The problem of self-determination of professionalism and ethics

by Henry Buchwald, MD, PhD, FACS

Only in literature and in the theater is the human embodiment of evil given an identity; a personification; a self-awareness; and even a boastful, commanding presence. Thus, Iago, in Shakespeare's *Othello*, with pride proclaims:

> Divinity of Hell! When devils will the blackest sins put on, they do suggest at first with heavenly shows, as I do now… I'll pour this pestilence into his ear.[1]

In 19th century opera, villainy is given even a stronger identity, and villains are given arias to sing. Thus, in Verde's *Othello*, the brilliant text of Arrigo Boito has Iago stating:

> I believe in a cruel god, who has created me in his image and whom, in hate, I name.[2]

In Puccini's *Tosca*, based on the novel by Victorien Sardou, libretto by Luigi Illica and Giseppe Giacosa, the arch villain, the police chief Scarpia, is also given an aria to proclaim his credo of lust and evil:

> I am gripped by desire. I pursue what I desire, take my fill and throw it away.[3]

In real life, however, evil people don't publicly state that they are evil, and I doubt most believe that they are. In our surgical microcosm of the world, I believe there are few, if any, truly evil and corrupt people—but there are those who are totally self-absorbed and self-serving, even ruthless, and who place their own ambitions above concern for their patients or above fair play for their professional associates.

How can we as surgeons in the community we serve rely on self-determination to set the standards for ethics and professional conduct in surgery?

The search for guidelines

Can we rely on guidelines to help us meet the self-challenge of determining our principles for behaving honorably in our professional lives and ethically in general? "Do unto others as you would have done unto you"[4] is an impeccable guideline. Unfortunately, it is often corrupted in daily affairs to "Do unto others before they can do unto you," or "Do unto others as others have done unto you." This guideline is, nevertheless, a sound first principle for the start of self-determination in our professional lives.

Seneca was the originator of many of the world's great aphorisms. Shakespeare provides an English translation of one of Seneca's most quoted guidelines for professional conduct:

> This above all: To thine own self be true,
> And it must follow, as the night the day,
> Thou canst not then be false to any man.[5]

Ironically, Shakespeare gives these lines in *Hamlet* to Polonius—a pretentious fool.

Why, as surgeons, should we not turn to the Oath of Hippocrates,[6] the essence of which has been summarized by many in the admonition, "Primum, non nocere," or, "First, do no harm"? Primarily, that precept is not found in the Oath of Hippocrates. It may well be a Latin translation of Hippocrates, but from his *Epidemics*, Book 1, Section XI, Hippocrates states:

> Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things—to help, or at least to do no harm.[7]

Secondly, the Hippocratic Oath disallows the profession of surgery: With the statement "I will not cut persons laboring under the stone," there goes biliary tract surgery and urology.

More to the point, we surgeons, as a rule, do harm in order to do good. By advice, drugs, chemotherapy, and radiotherapy, as well as operative intervention, we can do damage instead of, or as well as, offer benefits to our patients. By open, scopic, or natural orifice surgery, we extirpate, manipulate, or perform some other tissue damage to achieve a potential salutary goal. Many times, we harm but do not even accomplish good. We need to accept the fact that we may have to do harm in order to offer our patients the opportunity to be cured or ameliorated of their ills.

In 1803, Sir Thomas Percival published a thesis entitled, "A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons."[8] According to Percival, physicians should "unite tenderness with steadiness and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence." In 1847, these words were essentially repeated in the first Code of Medical Ethics of the American Medical Association (AMA), adopted at the first AMA Convention in Philadelphia of 268 physicians from 22 states.[9]

The AMA Code of Medical Ethics has undergone multiple revisions. In 1958, the Code was reduced to 10 Principles of Medical Ethics[10]; in 1980, to seven principles[11]; and expanded to nine principles in 2001.[12] The work of the AMA was supplemented in 1973 by the Patient's Bill of Rights published by the American Hospital Association, which emphasizes full disclosure of diagnoses, prognoses, treatment options, and the patient's right to refuse treatment.[13]

Outside of the U.S., the World Medical Association has published eight separate declarations of ethics, including the Declaration of Geneva and the International Code of Medical Ethics in 1948, and the Declaration of Helsinki in 1964.[14,15] The latter focused on the principle of informed consent for volunteers in biomedical research and was an outgrowth of the Nuremberg Code, issued after the trial of Nazi doctors who had experimented with Jewish prisoners in concentration camps during World War II.[16]

The AMA Code of Medical Ethics, similar codes, and the various medical oaths that have been promulgated over time all have in common a social compact not only among physicians but among physicians, patients, and society. By the 1847 AMA Code, the AMA set licensing requirements and minimal education standards and promised to drive out the unscrupulous from the ranks of medical practitioners.[9] In the 1958 Principles of Medical Ethics, Section 10 states:

> The honored ideals of the medical profession imply that the responsibilities of the physician

> extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.[10]

In the 1980 Principles, Principle VII states that: "A physician shall recognize a responsibility to participate in activities contributing to an improved community."[11]

The Principles of 2001 reiterate the idea from 1980 and add, as Principle IX: "A physician shall support access to medical care for all people."[12]

The American College of Surgeons was founded in 1913. The Fellowship Pledge of the ACS reiterates the ethical principles of the AMA Code and closes the circle to the precept of "Do unto others as you would have done unto you," by the pledge, "I promise to deal with each patient as I would wish to be dealt with if I was in the patient's position, and I will respect the patient's autonomy and individuality."[17]

A subtle transformation of emphasis from ethics to professionalism was initiated by the American Board of Medical Specialties Task Force on Competence and published by the Accreditation Council for Graduate Medical Education in 2002.[18] This current credo, though not as poetic as those of the past, may be as good as we are going to get in the 21st century. We periodically grade our residents on these principles of professionalism, summarized as follows:

- Demonstrates respect, compassion, and integrity
- Demonstrates responsiveness to the needs of patients that supersedes self-interest
- Demonstrates commitment to excellence and ongoing professional development
- Demonstrates a commitment to ethical principles as pertaining to patient confidentiality, informed consent, and business practice
- Demonstrates sensitivity

Personal autonomy and administocracy

In order for self-determination to guide us in achieving professionalism and ethics in medicine, we must have personal autonomy. Surgeons tend to be individualists and to espouse individual responsibility. Our years of training prepare us for this autonomy. We acquire a base of knowledge and the insight to apply facts and rational supposition to patient care. We obtain skills and have learned the art of being gentle with a firm and steady hand. We are sobered by death and bad outcomes. We are taught by the vagaries of human nature. We acknowledge our fallibility and our power to do harm. Ours is a profession where decisions are singular and responsibility is particular. Thus, when a surgeon reaches professional maturity, that individual has achieved personal autonomy.

Yet, of the wide circle of freedom, we are allowed only a small arc, and that arc is narrowed daily by the administrative policies of academia, hospitals, insurance companies, and government. Several years ago, I coined the term "administocracy" to epitomize top-down control of money, resources, and opportunities by all these forces that restrict the autonomy of the clinician and academic.[19] Unfortunately, administocracy has or is gaining control of our medical schools, our teaching and community hospitals, our income, and our ability to provide health care. We are being reduced to "vendors" of health care; this status is not a firm base for the autonomy necessary for self-determination in our profession.

The individual and the group

Today, most decisions are made by a group—an elected legislative body, an appointed judicial body, or an ad hoc team of consultants. This structure is true in government, in industry, in universities, and certainly in health care. There is comfort in the rule of the majority. Yet, in all these affairs of governance, there is a head, a president, or a chief executive officer, and the achievements, as well as the place in history of these organizations, are identified with that leader, for good and for ill.

The same is true for ethics and codes of morality. For the most part, dicta for appropriate conduct are written by groups that at times meet in conclave for generations. However, the great revelations in the changes in the course of moral behavior are brought about by individuals.

Has history taught us to rely on the judgment of the group in terms of ethics—in our case, in

professional ethics for the surgeon—or the judgment of individuals, or neither? The dilemma of individual choice is nowhere better illustrated than when personal judgment is in conflict with the recommendations of the group and is in discord with those of a respected leader. This conflict can occur in decisions and interactions between surgeon and patient, surgeon and colleagues. What code of conduct exists for us as surgeons to respond to these challenges? In the final analysis, the challenge for self-determination must rest precisely on the self.

Conflict of interest

Self-determination of professional conduct and ethics today is intimately enmeshed with the concept of "conflict of interest." (*Author's note:* I have examined this topic elsewhere in an editorial that informs much of my discussion here.[20])

The term "conflict of interest" is generally employed in a derogatory sense—an expression of implied wrongdoing. It is considered dishonorable to be tarred with the brush of conflict of interest; even to undergo investigation for conflict of interest is negatively perceived. There are various definitions for conflict of interest, but the expression is generally used in the narrow sense of involving access to money or the opportunity for financial gain. Was Honore de Balzac (1799–1850) correct when he stated that behind every great fortune, there is a crime?[21]

Would it not be more scientifically sound to view the potential of conflict of interest from a less narrow, more encompassing perspective? Is the perception of conflict of interest not present when promotion, career advancement, favorable media notoriety, or public recognition are concerned? Of all these inducements, money may, for some, be the least tempting. Arnold S. Relman, the legendary editor of the *New England Journal of Medicine*, basically agreed with this premise, noting the following:

> We recognize that in some sense, authors may be affected by conflicts of interest even when no commercial considerations are involved. Competitive pressures and concerns about research grants, peer recognition, or academic advancement may adversely influence behavior. Connections with investigator-owned businesses, therefore, may simply be another form of a pre-existing problem.[22]

The workplace

For the surgeon, the workplace is the hospital in which the surgeon holds privileges; for the academic surgeon, the workplace is the hospital and the university.

In 1986, Ross, in an article entitled, "Academic Research and Industry Relationships," stated the following:

> The potential for great personal enrichment is responsible for the university's concern that the individual scientist will divert energy from the pursuit of new knowledge to that which has a practical application and will generate dollars. Vannevar Bush put it well when he said 'applied research drives out the pure.' This is a legitimate concern. Scientists are people, and people are subject to temptation. To use epidemiological terminology, we could say that the fraction of the population who will be susceptible to temptation is proportional to the potential for financial reward.[23]*

A. Bartlett Giamatti took up this theme as well, concluding that "the university is the only entity that can enter into arrangements for cooperative research."[24] In essence, the individual is to entrust himself or herself to the institution that governs his or her workplace and its judgment, not his or her own judgment, in ascertaining where conflict of interest exists and what rules should be imposed to oversee this aspect of professional conduct.

Funding agencies

Definition and regulation of conflict of interest by funding agencies have, as a rule, followed the principles set down by the National Institutes of Health (NIH), in particular the 1989 NIH *Guide for Grants and Contracts*, which states:

> Growing expressions of public concerns suggest that NIH ought to limit possibilities for

*Vannevar Bush was scientific advisor to President Franklin D. Roosevelt.

> actual or apparent financial conflicts of interest by investigators in research and development projects funded by NIH extramural awards.... NIH therefore intends to take steps to develop appropriate guidance for such relationships.... Guidelines should also recognize special conditions under when restrictions should be waived to permit investigators with unusual skills and expertise to conduct studies which might otherwise be proscribed.[25]

Points of interest and emphasis in this statement are the definition of conflict of interest in monetary terms, primary concern with extramural awards, and an escape clause for certain investigators.

The 1989 NIH statement has subsequently been modified and supplemented by conflict of interest policies set by the individual institutes—a discussion beyond the scope of this essay. Also, the NIH has had to deal with various internal conflict of interest situations, often first revealed in the media, concerning Cooperative Research and Development Agreements and other financial arrangements between NIH institutes and industry, unreported NIH personnel consultative arrangements with industry, and the partial funding of large NIH trials by industry.

Thus, funding institutions, as well as the individual, can have great difficulty in navigating this arena. They seek to find the best applicants and the most scientific and socially promising projects. More often than not, these individuals will be those who demonstrate the ability for professional advancement, who attract public recognition, and who are offered opportunities to make money. Certainly, no one would propose a safe cadre of career researchers consisting of individuals who pledge themselves to remain anonymous, never to accept advancement, be devoid of attachment to their research, and, preferably, have no ideas of their own but perform as surrogate investigators for basic wages.

Presentations and publications

It is common practice today, indeed mandated, that all presentations and publications are preceded by listing the authors' financial and industry consultative relations. This acknowledgment is called "Disclosure of Potential Conflict of Interest" or just "Conflict of Interest Statement." In going through this exercise, it is best to reveal any monetary connection with industry, granting sources, patents, company ownership, and so on. (The official conflict of interest policy of the *Journal of the American Medical Association* is so inclusive as to occupy nearly a page of print.[26]) Unfortunately, the more such connections an individual has, the less will his or her work be considered free of bias. In a sense, this litany is protective for the individual, but it can also be used against the individual.

To perform scientific research that will be presented and published, an investigator needs money. There is not enough money to go around from public agencies to fund even a small fraction of worthwhile research, in particular focused drug or device research and trials. If research money comes from the NIH or another external funding agency, that funding source is accepted today without further questions by the publishers of scientific literature, even though these agencies are burdened by their own mandates and politics that, in the broader sense, pose a potential for conflict of interest. On the other hand, if the research is funded by industry, it is, prima facie, subject to suspicion. In a presentation or a publication, the funding source of the former is "credited" whereas the source for the latter is "disclosed."

Conclusions

Does self-determination of professionalism and professional ethics belong to the past? Are we today too confined by our institutions and society to determine moral conduct for ourselves? Do we welcome our limitations and restrictions and take comfort in the security they provide? Is the surgeon of the present and the future not the individualist represented by the surgeon of the past? These are complex questions for a complex world. There may be no easy answers, or even partial answers, to these questions. It is important, however, that these questions are continually being asked and, in the asking, framed to project concepts of self-determination and self-challenges.

In these reflections, there is hope for truth and for progress. The Talmud poses four self-challenges expressed as the following four questions of self-determination[27]:

Have I lived honorably on a daily basis?
Have I raised the next generation?
Have I set aside time for study?
Have I lived hopefully? Ω

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