Virtual Mentor
American Medical Association Journal of Ethics
January 2004, Volume 6, Number 1: 1-65
Physician Activism

Medicine and Society

Viewpoint

Upcoming Issues of *Virtual Mentor*

February: Paternalism in Medicine
March: Patient Safety and Medical Error
April: Medicine and the Social Contract
May: Medicine's Response to Terrorism

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.fred1-0401

From the Editor

An Obligation to Act

The theme editor introduces an issue examining various ways physicians can become involved in social issues that benefit patients and society at large.

Jeffrey T. Kullgren, MPH

Just as a significant proportion of the American public is deliberately disengaged from current events and elections, many physicians and medical students find politics repugnant. At a recent lecture on effective lobbying techniques for physicians, for example, a good number of my colleagues left the talk even less inclined to participate in advocacy than they had been an hour earlier. Many were incensed to hear about the importance of becoming skilled at executing "elevator talks" and the value of making donations to local candidates' campaigns. Some remarked that the talk only bolstered their view of politics as "the dirty way of getting things done." They left the lecture seeing no role for a competent and compassionate clinician in public affairs.

These remarks are distressing and represent the views of all too many medical professionals and students. Part of this attitude is derived from the general public's skepticism of politicians, but some of it stems from the primacy that our profession assigns medical services in the lives of patients. We often believe that the opportunity for restoration to baseline health is the most important thing that can be done. In reality, however, there are other issues in patients' lives that are at least as important to them as any remedy clinical medicine can offer. The antibiotic prescribed for a 30- year-old single mother's urinary tract infection, for example, may be less important to her than finding a job that pays a living wage, her inability to secure affordable day care for her 2 children, and her wish that she lived in a safer neighborhood. The hernia repair operation performed on a 45-year-old laid-off factory worker may be less important to him than his lack of health insurance, his need to acquire skills in order to find a new job, and his concern about retaining affordable housing while unemployed.

These concerns—and the countless other social, economic, and public health issues that medical professionals ought to be concerned about—are not problems that physicians can solve through the conventional means of writing a script or executing a well-crafted treatment plan. They are, however, problems that significantly affect our patients' well-being perhaps more than the ones we treat within the walls of our clinics and hospitals. If we are truly dedicated to improving the lives and well-being of our patients, and if we honestly care enough about the vulnerable persons that have trusted us to care for them, we have an obligation not only to provide health care of the highest quality, but also in some way, shape, or form to be active in public policy changes needed to better their lives.

In addition to the obligation to advocate for our patients, we also have rights as professionals to advocate for ourselves and our own best interests. Indeed, many physicians' main venue for participation in advocacy is

through membership in one of many professional organizations such as the American Medical Association, a state medical society, or a specialty association. This type of activism differs from public health activism and advocacy on behalf of disadvantaged patients but is just as necessary. In fact, the current malpractice insurance crises in many states demonstrate that if physicians do not advocate for themselves, they and their families may be left devoid of the livelihoods that they have worked hard to attain.

While a necessary part of medicine, physician activism is rife with ethical conflicts. Dilemmas can arise when either advocating for patient health or professional self-interests infringes on physicians' other ethical duties. Sometimes these 2 motivations are even in direct opposition to one another. Physicians also have a responsibility to maintain high ethical standards in the practice of activism inasmuch as they often wield substantial influence in the public policy process by virtue of their professional status. Polls of the general public consistently show that physicians constitute one of the most trusted professions, and policymakers' views generally seem to coincide. When advocating on behalf of patients, physicians are often seen as providing first-hand expert knowledge. When advocating on their own behalf, physician activism is very well-funded, an unsavory but important factor in today's political environment. Indeed, in both national and state political arenas, physician associations represent some of the most powerful advocacy groups in existence. This significant credibility and power offer enormous opportunities for impact but demand restraint if ethical standards are to be upheld.

This issue of *Virtual Mentor* seeks to address these opportunities and conflicts by exploring what activism should look like, where its ethical boundaries should be drawn, and how medical students and young physicians might appropriately participate. A special question-and-answer feature with 2 prominent physician-policymakers Dr. Antonia C. Novello, the Commissioner of Health for the State of New York, and Dr. Mark McClellan, FDA Commissioner, provides insight into the lives and thoughts of physicians who are making significant impact in both clinical medicine and public policy. Commentaries by ethicists and physicians on 3 clinical cases consider and seek to further define the appropriate roles and limits of physicians ' participation in civil disobedience, work stoppages, and political pursuits. In complementary opinion pieces, Drs Howard Brody and Nancy Dickey take opposite sides in response to the question "do physicians have an obligation to participate in the profession's national organization?"

In a special feature, our professional colleagues from the Korean Medical Association share a frank and disturbing—yet hopeful—account of the results of collective physician activism in their country in 2001. And a Policy Forum essay explores the ways in which civil disobedience both threatens and strengthens the fabric of civil society. Finally, 2 pieces specifically address the next generation of physician-activists—medical students. A review by Braden Hexom of the American Medical Student Association examines the roots of medical student activism as well as contemporary movements in which students are involved. Dr. Peter Lurie and colleagues describe an innovative approach currently being used at several medical schools to educate and nurture the next generation of physician activists.

In spite of the aversion of many physicians and medical students to politics, there are countless physicians who are making public policy an important—and even a central—part of their careers. Dr. Bill Frist, a transplant surgeon, is now the Senate majority leader. Dr. Howard Dean, an internist, is currently campaigning to become president of the United States. Dozens of physicians hold elected office in the United States House of Representatives and the nation's 50 statehouses. Hundreds more in private practice have captured the attention of national media and policymakers through highly publicized work stoppages to protest the malpractice insurance crisis.

Clearly not every physician can or should be expected to seek the public policy influence and visibility of Drs Frist or Dean. But certainly there are gradations of activism that we should all aspire to and on which the futures of our patients and our profession depend. It is my hope that these role models and the articles contained in this issue can offer new perspectives on physician activism as well as inspire readers to envision ways that they can effectively contribute to both medicine and public policy.

The learning objectives for this issue are:

- Understand physicians' obligations to engage in advocacy.
- Recognize conflicts between physicians' rights as private citizens and responsibilities as clinicians.
- Understand ethical boundaries of physician participation in the public policy process.
- Identify appropriate ways in which physicians can participate in activism and advocacy.

Sincerely,

Jeffrey T. Kullgren, MPH

Jeffrey T. Kullgren, MPH a second-year student at the Michigan State University College of Human Medicine, is from Midland, Michigan. He received a BS in sociology from MSU and an MPH in health management and policy from the University of Michigan School of Public Health.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.ccas1-0401

Clinical Cases

Campaign Posters in the Clinic, Commentary 1

Expressing political views in a professional setting can be detrimental to the patient-physician relationship.

Commentary by Marion Danis, MD

Case

Dr. William Harper is an obstetrician-gynecologist in a suburban group practice. He spends much of his time providing prenatal and reproductive health care to young women. Dr. Harper also has a strong interest in public policy and local politics. He has served twice on the city council and is also very active in the local chapter of his political party.

Dr. Harper's colleagues often do not agree with him, but they acknowledge his right to his own political stances and activities. They don't think he attempts to influence his patients' views, but they are sometimes concerned that his highly visible involvement in politics might make patients uncomfortable.

The state in which Dr. Harper practices is likely to have one of the closest races in the upcoming presidential election. He wants to do everything he can to support his party's nominee. His office is located on a busy street in the community, so he decides to place a sign supporting the candidate in his window.

His colleague, Dr. Marsha Robert, first sees the sign upon pulling into the practice's parking lot the next morning. Appalled, she marches directly into Dr. Harper's office to ask him about the sign. "It's going to be a close race, Marsha, and my candidate needs all the support he can get," says Dr. Harper.

"That's fine," says Dr. Robert, "But a physician's office is no place for a political advertisement."

"What do you mean, there's no place for it? Being a physician doesn't preclude me from having political views and making them known. I have a right to free speech too, you know," says Dr. Harper.

"You're right, William, you do have a right to free speech. But don't you think that knowing that you support this candidate—one of the most vocal opponents of a woman's right to choose—will make your patients feel uncomfortable? Don't you think that they'll be less likely to ask you about their different options and more likely to think that you agree with this candidate about women's reproductive rights?" says Dr. Robert.

"Listen, Marsha. My patients know me, and I know them. They know that they can talk to me about anything and that I won't judge them for the choices they make. Just because I support a candidate doesn't mean that I agree with him about every issue," retorts Dr. Harper.

Frustrated and concerned about the sign, Dr. Robert ends the conversation and goes to her office to start the day.

Commentary 1

by Marion Danis, MD

Given that a patient comes to the doctor to address health concerns, one can plausibly argue that the relationship between them should be confined to this agenda. A physician should exercise influence on a patient only to promote health-related goals such as encouraging healthy behavior and compliance with a medical regimen. So, while physicians, like all citizens, have the prerogative of endorsing political candidates and demonstrating this endorsement, I would suggest that political activities be separated from professional activities in some ways. Inside the walls of the clinic, it seems to me that it would be wrong to endorse a political candidate. This is so for several reasons largely connected to the special nature of the patient-doctor relationship and the role a physician plays in his or her workplace.

No matter how well a patient and physician know each other or how comfortable they are with one another, the unequal and privileged nature of the relationship obliges the physician to restrain the expression of personal views. Otherwise a patient may sense an expectation, even in the absence of overt stated pressure, to adhere to the physician's point of view. She may feel that she is expected to endorse the candidate that her physician endorses, and this would be an inappropriate expectation. Alternatively, the patient may strongly disagree with her physician's political point of view, and this may alienate her to the point of straining the therapeutic relationship. If the patient happens to support a different candidate than the physician, the patient may feel intimidated about acknowledging this, which may subtly inhibit her from expressing other unrelated but important issues to avoid alienating her physician. This pressure can distort the patient and physician's therapeutic alliance.

Outside of the clinical setting it is appropriate for an individual to campaign for a candidate in the course of his or her civic activities. This is simply an expression of a citizen's right. Physicians may contribute money to campaigns, help to raise funds, speak on behalf of a candidate, and participate in political rallies because they share a politician's point of view and want to support the candidate's election. There are, however, better ways for a medical professional to combine professional and political activities than putting campaign posters in the office. For instance, a physician might advocate that a professional organization endorse a candidate because he or she has a campaign platform that furthers the goals of the profession from the clinician's point of view.

Let's turn back to the case at hand, which focuses particularly on an obstetrician-gynecologist who endorses and wishes to use his office to advertise a candidate who opposes abortion. Abortion is among the most divisive political and moral issues in the United States today and has direct consequences for the practice of obstetrics and gynecology. Given the contentiousness of the debate, the need to separate politics and practice is particularly compelling.

Even if a gynecologist does not hang a sign endorsing a political candidate, it may well be that the doctor's views about termination of pregnancy cannot be avoided in the day-to-day conduct of his practice. Here, Dr. Harper's comment is quite apt when he says, "My patients know me and I know them. They know that they can talk to me about anything and that I won't judge them for the choices they make." It requires careful and explicit discussion to make sure this nonjudgmental attitude is plainly evident to patients.

Aside from the patient-doctor relationship, a physician's relationships with his coworkers are also important. His coworkers may or may not agree with his political perspective. If it were acceptable for one physician to endorse a candidate by hanging a campaign poster, it should be acceptable for anyone else in the office to do the same. So, while one solution to the question might be to allow any and all clinic or office staff to hang

political posters in the office, this does not seem advisable or practical. When a patient comes to a medical office with health concerns, it should be a safe place where she can be sheltered from outside pressures in sorting out what is best for her health and well-being. An office filled with competing political slogans hardly seems like the haven one would want.

The views expressed here are those of the author and do not reflect the policies of the National Institutes of Health or the Department of Health and Human Services.

Marion Danis, MD, is head of the Section on Ethics and Health Policy in the Department of Clinical Bioethics and chief of the Bioethics Consultation Service at the National Institutes of Health. She is also on medical staff at the National Naval Medical Center.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.ccas1-0401

Clinical Cases

Campaign Posters in the Clinic, Commentary 2

Expressing political views in a professional setting can be detrimental to the patient-physician relationship.

Leonard M. Fleck, PhD

Case

Dr. William Harper is an obstetrician-gynecologist in a suburban group practice. He spends much of his time providing prenatal and reproductive health care to young women. Dr. Harper also has a strong interest in public policy and local politics. He has served twice on the city council and is also very active in the local chapter of his political party.

Dr. Harper's colleagues often do not agree with him, but they acknowledge his right to his own political stances and activities. They don't think he attempts to influence his patients' views, but they are sometimes concerned that his highly visible involvement in politics might make patients uncomfortable.

The state in which Dr. Harper practices is likely to have one of the closest races in the upcoming presidential election. He wants to do everything he can to support his party's nominee. His office is located on a busy street in the community, so he decides to place a sign supporting the candidate in his window.

His colleague, Dr. Marsha Robert, first sees the sign upon pulling into the practice's parking lot the next morning. Appalled, she marches directly into Dr. Harper's office to ask him about the sign. "It's going to be a close race, Marsha, and my candidate needs all the support he can get," says Dr. Harper.

"That's fine," says Dr. Robert, "But a physician's office is no place for a political advertisement."

"What do you mean, there's no place for it? Being a physician doesn't preclude me from having political views and making them known. I have a right to free speech too, you know," says Dr. Harper.

"You're right, William, you do have a right to free speech. But don't you think that knowing that you support this candidate—one of the most vocal opponents of a woman's right to choose—will make your patients feel uncomfortable? Don't you think that they'll be less likely to ask you about their different options and more likely to think that you agree with this candidate about women's reproductive rights?" says Dr. Robert.

"Listen, Marsha. My patients know me, and I know them. They know that they can talk to me about anything and that I won't judge them for the choices they make. Just because I support a candidate doesn't mean that I agree with him about every issue," retorts Dr. Harper.

Frustrated and concerned about the sign, Dr. Robert ends the conversation and goes to her office to start the day.

Commentary 2

by Leonard M. Fleck, PhD

Undoubtedly Dr. Harper does have his free speech rights, but professional ethics requires that he exercise those rights away from his office practice. Considerations related to both his patients and his colleagues would seem to require this.

Dr. Robert suggests that patients might be made uncomfortable by a sign endorsing a prolife candidate. If a bit of psychological discomfort was the whole story, then it would not raise any serious ethical concerns. Should we say, then, that the sign is "offensive"? That might be too strong a description. If the candidate were known to have racist views, for example, and if a Confederate flag were part of the sign, then the sign would be offensive in a morally significant sense. The patients' discomfort is not the only issue of concern, however; there is a risk that patient trust might be undermined perhaps without Dr. Harper's knowledge. This is morally significant enough to warrant removal of the sign.

Trust is an essential part of the patient-physician relationship. Patients need to be confident that their physicians will render medical judgments on the basis of medical science and the best interests of the patient (as an informed and autonomous patient would judge those interests). A reasonable expectation is that physicians will not allow their personal values (eg, religious or political) to contaminate the professional and objective medical judgments patients seek.

Dr. Harper may in fact be quite attentive to this professional norm, never raising partisan political issues with his patients in the office setting. Still, his political sign could undermine patient trust. Many of the women in the waiting room will be pregnant. It is natural that some of them will have anxieties about the status of the pregnancy. His patients might wonder, for example, whether he would fail to suggest prenatal genetic testing when their fetuses might have a significantly increased risks of serious genetic disorders because he does not want to encourage abortions. Many, perhaps most, women would feel uncomfortable raising this issue with Dr. Harper, perhaps because they would feel as if they would be questioning his integrity and clinical judgment. These tensions may result in the patient's losing trust in her physician and being unnecessarily anxious for at least the duration of the pregnancy. This loss of trust can have corrosive effects on the patient-physician relationship, which are difficult to recognize and remedy. Dr. Harper may not even realize if this becomes an issue that he should address.

A defender of Dr. Harper could say that patients who have these concerns can always leave the practice and find another physician. This will be true for some patients; however, for others this is only a theoretical option because either insurance or geographic restrictions make leaving the practice nonviable. Apart from that, leaving a physician imposes additional costs on a patient.

Academics, for example, are in a similar position. If we have partisan political posters all over our offices that relate to issues that we must necessarily discuss in our classes, students will justifiably wonder whether they will be fairly graded if they voice contrary political views. Although the university campus is a place where free expression, especially political expression no matter how controversial, ought to be protected, the classroom and by extension an academic's office are not appropriate places for political campaigning. A political science professor could express her views on the Medicare prescription drug bill in the classroom, but she also has an obligation to present fairly the best arguments of her critics. She must be an educator in the classroom, not a political activist. This is not a threat to academic freedom but a way of protecting the integrity of that value.

Given my analysis, someone could raise the question of whether Dr. Harper must desist from all partisan political activities in public, thereby significantly squelching his political rights as a citizen. The argument would be that this sort of activity could make his patients just as uncomfortable and distrusting as having signs in his office. It seems to me that there is a real and ethically significant difference between these situations. In a public setting, women who are his patients can confront him more directly and comfortably. In that setting they are not "his patients"; they are his fellow citizens. In a well-functioning democracy this distinction is meaningful. There would not be sufficient reason, then, to have abstinence from all political activity as a professional norm.

We need to return to one other issue: this is a group practice. Though the sign is in "Dr. Harper's window," most passers-by would have no sense of that. The conclusion can be drawn that the sign reflects the political sentiments of the group as a whole. This is unfair to the other members of the group who do not agree with those sentiments or support this candidate. Of course, other members could post their own signs, which could correct the misimpressions of passers-by but would only worsen the problem we discussed above. It creates an impression in the public mind that physicians in their professional role as clinicians are politicized. Prudent patients would be more circumspect about discussing medical problems that have become a focus of political controversy with their physicians. This would be potentially subversive of the best interests of some patients, not to mention the professional comity required to serve patients well.

Finally, we have addressed this case as if it were about only physicians. Yet nurses, other health professionals, and office staff in general would all be part of this practice. Would all of these individuals have an equal right to hang partisan political signs in their office space? Would Dr. Harper comfortably approve their equal right to exhibit their political views in this way? We are fortunate, as a society, to have ample political space for engaging in political work in our role as citizens. There is no need for medical offices to be included in that space. How many of us would like to see medical offices become the clone of "talk radio"?

Leonard M. Fleck, PhD, is a professor of philosophy and medical ethics in the College of Arts and Letters' Philosophy Department and the College of Human Medicine's Center for Ethics and Humanities in the Life Sciences at Michigan State University.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.ccas2-0401

Clinical Cases

Physician Work Stoppages as Activism

Physician work stoppages in response to rising malpractice insurance rates are designed with the hope of raising public awareness about this problem.

Commentary by Alan J. Lippman, MD

Case

Dr. Alex Nelson is an internist at a large private urban hospital. He is one of the more junior members of the practice and finished his residency training at the same institution only 2 years ago.

Malpractice insurance premiums for Dr. Nelson and other physicians in the area have skyrocketed over the last several years. The situation has become so serious that his more senior colleagues ask him why he stayed in the area to practice after residency. Some of them indicate that they are considering retiring or finding other practice opportunities in another state. Not only can they not generate comfortable incomes after paying for malpractice premiums, they say, but they are also beginning to have trouble finding companies that will offer them any coverage at all.

Local physicians—including many of Dr. Nelson's colleagues—recently held a rally at the state capitol to draw attention to the situation in the hopes that legislators would take action to make malpractice insurance more affordable in the state. They have also lobbied their federal congressmen through professional associations. Despite their efforts, legislation to address the growing crisis remains stalled.

Frustrated by the lack of action on the part of policymakers, Dr. Nelson's colleagues decide that more drastic measures, which circumvent the traditional advocacy routes, are needed. Specifically, they decide to plan a work stoppage. Based on physician work stoppages in other states, they decide to set aside one day on which only physicians who provide emergency care will work. They think this will draw more attention to the issue and force the legislators to move on the stalled bill. They plan the work stoppage for the following Monday and will hold another rally and a press conference on the same day.

Dr. Nelson is not quite sure how he feels about the issue. On one hand, he knows that the malpractice insurance crisis is real and appears to be worsening. He also knows that legislators might not realize how serious the situation has become. On the other hand, he isn't sure whether these tactics are ethical. How, he wonders, can physicians advocate for sustained access to care by denying care?

Still undecided about the planned work stoppage, Dr. Nelson is approached by one of his colleagues the Wednesday before the planned stoppage. "So Alex, we'll see you down at the rally on Monday?" asks Dr. Sally Young, one of the practice's most senior physicians.

"I'm not sure if I'm going to do it, Sally. I'm just not sure how I feel about it. I mean, is it right for us to deny patients care to make our point?" replies Dr. Nelson.

"Come on, Alex," replies Dr. Young. "Maybe you haven't been around long enough yet, but this is the worst this malpractice situation has been in years. After almost 30 years of practice, I'm wondering if I'm going to be able to get insurance at all, let alone make mortgage payments and maintain my kid's college fund. We need to send a message to these guys down at the Capitol that this is serious. And that's not going to happen unless we all stick together and are part of this. So are you in?"

Moved by Dr. Young's justification, but still unsure that what they're doing is ethical, Dr. Nelson decides. "Yeah, I'm in."

Commentary

Is It Ethically Permissible for Physicians to Participate in Job Actions? by Alan J. Lippman, MD

Our nation's professional liability insurance system is broken. Skyrocketing medical malpractice insurance premiums, in some cases exceeding $100,000 per year, are forcing some physicians to limit services, retire early, or relocate to places where premiums are more affordable. The situation is particularly acute in some 30 states, where reductions in the physician workforce are already adversely affecting the availability of care in certain "high-risk" specialties, such as obstetrics and neurosurgery.

Major determinants of premium increases include escalating jury awards and the high cost of defending suits[1]. Physicians practicing in states that have been severely affected have been vigorously calling for legislative reform that would support stabilization of the insurance market and provide relief from the pressures threatening to undermine fair access to health care.

Solutions to the problem, however, are controversial. The issues are complex and confounding. Data supporting the factual basis for various arguments is incomplete or subject to interpretation. Biases, on the parts of both physicians and trial attorneys, represent obstacles to resolution of the matter. In response to frustration in the legislative arena, many physicians have supported so-called "job actions," or "work stoppages," the purposes of which are to raise public awareness of the issues and to force legislators to act favorably on pending bills.

For many physicians, including Dr. Nelson, this situation creates a dilemma. How can a conscientious physician advocate for sustained access to care by denying care?

In my view, job actions and work stoppages represent no more than wake-up calls to a slumbering public and a lethargic legislature. Let it first be said that responsible job actions never deny needed care. Emergency care cannot logically or ethically be withheld and never is. Temporary postponement of procedures such as elective surgery or screening mammography does not constitute abandonment. Practice interruptions can easily be rectified in a timely manner. Job actions are not intended to be punitive and should never be. Instead, such activities merely serve to bring the issues into sharp focus and to demonstrate, in a brief and effective manner, the acuity of a desperate situation and the potential consequences of failure to address its resolution.

There are several elements that constitute what the medical profession regards as essential to effective tort reform including the establishment of limits ("caps") on noneconomic damages, appropriate statutes of limitations, preclaim review, alternative processes for dispute resolution, and improved standards for expert

witnesses. Beyond these, however, there is one essential element that, arguably, represents the cornerstone of any meaningful reform— successful implementation of methods to enhance quality improvement and patient safety.

The Institute of Medicine, in a series of recent reports, has called attention to the harms caused by preventable medical errors[2]. Other reports show that patients are commonly harmed by problems arising from faults in the health care process itself, acts distinguishable from truly blameworthy behavior or system violations. The current tort system has been called a major driver of this problem by inappropriately apportioning blame and inhibiting system-wide improvements. Affixing blame should not be a prerequisite to compensation. In that "preventable, iatrogenic harm is inevitable," it is claimed, compensation should be "quick, equitable, fair, and timely." Change will require abandonment of a culture of blame and a shift away from tort toward "mediation" and "transparency"[3].

In concert with this strategy, some have called for an alternative to litigation that does not predicate compensation on proof of practitioner fault; rather, it is based on a "no-fault" systems model, not unlike that utilized in workers' compensation or automobile liability matters. It has been estimated that the costs of such a system would not exceed those of the current tort system and might well be more affordable[4].

In this context, can it be argued that physician job actions are ethical? I maintain that it can if the purpose of a job action is to call attention to a problem and not to be punitive and if the proposed solution is remedial. These actions are fully in concert with the moral principles that guide the profession, as encapsulated in the American Medical Association's *Principles of Medical Ethics*[5].

These ethical principles represent the standards of conduct that define the essentials of honorable behavior for the physician. Among other things, these principles call for:

- Respect for the law and a responsibility to seek change when existing law may be contrary to the best interests of the patient.
- Responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- Recognition that care of the patient is
- paramount. Support of access to medical care for all persons.

Our broken professional liability system threatens to disrupt the integrity of American health care by placing insurance premium rates beyond reach for so-called "high-risk" practitioners, limiting access to care, and hindering improvements in quality and patient safety. Important as it is to address the causes of medical errors, it is just as important to correct the deficiencies in the liability system that provides compensation for inadvertent consequences. Physicians' efforts to support these actions are appropriate, timely, and commensurate with the profession's highest ethical principles.

References

1. Saxton J, United States Congress Joint Economic Committee. Liability for medical malpractice: issues and evidence. May 2003. Accessed December 8, 2003.
2. Kohn LT, Corrigan JM, Donaldson MS, eds; Committee on Quality of Health Care in America, Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington DC: National Academies Press; 2000. Accessed December 2, 2003.
3. Runciman WB, Merry AF, Tito F. Error, blame, and the law in health care—an antipodean perspective. *Ann Intern Med*. 2003;138:974-979.

4. Studdert DM, Brennan T. No-fault compensation for medical injuries: the prospect for error prevention. *JAMA*. 2001;286:217-223.
5. American Medical Association. Principles of medical ethics. In: *Code of Medical Ethics Current Opinions*, 2002-2003 edition. Chicago: AMA Press; 2002:xii. Available at: http://www.ama-assn.org/ama/pub/category/2512.html. Accessed December 2, 2003.

Alan J. Lippman, MD, is in private practice in medical oncology in Essex County, New Jersey. He is also deputy editor of the *Journal of the Medical Society of New Jersey*.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.ccas3-0401

Clinical Cases

Physician Activism and Civil Disobedience, Commentary 1

Physicians need to exhaust every possible alternative to bring about political changes before resorting to breaking the law as an act of civil disobedience.

Commentary by Tom Tomlinson, PhD

Case

Dr. Garrison is a family physician who has been practicing at a health center in a high-poverty urban neighborhood for 20 years. She finds her work at the health center challenging and often frustrating, but she thinks it is important because the community is plagued by serious health and social problems.

In the last 5 years, for example, Dr. Garrison and her colleagues have observed a steady increase in communicable diseases such as hepatitis and human immunodeficiency virus (HIV). The county public health department has also recognized this trend and has attributed this increase largely to high rates of intravenous drug use in the community.

Dr. Garrison's clinical experience supports the findings of the health department. In addition to her work at the health center, each week she conducts patient outreach visits at social service organizations and community centers. She also goes on street outreach to provide health care to the homeless. In each setting, Dr. Garrison has been told of—and in some cases even witnessed—IV drug users sharing needles.

Each time Dr. Garrison sees or hears about needle-sharing, she sees an opportunity for education. She has told her patients about the risks involved and provided them with information about treatment centers for drug addiction. Despite her efforts, Dr. Garrison sees no progress; more of her patients and their friends are contracting HIV and hepatitis.

In a meeting at the county health department to address this public health problem, she learns of an approach that might be effective in the neighborhood. Evaluations of some programs that provide IV drug users with clean needles and syringes, she is told, have had promising results in reducing the spread of communicable disease in some communities. Intrigued, she reads and assesses some of available literature. She finds that indeed, providing IV drug users with clean needles and syringes can be an effective means for combating the spread of hepatitis and HIV.

Stunned and inspired, Dr. Garrison thinks a needle exchange program would be effective in the neighborhood where she practices. She wonders, however, whether the program is legal. In researching the effectiveness of needle exchange programs, she had learned that they are illegal in many communities.

Dr. Garrison calls one of her friends on the city council to talk about whether local ordinances forbid such programs and, in doing so, learns that both local and state laws prohibit the distribution of needles. Her initial enthusiasm turns to anger, and she makes an appointment to discuss the issue with her state representative.

Dr. Garrison's state representative is sympathetic to her cause but tells her that the legislature's priorities right now are to manage the budget deficit and revive the state's economy. Besides, he says, many state legislators think that needle exchange programs encourage drug use and that there are better and more appropriate ways to reduce the spread of disease. Frustrated with the legislator's response, Dr. Garrison decides it is time to take matters into her own hands and create a needle exchange program on her own time and with her own money. She knows that in doing so she is engaging in an illegal act that could endanger her career and reputation. She believes that this risk is worth taking, however, because providing her patients and others in the community with clean needles could help reduce the transmission of disease. She also hopes that the program and publicity it receives will draw more attention to the problem and will prompt local and state policymakers to address the issue.

Commentary 1

by Tom Tomlinson, PhD

Dr. Garrison's frustration is understandable. According to a recent review of the literature, the evidence is clear that needle exchange programs significantly reduce the incidence of HIV and hepatitis among IV drug users without increasing the rate of drug abuse[1]. Indeed, as the authors report, both the US Department of Health and Human Services and the US Surgeon General have reached this same conclusion. Based on this evidence, successful needle exchange programs have been instituted in the majority of states. Unfortunately, Dr. Garrison's state is not one of them. Dr. Garrison has good reason to believe that a needle exchange program would benefit her patients, but the law will not permit her to follow her well-founded medical judgment.

The question is whether this potential medical benefit warrants her breaking the law. A comprehensive discussion of the ethics of civil disobedience is beyond the scope of this commentary, but a few key points merit attention[2]. First, any such act bears a burden of justification, especially when the law in question is one which has been legitimately enacted within a democratic and just social order. I will presume for the sake of argument that this is the case with the law in Dr. Garrison's state. Consequently, Dr. Garrison must be prepared to offer a moral defense of her decision.

What form that defense takes, and what plausibility it has, will depend on what her purposes are. I can imagine 3. First, she may be breaking the law in order to change it. Second, she may be breaking the law in order to better care for her patients. Third, she may be breaking the law as a personal protest against the law's infringement on her professional judgment. Of course, her motives may be complex; perhaps she has all 3 goals vaguely in mind.
Nevertheless, they are clearly separable. One can embrace 1 of them without aiming at the others.

Still, there is 1 common element to their moral justification. Each must start with an argument that the law in question is not morally defensible. This is fairly straightforward if the law's justification is purely a matter of its public health consequences. Once it has been established that the law impedes effective reductions in the spread of HIV without any compensating benefits in reducing drug use, appeal to the consequences favors repeal of the law. This is not the end of the matter, however. The state legislature may object that even if needle exchange programs do not "encourage" illegal drug use in the sense of increasing its incidence, they might still be perceived to "condone" it. It might be these symbolic implications that concern policymakers, not just the measurable public health consequences. The reading of such symbols may mark a cultural divide

between Dr. Garrison and perhaps many of the constituents the legislature represents. This could be the same divide that would put the 2 parties at odds over public policies such as the dissemination of condoms or birth control information in public schools. In justifying her action, Dr. Garrison will need to explain why reason favors her interpretation and weighting of the symbols. This will be a more complex argument, and to the extent that people of good will still disagree on the conclusion it will be harder for Dr. Garrison to justify her civil disobedience.

Let us assume for the sake of argument that Dr. Garrison has succeeded in her moral criticism of the law and consider what else she would need to establish to justify breaking it.

What if her goal is to have the law repealed? The problem with this purpose is that there are other means still untried for accomplishing that goal. In order to make her ethical case, Dr. Garrison needs political allies. Without them, a lone protest may only galvanize opposition and reduce the chances for any change in the law. In acting by herself, she invites being labeled a self-righteous rebel, the sort of person whose cause is easily dismissed. However worthy her goal, the means cannot be justified if they are likely to backfire. Self-defeating behavior rarely makes good ethics. Talking to one's representative is only a start in garnering support. Mounting a public political campaign, perhaps with the help of the state medical society and backed by the epidemiological evidence, might be successful. In doing so, she could point to the many other states that permit needle exchanges. "Me too" works wonders on the legislative mind.

What if her goal is to help her patients? Here too, it may be that Dr. Garrison has not thought far enough ahead. Her help for them will last only so long as her needle exchange program is allowed to continue. What will happen to their care when she is arrested or has her license suspended? Her patients will have lost not only the benefits of the needle exchange but the services of a physician who is meeting a much wider range of health care needs. She may be desperate to do something, her desperation driven by the depth of her concern and idealism. Certainly, medicine needs more idealists like Dr. Garrison. Idealism must be hard-headed and practical in its tactics, however, or else it runs the risk of degenerating into self-righteous gestures.

Which brings us to the third possibility: she will break the law in order to register her personal protest. This, I believe, is the least worthy reason. This rationale would not be analogous to an act of conscientious refusal, in which a person refuses to obey a law which will force her to engage in actions she finds morally repugnant. Dr. Garrison is not like the religious pacifist who refuses to report for the draft, for example. The law prohibiting needle exchange programs does not require her to act in ways she finds morally objectionable. Rather, it prohibits her from acting in ways she finds morally preferable. She does not need to disobey it to protect her conscience, which can still be expressed in myriad legal ways. A strong statement of protest, emphasized by self-sacrifice, may feel very satisfying to Dr. Garrison. When it poses the risks described earlier, however, both to her patients' care and to the prospects for legal change, it is an unprofessional indulgence which overlooks her larger duties to her patients and public health.

References

1. Vlahov D, Des Jarlais DC, Goosby E, et al. Needle exchange programs for the prevention of human immunodeficiency virus infection: epidemiology and policy. *American Journal of Epidemiology*. 2001;154(suppl 12):S70-S77.
2. Childress JF. Civil disobedience, conscientious objection, and evasive noncompliance: a framework for the analysis and assessment of illegal actions in health care. *Journal of Medicine and Philosophy* 1985;10:63-83.

Tom Tomlinson, PhD, is a professor of philosophy and the director of the Michigan State University's Center for Ethics and Humanities in the Life Sciences.

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.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.ccas3-0401

Clinical Cases

Physician Activism and Civil Disobedience, Commentary 2

Physicians need to exhaust every possible alternative to bring about political changes before resorting to breaking the law as an act of civil disobedience.

Commentary by Barry DeCoster, MA

Case

Dr. Garrison is a family physician who has been practicing at a health center in a high-poverty urban neighborhood for 20 years. She finds her work at the health center challenging and often frustrating, but she thinks it is important because the community is plagued by serious health and social problems.

In the last 5 years, for example, Dr. Garrison and her colleagues have observed a steady increase in communicable diseases such as hepatitis and human immunodeficiency virus (HIV). The county public health department has also recognized this trend and has attributed this increase largely to high rates of intravenous drug use in the community.

Dr. Garrison's clinical experience supports the findings of the health department. In addition to her work at the health center, each week she conducts patient outreach visits at social service organizations and community centers. She also goes on street outreach to provide health care to the homeless. In each setting, Dr. Garrison has been told of—and in some cases even witnessed—IV drug users sharing needles.

Each time Dr. Garrison sees or hears about needle-sharing, she sees an opportunity for education. She has told her patients about the risks involved and provided them with information about treatment centers for drug addiction. Despite her efforts, Dr. Garrison sees no progress; more of her patients and their friends are contracting HIV and hepatitis.

In a meeting at the county health department to address this public health problem, she learns of an approach that might be effective in the neighborhood. Evaluations of some programs that provide IV drug users with clean needles and syringes, she is told, have had promising results in reducing the spread of communicable disease in some communities. Intrigued, she reads and assesses some of available literature. She finds that indeed, providing IV drug users with clean needles and syringes can be an effective means for combating the spread of hepatitis and HIV.

Stunned and inspired, Dr. Garrison thinks a needle exchange program would be effective in the neighborhood where she practices. She wonders, however, whether the program is legal. In researching the effectiveness of needle exchange programs, she had learned that they are illegal in many communities.

Dr. Garrison calls one of her friends on the city council to talk about whether local ordinances forbid such programs and, in doing so, learns that both local and state laws prohibit the distribution of needles. Her initial enthusiasm turns to anger, and she makes an appointment to discuss the issue with her state representative.

Dr. Garrison's state representative is sympathetic to her cause but tells her that the legislature's priorities right now are to manage the budget deficit and revive the state's economy. Besides, he says, many state legislators think that needle exchange programs encourage drug use and that there are better and more appropriate ways to reduce the spread of disease. Frustrated with the legislator's response, Dr. Garrison decides it is time to take matters into her own hands and create a needle exchange program on her own time and with her own money. She knows that in doing so she is engaging in an illegal act that could endanger her career and reputation. She believes that this risk is worth taking, however, because providing her patients and others in the community with clean needles could help reduce the transmission of disease. She also hopes that the program and publicity it receives will draw more attention to the problem and will prompt local and state policymakers to address the issue.

Commentary 2

by Barry DeCoster, MA

Given the epidemiologic evidence supporting needle exchange programs, it is reasonable to assume that by respecting the law (ie, by *not* providing clean needles), Dr. Garrison would be acting *against* her patients' best interests. It is easy to sympathize with Dr. Garrison's desire to lower local HIV transmission rates, but it appears that political rather than health and epidemiologic considerations may prevent her from carrying out her plans. Here, Dr. Garrison's duties as a citizen and as a clinician come into conflict. Even if the law against needle distribution is unfair or morally unjust, the key moral consideration is whether Dr. Garrison is justified in breaking the law so she may better treat her patients.

The broader question at hand is, how should physicians act when the law prohibits what they view as necessary treatment? One resource she might consult for guidance is the American Medical Association's (AMA) Principles of Medical Ethics. Acknowledging that physicians may face such dilemmas, the AMA suggests in its third principle: "a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient"[1].

Consistent with AMA guidance, Dr. Garrison initially sought to have the law changed. Her state representative's response, though, leaves little hope that this law will change quickly, if ever. This leaves her in a morally unsatisfying position. Should Dr. Garrison intentionally violate a seemingly inflexible law that is morally questionable? When attempting to answer this question, it may prove to be instructive to consider when, if ever, clinicians might rightly engage in civil disobedience.

It may be appropriate under some circumstances for clinicians to break the law, but justifying such illegal actions demands a strong moral rationale. Historical examples of clinicians engaging in civil disobedience include providing birth control and abortion services before either was made legal. Even in these cases, had clinicians acted without strong ethical reasoning as backing, they would have acted simply out of disregard for the law rather than in line with a stronger and more defensible moral purpose.

Acts of civil disobedience are distinguishable from other illegal actions—and thus can possibly be considered morally permissible or even commendable—if they are performed "publicly, nonviolently, and submissively in protest of a discrepancy between moral standards and some law, policy, or state of affairs"[2]. While we can add others, these criteria provide a set of minimum requirements for acts of civil disobedience. For the sake of argument, I'll assume that Dr. Garrison has met these conditions.

Beyond these 3 criteria for civil disobedience, I would argue one has the obligation to seek political change of a law through legal avenues before breaking the law can be justified. Without this requirement, illegal actions may undermine public support of and trust in our legal process rather than motivate positive changes, which I take to be an additional requirement of civil disobedience. This call for legal means of political change is echoed within the third principle of the AMA code as well.

I worry that Dr. Garrison moved too quickly into considering breaking the law. While she may have attempted political dialogue through conversations with her state representative, Dr. Garrison has not yet met the additional requirement for civil disobedience: she has not yet demonstrated a serious and continued commitment to legal reform before resorting to breaking the law.

What approaches might Dr. Garrison have considered as legal enactments of political change, especially regarding needle distribution? Surely, she could have contacted other state and local politicians rather than terminating her efforts after a single meeting. Dr. Garrison might eventually persuade policymakers of the public health benefits of needle exchange programs. Similarly, it appears Dr. Garrison has not yet garnered the support of her health care colleagues at her own clinic. Dr. Garrison also has failed to engage her patients on this matter. This oversight further marginalizes their voices rather than promoting their agency as patients and citizens, thus perpetuating the misconception that IV drug users' opinions are not worthy of attention. If Dr. Garrison succeeds in organizing these additional voices, state and local politicians may be encouraged to listen more attentively.

Dr. Garrison does not appear to have pursued other commonly employed public relations strategies for encouraging public debate and effecting public policy change. She might begin, for example, with the simple but sometimes powerful act of writing a letter to the editor of the local newspaper. Recruiting reporters from local print and television media might also improve the visibility of Dr. Garrison's political efforts.

Finally, it is unclear whether Dr. Garrison has made any attempt to forge partnerships with other similarly placed health centers in the state around this issue. Have other organizations found options that Garrison should know about? Can they, as a larger group, engage the state government to more effectively initiate legislative changes? If Dr. Garrison has not attempted to make connections with other groups and individuals, she may actually undermine her cause. If she is punished for breaking the law, this may impede the work of other groups seeking legal reform supporting needle exchange programs. Ultimately, she may unintentionally lose public support for needle distribution programs rather than generate beneficial positive backing.

Dr. Garrison need not exhaust each and every possible alternative in order to justify her breaking the law. In this case, however, Dr. Garrison may have considered breaking the law without sufficient effort to seek legal means to enact meaningful and beneficial political change. I applaud her efforts to pursue innovative, effective treatments to improve patient health. Her engagement in state and local politics highlights her desire to shape her character as a thoughtful citizen and clinician. Despite these positive aspects, Dr. Garrison may not yet have adequate ethical grounds for breaking the law, even if for a good cause. Although clinicians may face situations where civil disobedience is actually warranted, Dr. Garrison has not yet provided sufficient justification.

References

1. American Medical Association. Principle of Medical Ethics. In: *Code of Medical Ethics Current Opinions*, 2002-2003 edition. Chicago: AMA Press; 2002:xii. Available at: http://www.ama-assn.org/ama/pub/category/2512.html. Accessed December 2, 2003.

2. Childress JF. Civil disobedience, conscientious objection, and evasive noncompliance: analysis and assessment of illegal actions in health care. *Journal of Medicine and Philosophy*. 1985;10:63-84.

Barry DeCoster, MA, is a doctoral candidate in the Department of Philosophy at Michigan State University and works at MSU's Center for Ethics and Humanities in the Life Sciences. His major areas of research are health care ethics and the philosophy of science.

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.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.medu1-0401

Medical Education

Courses in Research-Based Health Activism

Incorporating research-based health activism into the medical school curriculum can help physicians be more efficient advocates for patients.

Oren M. Tepper, MD, Peter Lurie, MD, MPH, and Sidney M. Wolfe, MD

This article has 2 premises: research-based health activism can help shape health care delivery and health policy, and teaching such advocacy techniques helps to nurture the health advocates of the future.

Health professionals bring many distinct advantages to the advocacy field. First, they may notice developing problems that have not yet reached public awareness. Second, they usually have better access to data sources than nonprofessionals. Last, health professionals are generally afforded greater authority in the health advocacy arena.

Unfortunately, most health professionals are never exposed to or trained in research-based health advocacy or related areas. Rothman argues that a curriculum that teaches advocacy skills along with diagnostic skills could help rebuild medical professionalism[1]. Others have encouraged medical schools to go beyond teaching clinical skills and to become actively involved in socially oriented health policy[2]. Advocacy research could raise the overall standard of health care and also serve as an effective means of responding to public health issues[3].

Because of the lack of appropriate advocacy training, some academic institutions are now pioneering courses in research-based health activism. The current article discusses courses that have taught advocacy skills through both lectures and hands-on experiences. It begins with a description of a course taught at the University of Michigan and then describes other courses that have been based, in part, on it.

The University of Michigan Course

In the fall of 1997, 17 undergraduate students took part in a course at the University of Michigan, Ann Arbor. The chief goal of the course was to carry out research projects that could ultimately influence health policy. Over the course of 1 semester, students were responsible for (1) identifying a public health problem amenable to a focused research project, (2) writing a 5-page research protocol, (3) applying to the Institutional Review Board (IRB), if necessary, (4) collecting and analyzing the data, and (5) presenting the project to the class in oral and written form. The class met twice a week for 2 hours and included formal lectures on topics in epidemiology, questionnaire design, and sample size calculation.

Appropriate projects tended to be those that could be conducted quickly and inexpensively, typically secondary data analyses or simple cross-sectional studies. After identifying their topics, students learned about previous research or activist efforts related to their topics through telephone calls to experts as well as Medline and Internet searches. After settling on a topic, each group of 2 to 3 students developed a 5-page research protocol describing the study design, subjects, recruitment methods, study variables, and statistical

approach in detail. After the protocols were submitted at mid-term, students conducted pretests and began collecting data. About once a week, each group reported its progress; other students then offered suggestions on how to overcome any obstacles encountered. This format gave students an interest in each other's work, and they gained familiarity with research and advocacy techniques not directly relevant to their own projects. The course also included mock sessions in which students played the roles of radio, television, and print media interviewers and interviewees.

As the fall semester came to an end, most students wanted to continue their work. At their request, faculty member and member of the Public Citizen's Health Research Group, Peter Lurie, MD, MPH, offered a 2-credit independent study elective during the subsequent semester to 5 of the original 7 groups. Approximately every 2 weeks, the groups met with Dr. Lurie individually to work on the projects. There were also monthly potluck dinners at Dr. Lurie's house at which each group reported its progress, carrying over the interactive and collaborative pedagogic methods from the previous semester. Prior to each meeting, 1 group distributed its most recent write-up so that fellow students could prepare feedback. During these sessions, Dr. Lurie also led discussions on relevant topics that arose (eg, how to write medical journal articles).

Student projects addressed such topics as hepatitis B vaccination availability, sex education information on the Internet, cigarette labels in developing countries, and drug pricing (Table 1). The projects produced 3 peer-reviewed medical journal articles, significant press coverage, submission of comments to an international advisory body, and a press conference attended by a US congressman.

Examples of University of Michigan Student Projects Warnings on US Cigarette Packs in Foreign Countries

This project was a cross-sectional study of international cigarette pack warnings and took place while US policy makers were considering a comprehensive tobacco settlement that did not address international tobacco sales. The students joined GLOBALink, an Internet-based international tobacco activist network. They received data from 45 countries whose GLOBALink member described his or her country's law, or sent cigarette packs by mail, fax, or scanned as email attachments. The labels were then graded on a 0-10 content scale according to whether they included 10 particular health warnings.

In general, US tobacco companies did not go beyond compliance with inadequate local laws. The average content score for developing countries was 1.6, compared to 5.0 for developed countries. Developing country warning labels were somewhat smaller, more likely to be on the sides of the pack, less likely to mention tar or nicotine levels, and less likely to be part of a rotating system of labels.

The results were released as a report[4] at a press conference in Washington, DC, arranged by Public Citizen's Health Research Group and attended by Rep Lloyd Doggett of Texas, garnering modest television and print media attention[5,6]. The work was then published in the leading journal in the field, *Tobacco Control*[7], attracting additional press coverage[8,9,10]. The group also submitted comments based on its findings to the World Health Organization's Framework Convention on Tobacco Control.

Rates of Hepatitis B Vaccination Among Gay Men in Ann Arbor

Another group was interested in the health of gay men; Dr. Lurie suggested that they investigate hepatitis B vaccination rates. They designed a 25-item questionnaire and submitted their protocol to the IRB. Gay men were contacted through local gay organizations or functions: local bars, dance clubs, a swim team, a gay

fraternity, and gay advocacy groups. Sixty questionnaires were completed by the end of the first semester and an additional 58 were added in the second semester.

Sixty-seven percent of the participants were aware of the hepatitis B vaccine, yet only 22 percent had received the full set of 3 injections. Of those not vaccinated, 58 percent indicated they would be very willing to do so. University Health Services were the sources of information on hepatitis B vaccines for only 14 percent of respondents, compared to 25 percent who named newspapers and magazines as information sources. An article describing these findings was published in the *Journal of American College Health*[11,] and its release was covered in local newspapers[12,13]. The group sent a copy of the article to every University Health Service listed by the American College Health Association, urging them to conduct outreach to gay men.

Other Activist Courses

In 1999, Case Western Reserve University School of Medicine established an activist course featuring guest lecturers. This has been the most consistently offered activist course to date. Over time, the focus of the course has shifted increasingly to the design and conduct of research-based advocacy, although the lecture series remains an integral component. Eleven journal articles have been published and 2 are in press on subjects ranging from the content of physician lobbying of Congress to the sudden growth of Internet sites selling ciprofloxacin following the anthrax outbreak[14,15,16,17,18,19,20,21,22,23,24].

In early 2001, Public Citizen received a grant from the Medicine as a Profession program of the Open Society Institute to expand the teaching of research-based advocacy. Table 2 describes 17 courses that have been or are being offered. Twelve of these are ongoing, including new courses at Yale, Tulane, and the University of Michigan medical schools. Syllabi for all the courses, including model curricula, are available online at: http://www.citizen.org/hrg/activistcour/ index.cfm.

Almost half of the courses have required students to write protocols, and 3 have also required students to actually collect data. The course at the Albert Einstein College of Medicine brings in students from around the country for an intensive month-long course; almost all other courses are offered over several weeks or months. Some courses have emphasized media skills and direct action (eg, the 2 courses at the University of Pennsylvania), while others have been more research-oriented (University of North Carolina). Research from the latter course has been presented at a major medical meeting[25] and is currently under review at a medical journal.

Public Citizen acts as a consultant to the course directors by assisting in the design of the curriculum, identifying local faculty mentors, offering guest lectures, reviewing protocols during the course, and, where appropriate, assisting in dissemination. It also provides course grants in the range of $2000 to $4000 for materials preparation, guest speakers, and subject reimbursement. All projects involving human subjects are required to undergo review by a local IRB.

Discussion

The experiences described here illustrate the potential of research-based health activism as an instrument for both education and activist work. Such a course can benefit students even if they do not ultimately pursue a career in health activism. Being able to use and interpret biostatistics, write research protocols and journal-style papers, and present information to the lay public are useful tools in any health field. An activist course may also create a new career path or unmask an underlying interest in public health or epidemiology.

Health activist courses can be taught at 3 levels: (1) a basic course in which students learn about health activism through lectures and discussions, (2) an intermediate course in which students prepare research protocols but do not necessarily execute them, and (3) an advanced course in which students design and conduct their own research projects. The type of course offered will depend in part on instructor experience, the curricular structure, and the level of student education. A project-based course is clearly more time-consuming and difficult to teach, and therefore may not be feasible in many medical and public health schools. However, even undergraduate students, who are likely to be less experienced and thus may need more supervision, were able to complete some very successful projects. The Case Western medical school experience illustrates that more advanced students can be even more successful.

The instructor's range of experience is an important factor in determining the quality and scope of the course. One area where experience has proved especially crucial is helping students identify topics consistent with interests and practical within a limited time frame. The instructor, or a consultant, must also be able to help students assess the policy relevance of their project, identify other related activist work, and provide appropriate contact persons. Knowledge of research design, statistics, activism, and media relations also is needed. The instructor must be able to improvise lecture topics as the need arises because research-based health activism is often accompanied by unpredictable challenges that need to be addressed rapidly.

Clearly, incorporating new subject areas into already crowded health professions curricula, the structure of which vary from school to school, is a challenge. However, curriculum committees are opening their doors to the ideas and contributions of students in establishing new courses. In 1995, Dartmouth Medical School invited its students to organize electives addressing topics that were not being offered by the school. One group of students successfully developed a women's health elective. An article describing their efforts stated that their "experience shows that medical students' personal involvement and their unique viewpoint can be invaluable additions to any medical education reform effort"[26]. Nine of the courses described here were initiated or run by medical students or residents, reinforcing the Dartmouth experience.

Developing a research-based health activism course is challenging and time-consuming. Our experience suggests, however, that it is both possible and worthwhile. It is our hope that this article provides a framework for the development of additional courses.

Acknowledgment

Special thanks to Max Heirich who cotaught the University of Michigan course. Thanks also to the students in the University of Michigan course: Macksood Aftab, Rehan Ahmed, Sarah Alvarez, Emily Gertz, Angela Hallfrisch, Sierra Hillebrand, Rose Jacobs, Debbie Kolben, Sarah Meyers, Katie Neighbors, Julie O'Brien, Chinwe Oraka, Lee Roosevelt, Linda Shih, Meghan Smith, Oren Tepper, and Lauren Teras and to the Inteflex Medical Program and Residential College that sponsored the University of Michigan undergraduate course. This work was partially funded by the University of Michigan Research Opportunity Program and the Medicine as a Profession Program of the Open Society Institute, David Rothman, Director.

Tables

Table 1: Student projects at the University of Michigan, 1997-98. Table 2: Activist courses in the US, 1998-present.

References

1. Rothman DJ. Medical professionalism--focusing on the real issues. *N Engl J Med*. 2000;342:1284-6.
2. Peabody JW. Measuring the social responsiveness of medical schools: setting the standards. *Acad Med*. 1999;74:S59-68.
3. White KL. Health care research: old wine in new bottles. *Pharos*. 1993;56:12-6.
4. Aftab M Kolben D, Lurie P, Wolfe SM. Smokescreen: double standards of US tobacco companies in international cigarette labeling. *Public Citizen Web site*. 1998. Available at: http://www.citizen.org/documents/1456.pdf. Accessed December 8, 2003.
5. US tobacco firms mislead foreigners, Nader allies say. *Richmond Times-Dispatch*. September 10, 1998.
6. Monroe N. US tobacco warnings not exported. *Austin American Statesman.* September 10, 1998.
7. Aftab M, Kolben D, Lurie P. International cigarette labelling practices. *Tob Control.* 1999;8:368-72.
8. White C. Canada plans stronger health warnings on cigarette packs. *BMJ*. 2000;320:140.
9. Macdermid A. Tobacco firms under fire. *The Glasgow Herald*. January 6, 2000:5.
10. Bagnall J. ERs suffer across Canada; a roundup of events, big and small, that made news this week. *The Montreal Gazette*. January 8, 2000:B2.
11. Neighbors K, Oraka C, Shih L, Lurie P. Awareness and utilization of the hepatitis B vaccine among young men in the Ann Arbor area who have sex with men. *J Am Coll Health*. 1999;47:173-8.
12. Sheth T. Study finds vaccine rates low among local gay men. *Michigan Daily.* February 10, 1999:3.
13. Study shows many local gay men not getting beneficial vaccine. *Ann Arbor News*. January 28, 1999:D1.
14. Alexander GC, Sehgal AR. Why hemodialysis patients fail to complete the transplantation process. *Am J Kidney Dis*. 2001;37:321-8.
15. Alexander GC, Sehgal AR. Variation in access to kidney transplantation across dialysis facilities: using process of care measures for quality improvement. *Am J Kidney Dis*. 2002;40:824-31.
16. Landers SH, Sehgal AR. How do physicians lobby their members of Congress? *Arch of Intern Med*. 2000;160:3248-51.
17. Sehgal AR, Dor A, Tsai AC. Morbidity and cost implications of inadequate hemodialysis. *Am J Kidney Dis*. 2001;37:1223-31.
18. Tsai AC, Lurie P, Sehgal AR. An outbreak of web sites selling ciprofloxacin following an outbreak of anthrax by mail. *Am J Med*. 2002;113:424-7.
19. Goyal M, Mehta RL, Schneiderman LJ, Sehgal AR. Economic and health consequences of selling a kidney in India. *JAMA*. 2002;288:1589-93.
20. Tsai AC. Concern about drug reps. *Health Aff (Millwood)*. 2002;21:296-7.
21. Tsai AC. Free software and physician profiling. *JAMA.* 2002; 287:45.
22. Tsai AC. Conflicts between commercial and scientific interests in pharmaceutical advertising for medical journals. *International Journal of Health Services.* 2003;33:751-68.
23. Tsai AC. Policies to regulate gifts to physicians from industry. *JAMA*. 2003;290:1776.
24. Tsai AC, Tamayo-Sarver JH, Cydulka RK, Baker DW. Declining payments for emergency department care, 1996-1998. *Ann Emerg Med*. 2003;41:299-308.
25. Tran T, Sengupta S, Lurie P, Goodman R, Wolfe S. Violations of exhibiting rules at the 2002

American Psychiatric Association Annual Meeting. Presented at: 26th Annual Society for General Internal Medicine. Vancouver, British Columbia; 2002.
26. Atkins KM, Roberts AE, Cochran N. How medical students can bring about curricular change. *Acad Med*. 1998;73:1173-6.

Oren M. Tepper, MD, is currently doing surgery residency training in the NYU Medical Center Department of Surgery and Institute of Reconstructive Plastic Surgery.

Peter Lurie, MD, MPH, is deputy director of Public Citizen's Health Research Group, a Ralph Nader-founded advocacy group in Washington, DC. He has held faculty positions at the University of California, San Francisco (UCSF) and the University of Michigan.

Sidney M. Wolfe, MD, has been the director of Public Citizen's Health Research Group since 1971. Since 1995 he has been an adjunct professor of internal medicine at the Case Western Reserve University School of Medicine. He is currently a member of the Society for General Internal Medicine. His awards include receiving the MacArthur Foundation Fellowship in 1990.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.hlaw1-0401

Health Law

Federal Agencies Monitor Physician Prescribing for Pain

Physicians need to perform their due diligence and practice caution when prescribing addictive pain medications to relieve their patients' chronic pain due to increased federal monitoring of pain prescriptions.

Amy Young

Dr. Elisa Clark is a neurologist who specializes in pain management. This is a difficult specialty area for many reasons. It is not always easy to pinpoint the cause of pain and, when you manage to do so, the treatment problems begin. Individual patients react to pain relievers differently. Finding the proper pain relief and the correct dosage for a given patient can be tricky. The only true measure of pain severity is the patient's reported experience. This should be sufficient, as Dr. Clark sees it. After all, it's the patient's painful experience that is the target for the treatment. Moreover, the experience of pain has deleterious side effects that deprive patients of the adequate rest, nourishment, and activity they need in order to recover. But relief for neurologic pain comes chiefly from natural and synthetic opiates, which are controlled substances because they are addictive. So advances in pain management that encourage aggressive pain relief have been met by reservations about abuse, addiction, or sale of narcotics by patients. Hence, insurance companies and regulatory and legal agencies have begun to scrutinize prescriptions for controlled substances and the physicians who write them in the interest of safeguarding patients and society from addiction and the antisocial behaviors it can engender.

These pain treatment challenges engage Dr. Clark. She is a founding partner in a pain management clinic, maintains her own neurology practice, and conducts clinical research into chronic pain management. She is concerned that regulatory attention to pain prescriptions will undo more than a decade's work in educating physicians that patients do not have to suffer from pain. She has taken a strong pro treatment position on the issue and advocates for appropriate pain management through her clinical work and research publications.

Patrick Moran is a private patient of Dr. Clark's. He came to her office several weeks after an auto accident. He had been the front seat passenger in a car that did not have inflatable air bags. It appears, on x-ray, that one of Patrick's lumbar vertebrae twisted slightly when Patrick's right knee hit the dashboard on impact. He has been in severe, debilitating pain since a day after the accident and has remained as immobile as possible. Dr. Clark prescribed oxycodone and asked Patrick to return in 3 days so she could start him on some exercises as soon as the pain was under control. When he returned, Patrick Moran said he was still in severe pain and could hardly walk.

Dr. Clark knows that muscle inactivity at this point will only slow Patrick's recovery and could add to associated pain. She wants to increase his oxycodone to free him of pain and get him moving again. Her research has shown that some patients improve only with much higher dosages of pain reliever than others. Dr. Clark suspects, however, that her prescribing patterns are being monitored by both insurance companies and pharmacies. Her opiate prescriptions have attracted suspicion and attention. Regulatory agencies worry that, because there is no way to prove someone is in pain, physicians may prescribe opiates to "patients" who are not really in pain but who are either addicted to the drugs or wish to sell them. Dr. Clark does not intend to withhold what she thinks Patrick Moran needs to progress in his program of pain relief and returned function. To do so for her own protection would be unprofessional and unethical. On the other hand, if federal DEA officials show up in her office and threaten her license to prescribe controlled substances or her freedom, all of her patients will suffer.

Legal Analysis

Dr. Clark's concerns are not unfounded. Federal officials have burst into pain clinics and arrested the physicians there in the past[1], charging them with anything from drug trafficking to manslaughter. The Drug Enforcement Agency (DEA) points to cases like that of Dr. Graves to justify their actions. In *Florida v Graves*, a Florida physician was found guilty of 4 counts of manslaughter, as well as racketeering and drug charges, and sentenced to nearly 63 years in prison[2]. Investigations of Dr. Graves began when several pharmacists became suspicious of his prescribing patterns— some because the combination of medications seemed unusual to their past experience, some because the dosages seemed high, and some because of the frequency of the prescriptions. When Dr. Graves became aware of the pharmacists' concerns, he contacted Florida's State Attorney's office, asking for help and admitting his suspicion that some of his patients might be abusing their medications or diverting the drugs to others. The State Attorney did not inform Dr. Graves of their pending investigation but instead sent an agent posing as a patient to Dr. Graves and enlisted a few of his patients to wear wire taps during their appointments with him. Once the State Attorney's office had concluded their investigation, Dr. Graves was indicted for the overdose deaths of 4 of his patients, racketeering, and delivery of a controlled substance.

The manslaughter charges against Dr. Graves alleged that he was responsible for the overdose deaths of his patients due to his "culpable negligence"[3]. Dr. Graves was accused of illegally prescribing medications "not in good faith or in the course of his professional practice as a physician which caused the deaths of four patients"[4]. Dr. Graves argued, first, that he was not negligent in prescribing the medications and, second, even if he had been negligent in prescribing, his prescriptions had not *caused* the deaths of the patients—the patients' abusive usages of the drugs caused their deaths. Dr. Graves maintained that his patients lied to him to obtain prescriptions, did not take medications according to his instructions, and, in some cases, abused alcohol while taking medications. Pain specialists testified for Dr. Graves that patients develop high tolerances for certain medications, such as Oxycontin (a brand of oxycodone) and Xanax, which in turn necessitated high dosages and more frequent prescriptions. The prosecution argued that Dr. Graves was selling prescriptions for cash "without any real examination, diagnostic testing, or follow-up"5]. The jury sided with the prosecution, sentencing Dr. Graves to 62.9 years in prison.

Dr. Graves was the first physician to be found guilty of manslaughter for the overdose deaths of patients. Legal liability and criminal guilt require plaintiffs and prosecutors to prove an element of causation in every case. Prior attempts to prosecute physicians had failed because physicians argued successfully that a patient's choice to abuse medications was an intervening cause that eliminated the physician's responsibility for an overdose death of a patient. Many physicians are now wary to prescribe pain medications regularly and some patients have been left to shop for physicians willing to risk government investigations in the interest of sparing their patients from chronic pain. An estimated 50 million people suffer from undertreated

pain, and many physicians and patients still maintain that oxycodone is the best treatment for chronic pain. Despite repeated studies concluding that pain is consistently undertreated and a 2002 National Institute of Health report that people with cancer suffer needlessly from pain, physician apprehension of prescribing pain medications continue because of government investigations and DEA warnings[6].

The Federation of State Medical Boards published minimal standards for prescribing pain medications; physicians who prescribe pain medications in states that have adopted these standards will be free from prosecution if they "take a complete patient history, conduct a physical exam, develop a treatment plan, obtain informed consent, periodically review the care plan, consult a specialist when necessary, maintain complete and accurate medical records, and comply with controlled substances laws"[7]. These standards, however, are minimal and lack specific guidance for physicians willing to prescribe medications that are effective and safe when used for pain relief but are dangerously addictive if crushed into powder and used as a street drug. Many other states have begun investigations and prosecutions of pain specialists for the oxycodone-related deaths of their patients. Since the Dr. Graves conviction, pain specialists have become more concerned about what constitutes due diligence on their part if they suspect a patient is lying to them about their pain or their drug usage.

Questions for Discussion

1. When prescribing highly addictive medications like oxycodone, what measures can physicians take to protect their patients from adverse outcomes and themselves from liability?
2. How can physicians advocate for appropriate pain management for their patients?

References

1. Kaufman M. Worried pain doctors decry prosecutions. *Washington Post*. December 29, 2003:A-1.
2. *Floridav Graves*, No 01-422-CFA (Fla Cir Ct Feb 20, 2002).
3. Appellant's Initial Brief, *Graves v State*, No 1D02-1664 (1st Dist, Fl).
4. Ibid.
5. Douglas D. Physician receives nearly 63-year prison sentence for Oxycontin deaths. 11 *BNA Health Law Reporter* 469 (March 28, 2002).
6. Ammann M. The agony and the ecstasy: how the Oxycontin crackdown hurts patients in pain. *Reason.* April 2003. Accessed January 2, 2004.
7. Brushwood DB. Important lessons from a physician's conviction for drug diversion. *Mayday Pain Project*. March 2002. Accessed January 2, 2004.

Amy Young is a third-year law student at DePaul University College of Law. She also works in the Health Care Practice Group at Vedder, Price, Kaufman & Kammholz, PC.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.cprl1-0401

Clinical Pearl

Treatment of Dependence on Opiate Medications

Various therapies and treatments can help patients rehabilitate from opiate addictions and withdrawal symptoms.

Norman S. Miller, MD

Scope of Dependence on Opiate Medications

The National Household Survey on Drug Abuse demonstrates that 2.6 million people misuse pain relievers, including hydrocodone and oxycodone. This misuse of prescription medicines affects many people, particularly older adults, adolescents, and women. There has been a sharp increase in new users of prescription drugs for nonmedical purposes, particularly painkillers, among teenagers and young adults 12 to 17 years old (2.9 percent increase), and 18 to 25 years old (3.7 percent increase).

We have seen a 5-fold increase in the incidence of narcotic medication use for nonmedical purposes from the 1980s to the late 1990s and 2000. In 1999, approximately 4 million people were using prescription drugs nonmedically, which is about double the 2.1 million people who use heroin and cocaine.

Signs and Symptoms of Dependence on Opiate Medications

The principle behavior manifestation of the presence of addiction is loss of control over the use of these medications, which results in excessive and continuous use in the presence or absence of pain from other sources. Addiction is a compulsion to use opiate medications that is not necessarily linked to a pain state from an identifiable cause, eg, neurological pain. Paradoxically, pain from addictive use develops because opiate medications become of central importance to one's life, despite development of adverse consequences. The pattern of addictive use becomes evident in the behavioral constellation beginning with preoccupation with acquiring followed by compulsive use and finally a pattern of relapse.

Psychological Consequences (Chemically Induced)

- Anxiety
- Insomnia
- Depressed mood with suicidal ideation
- Fatigue
- Anhedonia
- Problems with concentration

Medical problems can be aggravated by the misuse of opiate medications, which can mask important normal pain pathways. Because addictive opiate use is not linked to a pain source, the usual signal, to refrain from behaviors that aggravate the underlying source of pain, is dulled or absent because of effects of the narcotic medications on the perception of pain. As a result, the pain source can become worse, with further destruction of tissue and increased neurological damage.

Occupational Difficulties as a Result of Addiction

- Decreased productivity
- Increase in number of missed workdays
- Loss of employment and subsequent financial problems

Patients with drug addictions may allocate their income for drugs at the expense of required items. These patients' relationships may suffer because they are preoccupied with maintaining their addiction at the expense of their family and friends. Being "unavailable" and not invested in the relationship is common, as is physical and mental abuse. They may also lie or do illegal activities to obtain their drugs.

Biological Mechanisms Underlying Addiction and Dependence

The major opiates include natural substances, such as opium, morphine and codeine (extracted from opium). Additional opiates include semi-synthetic and synthetic drugs produced by alteration in the chemical structure of the basic poppy products, such as semi-synthetic drugs, eg, heroin, hydromorphone (Dilaudid) and oxycodone (Oxycontin); synthetic drugs include propoxphene (Darvon), meperidine (Demerol), hydrocodone (Vicodin), and others. These opiate medications are metabolized similarly but differ in their absorption (low for heroin and high for propoxyphene) and their half-life.

All prescription opiates act primarily on the mu receptor (named after morphine) with much less action at the other receptors. The sites with mu receptors where opiates act are distributed widely in the central nervous system (CNS), including the brain and spinal cord, the peripheral nervous system, and the gastrointestinal tract. Activation of the mu receptor results in analgesia, euphoria, miosis, decreased breathing rate and muscle tone, decreased motility in the digestive tract and hormonal changes. Addiction is directly linked to the mu receptor, as it is responsible for "the rush" or "thrill" as well as the urge and drive to use more opiates (reinforcement of use).

Physiological Responses to Intoxication

- Papillary constriction
- Hypotension
- Constipation
- Slurred speech
- Psychomotor agitation or retardation
- Respiratory depression and cardiovascular collapse (in large enough doses)

Tolerance will develop selectively to various psychological and physiological parameters with combined use over time.

Tolerance and Dependence

Tolerance is the decreasing effect from the dose of the drug, or the need to increase the dose to maintain an effect. Intracellular changes occur, which account for tolerance and withdrawal. Tolerance develops to most addictive drugs, eg, a 20-to 100-fold increase in dosage for opiates compared to a 2-to 4-fold increase in dosage for alcohol, and can be expected as a neuroadaptation to drugs and alcohol with repetitive use and in higher doses.

Symptoms of Withdrawal from Opiates

- Dysphoria
- Nausea
- Vomiting
- Joint pain
- Back pain
- Anxiety/Agitation
- Muscle aches
- Lacrimation
- Rhinorrhea
- Pupillary dilation
- Sweating
- Diarrhea
- Yawning
- Fever
- Insomnia
- An intense drive to use more drugs, particularly opiates

The peak period and duration of withdrawal after cessation of a drug depends on the half-life of the opiate. In general, a shorter half-life leads to shorter withdrawal. Also, the longer the duration of use of the opiate and the higher the dose, the more severe and protracted the withdrawal. For example, withdrawal from short-acting opiates such as morphine will start 6 to 8 hours after the last dose, peak in 2 to 3 days, and will generally last 5 to 7 days. Withdrawal from longer-acting opiates such as methadone will start 1 to 3 days after the last dose, peak in 7 to 10 days, and last up to 21 days. A post-acute withdrawal syndrome (p.a.w.s.) also occurs in most opiate addicts. This protracted withdrawal can last months and includes the following symptoms: insomnia, irritability, fatigue, drug craving, sweating, and dysphoria.

Treatment of Withdrawal

Clonidine, a nonopiate alpha-2 agonist, decreases sympathetic outflow to the body. This can often reduce the symptoms of opiate withdrawal, particularly when given in an inpatient setting, by 50 percent to 75 percent, if given in adequate dosages. Generally, oral clonidine 0.1 mg qid and 0.1 mg qid as needed are given daily and a clonidine patch 0.2 mg is used weekly for 1-2 weeks. Doses should be held if the patient is too sedated or experiences orthostatic hypotension or if the blood pressure drops below 90 systolic/ 60 diastolic.

Benzodiazepines, such as diazepam, work at the GABA A receptor and are used to help with agitation, insomnia, muscle aches, and cravings. Doses are typically as follows: diazepam 5 mg qid as needed for 48 to 72 hours, although this can be given for longer periods of time, depending on the severity of the withdrawal.

Other medications used for helping with opiate withdrawal are hydroxyzine 50 mg, or trimethobenzamide 250 mg by mouth or 200 mg rectally for nausea and vomiting. Loperamide 4 mg is used for severe diarrhea. Dicyclomine 20 mg tid can be used for abdominal cramping while acetaminophen or ibuprofen are used for headaches and other pains.

Naltrexone is a mu antagonist and has been used in conjunction with the above medications for an accelerated detoxification. The advantage to this is shorter withdrawal time with less cost. Typically 12.5 mg are used the first day with an increase to 25 mg on the second day and 50 mg on day 3. Some motivated patients may also want to be on naltrexone 50 mg daily to help maintain abstinence from opiates. This seems to be especially helpful for addicted health care workers under direct supervision (someone who ensures the patient is taking the medication). Side effects of naltrexone include abdominal pain, headache, insomnia, anxiety, nausea, and vomiting. A more serious problem is potential hepatotoxicity, especially as the dose is increased above 50 mg. Liver enzymes should be monitored monthly for at least the first 6 months and every 2 to 3 months thereafter if the enzymes are normal. Naltrexone use is contraindicated in patients with severe liver disease, hepatitis, and those taking opiate agonists.

Opiate medications, such as methadone, which is a long-acting opiate, can be used for detoxification from opiate medications. They are effective in reducing symptoms of opiate withdrawal especially for intravenous opiate users and can be used instead of the above medications. Generally 15 to 20 mg of methadone is given on the first day. If the person experiences withdrawal, the dose will be increased by 10 mg increments. Once the patient no longer experiences withdrawal, the dose is decreased by 10 percent per day. However, there can be problems in withdrawing from methadone, eg, decrease in addicts' subsequent motivation to become drug free. Another challenge is that methadone can only be dispensed by FDA- and DEA-licensed clinics, which severely limits its use by most physicians. Buprenorphine, which is a partial agonist-antagonist at the mu receptor, is also being used for opiate withdrawal and maintenance and appears to be effective. Advantages to buprenorphine are its upper limits on analgesia and respiratory depression at higher doses. It also has a milder withdrawal syndrome compared to other opiates.

Continued Treatment

Helping opiate addicts through acute withdrawal is only the first step in sobriety. Next, patients should be referred to substance abuse treatment centers, either inpatient or outpatient depending on their drug history. Here they can gain a greater understanding of addiction, learn new coping skills, and receive help in making the personal and behavioral changes needed for recovery. This is accomplished through didactics, group, family, and individual therapies, and treatment of any comorbid medical or psychiatric conditions. Also of great importance is the patient's early involvement in a 12-step group such as Narcotics Anonymous for further support of his or her recovery. Studies show that patients' chances of remaining drug-free are much greater if they complete a treatment program and then continue in a 12-step program on a regular basis for an extended period of time.

Prevention and Long-Term Interventions

Importantly, alcoholism and other drug addiction are accepted as contraindication to the use of opiate medications in patients with chronic, noncancer pain. However, clinicians must always consider the potential for addiction during the treatment of any patient in acute and chronic administration. In addition, those patients at risk for the development of addiction, tolerance, and dependence to opiate medications include patients with idiopathic pain (no clear etiology) and high levels of psychological distress or disability. There

is general agreement that those at substantial and significant risk for the development of overuse and addiction are patients who have a prior or current history of alcohol and drug addiction. Patients should be screened for high-risk of problematic opiate use if they have any previous history of alcohol or drug misuse or addiction.

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994.
2. Lu HU, Passik SD, Portenoy RK. Management of chronic pain in the patients with substance abuse. In: Aranoff GM, ed. *Evaluation and Treatment of Chronic Pain*. 3rd ed. Baltimore: Williams and Wilkins, 1998:421-429.
3. Miller NS, Gold MS, Smith DE. *Manual of Therapeutics for Addictions*. New York: Wiley-Liss, Inc; 1997.
4. Miller NS, Greenfeld A. Patient characteristics and risk factors of development of dependence on hydrocodone and oxycodone. *Am J Ther*. 2003. [In press].
5. Schuckit MA. *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment.* 5th ed. New York: Kluwer Academic/Plenum Publishers; 2000.
6. Substance Abuse and Mental Health Services Administration. National household survey on drug abuse. 2001. Accessed December 30, 2003.

Norman S. Miller, MD, is a professor in the Department of Psychiatry and the director of Addiction Medicine at Michigan State University. He is also an attending physician for addiction services at St Lawrence/Sparrow Health Care System.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.pfor1-0401

Policy Forum

Civic Obligations in Medicine: Does "Professional" Civil Disobedience Tear, or Repair, the Basic Fabric of Society?

Professional civil disobedience can have benefits and risks to both medical professionals and patients.

Matthew Wynia, MD, MPH

The medical profession sits, sometimes uncomfortably, between the medical needs of our patients and the values and priorities of health care policy makers. Whether these policymakers work in the private or public arena or act in the interests of business or government, the medical needs of our individual patients will occasionally conflict with the diverse needs of the groups of which they are a part. Indeed, it has been argued that professions arise where vulnerable individuals are at risk of exploitation by the state or market forces—with professionals serving to protect the needs and rights of the vulnerable[1]. At the same time, medical professionals frequently are called upon to support the public health needs of society, even when individual patients might prefer otherwise (reporting of infectious diseases and isolation protocols come to mind as examples). Balancing these competing obligations is a sine qua non of professional life—sometimes we must act to preserve the health of the public despite the desires of individual patients, other times we must frustrate governmental and market forces to protect our patients' health and human rights. No one ever said being a medical professional was easy.

The possibility that these conflicts will be resolved in favor of patient or public health needs but against social rules is well-recognized. Accordingly, for a physician it may sometimes be ethical to break the law. For example, the AMA *Code of Medical Ethics* opines that:

"Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supercede legal obligations"[2].

Not quite a clarion call to civil disobedience, but the door is clearly ajar. Civil disobedience has been defined as a "public, nonviolent, conscientious yet political act contrary to law [and] usually done with the aim of bringing about a change in the law or policies of the government"[3]. Supporters have said that civil disobedience, in part, calls public attention to a "discrepancy between moral standards and some law, policy, or state of affairs"[4]. Yet detractors claim that it also represents disrespect for the legal system at best, and risks civil incohesion and chaos at worst. If we all feel quite comfortable breaking rules we don't like, civil society will crumble. Respect for the law is critical to maintaining the very fabric of a just society. Consequently, even bad laws, which we should work to change, should be respected. As Abraham Lincoln put it, "bad laws, if they exist, should be repealed as soon as possible, still while they continue in force, for the sake of example, they should be religiously observed"[5].

But respect for law has its limits and should not mean slavish acceptance of it. More importantly, professionals should recognize that "professional civil disobedience"—professional groups deciding together (not just individually) to break a social rule in order to support the medical needs of our patients—might actually reinforce social structures, if done right. Recall, after all, that professions are a part of the social fabric itself.

Much debate has surrounded individual acts of civil disobedience; what sorts of disobedience exist, which can be justified using what rationales, and so on. Traditional criteria for 'acceptable' acts of civil disobedience include that the protest be open and nonviolent, punishment for breaking the law be accepted, the situation under protest be widely recognized as wrong, and that the protest be likely to improve the situation or at least not make it worse. Some of these criteria are addressed elsewhere in this month's *Virtual Mentor*[6,7]. For physicians, specific forms of individual advocacy have also been spelled out, including the use of civil disobedience, along with an increasingly stringent set of justifications depending on the risk a proposed action might pose to our patients and the public[1].

Criteria for acts of individual civil disobedience are important, but they do not recognize the special role of organized professions in changing and repairing society through acts of collective advocacy, including civil disobedience when necessary. To realize this potential, we will need a reinvigorated understanding of the proper role of professions in society.

In the last 40 years there has been widespread and powerful criticism that professions serve primarily as monopoly power-brokers to advance the interests of members. But this can work only in the short term. Over the long haul, professions are the holders of a public trust. That is, professions don't exist to serve their members, they exist to preserve and protect fundamental social values, such as justice, health, safety, and equality of opportunity. When societies fail to deliver on core human values, it is the responsibility of organized professions to reassert the importance of these values through social discourse and action, thus repairing the fabric of a good society.

When professions fail to serve this repairing function, society is in grave danger. In medicine, one can recall, for example, dramatic failures of professionalism during the Nazi experiments, the use of psychiatric hospitals as prisons in the Soviet Union, the infamous Tuskegee Syphilis Study, the South African abuse of prisoners facilitated by organized medicine's blind eye to the horrors of apartheid, and so on. In each such case, the organized profession of medicine failed in its civic duty to protect health by provoking social change. It is hard to say what the effects might have been had the organized medical profession taken a strong stand against the rise of Nazism, or apartheid, or for civil rights in the US. But we can say that when professions fail in this way, eventually either social change is driven by others (as in South Africa and the civil rights movement in the US), or the entire society fails (as in the Soviet Union and Nazi Germany).

In addition, when professions fail to perform their civic obligations they risk their own demise by inviting increasing social regulation and control over professional work. Professions' civic obligations are so critical to their long-term existence that when they fail to carry out these obligations it appears they are eventually stripped of their social standing and privileges. I believe we are in the midst of just such a time today.

The American medical profession is ultimately responsible for stewardship of the nation's health. Patient by patient and community by community, we are charged with ensuring adequate access to care, appropriate and safe delivery of care, and proper attention to resource allocation within the health care system. Though we cannot, alone, make political decisions, as a group the medical profession must sometimes force itself on political processes that are failing to serve the health needs of our patients. If doing so effectively means using organized civil disobedience following careful debate within professional deliberative structures, then that is what we should do. When used within the professional framework, civil disobedience is a tool for repairing, not tearing, the social fabric of a good society.

Finally, however, we must recognize that using these tools for our own interests will inevitably backfire. Failure to be effective leaders for our patients will lead our patients to turn to others for help, and our social leaders to consider us to be self-centered, like any other nonprofessional interest group or lobby. This process of deprofessionalization is well advanced today[8]. If we were to start right now, we would already need to re-earn, not simply reinforce, our special professional status.

Sadly, not enough physicians today understand that professional privileges cannot be sustained through collective advocacy for our own interests—they must be continually earned through effective work for the interests of our patients. Because of this misunderstanding, and increasing physician frustrations, we have recently seen more physicians using aggressive advocacy tactics, but not always in service to the issues most important to our patients. Consider this: what might happen if America's doctors chose, as a group, to march on the Capitol to protest our broken health care system? To demand universal health care coverage, the elimination of disparities in health care, and dramatic increases in health care quality. What sort of society might such an action help to create? Would the social and political status of physicians rise, making us more effective advocates across the board? And how strongly woven might our social fabric become?

Acknowledgment

The author thanks Chalmers Clark, PhD, for his important contributions to the development of the ideas in this essay.

References

1. Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. *N Engl J Med*. 1999;341:1612-1616.
2. Opinion 1.02 The Relation of Law and Ethics. American Medical Association. *Code of Medical Ethics 2008- 2009 Edition.* Chicago, IL: American Medical Association; 2008:1-3.
3. Rawls J. *Theory of Justice*. Oxford, England: The Clarendon Press; 1972;363.
4. Childress JF. Civil disobedience, conscientious objection, and evasive non-compliance: analysis and assessment of illegal actions in health care. *J Med Philos*. 1985;10:63-84.
5. Clark CC, Wynia MK. Professional civil disobedience: a duty arising from trust. (manuscript in preparation).
6. Tomlinson T. Clinical case 3 commentary: physician activism and civil disobedience. *Virtual Mentor*. January 2003. Accessed January 5, 2003.
7. DeCoster B. Clinical case 3 commentary: physician activism and civil disobedience. *Virtual Mentor*. January 2003. Accessed January 5, 2003.
8. Schlesinger M. A loss of faith: the sources of reduced political legitimacy for the American medical profession. *Milbank Q*. 2002;80:185-235.

Matthew K. Wynnia, MD, MPH, an internist, is a clinical associate professor of medicine at the University of Chicago and director of the Institute for Ethics at the American Medical Association.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.pfor2-0401

Policy Forum

Human Rights and Advocacy: An Integral Part of Medical Education and Practice

Physicians who are aware of various forms of human rights abuses are better able to serve and advocate for their patients.

Allen S. Keller, MD

As physicians, we have a crucial role to play in promoting human rights. Such rights, as enunciated in the Universal Declaration of Human Rights, include fundamental civil and political rights—the right to free speech and the right not to be tortured—as well as social and economic rights, including a right to health and health care[1]. Our knowledge, expertise, and contact with patients—especially those from vulnerable populations—position us to be involved in advocacy efforts for policies that promote human rights at the local, national, and international levels.

Health and human rights are interrelated. When human rights are promoted, health is promoted. When human rights are violated, there are devastating health consequences for both the individual and the community. Implicit in the concept of human rights is the principle of the dignity and worth of every human being. Health is a critical element in sustaining human dignity. Historically, in medicine and in medical education, we have all too often focused solely on a disease-oriented model of health and illness. By considering the interrelationship between health and human rights, we are challenged to examine health within a broader context, such as that reflected in the World Health Organization's definition of health as a "state of complete physical, mental, and social well-being"[2].

My own introduction to the relationship between health and human rights came in 1985, when, after completing my second year of medical school at NYU, I spent a year working as a medical volunteer in a refugee camp along the Cambodian-Thai border. The squalor of the camp was a breeding ground for typhoid, cholera, and other infectious diseases. While it was certainly fascinating to see patients with diseases that I had only read about, I came to appreciate that there was much more to understanding health than what I had learned in pathology. The hundreds of thousands of Cambodian refugees in those camps weren't there because of natural disasters but because of wide-scale human rights abuses. Virtually every Cambodian I worked with recounted horrific stories of brutality; many had witnessed the slaughter of family members. Wherever you looked in the camp there were men, women, and children who had lost their limbs to land mines. This misery was not a tragedy of nature but intentional human-made suffering.

After my experiences in the refugee camp I returned to NYU and Bellevue Hospital to complete my medical studies. Bellevue is the oldest public hospital in the United States and has taught me a great deal about the relationship between health and human rights, including the importance of insuring access to health care. Another formative experience for me concerning the relationship between health, human rights, and advocacy occurred when I was a fourth-year medical student. I had the opportunity to sit in with one of my clinical instructors, a member of Physicians for Human Rights (PHR), who was preparing a medical affidavit

for a torture victim applying for political asylum. The patient was a student from an African country, who was arrested after organizing a peaceful demonstration to criticize the government. He was interrogated about who his collaborators were, and during this interrogation he was repeatedly beaten, kicked, and burned with a lit cigarette. He still had scars from the burns and nightmares from the screams of his friends who were also tortured. I remember asking him "What will happen if you are sent back?" "Then I will surely die," he said.

But fortunately, perhaps in part because of the medical affidavit we wrote on his behalf, he was not sent back and was granted political asylum. At the conclusion of his asylum hearing, which we attended, he said to us "You have given me back my life."

These and other experiences have taught me about several critical roles health professionals can and must play in advocating for human rights. Physicians must take a role in the identification, treatment, documentation, and education about the abuses of human rights.

Identification and Treatment

In clinical medicine, it is said that in order to make a diagnosis, you first have to think of it. You have to recognize that a patient may be suffering from abuse before you can properly treat him or her. For example, perhaps the sleep difficulties that a patient from the former Yugoslavia is experiencing are a result of the recurrent memories and nightmares of atrocities he witnessed there. Another example might be a woman who presents with stomach aches. Does she need an upper GI series or is her real health concern the fact that she is being battered by her husband and the stomach pains are somatic manifestations of this? Domestic violence is tragically all too common. Two to 4 million women are physically abused every year in the United States by their spouses or partners. An estimated 10-30 percent of all women will be assaulted by a partner in their lifetime[3]. Such human rights-related problems will only come to light through effective and empathic communication.

A crucial part of medical education is to explore opportunities to assist local communities and work with vulnerable populations, which can lead to important advocacy opportunities. For example, at NYU and many other medical schools across the country, there are student-run free clinics. Students have also taken the lead in a number of community outreach programs including vaccination and needle exchange programs.

In recent years I have spent a great deal of time working and advocating for a group for survivors of torture. In 1995, I founded the Bellevue/NYU Program for Survivors of Torture. Since our program began, we have cared for more than 1,000 victims of torture and refugee trauma from over 60 different countries. Torture continues to be routine in more than 90 countries around the world, and it is estimated that as many as 300,000 survivors of torture now live in the US[4]. Fortunately, there are now more than 20 specialized centers throughout the United States providing care for torture victims.

Medical students have played an integral role in our program from the very beginning. For example, on Monday nights, we have a clinic where third- and fourth-year medical students and residents provide ongoing primary care to patients in our program. First- and second-year medical students also frequently volunteer to tutor our patients in English.

Documentation

Physicians have a critical role to play in documenting the health consequences of human rights violations. For example, appropriate documentation of domestic violence and child or elder abuse can be used to hold the abusers accountable for their actions and help ensure the safety of the victims. Organizations such as PHR and Doctors of the World have networks of health professionals who volunteer to conduct forensic evaluations of torture victims applying for political asylum.

Physicians can also apply research and epidemiological skills in documenting human rights concerns. I have had the opportunity to participate in many human rights investigations both domestically and abroad. For example, in 1992, I worked on a survey in Cambodia examining the medical and social consequences of land mines among civilian populations[5]. This information was used as part of a body of evidence documenting that land mines pose an unfair burden on civilians. In 1999, during the Kosovo crisis, I worked with PHR on an epidemiological survey in the refugee camps of Albania and Macedonia, documenting patterns of human rights abuses among Kosovar refugees[6]. The information we gathered was important in documenting the magnitude of the human rights abuses there and also serves as evidence in future international tribunals.

Recently, the Bellevue/NYU Program and PHR completed a study examining the health of detained asylum seekers in the New York City area—many of whom are torture victims who fled persecution[7]. The study found that the mental health of these detained asylum seekers was extremely poor and worsened the longer that individuals were in detention. The study also raises concerns about the manner in which asylum seekers are treated upon arrival in the US and while in detention. Advocacy efforts are currently under way promoting alternatives to detention for asylum seekers.

Education

An important component of advocacy is education. It is critical that we, as physicians, educate ourselves and our colleagues, our elected representatives both locally and in Washington DC, and the public about health and human rights issues. Never underestimate the impact you can make by speaking up nor presume that if you don't speak up someone else will.

For example, The International Campaign to Ban Landmines, in which many health professionals have played a critical role, has garnered tremendous support in the last few years. As a result of this campaign more than 130 countries have agreed to a ban on the manufacture, distribution, and use of these cruel weapons[8]. That our own country has not yet signed this treaty is an outrage and reminds us that advocacy efforts still have plenty to do here in the US. The fact that more than 43 million Americans remain without health insurance[9] is another advocacy priority for physicians here in the US.

Learning the proper tools for advocacy is essential. Last year, we developed a seminar at NYU School of Medicine on advocacy in medicine in which students honed advocacy skills such as how to write position papers, effectively communicate health concerns to policy makers, and utilize the media to get the message out. Similar seminars are taught at several other medical schools around the country. The Soros Advocacy Fellowship provides support for physicians to further develop their advocacy skills[10].

In order to effectively advocate, it is critical to have a network of support, rather than working in isolation. Participation in organizations such as student chapters of the AMA, the American Medical Student Association, PHR, Physicians for a National Health Program, and other organizations offers important opportunities to be effective as advocates. In recent years, for example, PHR has organized advocacy trips for medical students to go to Washington, DC to meet with legislators about issues including landmines and the need for increased funding for AIDS treatment internationally.

In my work with torture survivors and other advocacy work, I am certainly reminded of the darker side of humanity and the potential for cruelty in this world. But I am also reminded of the extraordinary resilience of the human spirit. Participating in advocacy work will make the practice of medicine more enjoyable and rewarding and offer important contributions towards promoting the health of our society.

References

1. The Universal Declaration of Human Rights. In: *Twenty-Five Human Rights Documents*. New York, NY: Center For the Study of Human Rights, Columbia University; 1994.
2. World Health Organization. *Declaration of Alma Ata*. World Health Organization, Primary Health Care. Geneva: World Health Organization, 1978:1-3.
3. Keller A, Groisser S. Domestic violence. In: Link N, Tanner M, eds. *The Bellevue Guide to Out-Patient Medicine*. London: British Medical Journal Books; 2001.
4. Keller A. Caring and advocating for torture victims. *Lancet.*2002;360(suppl):s55-6.
5. Stover E, Keller A, Coby J, Sopheap S. The medical and social consequences of landmines in Cambodia. *JAMA.*1994;272:331-36.
6. Iacopino V, Frank MW, Bauer HM, et al. A population-based assessment of human rights abuses committed against ethnic Albanian refugees from Kosovo. *Am J Public Health*. 2001;91:2013-8.
7. Keller A, Ford D, Sachs E, et al. *From Persecution to Prison: The Detention of Asylum Seekers.* Boston: Physicians for Human Rights; 2003. Accessed December 30, 2003.
8. International Campaign to Ban Landmines. Available at: http://www.icbl.org . Accessed December 30, 2003.
9. Physicans for a National Health Program. Available at: http://www.pnhp.org. Accessed December 30, 2003.
10. Soros Advocacy Fellowship. Accessed December 30, 2003.

Allen S. Keller, MD, is society master for the May Chinn Society for Bioethics and Human Rights, NYU School of Medicine Master Scholars Program. He is also director of the Bellevue/NYU Program for Survivors of Torture and the NYU School of Medicine Center for Health and Human Rights. He is a member of the international advisory board of Physicians for Human Rights. Dr. Keller is an alumnus of the Soros Advocacy Fellowship, Medicine as a Profession Program, Open Society Institute.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.msoc1-0401

Medicine and Society

What Drove Korean Doctors into the Streets?

Wang Jung Lee, MD

It is a pleasure to introduce the experience of Korean doctors to the doctors and medical students of the United States. Although this article only skims the surface of the subject, its aim is to introduce the problems of the Korean medical system and the efforts made by the Korean doctors to fix them, hoping that this will help doctors worldwide to establish desirable medical systems and positive patient-doctor relationships.

Before beginning the discussion in full scale, it is necessary to explain the basic characteristics of the Korean medical system. The Korean medical system has a unique structure, and this uniqueness was at the root of the doctors' strike that broke out in the year 2000.

Distinct Characteristics of the Korean Medical System

The main characteristic of Korean medical system that sets it apart from others is that the delivery of medical services is in private hands while the government has complete control over the fees paid for medical services. It maintains this control by making it mandatory for all medical institutions and all citizens to be covered by the one and only government-run health insurance plan. Currently, 85 percent of sickbed capacity is possessed by the private sector, and most primary diagnosis medical institutions are also privately owned. The fundamental reason for the small percentage of public ownership of hospitals and other medical care delivery institutions is the fact that, following the Korean War, the establishment of a public health care system was considered less of a priority than other projects necessary to rebuild the war-torn country. Therefore, the establishment of the medical delivery system over the last few decades was almost entirely accomplished by private doctors. Even today, most medical schools and hospitals are independent, receiving no support from the government. The quality of medical service is quite high, and in several fields such as transplantation surgery, Korea is a world leader.

A second distinctive characteristic of the Korean medical system is the social insurance form of health care insurance introduced in 1977. This form of health care insurance started out as a benefit for government employees and corporation workers only. It became a form of social insurance in 1988 when it was extended to all citizens. Hence, in about 10 years, the goal expressed in the slogan, "Give all citizens the benefits of health insurance" was attained. The Korean health insurance system, however, turned out to have a fatal economic blind spot in its desire for "low premiums—low medical consultation fees—low pay." This is how it works. Citizens pay only 3 percent of their income for health insurance, but when they are ill, they must pay almost half of the total medical bill out of their own pockets. In order to make it possible for citizens to pay for medical services out-of-pocket, the government keeps the fees for medical services very low. In fact, according to one study, the fee paid for Korean medical service is, on average, less than 80 percent of the cost of the service. Isn't this surprising?

In such a situation, doctors and medical institutions were sure to go bankrupt. The medical institutions and the government needed an ingenious scheme. The scheme they came up with was an insurance coverage plan with certain exclusions (eg, expensive medications, high equipment use fees, cutting-edge medical technologies, plastic surgery etc. were not covered) and a scheme called the "pharmaceutical margin." Coverage exclusions need no further explanation, but the pharmaceutical margin does. The pharmaceutical margin refers to payments to physicians by pharmaceutical companies in return for prescribing and dispensing their drugs. These "unofficial" profits for physicians were possible because the activities of prescribing and dispensing drugs were not separated until 1999, and the government allowed the practice of unofficial or indirect profits by tacit consent.

There is a third distinctive characteristic of Korean medical services. As mentioned earlier, Korea has a history of having to build new systems out of chaos. Everything was in short supply following the Korean war, and naturally doctors were also scarce. Where doctors and hospitals did exist, people did not have enough money to pay for treatment. Under these circumstances, the group that often acted as primary-diagnosis doctors were pharmacists. Until recently, many Koreans chose to visit a nearby pharmacy and take the medication prescribed by the pharmacist. They visited medical institutions only to cure diseases that could not be cured by visiting the pharmacy. Within this tradition, doctors and pharmacists invaded each other's function. What is especially noteworthy is that, due to this historical background, there are many, many pharmacists in Korea. The current ratio of doctors to pharmacists is approximately 1.3 to 1, which is considerably different from the 3 to 1 ratio of doctors to pharmacists in the developed countries where the functions of diagnosis and prescribing are clearly divided from the function of dispensing.

In Korea, there is also an occupation called, "oriental medicine doctor." There are approximately 70,000 doctors, about 50,000 pharmacists, and about 12,000 oriental medicine doctors who graduate from university and obtain licenses after taking a national examination. The oriental medicine doctors enjoy a relatively high status because many citizens prefer "traditional medicine." Oriental medicine doctors use some modern medical knowledge, skills, and equipment under the name of "Western and Eastern medical collaboration." The fees paid for oriental medicine are estimated to be immense.

In the year 2000, most if not all Korean doctors undertook several large strikes. It started out when the government tried to enforce the separation of prescribing and dispensing (SPD). This is a system, like that in many developed countries, where doctors diagnose and issue prescriptions and patients go to the pharmacy to get the prescriptions filled. This seemingly logical system caused discord because it disrupted the prior system described above.

First of all, SPD meant that the doctors were no longer able to gain profit from the pharmaceutical margin because they were no longer allowed to dispense drugs. SPD also meant that the pharmacists who were accustomed to acting like "sub-doctors" must play the more limited role of pharmacist from then on. Before the separation of prescribing and dispensing (SPD) was enforced, doctors, pharmacists, and almost all citizens expressed disapproval of SPD. The pharmacists were concerned about the possibility of reduced profits due to the restriction of their role. The citizens feared the inconvenience and the increase of medical fees, since they would be going to 2 professionals instead of one.

The reasons for the doctors' opposition were more diverse. Of course, they were worried about their economic loss, but they also suspected that the habitual practice of diagnosis by pharmacists, though now illegal, would continue. Thirdly, they were concerned that the health insurance finance system, which was already in the red, would go completely bankrupt. And there was another grave matter. In the Korean medical culture, medication occupies a large part of treatment. Indeed, in traditional Korean medicine,

treatment=medication. Hence doctors worried that if they were not the ones to give the medication directly to the patient, the effectiveness of treatment and the trust in doctors might decrease.

The government presented various detailed countermeasures to resolve the concerns of everyone involved— doctors, pharmacists, and citizens—but made several mistakes in the process. These were: (1) the government misjudged the effect of SPD on health insurance finance funds, and the funds decreased even further; (2) it criticised excessively the doctors' "indirect" income from the pharmaceutical companies which it had tacitly condoned until then; and (3) it lacked any long-term vision for the fundamental improvement of the so-called "3 cheap" system (ie, low premiums, low fees, low pay).

There had been dissatisfaction and distrust toward the government medical policy for various reasons over the prior 20 to 30 years, and the Korean doctors who were not organized had not been able to fight back. At the onset of the SPD enforcement, they expressed their pent-up dissatisfaction and anger. There were 2 basic reasons for their dissatisfaction: the economic disadvantages of SPD and their fear of what it would do to the nature of the medical profession as a whole.

Approximately 70,000 Korean doctors came together under the simple slogan of "medical reform." The Korean Medical Association (KMA), which had never played a central role amongst the doctors, started to lead the fight by forming a special organization. The November 1999 street demonstration of approximately 30,000 doctors was the first of several full-scale assemblies between 2000 to 2001. The ardor of the doctors, more than half of whom participated in these demonstrations, surprised the whole society, not to mention the government. At first, the demonstrators were mostly private practitioners, but, as time went by, even the medical school professors and residents started to participate.

In spite of attention aroused by the several demonstrations, the doctors finally resorted to striking. The first strike began with the closing of clinics for 3 days from April 3-5, 2000. In July 2000, all hospitals and clinics including the university hospitals closed for 1 week. During this period, all medical services with the exception of the emergency room (ER) and the intensive care unit (ICU) were discontinued, leading to great confusion. The participation of residents in the full-scale strike led to actual paralysis of the medical service system. During this process, quite a number of the medical leaders including the Korea Medical Association (KMA) president were arrested. The strike of Korean doctors continued on a sporadic basis through September 2000. In the end, the government yielded a fair amount in terms of policy.

The government, the doctors, and the pharmacists all suffered from the strikes. The government of President Kim Dae Jung suffered a series of reform failures and a decrease in number of supporters of the Kim administration. The doctors lost the trust of the citizens, which had not been that strong to begin with, and suffered economic loss. The pharmacists and pharmaceutical companies also revealed their weaknesses and suffered loss of image.

The strikes stopped in October 2000, but the conflict and opposition between the Korean doctors and government continues. The doctors are even more dissatisfied now because the government enforces more severe reductions in the fees that can be charged for medical services in order to make up for the financial loss in the health insurance system. Doctors are also reacting strongly against government policies that make it difficult for them to conduct "text–book–type" (standard) practices.

Now, 3 years after the SPD, the Korean medical field is still faced with the problems of the past. The "low premiums, low medical fee, low pay" system continues in an environment of distrust between doctors and citizens. The state of primary, secondary, and tertiary medical institution management is aggravated, and citizens complain that, although they pay more for health insurance, their benefits are not increasing.

Doctors and many public health scholars hold the pessimistic view that Korean medicine will soon face system failure, and they agree that special measures must be taken to prevent this failure. They strongly disagree, however, on specific solutions. One side thinks that strengthening the government health insurance system can prevent economic harm to doctors and health risks to patients. The other side believes that the government should abolish the compulsory health insurance system and let the market take over providing insurance. It is yet unknown which way the Korean medical system will turn, but considering President Roh's political base, the former change is more likely. This means that the opposition between the doctors and the government will continue, at least for a while.

The events of the Korean medical field have been briefly illustrated. Although this process has been painful for the doctors, the government, and the citizens, it cannot be denied that gains have been made. Most importantly is that public opinion has formed about the seriousness of Korea's medical and health care problems. In the past, medical and health care problems have always been pushed aside as secondary to 2 main issues: economic development and democratization. Even though interest in public health problems has been rising due to the growth of the national income and the increase of the aging population, these kinds of issues have always been considered concerns of special groups only. Now, as a result of the events outlined above, people have come to realize that public health- related issues are complex and that the whole nation, all citizens, must come together to resolve them. This public realization is a step in the right direction toward solving the medical and health care system problems in Korea.

Secondly, the doctors' perspectives have changed. In the past, the doctors enjoyed a high socioeconomic position but did not act accordingly as professionals in society. Through their strike, the doctors recognized how important it is to gain a good reputation and the citizens' trust. They also discovered the importance of quality control and of raising the standard for ethical conduct of the profession as a whole. Finally, they recognized the importance of acquiring political influence.

Hence, Korean doctors are now thinking seriously about their new task. They are making an effort to break the stereotypical thinking of the citizens that "the doctors' benefit is the citizens' loss" and to persuade them instead that "the doctors' benefit can also be the citizens' benefit." They are trying to improve the image of doctors as "doctors for the citizens," "doctors working for citizens' health," and "the specialist group with a self-healing function."

These efforts have not paid off as of yet. Rather, the doctors of Korea seem to be in a state of despair. However, as the saying goes, "crisis is opportunity." The Korean medical field's defects and deception have peaked; the issues have been recognized as problems to be solved. From now on there must be cooperation on a plan for improvement, which is a positive prospective.

Isn't the precise diagnosis of a disease the most important step toward proceeding with the appropriate treatment? The Korean medical field now suffers a serious illness, but because the problems are known, we may hope to prescribe appropriately. We ask for the interest and encouragement of doctors worldwide for Korean doctors who underwent a lot of pain and are just beginning to face a new challenge.

Wang Jung Lee, MD is publisher of *The Korean Doctors' Weekly* and representative of Icheon Sarang Hopsital in the Seoul Metropolitan area.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.msoc2-0401

Medicine and Society

Beyond Medical School: The Frontier of Medical Activism

Medical students' activism in various public health programs has brought benefits to patients and the medical profession.

Braden Hexom

To speak of activism is to recall the divisive Civil Rights and anti-Vietnam War demonstrations, when activism to many Americans meant tear gas, police barricades, and sit-ins. While many students took to the streets in defiance of social injustice, medical students mostly focused on their educations. Fitzhugh Mullan, a medical student activist of the time, was concerned about his fellow medical students' noninvolvement, their "noncitizenship" in the community. Mullan wrote that the degree of noninvolvement "in his own community characteristic of the American medical student today seems almost designed to breed social lethargy. The medical student is traditionally concerned primarily with his own academic accomplishment and the specific goals of his future. More than most students his educational style is that of privatism"[1]. Indeed, medical students have never been considered an activist constituency, but there have always been a few willing to test the boundaries of mainstream medical education. Students dissatisfied with conventional teaching or upset by the lack of attention to socially relevant health care issues have often been the catalysts for significant and necessary changes in public health.

While their student colleagues marched in the streets, many medical student activists of the late 1960s took to the ghettos. Concerned with an ever-present and growing gap between the economically affluent and the disadvantaged, medical students protested against the disparities in health care delivery between private hospitals that provided care to those who could pay and public institutions that mainly served the poor and indigent. Medical students related these concerns to the lack of education in the traditional medical curriculum on issues such as poverty, abortion, racism, and discrimination[2]. To address these gaps and supplement standard medical school curriculum, a growing number of medical students set out to experience caring for the underserved so that they might be better equipped to fight the disparities in health care delivery.

At the time, very few medical students received community-based training, and an even smaller number experienced training in medically impoverished areas. Students at the University of Southern California, however, took it upon themselves to become immersed in these communities. They developed a program whereby medical students worked over their summer breaks in underserved areas in the Mississippi backcountry, the Bronx ghetto, and the rural migrant community of the California valley. Working alongside local high school student "interns," these medical students sought to understand and ultimately improve health care to the disadvantaged[3]. Over the course of a few years, similar programs became available for medical students through the Student Health Organizations (SHO) and the Student American Medical Association (later to be renamed the American Medical Student Association—AMSA)[4]. The results of these programs were mixed; students gained valuable learning opportunities but often found their experiences

frustrating and the relationships with their patients volatile and unsuccessful. One important lesson they did learn, however, is that the medicine taught in the classroom is drastically different from the practice of medicine in these communities.

Successive generations of medical student activists have benefited from subsequent community electives and externships. This inclusion of rural health electives and community clinic experiences in curricula has improved medical students' abilities to understand and treat social factors of disease. In fact, most medical students today will have some exposure to underserved populations during their medical school training. The difference between the experiences of past decades and those of today is that, previously, medical students had to organize and create these experiences themselves, often with little assistance from their school and always in addition to required courses[5]. Today, medical schools offer full credit for these experiences, coordinating their programs to allow students to take electives in underserved or isolated communities. Whether or not they realize it, students who participate in these opportunities are experiencing what at one time would have been foreign material to most medical students.

Following the precedent of the Student Health Organizations, which dissolved in the mid-1970s, medical students increasingly became involved in numerous other medical organizations. Today's medical students demonstrate their activism through a wide variety of established organizations. Many of these deal specifically with political aspects of health care, the underserved and uninsured, and disparities in health care. Groups such as AMSA, the AMA's Medical Student Section (AMA-MSS), Physicians for Social Responsibility, Physicians for Human Rights, Medical Students for Choice, the Student National Medical Association, and others have strong and sustained student membership and activity. The activism of these organizations has often led to significant changes in medical education and improvements in public health.

In the late 1970s, medical student activists sought to reduce public exposure to secondhand smoke. After passing numerous internal resolutions aimed at tobacco policy, medical students of the AMA-MSS developed a campaign to eliminate smoking from domestic airline flights. The students took their idea to the AMA House of Delegates, where they succeeded in pressuring the AMA to adopt policy against smoking on airlines. As one of the first campaigns to address the health risks of secondhand public smoking, the efforts of the AMA-MSS eventually led to a smoking ban on domestic flights beginning in 1989—a significant early success in the growing movement to ban public smoking[6].

Similarly, a recent campaign generated by activists within AMSA resulted in significant changes to resident physician working conditions. Despite decades of resistance by the medical community, medical students successfully initiated a public campaign to reduce excessive workloads, improve unsafe working conditions for medical residents, and reduce the number of medical errors caused by physician fatigue. After compiling significant evidence that excessive fatigue resulting from routine 100+ hour work weeks causes poor performance and patient care, AMSA launched a multi-year campaign to create regulations to limit resident work hours. Through a coalition of medical student, resident, and patient advocacy groups, AMSA petitioned the US Occupational Safety & Health Administration, helped introduce federal legislation, and sent tens of thousands of letters to Congress between 2001 and 2002. The Accreditation Council for Graduate Medical Education passed comprehensive work hour regulations in 2002 after decades of silence on the issue[7]. Unsatisfied with being cheap labor for hospitals, medical students and residents successfully stood up for improved patient safety and common sense with regards to abuse of medical residents.

While most medical student activists seek to change medical curricula and affect public health within the context of current institutions, a number of socially conscious and aggressive medical students have turned to the larger and perhaps more frightening challenge of combating the global HIV/AIDS pandemic. Many students engaged in this struggle have continued the precedent of their forebears by traveling to underserved

areas of the world to learn, teach, and treat. They have gone to AIDS-decimated regions of the world such as South Africa, Ghana, and Senegal. Domestically, medical students have actively confronted legislators and presidential candidates, hoping to use the tide of the 2004 election to force candidates to commit resources to the global fight against HIV/AIDS. These medical students publicized candidates' verbal commitments and brought about considerable change to many candidates' HIV/ AIDS policies.

Though not as visible as activists from the politically charged 1960s, today's medical student activists have continued to challenge the standardization of traditional medical training and have worked to improve public health through their political and social efforts. As applicable to medical student activists today as it was in 1968, Arthur Douville wrote:

"Activism is resistance to models of behavior which include coldness and indifference to patients, inadequate or outdated scientific skills, and irresponsible principles of narrow self-interest in dealing with the legitimate demands of the community for a reasonable level of care. Activism is resistance to the exploitation of students on the pretext of education, from clinical clerkships to internships and residencies. Activism is the inquisitive search for scientific excellence, social responsibility, and the sensitivity and idealism which distinguish the physician from 'the doctors'"[8].

While there will always be those students absolutely absorbed in their academic development, the socially-engaged future physician leaders will continue to create a path for the rest by extending the boundaries of traditional medical training.

References

1. Mullan F. The new dynamic. *Amer J Dis Child*. 1968;116:505.
2. Mullan F. A new mood in medical students. *Medical Opinion and Review.* March 1968.
3. McGarvey M, Mullan F, Sharfstein S. A study in medical action—the student health organizations. *N Engl J Med.* 1968;279:74-80.
4. The Student American Medical Association became independent from the American Medical Association in 1968. SAMA changed its name in 1975 to the American Medical Student Association.
5. Fagel B. Medical student externship as an opportunity to expand the base of medical education: the viewpoint of the Student American Medical Association. *JAMA*. 1970;213:2059-2061.
6. Merchen TD, Champion HC. The AMA-MSS: leading the charge for change. *JAMA*. 1996;276:1438.
7. Agrawal J, Rising J. Resident education and patient safety. *Am Fam Physician*. 2002;66:1569-1575.
8. Douville A. The new physician as activist. *The New Physician*. 1968;17:209

Braden Hexom recently completed his third year at the Medical College of Wisconsin in Milwaukee and has taken a year from medical school to serve as AMSA's Legislative Affairs Director.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.msoc3-0401

Medicine and Society

Interview with Antonia C. Novello, MD, MPH, DrPH

Antonia C. Novello, New York State Health Commissioner, discusses various public health and policy problems that medical professionals currently face.

VM interview with Antonia C. Novello, MD, MPH, DrPH

Recently *Virtual Mentor* posed several questions about physicians in public life to Antonia C. Novello, MD, MPH, DrPH, New York State Health Commissioner.

Q. Why did you get involved in politics and public policy?

A. I loved the practice of medicine, where the focus is on individual patients, but early in my career I realized that my strongest interest is in improving the health of large population groups.

I wanted to be able to do something about the major health issues facing people in this country, such as the need to increase access to health care for the uninsured, the need to ensure that the health care in this country is high-quality care, and the need to improve the health status of Americans through greater emphasis on prevention and healthy lifestyles.

To play a role in addressing these issues, you must enter the realm of public health policy. So I spent several years in the National Institutes of Health, eventually becoming deputy director of the National Institute of Child Health and Human Development. Then I became Surgeon General of the US Public Health Service. Today I am Commissioner of Health for the State of New York. In my current capacity, I have been able to play a role in implementing health care access, quality, and prevention initiatives.

Q. What is the biggest health care problem facing America today?

A. There are many serious health care problems, such as increasing access to care for the uninsured, preventing medical errors, reducing obesity, and preventing chronic diseases like diabetes and asthma. But if I had to focus on just one problem, I think it would be the need to reduce health disparities affecting the nation's minorities.

Today's physicians must respond to the health care needs of an increasingly diverse society with rapidly changing demographics. Consider that in this nation of 281 million people, 12.3 percent are African American, 13 percent are Hispanic, nearly 4 percent are Asian or Pacific Islander, nearly 1 percent are Native American and Alaska Native, and nearly 7 million people, or 2 percent, are multi-racial.

The nation's minorities are disproportionately affected by many health problems. They have a significantly shorter life span than whites and higher rates of disease and mortality from disease. This is partly the result of lack of access to a regular primary care physician. Consider that approximately 38 percent of Hispanics, 24 percent of African Americans, and 24 percent of Asian/Pacific Islanders in this country lack health insurance compared to 14 percent of whites.

But even when minorities have access to care, too often they must deal with physicians who don't know their language, don't know their cultural traditions, don't provide health education, and don't provide them with the same early access to high-tech diagnostic and treatment efficacies that whites receive. For example, studies have shown that, compared to their white patients, physicians are less likely to recommend their minority patients receive bypass surgery to treat atherosclerotic coronary artery disease and knee replacements to replace diseased and painful knees.

Q. What should be done to address this problem?

A. For one thing, we need to find creative ways to increase access to health care for minorities. New York state provides large numbers of minorities with access to health care through our Medicaid, Child Health Plus, and Family Health Plus health insurance programs. New York state also has the nation's largest school-based health center program, which serves large numbers of minorities in urban, underserved areas. Currently, 42 percent of the children served in these health centers are Hispanic and 37 percent are African American. Sometimes, you have to find ways to bring health care *to* the patient in settings where they feel comfortable.

There must also be more effort to provide minorities with culturally sensitive, language-appropriate health care. This can best be accomplished by increasing the number of minority physicians. Although 25 percent of the nation's population is African American, Hispanic, or Native American, only 7 percent of medical students currently come from these ethnic groups. Some states, like New York, are providing financial incentives to medical schools and teaching hospitals to recruit and train minority physicians.

Q. How do you prevent complex health positions and messages from being reduced to more simple, polarized positions when they enter the political arena?

A. My motto is "good science and good sense." In other words, I believe that if you keep the focus on the undisputable facts and statistics regarding the nation's health problems and encourage reasonable and practicable approaches to addressing them, you can avoid polarization. Of course, solving the nation's health problems requires public awareness and support. So, education is a huge part of what we do in public health. I am first and foremost a physician, so I try to keep the focus on public health, not politics.

Antonia Coello Novello, MD, MPH, DrPH, currently serves as the 13th New York State Health Commissioner. Prior to being appointed to this post, Dr. Novello served as the 14th Surgeon General of the US Public Health Service. Her appointment marked two firsts: Dr. Novello became the first woman and the first Hispanic ever to hold this position.
After her Surgeon General tenureship, she served as United Nations Children's Fund (UNICEF) Special Representative for Health and Nutrition (1993-1996), where she advised the executive director on issues pertaining to women, children and youth. Dr. Novello entered the US Public Health Service (USPHS) in 1978 after working in the private practice of pediatrics and nephrology. Until her appointment as Surgeon General, her USPHS career was spent at the National Institutes of Health where she served in various capacities, rising to deputy director of the National Institute of Child Health and Human Development.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.msoc4-0401

Medicine and Society

Interview with Mark McClellan, MD, PhD

Mark McClellan, Commissioner of Food and Drugs, discusses pharmaceutical company research and the problems faced by funding for public health programs.

VM interview with Mark McClellan, MD, PhD

Recently *Virtual Mentor* posed several questions about physicians in public life to Mark McClellan, MD, PhD, Commissioner of Food and Drugs.

Q. Why did you get involved in politics and public policy?

A. Throughout my career, my foremost interest has been in improving public health. As a clinician, I was able to bring medical treatments directly to patients. As a health economist, I have been able to understand how different policies and medical innovations truly impact public health. I got involved in politics and public policy so I could use the expertise I have amassed to make a real difference in the nation's health policy and help all Americans live longer, healthier, better lives.

The opportunity has never been greater to improve America's health through the latest biomedical and food innovations. And yet, the challenges have also never been greater. As FDA Commissioner, I have the extraordinary opportunity to lead this agency in filling its vital mission—to protect and advance the nation's health—by fostering a more efficient and effective health care system while also supporting the development of innovative new technologies.

Q. What is the biggest health care problem facing America today?

A. Our biggest public health challenge today is providing high-quality care that is safe *and* affordable for all Americans.

Today, there is more spending on biomedical R&D than ever before, and there are more new drugs and devices in development than ever before, and yet there are fewer new medical products reaching consumers than at any time in more than a decade. The bottom line is it's getting harder and more uncertain than ever to develop new treatments. At the same time, we're also facing unprecedented challenges involving affordability and access to the treatments that do make it to patients, especially prescription drugs. Many Americans cannot afford the necessary treatments for their health ailments and are unable to realize the full benefit of the products that are available. Too often, consumers are forced to make difficult choices between safe and affordable treatments.

The challenge for all of us is to ensure access to safe, affordable medical products and to get critical treatments in the hands of Americans who need them.

Q. What should be done to address this problem?

A. To address this major health challenge, we need to find solutions that do not force Americans to make choices between what they can afford and what they need. Rather, we need solutions that improve both safety and affordability.

The new Medicare legislation represents a major step towards solving this problem. Congress has taken action to meet the needs of the nation's seniors by providing a Medicare prescription drug benefit that will save them billions of dollars each year and will enable seniors to band together to reduce their drug prices substantially.

FDA is taking many other unprecedented actions designed to get more affordable medical treatments to Americans wherever we can without compromising safety. We are taking steps to lower drug costs by helping to speed the development and approval of low-cost generic drugs after legitimate patents have expired on branded drugs. This includes the biggest expansion ever of our generic drug program and a series of regulatory changes to make it easier for generic manufacturers to compete.

We've taken steps to improve the process and lower the high cost of developing new drugs. Specifically, we're improving the pathway for developing safe and effective new medical products by making it as clear, as fast, and as cost-effective as possible.

In addition, we need to enhance our capability to use these treatments effectively, to get the most benefits for patients while avoiding costly complications. To this end, FDA is working to prevent adverse events through new rules that will require bar coding for drugs and better ways to track adverse events automatically—with the goal of preventing billions of dollars in unnecessary health care costs each year. We're striving to promote electronic prescribing, to improve quality, and to reduce prescription costs. And we're taking other steps to provide better information to health care professionals and patients alike, including new and better electronic product labels and Internet-based information about the risks and benefits of medication choices available to treat a particular health problem.

Finally, we need a bolder effort to solve the global problem of drug pricing. Prescription drugs are truly global products today, and we need a global strategy to get the most benefit from new medications for all of the people of the world. Specifically, it's time for developed nations, recognizing their shared interest in bringing better treatments to market, to find ways to fairly share the cost of new drug treatments. This need not raise costs worldwide if other countries take steps to improve generic drug development and cost, work together to harmonize regulatory procedures, and ensure the most effective distribution and use of their drugs.

Q. How do you prevent complex health positions and messages from being reduced to more simple, polarized positions when they enter the political arena?

A. Agreeing on effective public health solutions is never easy going because health policy is complex and can make a big difference in the lives of all Americans. My job necessarily involves making tough decisions every day. The key to finding the best solutions to tough policy problems is to focus on the science and to make sure that all views are fairly represented. When I say "science," I am referring to the latest biomedical, managerial, and economic science, along with the latest thinking about how industry and government can best help promote the health of Americans. At the FDA, we try to use a very public process—including

advisory committee meetings, meetings to develop regulatory guidance, and many other steps to make sure we have heard all of the good ideas out there. In this "biomedical century," this is a more challenging process than ever. But the good news is that there are better, more sophisticated tools to help us make the best decisions for the public health.

Mark McClellan, MD, PhD, is the Commissioner of Food and Drugs. Previous to this appointment, he was an associate professor of economics at Stanford University, an associate professor of medicine at Stanford Medical School, a practicing internist, and the director of the Program on Health Outcomes Research at Stanford University. He was also a research associate of the National Bureau of Economic Research and a visiting scholar at the American Enterprise Institute. He was a member of the National Cancer Policy Board of the National Academy of Sciences and associate editor of the *Journal of Health Economics*. From 1998-99, he was Deputy Assistant Secretary of the Treasury for Economic Policy.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.oped1-0401

Op-Ed

Activism? Yes! The AMA? Maybe Not

Physician organizations have an ethical obligation to advocate for general improvement of public health, even if it is sometimes at the expense of interests of medical professionals.

Howard Brody, MD, PhD

Physicians have a social responsibility to become actively involved in organizational efforts to improve the health and well-being of their patients and of the community. Ideally the physician would become involved in at least 2 sorts of efforts. One is the improvement of medical practice through raising standards, enhancing continuing education, and other efforts. The other is advocating for political changes that would improve health or access to health care for all. In some cases, membership in the same organization can meet both goals. For example, as a member of the American Academy of Family Physicians (AAFP) I can work to enhance the quality of my specialty and also advocate for the AAFP's plan for national health care reform. While I use the example of the AAFP, the obligation does *not* require that physicians join any *particular* organization, and I would argue specifically that it does not require membership in the American Medical Association (AMA).

Social activism of the highest caliber requires that the organization send a clear message. It is quite appropriate for a physicians' organization to advocate on behalf of the health of the public. It is also appropriate for a physician's organization to advocate on behalf of the interests of physicians themselves. After all, if not us, then who would? What is not appropriate is for the organization to do the second under the guise of the first. As the AMA rose to a position of almost unparalleled power during the first half of the 20th century—to the extent that it could defeat virtually any member of Congress who disagreed with its stance against "socialized medicine" in 1946-48—it often abused that power by claiming to defend the public's health when its real agenda was to defend physicians' incomes and privileges [1, 2]. The AMA has tried in many ways to modernize and to occupy a new role in a world that has changed dramatically since the 1940s. Yet the old patterns of behavior are still in evidence often enough for many physicians to feel ethically compromised by AMA membership.

The usual counterargument is that if you wish to reform the AMA, you must join and try to change the organization from within. The difficulty in doing this, however, was revealed by the debate over physician-assisted suicide. The AMA has taken a very uncompromising position on this issue. When the Michigan State Medical Society adopted a moderate stance, for example, stating that physicians of conscience might disagree on this contentious issue much as they do on abortion, the AMA applied considerable pressure to get the Michigan House of Delegates to repudiate the state position and adopt the more conservative AMA position. A survey of physicians' attitudes revealed a singular difference between rank and file AMA members and the AMA leadership. The leaders were considerably more conservative politically than the general membership. Many more members than leaders of the AMA had at least some sympathy with the

physician-assisted suicide option[3]. It does not appear, then, that the AMA consulted its membership before stating its uncompromising position on this issue. Consequently, it appears that change from within is not a viable option.

In other instances, the AMA did consult with its members but ironically to the detriment of its ethical stance on issues such as selling health-related products from the physician's office and treating members of one's family. In these cases the Council on Ethical and Judicial Affairs was reportedly prepared to offer guidelines that called the membership to a higher level of ethical behavior. The House of Delegates, it was reported, was offended by the idea that man practitioners' behaviors might be viewed as unethical. In this case the "good ol' boy" network presumably prevailed. The ethical stance eventually adopted was based on the lowest common denominator rather than aspiration toward something better.

One of the most telling indictments of the AMA's ethical stance on the health of the American public has been its record in health care reform debates. The prime example is the 1993 debate over Clinton administration's health reform proposal. Initially the AMA opposed many aspects of the Clinton plan but endorsed the basic idea of an employer mandate–that all employers should pay at least something toward health insurance for their employees. After extensive debate, the AMA House of Delegates backed off support for an employer mandate. The main reason, according to press accounts, had nothing to do with what was best for the health of the nation. Rather, it had to do with the fact that private medical practitioners are small businesspersons. One third of the AMA membership it was reported, do not provide health benefits for their own office employees and objected to a possible demand that they do so in the future[4]. That is, numerous members of the House of Delegates were willing to go on record as being opposed to adequate access to health care for their office staff rather than reduce their profits. Health reform proposals that have been offered by the AMA since the defeat of the Clinton plan all seem to have the same characteristics. Above all, these plans appear to protect physicians more than the public's health. They have tended to assure high reimbursement for physicians yet have been notably weak on features that would actually guarantee quality, affordable care for all Americans.

The task of improving the health of the public is too large to be handled satisfactorily by medical practitioners seeing patients in our offices one at a time. Without organized group efforts, we physicians will never be fully effective in addressing the entire range of health concerns. I would, however, hate to see the ethical obligation to devote a reasonable portion of one's busy schedule to these efforts become misconstrued as an ethical obligation To join any particular national organization—even the principal organization representing American physicians. While perhaps some day in the near future this organization will clean up its act and prove itself worthy of the allegiance of all thoughtful and conscientious American physicians, I believe it still has a long way to go.

References

1. Stevens R. *American Medicine and the Public Interest*. New Haven, CT: Yale University Press; 1971.
2. Starr P. *The Social Transformation of American Medicine*. New York: Basic Books; 1982.
3. Whitney SN, Brown BW Jr, Brody H, Alcser KH, Bachman JG, Greely HT. Views of United States physicians and members of the American Medical Association House of Delegates on physician-assisted suicide. *J Gen Intern Med.* 2001;16:290-296.
4. Weisskopf M, Priest D. AMA steps back from major part of Clinton health care plan. *Washington Post.* December 8, 1993:A3.

Howard Brody, MD, PhD, is a professor in the Department of Family Practice and Center for Ethics and Humanities in the Life Sciences at Michigan State University in East Lansing, MI. He is author of several books on medical ethics and other medical issues including *The Healer's Power*, *Stories of Sickness*, and a co-author of *Cholera, Chloroform, and the Science of Medicine: A Life of John Snow*.

Virtual Mentor. January 2004, Volume 6, Number 1.
doi: 10.1001/virtualmentor.2004.6.1.oped2-0401

Op-Ed

Physician Activism--An Obligation or Filler for Spare Time?

A past president of the AMA discusses the obligations of physicians to participate in health and social activism.

Nancy W. Dickey, MD

According to Webster's dictionary, an obligation is a "moral or legal duty, the act of obligating oneself or a debt of gratitude." As I pondered those words, I wondered if concurring that membership in medical organizations is an "obligation" was too strong a word. I decided that obligation is indeed just the right word. Physicians—and physicians in training—should feel an obligation to support and to be a member of those organizations that are committed to advancing and enhancing medical education, representing physicians, and establishing and upholding the ethical framework of the profession as a whole.

Medical organizations have been formed for many purposes but most often to advance the science, ethics, or educational standards of the profession or some subset of the profession. More than 150 years ago, the American Medical Association (AMA) was formed in an attempt to bring physicians' collective voices together to speak out for improvement in educational quality and standards. Organizers of the AMA also sought to establish an ethical framework that would assure patients that the profession stood for commitment to patients and quality of care. In more recent years, representation and advocacy for physicians and patients has been an increasingly predominate activity of the AMA.

The ethical code written as a result of that first meeting spoke vehemently to the importance of putting patient welfare first, caring for the poor, and identifying the incompetent (ie, the "quacks") within the ranks of medicine. Since then, the AMA's *Code of Medical Ethics* has been continually revised and expanded. It has become the standard in court rooms, state medical licensing boards, and other civic arenas, as well as the foundation for ethical norms within virtually all medical organizations. The creation and maintenance of ethical standards is one of the characteristics that initially set medicine apart as a profession, rather than merely a career.

Physicians have responsibilities to themselves, their profession, their patients, and their communities. To fully meet their obligations to any or all of these groups, participation in organizations that represent them is virtually obligatory. The standards by which physicians judge whether or not they have satisfied their obligations cannot be established individually but must be created by a group—preferably the whole group. This process requires an organization. Webster defines standards as "measures used as the basis for judging value, quality, or extent of." During a time when the medical profession and the public are concentrating on quality and variations of care, it is important to have guidelines not only for beta blockers after an MI, but also for physician relationships with pharmaceutical companies, HMOs, and patients. Just as we turn to evidence-based medicine to help patients select among therapeutic options, there should be some standard for weighing ethical stance—a standard that is generally recognized and authoritative.

It takes more than a single voice to create the standard for the profession. Indeed, it takes many voices finding a basis for agreement, and then creating an expectation of adherence to that standard. Defining the medical profession's collective voice is the job of the AMA's House of Delegates (HOD). The HOD is a representative body whose members are selected by the principal governing body or the memberships of state and specialty medical societies and the corps of military physicians. As with representatives in the US House, the number of representatives from each association is based on its physician membership in the AMA. And, again, as in the US Congress, representatives generally vote in accord with the wishes of their constituencies. If non AMA members think that the AMA resolutions and advocacy agenda do not reflect the interests and concerns of the majority of today's physicians, there is a reason for that: the majority of today's physicians are not AMA members. And there is a solution to the problem: those US physicians who do not feel represented by the AMA should join and have their voices heard because the AMA is still the national organization of physicians with both the largest and the broadest membership, and, hence, the profession's strongest voice.

Like legislative groups in all representative forms of government, the AMA House of Delegates experiences tension between enacting resolutions that reflect current membership opinion and attempting to lead its constituency to higher standards of professional and ethical conduct. This tension and the sometimes rancorous deliberation it produces are the essence of the democratic process, though not the most direct or efficient path to change and improvement. As Winston Churchill said, "No one pretends that democracy is perfect or wise. Indeed, it has been said that democracy is the worst form of government except for all others that have been tried." For the deliberative process to work effectively in the best interest of those represented, everyone—or at the least, a sizable majority of the represented— must participate. What AMA's detractors often allege about the association's advocacy positions is similar to what disgruntled voters describe when their candidates or issues fail to win majority support because, unfortunately, the majority did not vote. The process can be slow and frustrating but its ability to succeed is demonstrated by students changing the investment policies of the AMA toward socially sensitive investment and the addition of a ninth principle to the 156-year-old "Principles of Medical Ethics" in June 2001 that declares, "A physician shall support access to medical care for all people."

Though medicine today often seems to be a conglomeration of multiple professions rather than a single profession, in reality we share the same obligations to our patients and society and the same challenges in meeting those obligations. We must have a process and a place where we can discuss—vociferously if necessary—our differences, seek common solutions, and resolve conflicts, and it should occur within the family. The American Medical Association is the best resource for all of the above that is currently available to us. If the organization is not what we wish it were, or if it is not all that it could be, the fault lies with us, with the profession. Our patients deserve a strong profession with a strong voice to advance their care. Our colleagues—and we as physicians and physicians-in-training—deserve a strong profession with a strong voice to represent both our ideals and our needs. Having taken advantage of the stature, the better-than-average income, and the respect that comes with being a physician, it is our obligation to give back. And one of the most important and effective ways to give back is to help assure a strong profession speaking to the right issues, with the right perspective and the right priorities. This situation is perhaps possible by working as individuals, but it is more likely to occur when we combine our efforts as a group that works together through an organization. That organization will best serve its purposes for both the profession and the patient if many perspectives are present to be honed into collective, representative, and articulate positions.

Nancy W. Dickey, MD, is president of the Texas A&M Health Science Center and Vice Chancellor for Health Affairs for The Texas A&M University System. She is founding program director of the Family Practice Residency of the Brazos Valley, professor of family and community medicine at the A&M Health Science Center College of Medicine, and a past president of the American Medical Association.