Virtual Mentor
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Exploring Professionalism

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FROM THE EDITOR

A Good Walk Spoiled

Audiey Kao, MD, PhD

Golf is addictive. Based on observations of family and friends, the golfers among us seem to spend a disproportionate amount of their free time in pursuit of this game. Decisions about where they vacation are regularly contingent on whether the destination has a highly touted course of the 18-, 36- or 54-hole variety. Spouses who golf together also seem happier than those in marriages where one spouse golfs and the other doesn't. Finally, golf has reached such prominence in our society that most of us, even those who wouldn't know a birdie from a bogey, would recognize Tiger Woods.

It is also a well-known truth that golf and medicine share a certain bond. Many physicians are avid golfers, especially those who have retired. In medicine, a standing joke is that it's nearly impossible for patients to get a hold of their doctors on a sunny Wednesday afternoon. Many medical organizations commonly use golf tournaments as a means of raising money. To my knowledge, there have never been any scientific studies that examined whether genetic factors contribute to the metaphysical relationship between physicians and golf. But I wouldn't bet against the presence of an autosomal recessive gene that contributes to the link between playing golf and practicing medicine.

Mark Twain used to joke that "golf is a good walk spoiled." In traveling and speaking to physician audiences, I often find that the majority of those in attendance are retired and that many of them are golfers. First, retired physicians are more likely to attend because, even with tee time factored in, they have more free time on their hands than practicing doctors. Second and, to me, more importantly, those who are retired want to retain a connection to medicine and their past professional identities. By attending such gatherings as my presentations, physician retirees can keep abreast of the major ethical and professional issues confronting medicine and interact with their physician colleagues at the same time. I have also noticed that since the tragedies of last September 11, many retired physicians that I have been fortunate enough to meet very much want to contribute their time if not their expertise to help others.

While golf, especially if you walk and carry your own bags, is an excellent way for older individuals to engage in regular physical activity, I would say to my colleagues of earlier generations that your willingness to continue contributing to our profession is welcome and more necessary than you may think. For example,

students of medicine would undoubtedly benefit from your experience and wisdom. Given the current challenges facing medicine, students and new physicians could well use a reminder of the profession's timeless core values. Therefore, I encourage physicians, retired or not, to volunteer to serve as mentors by registering for our Physician Mentor Registry. In addition, please stayed tuned for breaking developments on the planned launch of a world community service campaign, the success of which will depend on the help of all physicians.

I look forward to my next online opportunity to share some thoughts with my colleagues. In the meantime, here's wishing you a hole-in-one.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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CASE AND COMMENTARY
The Physician's Role in On-Duty Injury Claims
Commentary by Rita Mitchell

Case
A father of three and the sole provider for his family, KC is a loading dock maintenance worker at Peterson Memorial Hospital. He presents to the Department of Employee Health Services complaining of severe lower lumbar pain, and tells the Health Services physician that he injured his back while shifting heavy boxes around on the dock. The Health Services physician advises KC to seek treatment with his primary care physician, Dr. Carlson. Dr. Carlson has been KC's physician for many years, and the 2 enjoy a close and trusting patient-physician relationship.

Dr. Carlson notes the evidence of severe pain when KC is instructed to perform physical tasks and authorizes him to be "off duty." KC continues off duty for a period of 24 weeks, during which time Dr. Carlson notes his continued complaint of the inability to bend, twist or to reach overhead without feeling a sharp pain that radiates downward. During the treatment course, X-rays and an MRI confirm that KC has significant injury to his back.

Dr. Carlson provides Dan, a third-year medical student who is completing a medical rotation in Internal Medicine, with the opportunity to participate in KC's follow-up care. During a lunch break one afternoon, Dan joins two other medical students who are discussing recent sports activities. As the two medical students talk about a friendly game of afternoon football that ended abruptly when one of the players injured his back, Dan soon realizes that the injured party is KC. The 2 students agree that KC was hurt pretty badly and would require extensive and long-term rehabilitation.

At KC's next clinic visit, Dan questions him about the cause of his injury. KC acknowledges that he was really injured playing football but asks Dan not to tell Dr. Carlson how the injury occurred and even offers to pay for Dan's silence. KC explains that if he loses his Workers' Compensation benefits, he fears that he will lose more than his ability to care for his family; he is afraid he will be prosecuted for fraud and asks Dan to help him out because, after all, only KC and Dan would know.

Questions for Discussion
1. Should Dan inform Dr. Carlson of his conversation with KC or keep the matter in confidence?

2. Does a patient-physician relationship exist between KC and Dan? Would Dan violate patient-physician confidentiality by telling Dr. Carlson what he knows? See what the AMA *Code of Medical Ethics* says about this topic in Opinion 10.01. Fundamental elements of the patient-physician relationship. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998. What are KC's responsibilities in this matter? See what the AMA *Code of Medical Ethics* says about this topic in Opinion 10.02. Patient responsibilities. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.
3. Do you believe that Dan's silence is justified to avoid personal harm or hardship to KC and his family?
4. How might Dan's action in this case affect his medical education or his medical career? See what the AMA *Code of Medical Ethics* says about this topic in Opinion 9.04. Discipline and medicine. American Medical Association. *Code of Medical Ethics 1998-1999 Edition*. Chicago, IL: American Medical Association; 1998.

Rita Mitchell is a research assistant in the AMA Ethics Standards Group.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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IN THE LITERATURE
Competence and Professionalism
Sam Huber

Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226-235.

Quality assessment and competency-based training are hot topics in medical education. Defining competence and validating performance measures are the major sticking points thus far in developing a systematic approach to evaluation. In a review of the relevant literature and their own experience in developing novel medical curricula, Drs. Ronald Epstein and Edward Hundert synthesize a prescriptive definition of professional competence and present their own views on assessment in a recent *JAMA* article, "Defining and Assessing Professional Competence".[1] Integrating current thinking about medical education and professional assessment, the authors set the stage for the next round of medical culture and curriculum design.

Competency-based assessment is a common idea in business and management circles. There are even companies with validated competency measures for certain industries.[2] The Accreditation Council for Graduate Medical Education has led the way in identifying and requiring certain competencies in residency training. It is anticipated that future licensing requirements at all levels of medical education will require some sort of competency-based assessment, rather than just coursework and time-based standards. In the rush to embrace a popular new idea, few have taken the time to consider substantively and systematically the skills, attitudes, levels of knowledge, and behaviors of a competent physician, and how these standards may be measured. Epstein and Hundert recognize the need to use evidence-based critiques for assessment standards in medical practice just as they would be used on any scientific innovation.

Epstein and Hundert pose the following definition of professional competence: "*the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served*." They describe dimensions of competence in cognitive, technical, integrative, context, relationship, affective/moral, and habits of mind categories. They add that, "professional competence is developmental, impermanent, and context-dependent."

A definition of professional competence is only as useful as it is measurable. In the manner of a review article, the authors have identified the relevant medical literature on assessment, with specific inclusion criteria and search strategies, and then synthesized the data around trends in performance measurement. Not surprisingly, multiple-choice examination, subjective supervisor assessment, and standardized patient encounters were found to be the most commonly used methods for professional evaluation. The authors found disagreement about the validity of such methods in certain situations and about the relationship between test scores and success as a physician. Defining criteria for evaluation is a complex endeavor, and test reliability has been challenged by many authors. From their literature survey, Epstein and Hundert meditate on the normative purposes of assessment and offer some suggestions for creative improvement in assessment technique, some of which have been validated already. Assessment is addressed as formative rather than evaluative, with benefits to the trainee, the curriculum, the institution, and as a trust-building mechanism for the public.

The relationship of the authors to medical education adds weight to the article's findings and conclusions. Hundert is dean at the University of Rochester School of Medicine and Dentistry and the main designer of the integrative curriculum used there. Epstein is involved in a student assessment program at Rochester that models many of the innovations proposed in their article. Given the authors' proximity to assessment and interest in competency development, both their definitions and suggestions appear practical as well as aspirational.

Epstein and Hundert speak to competence as a form of professionalism. While ethics is explicitly addressed only briefly, the undertone of the entire article suggests that a commitment to competence and excellence is a way of ensuring a culture of ethical behavior. Since many of their competencies are based in communication skills and the patient-physician relationship, success in the Epstein-Hundert paradigm serves as a kind of ethics dilemma prophylaxis. Although such an approach may sound like virtue theory, it serves their model of defining and assessing competence on a continuing basis and in a context-dependent manner.

Questions for Discussion

1. Ethics and moral reasoning are mentioned briefly, and only in passing in this article, but are undoubtedly important to competence as well as to the authors. Do "ethics competencies" comprise what amount to a virtue-ethic, and if so, does this alter the importance of codes or moral reasoning in clinical practice?
2. Is the role of competencies aspirational, normative, or descriptive?

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MEDICINE AND SOCIETY
Medical Oaths and Codes of Ethics
Audiey Kao, MD, PhD

With the aim of encouraging greater understanding of the importance of medical oaths and codes of ethics, we offer our readers who are teachers of medicine a PowerPoint® presentation that can be easily adapted for medical students, residents, and other physician audiences. This presentation provides a brief historical overview of medical oaths. Through the use of ethical scenarios, the presentation also highlights how the AMA's *Code of Medical Ethics* can provide valuable guidance to students and physicians who confront challenging issues in medicine.

Shaping Professionalism: Medical Oaths and Codes of Ethics [PowerPoint® presentation]

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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ART OF MEDICINE
Doctor and Doll
Mary Winkler, PhD

Norman Rockwell described the essence of his artistic approach thus: "I guess I am a storyteller, and although this may not be the highest form of art, it is what I love to do."[1] His chosen style was realism, intensified by a rigorous attention to closely observed detail, and his chosen subject was the commonplace.

In response to the current exhibition of his work at the Guggenheim Museum, there is renewed interest in his vision of American life and in his artistic status. For decades, while critics scorned his paintings as morally simplistic and artistically retarded, the general public has embraced both his vision and his naturalism. Now many critics are recognizing virtues that generations of viewers have seen. Perhaps our "period eye" is more attuned to the pleasures and merits of realism than that of the twentieth century critic who easily recognized and assimilated the visual cues of abstraction. Moreover, the so-called culture wars of recent years have revealed a vein of desire for an unshaded moral universe—for innocence.

This is where the paradoxes in Rockwell's work play their role. Certainly Rockwell's world is one where simplicity, goodness, and innocence are revealed and celebrated. Rockwell confessed that he couldn't "paint evil sorts of subjects."[2] Yet he finds his subjects not among the privileged, the beautiful, and the talented, but among the recognizably ordinary, the gawky, the wholesome, the plain. His subjects are innocents who often arouse a somewhat amused indulgence. Simultaneously, they serve as reminders that the world is never unambiguously innocent. That is the source of the paradox and of the viewer's tender protective response.

As Arthur C. Danto observed, "Rockwell not only shows us situations with which everyone was familiar, he showed them as having the feelings that go with being in those situations. But more takes place in the typical reader than recognition. The reader is moved or touched by the feelings they display. And probably one is moved by the fact that one is moved, momentarily flooded with a feeling of warmth."[3]

This feeling of warmth may arise from an honest sentiment or it may be a gush of sentimentality—what has been defined as having more tenderness toward the subject than God would. Often the viewers of Norman Rockwell's work are uncertain which of these they are feeling. Perhaps both.

On March 9, 1929, *The Saturday Evening Post* cover was a Norman Rockwell vignette called "Doctor and Doll." It was one of hundreds of covers the artist painted on commission for that popular magazine. As was customary, the *Post* cover tells a story. A little girl, perhaps 7 or 8 years old, has brought her doll to the doctor's office. The doctor, a grandfatherly man with twinkling kindly eyes, is gravely listening to the doll's "heart" with his stethoscope. The trio float on a spatial island that, by deleting the room surrounding, concentrates the meaning of the image on the actors. Every object and article of dress works to reveal the status and character of the actors of this little drama. The viewer ("reader" Danto would call him) can read from the somewhat battered roll-top desk, the medical books, the candle sticks, the homey hooked rug, the doctor's chair with its worn rungs and armrests, that the central actor is a country doctor of comfortable but modest means, long in practice. He wears a fine black suit, a white shirt with crisp collar and cuffs, gold cuff links, well-shined black shoes, a natty cravat, and a signet ring on the little finger of his right hand. His face is ruddy, perhaps weathered (Rockwell often chose his models from New England villages), and its contours suggest a habitual cheerful benevolence, even humor. The sense of his humanity is accentuated by the shock of unruly gray hair that is in contrast with his sartorial fastidiousness.

The little girl who stands facing him proffering her "baby" for examination is well-nourished and warmly dressed. (The viewer knows that she has come to the doctor's office because she is still wearing her red tam, scarf, coat, and rubber boots.) She has braved the wet and cold of early March to bring her doll for the doctor's cure. She stands formally, even rigidly before the physician. The anxious little mother knows the rituals of office examination because she has removed the doll's dress, tucking it under her arm.

The story the image tells is of perfect trust. The "good mother" brings her "baby" to the doctor as she herself has been brought. She knows and trusts the customary medical rituals because she knows and trusts the doctor. He accepts the trust and enters into the child's creative play, listening gravely to the heart that isn't there.

The viewer may smile tenderly or indulgently at the timeless moment. This magazine cover is, however, also a kind of historical document, belonging to a certain period in American medicine. It is illuminating to set Rockwell's visual narrative in the context of another nearly contemporaneous narrative about science and medicine: Sinclair Lewis' *Arrowsmith*, published 4 years earlier.

Arrowsmith is a veritable Pilgrim's Progress through the landscape of early 20th century medicine in which Lewis sends his protagonist Martin Arrowsmith on a search for self-knowledge and maturity. He turns an iconoclastic fervor on the array of scientific movements, social issues, and cultural fads that accompany Arrowsmith on his journey toward middle age and professional success. Arrowsmith encounters corruption, ignorance, careerism, and hypocrisy as well as loyalty, kindliness, and fierce dedication to the principles of science. Lewis examines the etiquette of small-town practices and expensive clinics, attitudes

toward public health, the fascination with eugenics, the fear of socialism, and the rise of bacteriology and immunology, and he employs a naturalistic style to expose the flaws in his characters and in his society. Verisimilitude works to establish credibility.

Verisimilitude and attention to the details of their chosen milieux are what Sinclair Lewis and Norman Rockwell share. Both aim at bringing about a frisson of recognition. Ah yes, I have known or seen a situation or person like that. It is useful, therefore, to explore where their aims and purposes part company. There is the question of scope. Lewis' vision takes in the whole range of social and psychological issues, and he describes how they interact. Lewis is astute in perceiving the personal foibles, anxieties, and ambivalences that drive individuals and communities. *Arrowsmith* is both the study of one man's character and tonic social criticism. Rockwell, by contrast, selects vignettes, revelatory frozen moments that seek to remind the viewer of a kind of goodness that is simple and innocent.

Saturday Evening Post readers certainly knew about the social problems (public health measures, for example) that Sinclair Lewis examines. From *Arrowsmith* one reads what parents in the 1920s knew intimately: childhood was dangerous. Diphtheria, pneumonia, tainted food, influenza were scourges even affluent parents feared. Presumably many had encountered the kind of venal, inept, or ill-educated doctors that populate *Arrowsmith*.

"Doctor and Doll" simply ignores that world. Instead, Rockwell offers a vision isolated, timeless. Details enforce this isolation: the floating central tableau, the furniture that was already outmoded in 1929. One detail, however, is especially significant. On the doctor's desktop, tucked behind his books, is a small group portrait that looks like Rembrandt's study of the anatomy faculty. Our doctor's black suit and crisp shirt (no doubt as recognizable to his contemporaries as is the doctor's white coat of today) links him visually to those somber pioneers of medical science—and emotionally to all physicians. He is the Good Doctor.

Analyzing the cumulative effect of the Rockwell oeuvre, Danto posits that the illustrations show American people as we see ourselves, and asks: "Do the tender feelings Rockwell's images instill define the default state of the American persona?"[4] Do, then, the tender feelings "Doctor and Doll" instill define the default image of the doctor/patient relationship? Does this innocent interaction, so leisurely, so full of imagination and empathy and—perhaps—the tender condescension adults bestow on children—visualize for *us* an escape from the scientific, social, and ethical dilemmas and issues of *our* day? (It is not impossible to think that earlier *Saturday Evening Post* readers found it so.)

What might this default image represent? A flight from engagement with complexity? Or a refreshing but momentary contemplation of a kind of ideal?

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VIEWPOINT

Addressing End-of-Life Treatment Conflicts through Improved Communication

Audiey Kao, MD, PhD

One of the more challenging situations in clinical medicine occurs when patients and their physicians have differing opinions on the utility of life-sustaining treatments. Such conflicts over the use or futility of treatment often present in the following manner:

A 75-year old man with stage IV colon cancer is admitted to the hospital for a sudden change in mental status. An evaluation, which included a head CT and sepsis work up, revealed that the cause for his mental status change is uremia secondary to acute renal failure. After considering hemodialysis as an option, the attending physician recommends against it, given the patient's poor prognosis and the potential downsides of long-term hemodialysis. After the patient's wife hears the facts, she wants "everything done" and demands that the physician proceed with hemodialysis immediately.

In this case, the wife's demand for hemodialysis is driven, understandably, by her emotional response to the situation more than by her true grasp of the prognosis. The ensuing discussions will proceed more smoothly if the attending physician can bear in mind that the current hospitalization is one chapter in a long story for the patient and his family. Some chapters in this ordeal have been punctuated with hope and optimism that the patient's battle with cancer would conclude happily.

Confusion about the medical facts of the current incident can contribute to conflict between, in this case, the patient's wife and the physician. In helping the patient's wife understand her husband's present condition, the physician should avoid using jargon and technical language such as "vegetative state" or "hemodialysis" that confuse patients and their families. Because the use of medical terms and technical language is difficult to avoid completely, physicians and other members of the health care team should assess their patients' (or patients' surrogates') understanding of the information they provide. At the same time, information from sources such as television, magazines, and the Internet can foster unrealistic expectations concerning a given situation. In these situations, the ability to communicate a patient's prognosis clearly and accurately is critical. This is neither comfortable nor easy, especially given that physicians' prognostication skills are generally not on a par with their diagnostic and treatment skills.

Because none of his prior hospitalizations was terminal, the patient's wife may expect that, given proper treatment, her husband will go home again this time. Thus, she may not be psychologically prepared to hear and act on the facts of her husband's current prognosis and the physician's recommendations. Commands to "do everything" can be motivated by, in addition to denial, a wish to avoid guilt, a common emotional response to the death of a close relative. Statements such as "I cannot do this" or "I will not be able to live with myself" signal that a patient's decision maker is avoiding being party to decisions that could hasten the patient's death.

When talking with patients' relatives or decision makers who may be either confused about the true prognosis, in psychological denial, trying to avoid guilt, otherwise emotionally unprepared, or any combination of these, it is important that physicians be responsive listeners and clear communicators. Communication techniques that can help in these difficult conversations include active listening (repeating the speaker's thought or sentiment in your own words), simple silence, and open-ended questions. For example, physicians may initiate the discussion using opening statements such as, "It must be very hard for you to see your husband so ill," and, "You've been a wonderful caregiver for your husband during all this time that he has been sick." Avoiding language such as "withdrawing care" and "comfort measures only" may lessen the potential for future guilt. Instead actions that set positive objectives (e.g. maximizing comfort) should be the subject of these discussions.

Conflicts over the use or futility of treatment are unlikely to be resolved in a single conversation and will likely require follow-up discussions. The first step is to identify, through responsive listening and communication, the multiple causes of the conflict; then to begin, with further careful and unambiguous language, the process of resolving the conflict. A mutually agreeable decision, while never guaranteed, is more likely attainable when physicians take adequate time for proper communication.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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VIEWPOINT

What Is Your Handicap?

Audiey Kao, MD, PhD

- The earliest written record of golf dates to 1457, while the earliest known written regulation of the practice of medicine is the Code of Hammurabi, in cuneiform, circa 1700 BC.[1]
- In 1899, a dentist named George F. Grant patented the first golf tee. In 1922, dentist William Lowell designed a cone-shaped wooden peg with a small concave platform that was patented and became the world's first commercially produced golf tee. The most recent person to tinker with golf tee design is another dentist, Arnold DiLaura, who patented the Sof-Tee, a tee that sits on top of the ground instead of in it.
- Every year since 1890, with short pauses for world wars, an interesting interaction occurs between golf and medicine in Scotland. In 1890, the Royal Colleges Golf Club was formed. Its members are from the Royal College of Physicians (founded in 1681) and the Royal College of Surgeons (founded in 1706). Each year, the two colleges play a golf match, which has added much spice to Edinburgh medicine.
- The caloric cost of playing golf is 3.6 to 6.0 kcal/min, with total energy expenditures estimated between 622 to 960 kcal per 18 holes. Golf traditionalists espouse walking and carrying one's own clubs. Carrying golf clubs has been shown to cause a 15 percent increase in oxygen consumption, a 25 percent rise in minute ventilation, and a 10 percent increase in kcal/min expended compared with normal walking.
- In a series of experiments using highly skilled miniature golf players, researchers found that younger and older players had a similar increase in heart rate and anxiety ratings. However, under competitive conditions, younger players improved their motor performance while older players showed a decline.
- Among common recreational sports, golf is the one most often being played when death occurs. The reason is the frequency of pre-existing coronary artery disease among golfers, who tend to be male and, on average, older than those who engage in other recreational sports. At least 1 death has been recorded in an 18-year-old patient who was struck across the chest with a golf putter. At autopsy, his heart had multiple internal ruptures.
- Among anesthesiologists, the expression "to carry a full set of clubs" is used to indicate that all the equipment they need is at their immediate disposal in the operating room. Likewise, "replace your divots" means that

anesthesiologists should take care of the operating room equipment and clean up after themselves.

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Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.

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VIEWPOINT

H. Tristram Engelhardt, Jr, MD, PhD
Faith Lagay, PhD

In an endeavor to explore the many shapes a career in medicine can take, Virtual Mentor will, in the coming months, profile medical doctors whose major contribution to medicine lies outside clinical practice and research. This month, VM looks at the career of H. Tristram Engelhardt, Jr, PhD, MD

Professor Engelhardt is among the pioneers of the movement known as bioethics, though that term characterizes the scope of his work far too narrowly. He has written more than 300 books, chapters, and articles that examine personhood and identity, bioethics, genetics, secular humanism, the deprofessionalization of medicine, Christian theology and ethics, animal rights, health policy, and much more. Professor Engelhardt has written and presented in 3 languages and been translated into 7 more. His *Foundations of Bioethics*, first published in 1986, was translated into Chinese in 1996 co-incident with the appearance of its 2nd edition in English. He is currently professor of philosophy at Rice University and professor emeritus at Baylor College of Medicine.

In answer to the rather bluntly posed, "Why did you decide not to pursue the practice of clinical medicine?" Professor Engelhardt answers that he is and has been a licensed physician since 1972 and enjoys clinical encounters with patients. But, he says, loosely quoting Spinoza, "to be one thing, a man must decide not to be many others." Engelhardt decided to be a doctor of medicine in the broadest sense of that term. To explore, as for centuries medicine had allowed physicians to do, the condition of human beings, their finite nature and the inevitability of suffering. At the time and place Engelhardt entered medicine—the 1960s and the American South—medicine still applied itself to understanding the human condition and not merely the diseases and dysfunctions of the human body. His internist father, Dr. Engelhardt senior, combined clinical practice in Texas with the translating of medieval Latin texts into "Texan." Engelhardt junior studied medicine at Tulane University, deep in the heart of physician-philosopher-writer Walker Percy's New Orleans. "There simply was no distance between studying medicine as a means for understanding the human condition and studying it as a science," Engelhardt says. "The profession attracted and fostered development of extraordinary men and women, permitting them—encouraging them—to be egregiously different." Engelhardt's anatomy instructor invited the 4 students assigned to 1 corpse to select a novel to read and discuss as they dissected their cadaver. The group chose Lawrence Durrell's *The Alexandria Quartet*.

Taking a leave of absence from medical school, Engelhardt attained a PhD in philosophy at the University of Texas in 1969, writing his doctoral dissertation on Kant, Hegel, and Husserl and the mind-brain problem. He returned to Tulane and completed his medical education, graduating with honors in 1972.

Medicine's course over the second half of the 20th century has been one of increasing deprofessionalization, as Engelhardt sees it, moving from a self-governing professional guild to a trade governed by society, the legislature, and the Supreme Court, itself. The main reason Engelhardt writes and teaches and studies and lectures rather than spending his days at the bedside is so that he can study medicine in the classical sense, as a scholar who comes to understand the framing context of medicine. This leads him to the history and philosophy of medicine. Western medicine developed in a Western Christian culture that believed in a divine creator, author of nature and humanity; it developed in a social context that trusted in the power of reason to uncover universal truth. "In our secularized, postmodern world, both a common belief in God and a trust in a common notion of moral rationality are absent," he says. How does medicine proceed when its foundation, its framework for posing and resolving problems, has crumbled? Pursuing such questions, Engelhardt wrote, in 2000, *The Foundations of Christian Bioethics* in which he asserted the need for a Christian ethic in a post-Christian world. He is currently working on a history of medicine project.

Can medicine regain a rightful claim as one of the learned "professions"? Engelhardt wants to say yes, but he doesn't see much encouraging evidence. For medicine to become a profession again, he says, physicians must reflect on their power, not respond and adapt uncritically to the morality around them. And they must begin by talking about the limits of life and the inevitability of suffering and death. As long as physicians turn their backs on these essential aspects of the human condition in doomed attempts to extend life at all cost, to dispense with all suffering, and to mend everyone's problems with medicine, they are, in Engelhardt's words, "uttering pious nonsense" and further eroding confidence in the profession. If physicians were to begin talking honestly about what medicine can and should do, Engelhardt believes that people would listen. As an example of someone who has done so, Engelhardt offers Dr. John Kitzhaber, governor of Oregon since 1995. Recognizing that no society can provide all the care that every citizen might like, Kitzhaber authored the ground-breaking Oregon Health Plan while he was president of the State Senate in the early 1990s, leading the citizens of Oregon in deliberating and coming to consensus on a system for rationing health services.

"Well, that's only one," Engelhardt says, "but it's a model of the expert, scientist, humanist, scholar, politician who can restore medicine to professional status." For his part, Tris Engelhardt, heading to Australia for a series of lectures on bioethics in February, continues to be, though not a clinician, most certainly a doctor of medicine.

Faith Lagay, PhD is managing editor of *Virtual Mentor*.