elected officials, these physicians possess a unique body of knowledge, and this knowledge and subsequent power can be exploited or manipulated, or it can be used for good ends. This article will look at 4 physician-congressmen—2 in the House and 2 in the Senate—to examine the degree to which each identifies himself as a physician in his political role, understand how the medical background of each may have influenced his decisions to introduce or support specific legislation, and assess how successfully each manages his dual role.

Some history about physicians in the legislature will establish a context for this discussion. Since the first Congress, there have been a total of 47 Senators who have studied medicine, 10 of whom did not practice (6 of those 10 studied both law and medicine and chose careers in law) [2]. Despite this strong history, there were no doctors serving between 1935 and 1959, and there was a gap again between 1969 and 1995. A 2004 article in the *Journal of the American Medical Association* entitled “Is There a Doctor in the House...or the Senate?” observes that, unfortunately, “as the political salience and economic impact of health care in the United States have increased, physicians have taken a smaller role as congressional members” [3]. Authors Kraus and Suarez offer several hypotheses for this trend including financial concerns—most physicians today are making as much money (if not more) practicing medicine as they would as US Congress members—and the decline in numbers of physicians in the US relative to members of other professions, particularly attorneys who top the list of professions of legislators. One of the most fascinating reasons that the authors suggest for the decline of physicians in politics is that there has been a “general decrease in professional morale among physicians, precipitated by an increased workload, changes in practice driven by managed care and biotechnology, lower reimbursements, and increasing expectations from health care consumers” [3]. Kraus and Suarez believe that the current demands and stress of medical practice leave many feeling that civic

participation is unnecessary or too difficult to manage along with their other obligations. [3] Physicians may have faded in *number*, but today there are 2 powerful, outspoken physicians in the Senate. Those men are Dr Bill Frist, R-Tennessee, and Dr Tom Coburn, R-Oklahoma. In the House of Representatives, while there are more than 2 doctors, I will take as examples Drs Phil Gingrey, R-Georgia, and Joe Schwarz, R-Michigan.

Identity as a Physician-Politician

These physicians do not have expertise in the same medical specialties, and they serve different constituencies; nevertheless there are similarities among the 4. All are Republicans, all were practicing medicine when they were elected to the Congress (and some still are), and each has used his medical knowledge while serving his respective branch of the legislature. But how each man goes about this is different. Three of the 4 draw their identities as much from their medical professions as from their political careers.

This year Representative Phil Gingrey has combined his medical knowledge and his political reach to call the attention of Georgia citizens to important facts and information about the “bird flu,” the need to spend health care dollars (specifically Medicare dollars) more effectively, and the role of preventive medicine in Medicare, all through newspaper op-eds. In 3 separate publications Gingrey prefaces his writings with the phrase “as a physician” before he continues to make his medical *as well as his political* point [4-6]. A review of his most recent articles indicates that Gingrey does not take strict partisan positions, but he does call upon his role as a physician to add weight to arguments that carry political consequences.

Similarly, Senator Bill Frist has emphasized his role as a physician-congressman in a variety of political ways. He has relied upon his training to assess the threat of cholera, malaria, and typhoid in Southeast Asia following the 2004 tsunami; in 2001 he wrote a book entitled *When Every Minute Counts: What You Need to Know About Bioterrorism from the Senate's Only Doctor* [7]. Frist also employed analogies of healing and diagnostic skills in his 1994 campaign [7]. Clearly Senator Frist is proud to be a physician when he declares, “Every morning I get up, I see a physician. . . . I spent 20 years, every day, getting up and looking at that mirror and seeing a heart surgeon” [7]. Like Gingrey, Frist makes little-to-no effort to separate the physician from the politician.

This willingness to combine medical training and expertise with politics is seen, perhaps most strikingly, in Senator Tom Coburn. Senator Coburn has sponsored a lecture/slide show on a current public health topic for congressional staffers and Congress members annually since he began in Washington politics in the 1990s. In 2005 he premiered a slide show entitled “Revenge of the STDs” to a roomful of mostly speechless colleagues [8]. Like Representative Gingrey, Senator Coburn has pushed the issue of preventive medicine and the need to limit frivolous or excessive medical lawsuits [9]. Coburn has been an outspoken advocate of the pro-life movement and has called upon his expertise as a physician who has delivered more than 4000 babies to oppose expansion of stem cell research and abortion.

Representative Joe Schwarz stands alone in this group of 4 as a more seasoned politician who does not explicitly see being a physician as an inseparable part of his political identity. Before going to Washington he served in the state legislature where, as the only physician, he was called upon frequently as a medical expert. Today he does not highlight his medical background nearly as much as his role as an education advocate who wants to ensure that the Congress is “keeping the avenues of scientific and medical research open to our young people” [10].

Introducing and Supporting Legislation

Although these congressmen must personally decide how to vote on a proposed bill, they must also, as representatives of constituencies, take into consideration how those who elected them want them to vote. Each of the profiled men is active in health care issues, and a look at their records shows how their medical backgrounds influence their decisions about medically related topics.

Gingrey has a record of supporting legislation to prevent the spending of Medicare monies on certain drugs. He writes, “As a physician and a Member of Congress, I support...introduced legislation in the U.S. House to prevent federal dollars from being spent on drugs for sexual dysfunctions. I am a proud co-sponsor of this legislation” [4]. Gingrey also introduced a medical reform bill—HR 5, also known as the HEALTH Act—which passed in the House in July. The goal of the bill was to “discourage[s] baseless lawsuits by limiting the incentives for filing meritless claims, including placing limits on non-economic and punitive damages” [11]. Recently, Gingrey also sponsored health care bills for Hurricane Katrina victims. It is clear that Gingrey’s health care background has influenced the themes of his bills and that he has succeeded in bringing his first career as a physician to bear on his new one as a representative.

As the majority leader in the Senate, Bill Frist serves as the chief spokesperson for the Republican senators, and he manages the legislative and executive business of the Senate [12]. It is in this capacity that he works very closely with the Bush administration; yet there are times when Frist abandons his coordinator role and speaks more passionately and personally about current bills in the Senate. Two recent examples occurred in the debates about Terri Schiavo and the stem cell legislation. During the Schiavo debates Frist began “speaking more as a physician than as a United States Senator” and wanted to “really speak to my involvement as a physician and—and as a Senator as leader in the United States Senate in what has been a fascinating course of events...” [13]. Many of his subsequent comments angered his fellow doctors to the point where 31 of his former medical school classmates sent him a letter accusing him of improperly using his medical degree [14]. This speech left little doubt that Frist was willing to leverage his knowledge as a doctor to achieve a political end. During the stem cell debate, to the surprise of some, Frist broke from the Bush administration and decided to support fewer restrictions on embryonic stem cell research by declaring:

I’m a physician. My profession is healing. I’ve devoted my life to attending to the needs of the sick and suffering and to promoting health and well being. For the past several years, I’ve temporarily

set aside the profession of medicine to participate in public policy with a continued commitment to heal...stem cells offer hope for treatment that other lines of research cannot offer [15].

Despite having one of the most consistently conservative records, Frist has recently shown a willingness to allow his medical judgment to guide some of his most controversial votes—even when they seem to be atypical of his voting trends.

Back in the House, Representative Schwarz has a voting record that demonstrates his interest in both medicine and education. Recently, he has co-sponsored HR 1227, the Genetic Information Non Discrimination Act which “expand[s] the prohibition against discrimination by group health plans and health insurers in the group and individual markets on the basis of genetic information” [16]. Schwarz also co-sponsored HR 4166, the Family Asthma Act that would allow the “National Institutes of Health to improve asthma management and increase our knowledge of the environmental and genetic links to asthma. It also increases funding to the Centers for Disease Control to increase the CDC’s educational efforts with state, local and nonprofit partners...” [16]. Representative Schwarz supported the Stem Cell Research Enhancement Act and Gingrey’s HEALTH Act.

Senator Coburn’s legislative record also prominently features health care bills. In June of 2005 he introduced the Parent’s Right to Know Act that “mandate[s] that parents be notified five business days before contraceptive drugs and prescription devices are distributed to their minor child by Title X clinics” [17]. Coburn said that he decided to introduce this legislation because “as a practicing family physician, and as a member of Congress, I have seen first-hand the painful consequences associated with our federal policy...” [17]. Coburn also explicitly declared that he was at odds with Senator Frist in regards to stem cell research and wrote that “at the dawn of what will likely be the biotech century, advocating taxpayer-funded destructive experimentation on human embryos that will be ‘thrown away anyway’ would set us on a dangerous course” [18, 19]. As a counter to the Stem Cell Research Enhancement Act, Senator Coburn introduced the Respect for Life Pluripotent Stem Cell Act of 2005.

Managing the Dual Role

It is never easy to work multiple jobs, let alone juggle a political career with the responsibilities and privileges that come with a medical career and, for some, limited medical practice. These 4 men have worked hard to maintain integrity in both of their professions, and they have met this challenge with mixed results.

Representative Gingrey is founder and co-chair of the Medical and Dental Doctors in Congress Caucus. He has chosen to remain active in health care beyond policy and practice and has volunteered his medical skills to help in the event of a Capitol-area emergency. In November 2005 “Gingrey was briefed on the location and operation of emergency medical equipment, so he can quickly assist others in the case of an emergency” [20]. Gingrey spent part of his summer traveling throughout Georgia to hold town hall-style meetings to explain and promote the Medicare Part D program. One doesn’t often see Representative Gingrey in the national media spotlight, but it

seems that he has worked hard to keep political pressures from overwhelming his medical judgments.

Senator Frist has recently found himself in medical and political hot water. Following the Terri Schiavo floor speech, his medical judgment was called into question by fellow physicians and the media alike. Earlier this year, while discussing the importance of abstinence-only education, Frist was asked on ABC's "This Week" if AIDS could be contracted through tears or sweat and he answered, "I don't know" but later conceded that "it would be very hard" [7]. According to the Centers for Disease Control and Prevention, "contact with saliva, tears or sweat has never been shown to result in transmission of HIV" [7]. But Frist's willingness to openly break from the White House position by supporting the Stem Cell Research Enhancement Act has demonstrated that his medical judgments can trump loyalty to the administration when necessary. Some have also criticized Senator Frist for trying to be both a doctor and a powerful politician by saying, "He should stop being a doctor and be a politician. He can't have it both ways" [7]. As Frist's political power and star continue to rise in Washington, his ability to stick stubbornly to traditionally conservative ideals may come increasingly into conflict with his scientific and medical knowledge, and, as he weighs a run for the Presidency, his ability to balance medicine with politics will be severely tested.

Representative Schwarz has been able to balance being a physician and a politician with apparent ease. He has had the fortune of representing a district that is surrounded by institutions of higher learning that often support his educational and occasionally controversial medical initiatives. Much like Representative Gingrey, Schwarz has stayed away from the national media spotlight. Within his own district, his long record as state senator, a member of the city commission, and mayor has allowed his constituents to come to know his positions, both medical and political.

Finally, Senator Coburn has had perhaps the most volatile experience trying to balance his physician and politician selves. In 1998, while in the House of Representatives, Coburn threatened to leave office because of the ethics rules that severely limit a congressman's ability to practice medicine and do not allow physician-congressmen to make a profit from their practices [21]. At the time, Coburn stated that "If I can only practice medicine or only be in Congress, I'll practice medicine" [21].

Coburn has also appealed to his medical skills to form unconventional and, at times, inflammatory points of view, and those have been expressed on influential shows such as "Meet the Press." During his Senate race in 2004 Coburn stated that he believed that doctors who performed abortions should face the death penalty. Consider this exchange with Tim Russert on October 3, 2004:

Coburn: Tim...as a doctor that's delivered 3,500 babies, cared for every complication of pregnancy you can imagine and have seen the procreation and creation at it's earliest states, you know, I believe when we take innocent life intentionally...we are violating moral law.

Russert: But you think the death penalty would be an appropriate penalty in that situation.

Coburn: If somebody intentionally takes life at any stage throughout the country, except to save a life, and that's innocent life, I think we have to use the law that's on the books to respond to that. I sure do [22].

In November of 2005, Coburn stated that he relied upon his training as a physician to ascertain whether people testifying before Congress were telling the truth. During the John Roberts Supreme Court hearing he told Mr Roberts, "I've tried to use my medical skills of observation of body language to ascertain your uncomfortableness and ill at ease [sic] with questions and responses. I will tell you that I am very pleased both in my observational capabilities as a physician to know that your answers have been honest and forthright" [23]. When asked by Tim Russert whether there were other times when his skills as a physician helped him to determine someone's honesty during Senate proceedings, Coburn answered, "Yeah. And then what you do is you go...and see where the problem is and all of a sudden you find, wait, this isn't truthful" [23]. Taken at face value, Coburn's comments can lead one to question whether his dual allegiance may cause him to make judgments that cast a doubt over the plausibility of mixing medicine and politics.

Conclusion

Physicians and politicians hold special places in the American occupational landscape. These are 2 of the most influential positions one can hold, and it is rare today for a person to hold both esteemed positions in a lifetime. Physicians are entrusted with the life and the health of individuals and the greater population. They are told intimate truths by their patients; they have the ability to cure and heal and, likewise, they have the ability to harm and kill. Because of this extremely sensitive and powerful role, physicians are widely trusted and held in highest esteem. In return, they are expected to remain educated and up-to-date on innovations, to use science and direct evidence to come to their conclusions, and to hold themselves above political posturing.

Politicians, specifically legislators, make laws and debate the important issues of the land. Because they are elected by local constituents, politicians often are compelled to vote with "the party." A politician holds his or her job only as long as the voter is happy with his or her record, and awareness of this fact leads many politicians to make judgments they might not otherwise have made. Therefore, when politicians combine their objective, medical judgments with the necessarily subjective political obligations, the result can be a record that reflects a collision of science, professional obligations, public opinion, and party unity.

This piece has looked at 4 men who find themselves at the junction between politics and medicine. Each has chosen a unique approach to his role and each has managed his political position differently. But there is one common thread: medicine is never far from the consciousness of each, and each is astutely aware that he holds an unparalleled place of influence in this country.

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Op-Ed

Citizen MD

by Paul Costello

I'm afraid we live in loopy times. How else to account for the latest entries in America's culture wars: science museum docents donning combat gloves against rival fundamentalist tour groups and evolution on trial in a Pennsylvania federal court. For those keeping score, so far this year it's Monkeys: 0, Monkey Business: 82. That's 82 evolution versus creationism debates in school boards or towns nationwide—this year alone. [\[1\]](#)

This past summer, when most Americans were distracted by thoughts of beaches and vacations or the high price of gasoline (even before the twin hits of Katrina and Rita), 2 heavy-weight political figures joined the President of the United States to weigh in on a supposedly scientific issue. US Senate Majority Leader Bill Frist, Arizona Senator John McCain, and President George W. Bush each endorsed the teaching of intelligent design alongside evolution in the science classroom. Can anyone reasonably convince me that these pronouncements were not just cynical political punditry but, rather, were expressions of sincere beliefs?

So you have to ask yourself in light of all of these events, are we headed back to the past with no escape in the future? Are we trapped in a new period of history when science, once again, is in for the fight of its life?

In times like these, as inundated as we are by technical wizardry, one might conclude that American technological supremacy and know-how would lead, inevitably, to a deeper understanding or trust of science. Well, it doesn't. Perhaps just the opposite is true. Technology and gee whiz gadgetry has led to more suspicion rather than less. And a typical American's understanding of science is limited at best. As far as evolution is concerned, if you're a believer in facts, scientific methods, and empirical data, the picture is even more depressing. A recent survey by the Pew Forum on Religion and Science found that 64 percent of respondents support teaching creationism side by side with evolution in the science curriculum of public schools. A near majority—48 percent—do not believe that Darwin's theory of evolution is proven by fossil discoveries. Thirty-three percent believe that a general agreement does not exist among scientists that humans evolved over time [\[2\]](#).

What if we become a nation that can't chew gum, walk down the street, and transplant embryonic stem cells all at the same time? Does it matter?

New York Times journalist Cornelia Dean, who balances her time between science reporting for the *Times* and lecturing at Harvard, told me that she believes that science stands in a perilous position. “Science, as an institution, has largely ceded the microphone to people who do not necessarily always embrace the scientific method,” she says. “Unless scientists participate in the public life of our country, our discourse on a number of issues of great importance becomes debased” [3].

Others, such as journalist Chris Mooney, point to the increasing politicization of science as a pollutant seeping into our nation’s psyche. In his recent book, *The Republican War on Science*, Mooney spells out the danger of ignorance in public life when ideology trumps science.

Science politicization threatens not just our public health and the environment but the very integrity of American democracy, which relies heavily on scientific and technical expertise to function. At a time when more political choices than ever before hinge upon the scientific and technical competence of our elected leaders, the disregard for consensus and expertise—and the substitution of ideological allegiance for careful assessment—can have disastrous consequences [4].

Jon D. Miller, PhD, a political scientist on faculty at Northwestern University’s School of Medicine, believes that the sophisticated questions of biology that will confront each and every American in the 21st Century will require that they know the difference between a cell and a cell phone and are able to differentiate DNA from MTV. For decades, Miller has been surveying Americans about their scientific knowledge. “We are now entering a period where our ability to unravel previously understood or not understood questions is going to grow extraordinarily,” says Miller. “As long as you are looking at the physics of nuclear power plants or the physics of transistors [all 20th Century questions]...it doesn’t affect your short-term belief systems. You can still turn on a radio and say it sounds good but you don’t have to know why it works. As we get into genetic medicine, infectious diseases...if you don’t understand immunity, genetics, the principles of DNA, you’re going to have a hard time making sense of these things” [5].

Culture Wars and 82 Evolution Debates

Yet in some corners today, knowledge isn’t really the problem. It’s anti-knowledge that is beginning to scare the scientific community. Glenn Branch, deputy director of the National Center for Science Education, calls 2005 “a fairly busy year” when he considers the 82 evolution versus creationism “flare-ups” that have occurred at the state, local, and individual classroom levels so far. According to a spring 2005 survey of science teachers, the heat in the classroom was not coming from Bunsen burners or exothermic reactions but rather from a pressure on teachers to censor. The National Science Teachers Association’s informal survey of its members found that 31 percent of them feel pressured to include creationism, intelligent design, or other nonscientific alternatives to evolution in their science classroom [1]. Classrooms aren’t the only places feeling the heat. Science museums have also become conflict zones. In her *New York Times* article, *Challenged by Creationists, Museums Answer Back*, Dean detailed special

docent training sessions that will enable the guides to be better armed “to deal with visitors who reject settled precepts of science on religious grounds” [6].

These ideological battles aren’t likely to vanish any time soon. If anything, an organized and emboldened fundamentalist religious movement buttressed by political power in Washington will continue to challenge accepted scientific theory that collides with religious beliefs. So one must ask, is it too farfetched to see these ideological battles spilling over into areas of medical research and even into funding at the National Institutes of Health?

Now I am not asking for a world that doesn’t respect religious belief. My education as a Roman Catholic balanced creed and science. In the classroom of my youth, one nun taught creationism in religion class while another taught evolution in science, and never the twain did meet.

Where Is the Medical Community?

The medical community as a whole has been largely absent from today’s public debates on science. Neither the American Medical Association nor the American Psychiatric Association has taken a formal stand on the issue of evolution versus creationism. When physicians use their power of political persuasion in state legislatures and the US Congress, it’s generally on questions more pertinent to their daily survival—Medicare reimbursement, managed care reform, and funding for medical research. Northwestern’s Miller believes that the scientific community can’t fight the battle alone and that, as the attacks against science accelerate, the medical community will have to use its privileged perch in society to make the case for science. “You have to join your friends, so when someone attacks the Big Bang, when someone attacks evolution, when someone attacks stem cell research, all of us rally to the front. You can’t say it’s their problem because the scientific community is not so big that we can splinter 4 or more ways and ever still succeed doing anything” [5].

So what does one do? How can a medical student, a resident, or a physician just beginning to build a career become active in these larger public battles? Burt Humburg, MD, a resident in internal medicine at Penn State’s Hershey Medical Center, is one role model. He’s been manning the evolutionary ramparts since his medical school days in Kansas in the late 1990s when he became active in Kansas Citizens for Science. On a brief vacation from his residency volunteering as a citizen advocate for the federal trial in Pennsylvania, he said education is the key role for the physician. While he realizes that medical students, residents and physicians might not view themselves as scientists, per se, he sees himself and his colleagues as part of the larger scientific collective that can’t afford to shirk its duty. “The town scientist *is* the town doctor, so whether we want it or not, we have the mantle—the trappings—of a scientist” [7].

It is time for the medical community, through the initiative of individual physicians, to address not only how one can heal thy patient, but also how one can heal thy nation. There are many ways to get involved; from the most rudimentary—attending school board meetings, sending letters to the editor, and volunteering at the local science

museum—to the more demanding—running for office, encouraging a spouse or partner to do so, or supporting candidates (especially financially) who are willing to speak out for science. As Tip O’Neill, the larger-than-life Speaker of the House of Representatives, famously declared, “All politics is local.” Speak out for science. Isn’t that a message that should be advanced in every physician’s office?

Northwestern’s Jon Miller concedes that speaking out may come with a price, “It won’t make...[physicians]...popular with many people but is important for any profession, particularly a profession based on science” to do so [5]. Consider this: shouldn’t civic leadership be embedded in the mind of every blooming physician? In the end, doesn’t combating this virulent campaign of anti-knowledge lead us back to that old adage of evolutionary leadership by example, “Monkey see, monkey do?” Seize the day, Doc.

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