Presidential Address

# Professionalism, managed care, *and the* human rights movement

*by*
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"Modern medicine is science, while medieval medicine was less powerful but more important, ethics."[1]

*—John Herman Randall, PhD*

As the 21st century approaches, many of society's institutions are undergoing profound change. Prominent among these institutions undergoing change are the professions. The medical profession in particular is being transformed as society moves into a knowledge-based epoch, characterized by a richness of information, scientific advances, a proliferation of technology, and a corporate orientation.

The study of the professions has occupied the attention of sociologists, the public, and the professions themselves for years.[2] Alfred North Whitehead noted that the professions are an avocation whose activities are subject to theoretical analysis and are modified by theoretical conclusions derived from that analysis, which he felt differentiated a *profession* from an *avocation*.[3]

## *Challenge to professionalism*

According to Lynn, the professions are as characteristic of the modern world as the crafts were of the ancient one.[4] In the 1960s, Clark Kerr, president of the University of California University System, noted that an impressive percentage of the gross national product was spent on training professionals. He predicted a day when the "knowledge industry" would occupy the same key role in the American economy as the railroad industry did in the 19th century.[5] In a similar vein, Peter Drucker has labeled the late 20th and early 21st century as the period of the "knowledge society."[6] With an increasingly educated, technology-tolerant populace, Thorstein Veblen's 60-year-old dream of a professionally run society may be approaching reality. As the knowledge society evolves, it may even be a legitimate societal goal to "professionalize" many avocations, as definitions and obligations of professions are examined.[7]

It is the contention of this presentation that ethical codes are the major characteristic that differentiates occupations from professions. Ethical behavior is under challenge by an increasingly commercial society presenting the challenge of reconciling business ethics, professional ethics, and human rights in the context of a secular libertarian tradition. These challenges occur in the context of reconciling Hippocratic medicine (doctor-patient) with population-based health care. Population-based health care is less personal, potentially more cost-effective, and ideally distributes health resources for the greatest good to the greatest number.

Within the context of these challenges, professionalism must survive. Five characteristics of a profession are usually accepted, and the following are understood in the context of a covenant between physician, patient, and society:[8-10*]

1. Engagement in a societal or social service—that is, altruism.
2. The requirement for special education, training, and a high degree of knowledge.
3. An ability and willingness to apply the knowledge and skill to a greater societal good.

Dr. Sheldon delivered the Presidential Address on October 29, 1998, in Orlando, FL, during the Convocation ceremonies of the Clinical Congress.

* The five characteristics are derived from many authors. They were, more or less, agreed upon in a two-year study, "The professions in the 21st century," sponsored by the University of North Carolina at Chapel Hill, under the Carolina Seminars Program, co-convenors Judith Wegner, JD, dean of the law school and George F. Sheldon, MD, chair of surgery. These characteristics were outlined by Will Willmon. Reference: Willmon W: "Clergy Ethics: Getting Our Story Straight," in: Goldberg M (ed): *Against the Grain: A New Approach to Ethics*. Harrisburg, PA: Trinity Press Intl., 1992.

4. Autonomy—that is, the right to regulate.
5. The conformance to and development of a body of ethics.

The body of ethics and its evolution is the single differentiating feature of a profession from other occupations that require knowledge, special education, and training.

Professions arise in part because of increasing specialization and the process by which a skill is transferred.[11] Objective standards of competence (such as licensing), certification, and the growth of the service ethic are additional requirements of a profession.

Beyond medicine, law, and the ministry, there is disagreement as to the degree of professionalization of other occupations.[12] Evolution of an occupation into a profession requires that the occupation be full-time, that there is an appropriate educational forum; the organization of a professional association; and the protection of the law for the area of expertise and the public. Sustaining a code of ethics as the profession matures further distinguishes a profession. Barriers to professionalization are threats to autonomy and to the service ideal.

Many threats to professionalism in medicine are evident today. Patients are labeled "clients," "customers," or "consumers," assuming a business relationship that is at odds with the service ideal and corporate in terminology as well as culture. For example, advertising is a characteristic more common to the corporate professional world, but is now universal in medicine. Internal conflicts between the needs of patients and the needs of an educational and research forum can be threats to professionalism. Claims to exclusivity by other professionals or by a system of health care is also a threat. A reaction by the public and by professionals to the corporate orientation of health care is the current political debate over the Patients' Bill of Rights.

Technologic and scientific advances pose unfamiliar challenges that strain professional ethical codes. Among these challenges to professional ethics include such issues as birth control, cloning, euthanasia, physician-assisted suicide, genetics, and confidentiality—which may have different resolutions in a corporate, as opposed to a professional, culture. An additional fundamental conflict exists between a health care system that is population-based and one that is based upon the individual doctor-patient relationship.

Expressed as a code, ethics implies morality and distinguishes a profession from a craft. The code, spoken or unspoken, is modified and influenced by social change, but retains a constant force. Professional codes are an evolutionary amalgam of ethical theory, etiquette, law, and professional socialization. They are influenced by religion, social mores, and corporate culture, as well as the societies in which they are practiced. A core of morality is paramount if codes of ethics are more fundamental than contemporary practices.

Although subject to challenges, professional ethical codes deal with understandings and conventions within the profession, between society and the profession, and with individual patients. These implied understandings are described by the ethicist R.M. Veatch as the "covenant theory."[13] A covenant, like a contract, can be: created by God or deity; required by reason; or be empirical. These implied covenants or contracts emphasize moral bonds and fidelity. Because medical ethics involves a relationship between lay people and health professionals, it, therefore, is based on loyalty, fidelity, respect, and trust. As noted by S.B. Nuland:

> . . . it is no surprise that medicine's great advance has been at once high-minded and profit-minded, selfless and selfish, inspired and pragmatic, sublime and boorish. With its emphasis on technology, the juggernaut of medical science has often been strained and frayed the traditional bond between doctor and patient. And if that were not enough, it confronts society and government with the urgent problem of just how to pay for it all.[14]

## *Religious, societal influences*

Medical ethics are learned by new members of the profession as part of their socialization to professional behavior. Medical ethics includes elements of the Judeo-Christian religion, the Kantian ethic, the utilitarianism of health care planners, the libertarianism of American pluralism, and the natural law tradition of Catholics, Calvinists, and modern lay people. An additional,

and newer, influence on medical ethics is the human rights movement, in which a fundamental concept is that the decisions are made autonomously by informed patients. Human rights are a dominant force in society and have significant, positive implications for health care and medical ethics.

The medical ethic that has developed over the centuries has been altered by religion, social change, etiquette, and behavior of physicians and patients.[15] The Christian ethic of faith, hope, love, and charity has been amalgamated into the ethical code of physicians with a Christian background. Our medical ethic has been tempered by the Greek ethic and by classical thought, which includes the concepts of justice, prudence, temperance, and fortitude. The Hippocratic Oath has been modernized and altered by deleting references to pagan deities and to the prohibition of surgery.

The earliest code that applies penalties and regulations on the physician to protect the patient is the Code of Hammurabi, King of Babylon (1792-1750 BC). Approximately eight sections among the 282 paragraphs are related to physicians and their services, and to the penalties in case of injury or death.[16] The fee scale and penalties were graded according to the social status of the patient.

The Greeks had no specific law related to the practice of medicine. Romans also provided no legal regulation of practice but did regulate the number of physicians practicing in a community. The *lex talionis,* which basically was a penalty for bad results, was invoked in the German tribes.

The first extensive law related to the practice of medicine was enacted by Frederick II in 1224. The law specified the education of the physician, regulated fees that might be charged, and addressed public hygiene. These laws brought the School of Salernum in Italy into prominence during the Renaissance, and, in general, with the rise of the city states, the practice of medicine became increasingly regulated by local statutes.

Legends of the training of Hua Tu, a Chinese surgeon (circa 115-205 AD) included ethical admonitions. The Hindus also had considerable moral protections for the patient.

Most great leaders in Western medicine echoed the ethical principles of the Hippocratic variety. These leaders included Isaac Judeus (10th century), Guy de Chauliac (1300-1370), Henry Demondeville (14th century), Paracelcus (1493-1541), Ambrose Paré (1510-1590), and especially Thomas Sydenham (1624-1689). These men attempted to develop an esprit de corps in medicine, and the 16th century *statuta moralia* of the Royal College of Physicians is an example of this development.

The oldest (over 2,500 years) medical code is the Hippocratic Corpus, known as the Hippocratic Oath, and contains the following elements:[17]

- A commitment to benefit patients—but it is the physician who interprets what is a benefit, that is, paternalism.
- The beliefs and values that influence such judgment.
- The admonition "Do no harm" *(primum non nocere).*



Hippocrates: the Father of Medicine. Although little is known of his life, he was born around 460 B.C. on the Isle of Cos in Asia Minor. His school of medicine, the Hippocratic Corpus, divorced medicine from superstition, and described a code of etiquette among physicians. It described the primary responsibility of the physician was to the patient and to do no harm.

## The Oath of Hippocrates

I SWEAR BY Apollo the physician and Aesculapius, and Health (Hygieia), and All-Heal (Panacea), and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this Art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.

With purity and with holiness I will pass my life and practice my Art.

I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work.

Into whatsoever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

*(Translation of Dr. Francis Adams, 1849)*

From Adams, F. *The Genuine Works of Hippocrates.* London: New Sydenham Society, 1849 (Birmingham Classics of Medicine Lib., 1985).

The Hippocratic Oath actually is one of a number of doctors' oaths. It emphasizes love of the art of medicine, paternalism toward patients, and code of etiquette and behavior among physicians. It has evolved through the ages and incorporates religion, philosophy, and human rights in its various versions. It proscribes and prescribes some remarkably contemporary issues such as confidentiality and euthanasia.

- The love of the art of medicine is central and has elements of purity, and even holiness.
- Reverence for teachers and colleagues.
- The notion of consent as being in the hands of the physician rather than the patient, a tenet that is incompatible with the current patients' rights movement.

The oath appeals to a deity, initially pagan gods, and in later centuries the Christian God. The focus of this oath is exclusively to benefit the patient as opposed to the benefit of a broader population.

The Hippocratic tradition includes ethical theory from religions that have medical codes intermixed with or responsible to the authority of the religion. In the Jewish religion, for example, there is what has been called the Jewish Hippocratic Oath—that is, the

Oath of Asaph Horafe (Asaph the physician). The Oath of Asaph Horafe, much like the Ten Commandments, is composed of many "shall nots"—shall not kill, covet, nor harden one's heart against the poor and needy—but instead, one is to heal them. This concept of serving the poor and needy is absent from the Hippocratic Oath, but is present in Chinese medical codes.

Jewish medical ethics (Jakobovits) contain six characteristics:

- Sanctity and dignity of human life.
- Duty to preserve health.
- Opposition to superstition and irrational care.
- Dietary codes.
- Sexual morality.
- Rights of the dead and dying.

The Jewish medical ethical codes are perhaps the strongest and most specific of any religion. They hold the sanctity of life uppermost and prescribe rules for the living, the dying, and the dead. Conflicting concepts exist, in that autopsies are precluded by an obligation to the dead, while organ transplantation is acceptable.[18]

Medical ethics from the perspective of the Catholic religion are approached from the systematic doctrine of the Roman Catholic Church. Although the Hippocratic Code has a separate identity, the evolved Hippocratic Oath includes the Catholic moral tradition of St. Thomas Aquinas, whose role model for physicians is Christ rather than Hippocrates. In fact, the oldest extant manuscript of the Hippocratic Oath is called the Cruciform Oath (from the 10th or 11th century), and is in the Vatican Library.

Catholic theology includes the concept of casuistry or "double effect"—a concept that has become of interest in current "end-of-life" debates. The Catholic religious tradition contrasts with Hippocratic ethics in the absence of an exclusive focus on benefits of the individual, and contains broader ethical concepts applicable to a population. Roman Catholic medical ethics or principles are:[19]

- Stewardship—that is, "life from God."
- Inviolability of human life.
- Totality—the concept of the "body on loan."
- Sexuality and procreation codes.
- The double effect justifies certain acts of intention.

The medical ethical codes amalgamated with Protestant religion are less sharply formulated than Hippocratic, Jewish, or Catholic ones. They are based more on categories of ethics and are compatible with the covenant theory. Some of the Protestant medical ethics include the "calling" to the service of medicine and involve natural law.

Medical ethical codes, as they are formulated or practiced within society, absorb or include the

### From the Oath according to Hippocrates insofar as a Christian may swear it

Blessed by God the Father of our Lord Jesus Christ, who is blessed for ever and ever; I lie not. I will bring no stain upon the learning of the medical art. Neither will I give poison to anybody though asked to do so, nor will I suggest such a plan. Similarly I will not give treatment to women to cause abortion, treatment neither from above nor from below. But I will teach this art, to those who require to learn it, without grudging and without an indenture. I will use treatment to help the sick according to my ability and judgment. And in purity and in holiness I will guard my art. Into whatsoever houses I enter, I will do so to help the sick, keeping myself free from all wrong-doing, intentional or unintentional, tending to death or to injury, and from fornication with bond or free, man or woman. Whatsoever in the course of practice I see or hear (or outside my practice in social intercourse) that ought not to be published abroad, I will not divulge, but consider such things to be holy secrets. Now if I keep this oath and break it not, may God be my helper in my life and art, and may I be honoured among all men for all time. If I keep faith, well; but if I forswear myself may the opposite befall me.

The Cruciform Oath is the oldest extant form of the Hippocratic Oath and is in the Vatican Library. It illustrates the phenomenon of retention of the core Hippocratic concept while modernizing and deleting pagan gods while incorporating the Christian faith and its healing association. Source: Leake, CD. *Percival's Medical Ethics.* Baltimore: Williams and Wilkins, 1927, p. 213-214.

18

religious calling of the practitioner. Some sectarian religions, such as Jehovah's Witnesses, proscribe blood transfusions based on the scriptural prohibition against eating of flesh. Another Christianized influence on medical ethics has been in Christian Science, which has a more expansive theory of the relationship of secular and organic medicine to healing.

## *Modern medical codes*

In 1512, the barber surgeon's guild was granted a charter by Henry VIII that forbade the practice of surgery by anyone except members of the guild. During the reign of Henry VIII, the Royal College of Physicians was also chartered, in 1518.[20] The early ordinance required scrupulous moral relations with patients, enumerated the reciprocal obligation of members to each other, and indicated the attitude to be taken toward the public.

In Elizabethan England, there were at least four versions of the Hippocratic Oath. All versions incorporated the core concepts of the patient's welfare and of etiquette among practitioners, but had no population-based orientation. The 18th century Scottish Enlightenment, with its profound effect on institutions, was instrumental in the establishment of modern professional ethics. John Gregory (1724-1773) placed his teaching of medical ethics in the context of Baconian Science and Hume's Sympathy, which influenced the better-known tradition of Sir Thomas Percival. (His contribution was to emphasize the physician's role as the moral fiduciary of the patient.[21])

The best known precursor of modern medical codes is traced to 1789, when an epidemic of typhus or typhoid occurred in Manchester, England. Sir Thomas Percival articulated a code of behavior for physicians, surgeons, and apothecaries because of conflict that occurred among these health care "providers" under the stress of the epidemic. His "Scheme of Professional Conduct Relative to Hospital and Other Medical Charities" was embodied in *Medical Ethics, or a Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons.* Percival's medical ethics were descriptive of the character traits of a gentleman of 18th century England and included tenderness, steadiness, authority, and condescension. Strictly speaking, they were more of a code of etiquette than a code of ethics.[22] In the United States, Dr. Samuel Brown (1769-1830) of Transylvania University in Lexington, KY, organized a secret fraternity of the better physicians, the Kappa Lambda Society of Aesculapius, and based this group's ethics on Percival's code. Abridged editions of Percival's work were widely circulated and many organizations came up with their own code of ethics. The New York State Medical Society, for example, established theirs in 1823, again based on Percival. The Medical Chirurgical Society of Baltimore generated a system of medical ethics in 1832 and acknowledged Dr. Percival.

Dr. Nathan Smith Davis (1817-1904), in spite of much opposition, succeeded in organizing the American Medical Association in New York City in 1847.[23] Its chief business at the first meeting was the formulation of an ethics code, as well as minimal requirements for training. The debt to Percival's code was extensive. The AMA ethical code was extended to the founding of a judicial council in 1912, chaired by Frank Billings, a prominent Chicago physician. The AMA code has undergone many revisions since that time, the most recent in 1998.[24] A significant change in recent versions has been broadening the code beyond the Hippocratic commitment to exclusively benefit the patient, and includes responsibility for the interest of society, physician rights and duties, and benefits.

Seven basic principles are described as standards of conduct for the "essentials of honorable behavior for the physician." The term "ethical," according to the AMA Council on Ethical and Judicial Matters, refers to: (1) moral principles or practice, (2) customs and usage of the medical profession, and (3) matters of policy, not necessarily involving issues of morality in the practice of medicine. The AMA has recently founded the Institute of Ethics, a timely venture in today's health care climate, headed by Linda L. Emanuel, MD, PhD, and deputy head Stephen R. Latham, PhD. It is designed to work closely with the long-standing AMA Council on Ethical and Judicial Affairs. This ambitious program, with a staff of over 20 persons, oversees potential issues

in health care such as end of life, professionalism, managed care, and genetics. Their deliberations are intended to provide real-time assistance to physicians in practice.[25]

### American Medical Association: Principles of medical ethics

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. 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.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Source: American Medical Association *Principles of Medical Ethics*, 1998.

The Council of Medical Specialty Societies (CMSS) has recently developed a consensus statement on the ethic of medicine.[26] The statement includes:

- The primacy of the covenant among physicians, patients, and society.
- Affirms that the physician's duty of patient advocate should not be altered by the system of health care delivery.
- Articulates a societal responsibility to participate in health care policy. This document addresses the conflict all specialties are encountering in balancing the primacy of patient responsibility with the constraints of managed care and population-based health care.

In 1997, the Senate of Surgery of Great Britain and Ireland, comprised of 16 surgical organizations including the Royal Colleges, published a short guide to medical ethics and law entitled *The Surgeon's Duty of Care*. Chaired by Professor Alan G. Johnson of Sheffield, a noted surgical ethicist, the document notes:

> For surgery to be successful, there must be a relationship of trust and confidence between surgeon and patient. To achieve this, surgeons must be sensitive to the vulnerability of patients and respect their human dignity—their ability and right to plan for their own future.
>
> The surgeon's duties of care are based on an understanding of the rights of patients.[27]

The document has general and specific guidelines. As with most modern consensus statements on the ethic of medicine, it emphasizes patients' rights.

## *The human rights movement*

The concept of human rights and its inclusion into codes of ethics has a long history. The Magna Carta (1215 AD, Runnymede, England) was the resolution of an insurrection to end King John's abuses by a peaceful signing of a document of mutual understanding. This example is referenced by heads of state such as Margaret Thatcher, who called for a "European Magna Carta" for Eastern Europe. Eleanor Roosevelt called the United Nations' "Universal Declaration of Human Rights" a "Magna Carta for mankind."[28]

England's Petition of Rights (1628) was a charter addressing the abuses of Charles I and limit-

ing the king's rights to tax, court-martial, and quarter. The English Bill of Rights (1689) addressed grievances of Charles II and James II. These documents were direct precursors to the United States Bill of Rights. British America, however, had a variety of European and indigenous influences. According to Devon A. Mihesuah:

> American Founding Fathers . . . were influenced not only by European writers such as Locke, Rousseau, Montesquieu, as well as ideas found in the Magna Carta and the Greek and Roman Empires, but also by the powerful, well-organized Haudenosaunee (Iroquois) Kaianerekowa (Great Law of Peace). The Constitution framers therefore adopted certain aspects of the Iroquois Confederacy . . . impeachment, equal representation of nations (states), checks and balances, and the concepts of freedom, peace, and democracy.[29]

Virginia was the colony with the first charter guaranteeing human rights. It was the first sovereign state to embody in law protection from impinging on human rights. This law served as a model for other states and for the United States Constitution and Bill of Rights in 1789.

When the United Nations was founded after World War II, its charter, declarations, and works incorporated codes to protect individuals. The charter and the Universal Declaration of Human Rights were a reaction to the Axis governments, which had subjected citizens to state tyranny. This tyranny involved the use of unwilling human subjects for research and the euthanasia of "undesirable" citizens.

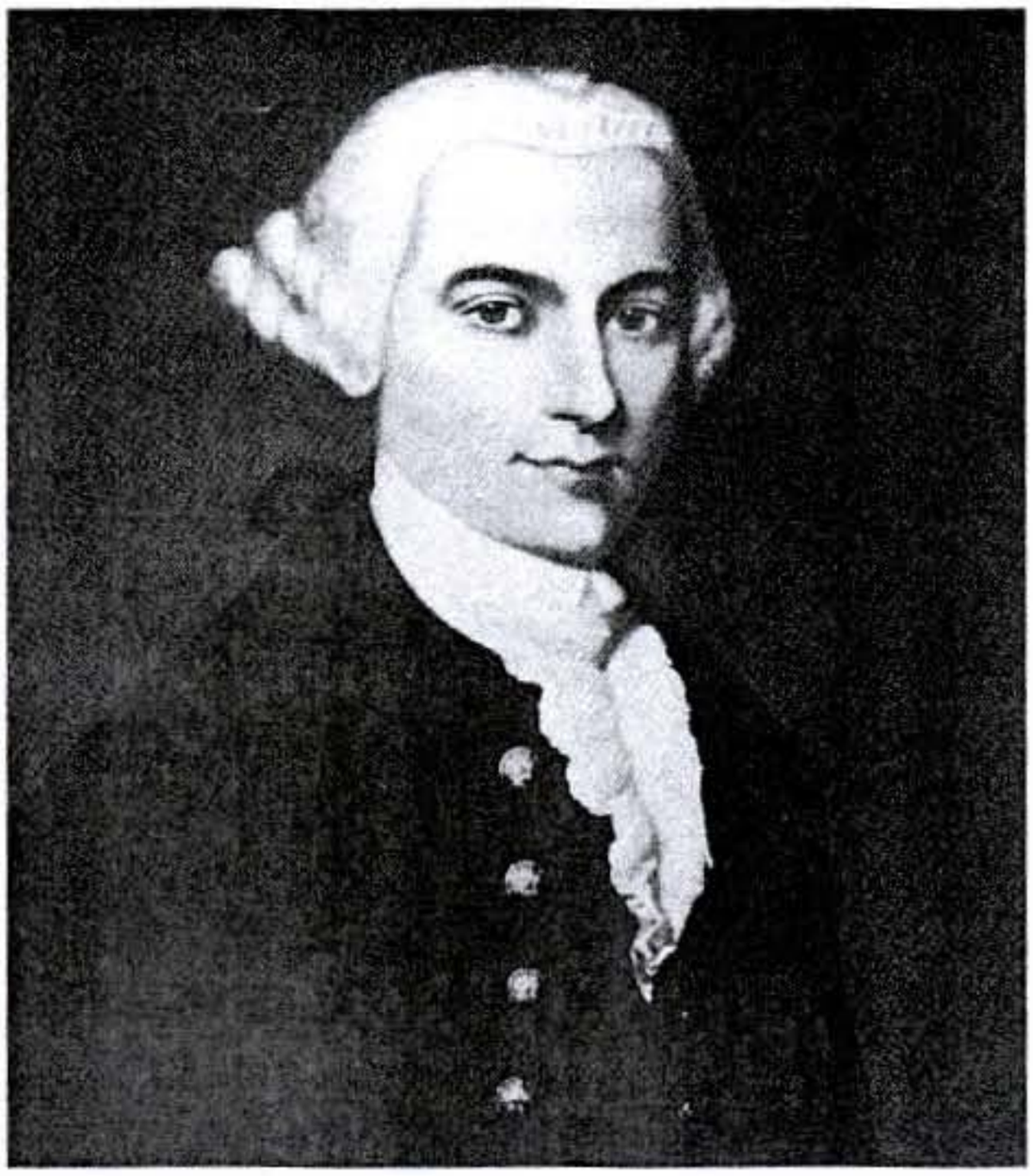
As this is the International Decade for Human Rights Education (1995-2004), as well as the 50th anniversary of the Universal Declaration of Human Rights, it is useful to examine the implication of an evolving human rights culture. In 1950, the United Nations promulgated the Nuremberg principles now codified into many nations' legal systems. The first director of the United Nations Human Rights Division, John Humphrey, wrote:

> The Declaration is now part of the customary law of nations and is therefore binding in all states. The Declaration has become what some nations wished it to be in 1948: The universally accepted interpretation and definition of the human rights left undefined by the charter.[30]

In 1948, the Declaration of Geneva was written as a broader interpretation of the rights of physicians than the Hippocratic Code. In 1949, the International Code of Medical Ethics was developed, which was Hippocratically centered but contained the precept that a commitment to "any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Much of the legal foundation for the human rights movement, especially as it has influenced medical ethics, is due to Gen. Telford Taylor, a prosecutor during the Nuremberg trials.[31] The Nuremberg Code on the Ethics of Human Research consists of 10 principles that were developed out of the trials of 23 Nazi doctors (seven were acquitted and seven were sentenced to death by hanging). In his opening statement, General Taylor, the prosecutor, noted that, "This was no mere murder trial," because the defendants were physicians, sworn by the Hippocratic Oath to "do no harm." A recurring theme in the trial was Hippocratic ideals and their relevance to the rights of the patient participating as a subject in research. The 10 human rights principles that evolved from the trial altered medical practice and ethics. The Nuremberg Code challenged Hippocratic ethics, which had traditionally allowed the physician to determine what was in the subject's best interest. By mandating informed consent, the Nuremberg Code gave the subject as much authority as the physician.

The Hippocratic Code, comfortable in the climate of American political thought and modernized by the informed consent principle of The Nuremberg Code, has been broadened by legal interpretation.[32] This affirmation of the principle of self-determination is now the starting point in medical decision making. Informed consent is a concept not embodied in Hippocratic medicine, in that it implies a formalized extension of the social contract between the physician and the patient. Rather, the liberal affirmation of self-determination and tolerance is based in the Enlightenment concept that all people are created equal. It has been affirmed in law: In 1957, in *Salgo v. Leland* Stanford University board of trustees, "informed" was added to "consent" as an explicit requirement.



MANCHESTER LITERARY AND PHILOSOPHICAL SOCIETY

Sir Thomas Percival (1740-1804). As a result of professional discord arising from the behavior of physicians, surgeons, and apothecaries during a plague of typhus or typhoid (1789), Percival was asked to write a "scheme of professional conduct." He labeled his product "Medical Ethics," but it is more a code of gentlemanly virtues but has some features of the Hippocratic Oath. It became widely published and the basis of many codes of ethics of medical societies in 19th century United States. It was liberally adopted in the Code of Ethics of the American Medical Association when it was founded in 1847. The portrait was destroyed in 1940 during an air raid.

The committee that crafted the United Nations' Universal Declaration of Human Rights was chaired by Eleanor Roosevelt.[33] In a sense, the Universal Declaration of Human Rights is analogous to the addition of the U.S. Bill of Rights to the Constitution of the United States, since it was to be attached to the United Nations charter. During the committee's formulation of the declaration, American political leaders proposed that the "life, liberty, and pursuit of happiness" feature in the U.S. Bill of Rights would be sufficient for the United Nations charter. With strong input from Russian and other socialist countries, a broader definition of human rights evolved to include the right to work, health care, and so on.

The Universal Declaration of Human Rights consists of four tenets: (1) the basic right to human dignity, (2) civil and political rights, (3) economic, social, and cultural rights, and (4) solidarity rights.[34]

*Human dignity* is a historical right, which has evolved from many religions, philosophies, and traditions, including the Judaic-Christian, the Koran, and the Talmud. It is the most ancient of the ethical tenets.

The second notion embodied in the United Nations' Declaration is the liberty to pursue human dignity against the abuse of political authority, known as *civil and political rights.* These philosophical rights are derived from 17th and 18th century political thought, and are embodied in documents such as the American Declaration of Independence, the United States constitutional amendments, and the Bill of Rights. These concepts, originated by theorists during the Enlightenment, are known as *first generation* or *negative rights,* because they limit and restrict government.

The *second generation* or *positive rights* are those that hold the government responsible for provision of societal needs such as health care, employment, and protection for the aged and vulnerable populations. These rights are mostly an outgrowth of the industrial world of the 18th and 19th centuries and have philosophical advocates such as Karl Marx and Thomas Paine. The Soviet constitution of 1936 contains provision for the government to protect such rights.

*Solidarity rights* are the last crucial notion in the United Nations' Declaration. They address the failure of domestic sovereignty that has been prevalent during the last part of the 20th century, when pollution, environmental protection, war, and international distributive justice have come to the forefront. International cooperation to distribute food and other basic needs, and to provide for justice on a global scale illustrate applications of this right. Its provision was anticipated by Immanual Kant (1724-1804), who recognized the hypocrisy of nations and implied the need to protect solidarity rights.

Contemporary emphasis is on the interdepen-


UNITED NATIONS PHOTO 23783, DOC WP/GAVAL2, NEW YORK, NY

Eleanor Roosevelt (1884-1962) holding the Universal Declaration of Human Rights, which she called a "Magna Carta for mankind." Elected Chair of the United Nations' 18-member commission, she incorporated elements of many cultures in the Declaration. There are many aspects of the Declaration which address health care. The "rights" movement has become an important part of daily life extending to recent debate over a variety of patient's rights.

dence of all four tenets of human rights. Although capitalist-oriented countries emphasize the first generation rights that limit government, socialist countries emphasize second generation, or positive, rights. Solidarity rights are most applicable to the poorest countries of the world. Most developed countries have accepted the concept that health care is a human right and needs to be a government responsibility.[35]

Modern medicine has become an element in the political stability of governments: an unhealthy society is a politically unstable society. A recent example is that demographers studying life expectancy in Russia predicted an unstable government—a prediction validated by the break-up of the Union of Soviet Socialist Republics (USSR)—based on the striking divergence in Russian mortality from other industrialized countries. In the USSR there was an age-adjusted increase in mortality of almost 33 percent between 1990 and 1994.[36] Life expectancy declined dramatically from 63.8 to 57.7 years in men, and from 74.4 to 71.2 years in women. Cardiovascular disease (heart and stroke) and trauma accounted for 65 percent of the decline. By contrast, recent data in the United States show an increased life expectancy of 76.1 years (73.8 men, 79.8 women), with a fall in death rates from cardiovascular disease and stroke. However, African-American males (66.1 years) and females (74.2 years) still lag

behind the more advantaged members of society in life expectancy.

Some national constituencies, such as Sweden and Cuba, emphasize economic and social rights, which include rights to work, health care, shelter, and education. In the United States, most such issues are at the level of state government. In the United States, Hawaii is the only state to include in its constitution the idea that health care is a right.

While not codified in law in the United States, the human rights movement has influenced many avenues of health care.[37] In 1973, the American Hospital Association promulgated the Patients' Bill of Rights, and the patients' rights movement has continued to have an impact on secular medical ethics. In 1978, the National Commission for the Protection of Human Rights was formed, continuing the amalgamation of the modern human rights movement and ancient medical ethics. Ethical concepts exemplified by the human rights movement begin as theory, evolve to inclusion in codes of ethics, and become entitlement as they are passed into law.

In 1974, Minnesota became the first state to pass patient rights legislation. The Parliamentary Assembly of the Medical Council of Europe (recommendation #779) on the "Rights of Sick and Dying" soon followed.

The Department of Health, Education and Welfare passed the Patients' Rights in Nursing Facilities Act in 1974; rights for Medicaid patients as a requirement for federal funding were added in 1976. The patients' rights movement has now been extended to include the concept of entitlement for certain health services.

American law has easily assimilated modern concepts of human rights into many areas, including medicine. American law starts with the premise that the person is the master of his or her life. Patients may select their physician and treatment, and may also refuse treatment. The affirmation of the principle of self-determination as the starting point of medical decision making is not in the ancient religious medical ethics nor in the Hippocratic Corpus. It represents the evolution and amalgamation of other ethical concepts—human rights and autonomy, in this case—into medical ethics and practice.[38] Specifically, the concepts are equity (or justice) and entitlement. Entitlement rights extend beyond the others in that they include actual health services that are the responsibility of government to provide. Entitlement rights can become controversial and can conflict with ethical precepts. Examples of this conflict are abortion, euthanasia, and so on.

## *Ethics, rights, and entitlement*

Francis D. Moore, MD, FACS, said, "Corporate standards for social behavior and community responsibility should not be confounded with detailed clinical and ethical guidelines."[39] Professional ethical codes that have absorbed religious and cultural values assume authority when they become law. The human rights movement is central to late 20th century law affecting professional values. Human rights have become a dominant influence on practical medical ethics. An inherent problem is occasionally created when ethics become law: law guarantees rights that may become entitlement, and entitlement may conflict with ethics.

The United States has been on the verge of establishing a federal system of health care on several occasions including the New Deal, the Fair Deal, and, most recently, the Clinton Health Security Act. The political defeat of the Clinton Health Security Act opened the way for health care reform, by default, to be subsumed by corporate America through a variety of business insurance interests broadly labeled "managed care." The current patchworked health care system, based on managed care, represents a deviation from the trend of the 1960s. The legislation of the 1960s was designed to increase access to health care by less advantaged segments of the population. Remedial legislation, Medicare and Medicaid, paved the way for universal access. The goal of universal access to health care has now been replaced by cost containment as public policy.

Linda Emanuel, MD, PhD, chair of the Ethics Institute of the American Medical Association, notes, "The essence of professionalism is about self-regulation in exchange for expertise . . . forgotten was the ethical obligation to provide access to care which was the root stimulus for reform."[40]

The managed care movement transiently

slowed the rise in health care costs. Increased costs are now reoccurring, as happened previously in the insurance industry. Most industrialized countries, regardless of their system, have problems containing health care costs due to expectation of health care as an entitlement, the aging of the world population, and the increase in health care technology.

In the United States, unlike the rest of the world, the responsibility for the health system has by default been assumed by corporate America, even though there is inherent conflict between professional and business ethics. Properly considered a positive right, health care is unlikely to be successfully delegated to managed care organizations (MCOs). As we have established, an inherent ethical conflict occurs between the professional culture of medicine and the ethics of business. The inherent conflict within the managed care organization is that the individual physician has ethical obligations in the delivery of health care. Fair competition in the business world assumes some equality among purchasers of a product and a voluntary choice. According to ethicist E. Pellegrino, "Managed care by its nature places the good of the patient in conflict with (1) other patients served by the plan, (2) the good of the plan and the organization, and (3) self-interest of the physician."[41] In contrast to medical ethics, business ethics are concerned with the conduct of business in a competitive marketplace tempered by the values of honesty, truthfulness, and dependability. The ethical dilemma of managed care is that physicians are at financial risk for treatment decisions that blend probability risk (the likelihood of medical events based on characteristics of patient populations in a given pool) with efficiency risks (how competently and efficiently the care is rendered). The probability risks have been the traditional responsibility of insurance.

Preserving the physician-patient relationship in a corporate, population-based health care system is problematic without significant federal regulation. The Patients' Bill of Rights, supported by President Clinton, the American Medical Association, and the American College of Surgeons, is a political response to the inability of MCOs to solve fundamental health care needs of the public.

The United States health care system is flawed by lack of universal access to health care for all persons and by the unlikely solution emanating from MCOs. Our evolving system is confronted by the need to deal with decisions that grow out of the inherent conflict between population-based medicine and Hippocratic medicine. The basis for the current conflict is the aging population, the increasing cost of health care, and the application of new technology. Resource allocation and health care delivery require evaluation of efficiency models in which the standards are to seek cost-benefit analysis and utility maximization.

## *Rights vs. entitlement*

There are different implications for medicine in equity and entitlement rights. These implications involve perceptions of morality and resource allocation, in which entitlement rights may conflict with ethical fundamentals. For example, ethical codes, such as those that are based in religious faith or doctrine, have relevance to—and may conflict with—the physician when he or she is the instrument of providing care ensured by law or entitlement.

The patients' rights movement that evolved from the informed consent legislation embodied an equity or positive right. The current patients' rights movement is a reaction to the managed care movement and is more akin to negative rights, seeking as it does to proscribe certain acts or practices of MCOs. The managed care industry is aware of the inherent conflict between the ethics of business and professional ethics. Professional ethics ensure the fiduciary relationship between physician and patient. Managed care is a corporate contract that is obligated to provide the coverage of the insurance contract.

Because patients expect more of the health care provider than a narrow insurance obligation, dissatisfaction occurs. To respond to the expectations of patients, some MCOs have begun to address issues of quality and rights. The managed care industry has developed a nongovernmental agency, the National Commission for Quality Assurance, as an independent, not-for-profit group to evaluate the quality of MCOs. The American Association of Health Plans has developed a document similar in spirit to the National

Commission for Quality Assurance document to serve the same end. The American Association of Health Plans' intention of "putting patients first" was described by Jerome P. Kassirer, MD, editor of the *New England Journal of Medicine,* as a "thinly veiled attempt to ward off state and federal legislative actions to curb the abuses of managed care."[42]

Dr. Jordan Cohen, president of the Association of American Medical Colleges, in a recent editorial entitled, "People want their doctors back," noted:

> . . . As technology, and now economics, is intruding so prominently into the innermost sanctum of medicine, the essential transaction between doctor and patient is being threatened as never before . . . [Patients] see medicine coming under the influence of big business and turning to assembly-line, clock-punching methods. That's not what they want. What they want is to have their doctors back. Indeed, it's precisely that sentiment that's fueling the present clamor in Congress to enact some sort of "Patients' Bill of Rights." The aim is to protect the "consumer" from the impersonal health care marketplace.
>
> Consumer! That's a word drawn from commercialism, not from professionalism. Commercialism views sick, or could-be-sick, people not as patients but as consumers; it views doctors as providers and medical services as commodities. . . . Commercialism's failure to see beyond the cost-containment dimension of this dilemma is poisoning people's confidence in the entire health care system. . . .
>
> Professionalism, the commitment to subordinate one's self-interest to the interest of one's patients, constitutes the very foundation of trust upon which our social contract rests. And maintaining mutual trust in the doctor-patient relationship is, to my mind, the only way to assure the public that medicine is fulfilling its sacred obligation. No laws, no regulations, no patients' bill of rights, no fine print in the insurance policy, no watchdog federal agency, nothing can substitute for trustworthy doctors who care.[43]

Values

| Corporate | Professional |
|---|---|
| Profit | Service |
| Competition | Advocacy |
| Responsibility to stock holders | Altruism |
| Market driven | Services of specialized knowledge |
| Standards set externally | Standards set internally |
| Consumerism | Humanism |
| Short-term goals | Long-term goals |

Modified from Swick HM: Academic medicine must deal with the clash of business and professional values. *Acad Med,* 73:751-755, 1998.

Some health plans have developed consumer protection language to modulate the conflict between business and professional ethics. The principles for consumer protection promoted by Kaiser Permanente Group Health of Puget Sound and by the Health Insurance Plan of the American Association of Retired Persons and Families in 1997 are approaches to this problem that George J. Annas labels "small and pathetic."[44]

These contract-centered proposals are irrelevant to the typical patient who has made comprehensive patients' rights legislation seemingly necessary. In 1997, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry enumerated four categories of traditional patients' rights based on the *Consumer Protection and Quality in the Health Care Industry Act:* (1) Make medical decisions based on full information (informed consent); (2) the right to confidentiality; (3) the right to emergency care; and (4) the right to be treated with respect.[45]

The core of the patients' rights movement is the right to receive care from an accountable physician. Annas lists five provisions that should be included in a Patients' Bill of Rights: (1) informed participation in all decisions; (2) the right to privacy and dignity; (3) the right to refuse treatment; and (4) the right to emergency care; and (5) the right to an advocate.[45]

Ironically, the Health Security Act of 1993, which failed to become law, launched the greatest change in health care organization that has occurred in 100 years. A recent research report from *The Economist,* "The future of the managed care industry," concludes that managed care will not only continue its meteoric growth in the United States, but will increasingly be exported

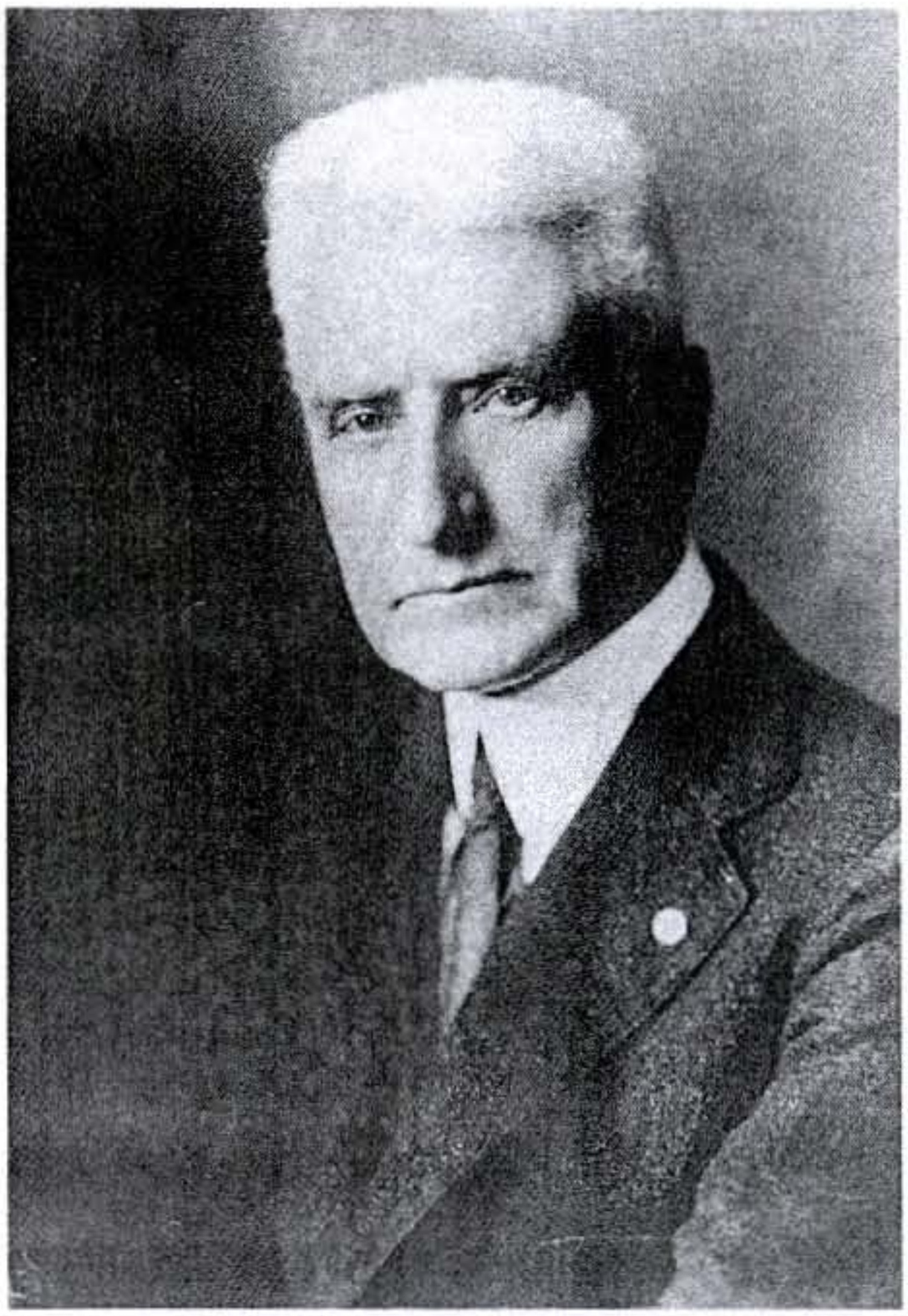
to other industrialized countries, and that MCOs "... have to become more patient and doctor friendly organizations and ensure that quality and service have the same priority as cost control. If they achieve all this, managed care will be ready to take on the rest of the world."[46]

If we conclude that managed care is likely to be the dominant mode of health care delivery, a rapprochement is needed among patients, physicians, and other legitimately interested parties, including government. The resolutions require solution in the ethical venue as well as the administrative and commercial venues. While most medical organizations, including the American Medical Association and the American College of Surgeons, support the Patients' Bill of Rights legislation now in Congress, that bill is basically a negative right, designed to curb the numerous inadequacies of managed care. It predictably will be inadequate to the larger task of reconciliation of positive rights.

The fundamental issue requiring resolution is to ensure universal access to a basic level of health care. The incremental approach to change in health care has been inadequate to the task. In a time of unprecedented economic growth, a partially financed federally mandated structure should be reexamined. The number of uninsured patients continues to increase, now exceeding 41 million, at a time when welfare numbers are dropping and 14 million jobs have been created.[47] The problems with the piecemeal approach are demonstrated by the Kassebaum-Kennedy Bill of 1996. Designed to ensure employee insurance portability, it has been thwarted in many of its goals. For example, most new jobs are in the lower-paid sector. While the bill ensures individual coverage for people losing group insurance, it does not limit how much they can be charged. Prohibitive rates have occurred, even to the amount of a charge five times the previous rate. It is estimated that as many as six million workers are offered health insurance by their employers or unions, and choose not to take it.

Another issue of ethical and practical importance is confidentiality. The 1996 Health Insurance Portability and Accountability Act requires a new privacy law.[48] Hospitals and health plans had been advocating a rules-easing sharing of information about patient health. The right to confidentiality is a tenet of the Hippocratic Oath and deals with trust between physician and patient.

Rationing, a concept of distributing services



Franklin H. Martin, MD, FACS (1857-1935). Founder, Regent, President and Director-General, American College of Surgeons, as well as founding editor of *Surgery, Gynecology, and Obstetrics* (now *Journal of the American College of Surgeons*). His vision for the American College of Surgeons was described by W. J. Mayo as "An association that would have for its purpose the better care of the American people ... who needed surgical care. Knowledge alone was not sufficient. He sought in those who were to become Fellows in the College, character and honesty of purpose, joined with adequate surgical training and experience."

based on choices of care, is an area within which a compromise is possible. An unresolved conflict will always exist between the population ethic and the individual, especially in today's economically dominated corporate health care system. Another issue is fairness and equity, a strong value held in Western culture and applicable to health care. While equity always falls short of being totally applied, it has been an explicit principle of most health care systems in the Western world.

While insurability, financing, and confidentiality are prominent ethical issues, our current corporate-oriented system is challenged by new technology and its ethical ramifications. The human genome project, which is well advanced, allows uncommon monogenic diseases to be predicted. Screening for Huntington's Chorea is an example of the almost unlimited potential for genetic screening. The genetic test for familial adenomyosis polyposis, which can predictably detect a family that will develop colon cancer by the sixth decade of life, is another example. The issues are: how widespread should the screening be, how will it be funded, and how will the families involved be assisted in using the information to make autonomous decisions?[49]

Another arena of substantial ethical, legal, and entitlement complexity is reproductive rights. Reproductive rights have been dealt with under the legal concept of privacy since *Roe v. Wade* in 1976. While the issue has been dealt with regarding the law and entitlement, it remains an unresolved and conflicted ethical issue.[50]

Human cloning research, or its application, is an area legislators have rushed to proscribe by law. Since Scottish scientists announced the birth of a sheep named Dolly that was cloned by combining the nucleus of an adult mammary egg and an enucleated sheep egg, people have been concerned over visions of human cloning factories. Because research on cloning holds promise, it is an area of needed collaboration among scientists, ethicists, and policymakers. Currently, most European countries have banned research in this area.[51]

The thorniest ethical issue is the question of entitlement as a constitutional right in cases of euthanasia or physician-assisted suicide. If allowed to be law, and dealt with as entitlement, a direct conflict with the physician's ethical proscription against causing death is present. The fundamental question is: Do patients have a constitutional right to have physician-assisted suicide or euthanasia?[52] Remember, the physician-assisted suicide and euthanasia is an act proscribed by the Hippocratic Oath.[53] However, in the Netherlands, physician-assisted suicide and euthanasia represent 2.3 percent and 0.4 percent of all deaths. Recently, the United States Supreme Court *(Washington v. Glucksburg* and *Vacco v. Quill)* rejected the constitutional right to physician-assisted suicide.[54] Cited in the *amicus curiae* briefs were concerns of linking physician-assisted death to the effort to reduce the high cost of terminal care. The Supreme Court noted the cost-saving potential of physician-assisted suicide: "If physician-assisted suicide were permitted many might resort to it to spare their families the substantial financial burden of end-of-life care cost." Recent publications have examined end-of-life issues, including how much money could be saved by a program of physician-assisted death and euthanasia as a business practice in managed care plans.

As rights become law and law becomes entitlement, conflicts arise. While no one would contest the right and entitlement for decent food, shelter, and health care, the obligation to provide for such needs involves the assumption of responsibility by government, church, or some other entity. It involves not just the assumption of responsibility, but a determination of the quantity and quality of the service to be provided. In a perfect world, what would be provided would be what was needed, and it would be qualitatively and quantitatively equal to what was available to anyone in the society. Because determining what an acceptable standard should be defies absolute definition, details become important. Rights and entitlement can be interpreted so expansively as to include the right to irresponsible behavior without obligation or consequences. The concept of human rights can be diminished by placing each issue, social ill, or need in the context of a right or an entitlement. For example, it is repugnant to consider an issue such as euthanasia as a potential mandated right or entitlement, which becomes a legal obligation, requirement, or service of a physician.

The patients' rights movement has reasonable entitlement expectations. It remains to be seen if the movement will evolve to more specific and controversial expectations. The fiduciary responsibility of the physician to the patient is for informed advocacy, as well as competent care. The patients' rights movement carries with it the obligation for patients to learn and for the physicians to teach. This right brings with it an obligation for a patient to be more than a passive recipient of entitlement.

## *Recommendations*

The reconciliation of medical ethics, human rights corporate care, and population-based health care with physicians' fundamental fiduciary responsibility to the patient requires a fundamental reorientation.[55] Clearly, the corporate ethic of managed care is inadequate, as it has focused on cost, instead of quality or access. In the balance of physician responsibility between population-based health care and doctor-patient personal health care, the patient's right of autonomy must dominate, even if financially unjustifiable. The corporate dominance of health care in its current state of development is inadequate to ensure protection of patients.

The meeting ground for resolution of these conflicts—in the realm of ethics—resides in the human rights movement, which has profoundly influenced society in general and medical ethics in particular during the past 50 years. The human rights guarantees of autonomy and other basic rights have effectively modernized the codes of medical ethics. The human rights movement is influencing the insurance industry and legislators who are drafting the Patients' Bill of Rights in Congress.

Returning to the theme of the essential role of ethics in defining a profession is the requirement of a common ground for reconciliation of the corporate and professional ethical orientation. Acknowledging the timeless fiduciary basis of medical ethics, there is room for the equally lofty, if more modern, concept of human rights. In this 50th anniversary year of the Universal Declaration of Human Rights, it would be appropriate for both the professional, as well as the corporate, medical community to establish human rights as the basis for reconciliation.

### Basic rights of patients

- Not to be killed intentionally or negligently.
- Not to be harmed by intent or negligence.
- Not to be deceived.
- To be informed of risks and benefits.
- To be treated by knowledgeable, competent practitioners.
- To have his/her health and well-being more highly valued than the surgeon's economic interest
- To decide to accept treatment under above conditions.

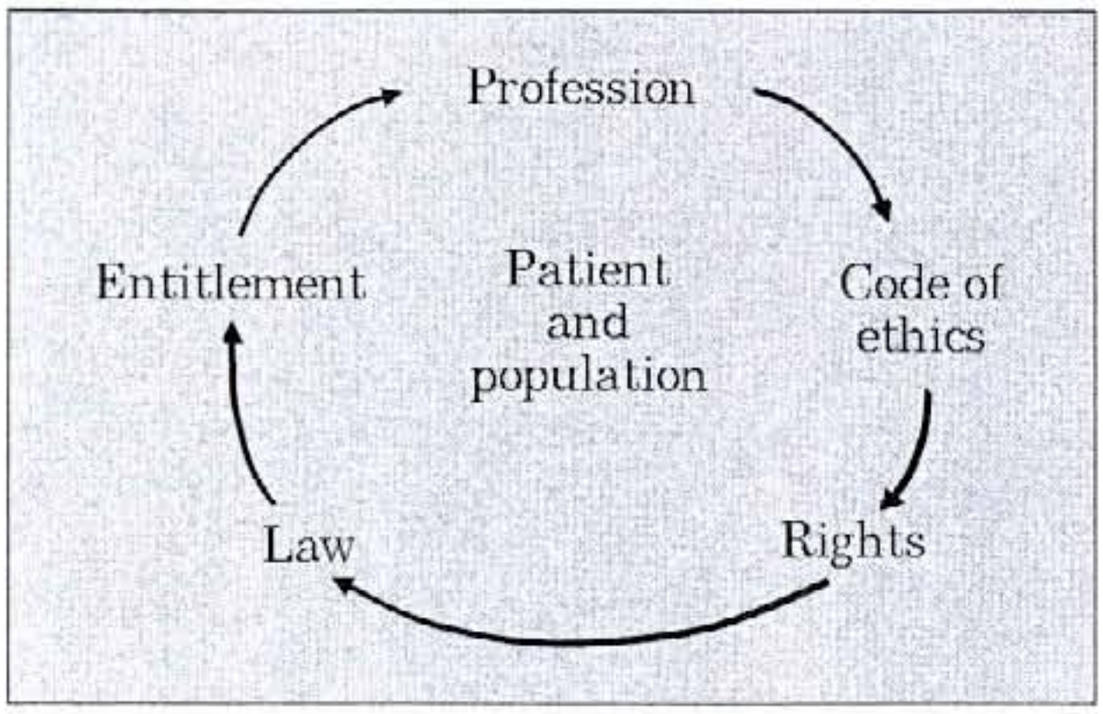
Source: Basic Rights of Surgical Patients, from McCullough LB, Jones JW, Brody BA: *Surgical Ethics*. Oxford, England: Oxford University Press, 1998, 5.

Just as Hippocratic medicine must be practiced with focus on proper and ethical treatment of a patient, broad societal responsibilities are a legitimate obligation of physicians. The inherent ethical problems in Hippocratic medicine and population-based medicine need not be in conflict. A human rights culture can reconcile the ethical dilemma of the corporate and business culture.

While finding an ethical basis for resolving conflicts in our health care system is a giant step, other steps are required. Application of the human rights goal would reestablish our evolution toward universal access and coverage. Since the Health Security Act (1993) failed to become law, a gradual approach seems inevitable. If a Patients' Bill of Rights becomes law, it should be accompanied by specific federal regulations.

The historical method of dealing with irresponsible capitalism is with a regulatory commission. The Federal Trade Commission and the Security Exchange Commission are models that might be emulated for regulation of managed care organizations. While most physicians are not advocates of government regulation, it is the corporate transformation that is disruptive to the provision of health care.

Managed care in its current form will not remain the dominant force in health care delivery.




The interconnected, sometimes conflicted relationship of the profession, distinguished from occupations by a code of ethics, which become rights, which become law, which become entitlement. At the center is the patient and the population.

It is certain, however, that some of the features of managed care will persist in our evolving health care system. The legacy that is likely to persist is that of an organized system of care, cost consciousness, and outcome justification. To these features, the evolving system will add a priority for universal access, quality, and choice. The evolving system will require a basic health insurance program through an extension of a federal program such as Medicare. The role of the physician as the moral fiduciary of the patient must be preserved as the system evolves.

Physicians, as well as patients, will adapt to different responsibilities in a changing health care system. Physicians will enhance their capacity to evaluate and adapt to new technology and its role. They will retain their historic role as patients' advocates in the context of realistic use of health care resources and their cost.

The timeless conflict between doctor-patient and population-based health care requires a collaboration between the professions of medicine and public health. Today's functional separation of the two fields is of post-World War II vintage and even has roots in antiquity. Two deities in Greek mythology, Panacea and Hygeia, were sisters representing the relationship between healing and health. Hippocrates included considerations of public health in the diagnosis and treatment of disease, noting that air and water have potential for affecting the health of the population. The two fields differ in that *medicine* focuses on an individual patient and uses the tools of biology to diagnose and treat. *Public health* focuses on populations and uses the tools of epidemiology and statistics.

Both medicine and public health are profoundly involved in the changing health care system. Medicine could benefit from population-based analytic methods. Some surgical fields, such as trauma, have evolved beyond the provision of operative care to involvement in trauma systems, outcome measures, and injury severity scoring. The American College of Surgeons, through the establishment of the NTDB (National Trauma Data Bank), has been involved in public health methods and the public health community. Both public health and medicine have a common interest in influencing health system policy, collaborating on databases and assessing the economics of health care and performance. As much as managed care and an organized health care system will need population-based analysis, the prospects of positive changes in the health care system will be well-served by a collaboration. The American Medical Association, the American Public Health Association, the New York Academy of Medicine, and the Robert Wood Johnson Foundation are leading the effort to enhance the common efforts between medicine and public health.[56]

## Conclusion

It is essential that professionalism and its defining feature, ethics, persist. As managed care is likely to remain our mode of health care with enhanced federal regulation, a duty of physicians must be to inculcate a professional ethic into the culture of managed care to displace or modulate the business ethic. The basis of that evolution is in the human rights movement.

It is important to understand the role of population-based medicine in our health care system and the predictable strain between it and the individual fiduciary relationship of physician to patient. Most surgeons in the performance of

# Fellowship Pledge

Recognizing that the American College of Surgeons seeks to exemplify and develop the highest traditions of our ancient profession, I hereby pledge myself, as a condition of Fellowship in the College, to live in strict accordance with its principles and regulations.

I pledge myself to pursue the practice of surgery with honesty and to place the welfare and the rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position, and I will set my fees commensurate with the services rendered. I will take no part in any arrangement, such as fee splitting or itinerant surgery, which induces referral or treatment for reason other than the patient's best welfare.

Upon my honor, I declare that I will advance my knowledge and skills, will respect my colleagues, and will seek their counsel when in doubt about my own abilities. In turn, I will willingly help my colleagues when requested.

Finally, I solemnly pledge myself to cooperate in advancing and extending the art and science of surgery by my Fellowship in the American College of Surgeons.

The Fellowship Pledge of the American College of Surgeons is remarkable for having patient rights embodied in the pledge, anticipating the post-World War II and current focus on the fiduciary relationship between doctor and patient.

daily patient care regard the individual patient as the focus of attention rather than the patient as part of a population, linked only by having a similar disease.

When the American College of Surgeons was founded in 1913, it strongly emphasized the *Fellowship Pledge*. It was suggested by the founders that technically able but unethical surgeons should not be admitted to membership. Franklin H. Martin, MD, FACS, and associates founded *Surgery, Gynecology, and Obstetrics,* now called the *Journal of the American College of Surgeons,* to have an editorial staff to guarantee ethical and scientific standards. For over 80 years, the College's Central Judiciary Committee has diligently maintained oversight of standards and discipline. The Board of Regents has published a number of statements on positions deemed proper for the ethical practice of surgery.

As noted by C. Rollins Hanlon, MD, FACS, a former President and Executive Consultant of the American College of Surgeons:

> In both the ancient and recent past, the problem for the physician has been maintaining a true fiduciary relationship with the patient. The Fellowship Pledge of the ACS states . . . 'I pledge myself to pursue the practice of surgery with honesty and to place the welfare and *rights* of the patient above all else.' Faithful adherence to such a pledge will do more to maintain the reputation of our profession than many pages of philosophical thought.[57]

The venerable pledge of the American College of Surgeons contains the basis for the evolution of the health care system by providing the basis for ethical rapprochement between corporate, professional, and government perspectives. That basis is the concept of human rights, a key feature of modern international law, health care, and human ideals. It was identified as a key concept in patient care by the founders of the American College of Surgeons. Ω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