Physician, heal thyself: Doctors in a pluralist democracy

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Key points:

- Although medicine holds a preeminent place in the modern world, increasing health care costs, government oversight of physician behavior, market pressures, and lawsuits against physicians contribute to low morale and the erosion of medicine as a profession.
- Physicians must nonetheless uphold the notion of medicine as a profession by practicing it on an individual basis in which they, as individual professionals, make individual decisions about individual patients.
- Restoring medicine as a profession requires changes in the attitudes and practices of physicians, organized medical societies, the government, and the private sector.

Today’s physicians are a beleaguered bunch. They find themselves attempting to satisfy multiple conflicting demands, morally adrift, spiritually depleted, and politically powerless. They have become trapped in a vice, squeezed between the grips of the market and government, with no apparent escape. Public trust in US physicians is at an historic nadir, with the United States ranking 24th among 30 industrialized nations, ahead only of Chile, Bulgaria, Russia, and Poland. Morale is at an all-time low. Many are leaving the practice. Only a minority would recommend that their children become physicians.
Yet all this is happening at a time when medical care occupies a proportion of the economy that exceeds even defense, and when physicians’ technical powers and skills have never been greater. Smallpox has been eradicated. Breast cancer has become a chronic disease. Robots perform surgery. Life expectancy in the developed world is approaching biblical standards. Medicine seems so powerful.

And medicine’s cultural reach is as broad as it is deep. Medicine now colors nearly everything about our lives. We are so dependent on drugs that there seems to be a pharmacy on every other city street corner. We receive more and more vaccines, but we also live in constant fear of exotic infections. New medical devices have become big news for business. Stories about disease prevention with colonoscopies or prostate-specific antigen testing make the front pages of leading newspapers.

Furthermore, the US Supreme Court makes regular decisions about such medical topics as health care financing, the patenting of diagnostic tests, the mandating of insurance coverage for particular drugs and devices, and the conscience claims of practitioners and patients. Everyone knows someone whose death has involved a decision about whether to withhold or withdraw a life-sustaining treatment. Neuro-cognitively normal students take drugs to perform better on tests, and athletes take drugs to hit more home runs.

Medicine holds a preeminent place in the modern world. So why are physicians so unhappy? The reasons are numerous and complex. First, and perhaps most salient, is the fact that increasing medical care costs have led those who pay for care—largely, government and private
employers—to try to find ways to decrease health care expenditures through the regulation or manipulation of physician behavior or by decreasing payments. This has meant rising pressure on physicians to be more efficient and an increasingly burdensome bureaucratic system designed to implement the cost-cutting regulatory apparatus. The constant burden of regulation, paperwork, and appeals—and physicians’ growing weariness toward various attempts to alter their behavior by changing financial incentives and other behavior-modification techniques—weighs heavily on practitioners.

Second, these cost pressures lead physicians to see more patients (and to subsequently spend less time with each patient) just to maintain their levels of income. Those who value their relationship with patients are grieving the loss. And partly flowing from these cost pressures, but also owing to other sociocultural trends, physicians are being urged to change their focus from the care of individual patients to the care of populations of patients.

Since, as Aristotle once observed, physicians do not treat humankind but “Callius or Socrates or someone else” who is sick, the metaphysical impossibility of the task set before them has become a source of perplexity and angst at the bedside. Physicians (correctly) feel incapable of doing what they have been asked to do.

Third, the very technology that mediates medicine’s current prowess has become a source of alienation. For example, technology has long been a source of alienation for patients who feel increasingly treated as objects of it rather than respected as individuals. Patients are grateful for
the technology that extends, saves, or improves their lives but question whether access to this technology requires that they sacrifice a sense of personal care.

Lesser known is the fact that clinicians are also now experiencing alienation from the technology that they deploy. An intuitive sense that medicine is more than applied technology haunts many practitioners, even as they see their time and attention increasingly focused on the chemical compounds, machines, calculations, and techniques of care and decreasingly on the persons this technology is intended to serve.

Fourth, the technology now empowers physicians to make interventions that once lay outside the purview of medicine, leading to questions about what medicine is for and what its goals might be: How long should human life be extended? Are there moral limits to what ought to be done to assist infertile couples? Is there a difference between giving growth hormone to a child who is short statured because of deficiency in that hormone versus giving it to a child with normal hormone levels but whose parents desire a taller child? Physicians are increasingly uncertain about what medicine is.

Fifth, the rise of consumerism in health care has amplified these questions. What began as an insistence on being informed and involved in decision making, including a right to refuse recommended medical interventions, has evolved into an ethic of informed (or sometimes uninformed) demand for interventions on the part of patients and families. Physicians were once, in an unjustified and paternalistic approach, the sole medical decision makers. Now, the pendulum has swung to the opposite extreme. Physicians have come to be considered providers
of a consumer good that must be dispensed on demand. This negatively impacts physicians’ sense of themselves as independent professionals.

Compounding this consumerism as a cause of physician distress is the markedly litigious atmosphere that has come to surround the delivery of health care. Seven percent of physicians are sued each year (19 percent for neurosurgeons). By age 65, 75 percent of physicians in low-risk specialties (and 99 percent in high-risk specialties) will have been sued at least once. In 2004, annual malpractice premiums for obstetricians averaged between $80,000 and $174,000 per year, leading many obstetricians to retire early or limit their practices to gynecology and cease delivering babies.¹ Maintaining income is beside the point—they could always increase their fees. Physicians feel deeply hurt when sued for bad outcomes, even when they are not at fault.

Sixth, the information explosion has made it impossible to know all there is to know about medicine. This has made the generalist’s job far more difficult and has helped, in part, drive a subsidiary problem: hyper-specialization. Medicine is no longer a unified field with camaraderie across specialties, but rather a collection of specialists, subspecialists, and sub-subspecialists who know little about other aspects of medicine and who communicate poorly with colleagues in medicine outside their fields. As a result, care is fragmented and the whole patient is lost in the sea of subspecialists.

Generalists, who might be called on to coordinate the various aspects of care, lack the necessary information and control to exert much influence in this coordination and are made to feel
inadequate and inferior. Compounding these matters, the remuneration scheme for medical practitioners overcompenses specialists and undercompenses generalists. Thus, the best and brightest new medical students want to be dermatologists, ophthalmologists, and radiologists, which are all highly compensated, procedure-oriented specialties with little on-call commitment and little investment in long-term patient relationships.

Seventh, the introduction of the electronic medical record (EMR) has not been an unqualified good. The EMR does facilitate communication among physicians about common patients and can warn physicians about drug interactions or prompt them to order routine periodic tests, such as mammograms. By and large, however, the EMR has become an instrument of the bureaucracy. It helps institutions capture language and codes that are required for billing and helps assure compliance with a host of regulations and insurer requirements.

Ironically, the EMR actually drives up health care costs because hospitals and private practices can now more readily prove that they provided the services for which they charge. In demanding all this documentation, the EMR has added to the bureaucratic burdens that physicians face. While it speeds up note writing, the drawback is that medical notes have become incomprehensible masses of undigested medical information. Patients complain that physicians now make more eye contact with computer monitors than with them. Physicians, in turn, feel more like clerks than professionals.

Numerous as they are, the abovementioned external factors are not the only causes of physician demoralization. Physicians have brought some of the demoralization on themselves. Rather than
collectively resisting external forces deleterious to the profession and the public and suggesting constructive alternatives, physicians have by and large acted, both independently and collectively, in ways that seem to serve their own self-interests. For instance, rather than fighting against decreases in payment per visit, they have increased the number of visits and decreased time spent with patients. It is also physicians who have so emphasized science in medical education that the needs of patients as persons have been lost.

**The Deprofessionalizing of Contemporary Medicine**

Perhaps a more straightforward way to explain the unsatisfactory state of the medical profession is to characterize it as having been deprofessionalized. As sociologist Paul Starr has observed, the idea of medicine as a “cottage industry” has passed. Contemporary medicine is costly and complex. Its efficacy now requires a complex delivery system including machinery, drugs, information systems, and highly specialized personnel working in teams. The days of the country doctor working solo, carrying all that was needed to care for the sick in one small black bag, have long passed. In fact, the majority of physicians are now employees of hospital-based care systems or large care organizations such as Kaiser-Permanente.

Beginning in the 1960s, against this background of the changing socioeconomic character of American health care, powerful currents of consumerism and skepticism about claims of expertise and authority swept the Western world. Not only was the ideal of the country doctor no longer a reality, but the idea that anyone could ever be such an ideal figure was also called into question.
Professional claims to special knowledge or social roles were cynically dismissed as thinly veiled attempts to amass power and income and to maintain monopolistic control over the populace. The very idea of a profession, medicine included, was dismissed as elitist. On this view, society would be much better off gaining its own access to medical information and wresting decision making out of the hands of so-called professionals who were using their social standing to maximize their own self-interest.

Accordingly, the public has largely knocked physicians off their pedestals, and physicians are increasingly controlled by their employers or by oversized bureaucratic regimes. The idea of medicine as a profession has been undermined.

The Ideal of Medicine as a Profession

Despite the barriers physicians face and the changing state of the profession, it remains true that medicine must inevitably be practiced one patient at a time in an encounter between a person who is sick or injured and another, highly trained and socially authorized person who has publically professed to help. This encounter undergirds the persistence of the notion of medicine as a profession.

At the beginning of the 20th century, Abraham Flexner, the great reformer of American medical education, suggested that professions, as distinct from other occupations, had six characteristics:

- They essentially involve intellectual operations requiring heavy individual responsibility on the part of the profession’s members;
- They are dependent on continuous investigation and learning;
• They put their learning to a practical and definite end;
• They are the keepers of an educationally communicable technique;
• They engage in self-organization and self-regulation; and
• They demand an altruistic motivation for membership and practice.\(^3\)

By Flexner’s criteria, medicine remains a profession par excellence. Whether paid for on a fee-for-service basis or by a salary, medical care ultimately involves individual professionals making individual decisions about individual patients. These decisions are weighty; they may even mean the difference between life and death. Physicians must be committed to lifelong learning.

Medicine is constantly changing, and usually for the better. Physicians have obligations not only to keep up with the pace of progress but also to contribute to that progression of knowledge by fostering research, even if they do not conduct it. The long schooling and continued learning of medicine has resulted in a body of knowledge that, while not accessible to the average person, is nonetheless put to the service of all persons.

The practical ends of prevention, cure, amelioration of dysfunction and symptoms, and the provision of comfort are all responses to our common human predicament. Physicians must still undergo long periods of training to learn to do such things as use a stethoscope, interpret an electrocardiogram, write the correct prescription, and perform a complex operation. And the profession teaches its own members.
Medicine is self-organized into schools, specialties, subspecialties, and societies. It is physicians, for instance, who had the authority to decide to make palliative care a new specialty, not the government, employers, or drug manufacturers. Physicians are expected to certify whether another physician has had sufficient training to perform a certain procedure, and it is physicians who set standards for medical-school curricula.

Professional medical performance is subject to peer review, such as through morbidity and mortality conferences. Medical societies can dismiss members for failing to meet professional ethical standards. While they admittedly do not always live up to professional standards, physicians are expected to engage in their professional lives motivated by a sense of altruism.

For instance, patients need to trust that physicians are ordering tests on the basis of what those patients need rather than for personal profit. While not all physicians need to be so altruistic as to fly to Liberia to help fight Ebola, physicians who would refuse to treat a patient with Ebola, provided they had reasonable protection, would have failed to fulfill their professional responsibilities. While not everyone meets these standards, and while motives are often mixed, this expectation of some modest abnegation of self-interest on the part of the practitioner is part of what is meant by calling a physician a professional.

**The Place of Professions in a Modern Democratic Polity**

Fully understanding what it means for a physician to be “professional” requires, however, stepping outside the specific profession to more broadly appreciate the role of professional life in a democratic society.
Modern, pluralistic, representative democratic societies can be chaotic and tumultuous. At best, one may deem that model the least bad among alternative ways of structuring a society. Democracies achieve their most exciting and productive status precisely when they recognize that it is human fallibility that makes democracy the least worst choice. Systems of checks and balances reflect recognition of that fallibility. Modern societies can thrive, but only if they rest on strong and diverse institutional foundations that provide such a critical, self-correcting function.

The institutions most crucial for a healthy representative democracy are (1) the family, (2) markets, (3) the academy, (4) the press, (5) religions, (6) other private associations, (7) the government, and (8) the professions. When all of these institutions are robust, thriving, and collaborative but independent—and each dedicated to advancing its own vital social contribution—a modern democratic polity can flourish. When any particular one weakens, becomes assimilated into another, or disappears, the polity becomes unstable and the society struggles to maintain itself.

As critically important as it is, government is but one of the necessary pillars of a flourishing, modern, pluralistic, and representative democratic society. The government must be not only sufficiently representative to express the collective will of a majority of a people, but also constitutionally constrained from ignoring the interests of minorities. The government of this kind of democracy must also recognize, respect, uphold, and depend on the discrete functions of the other six primary institutions necessary for the flourishing of society.
In particular, the professions have a distinct, irreplaceable role in the flourishing of representative democracy. While other occupations might fit the definition of a profession offered in the previous section, the traditional medieval professions of law, medicine, and the clergy do so paradigmatically. To properly fulfill their public roles, professions must maintain a place in society that is independent of the other social institutions, particularly markets and the state.

Members of the legal profession, for instance, are not agents of the state, even though they serve government in very important ways. The legal profession may also play an active role in the economy, but a lawyer must be prepared to recommend against legal action (and the concomitant personal profit that might accrue from it) if he or she has determined that the client’s interests would not be best served by such action.

Likewise, the clergy ought not be controlled or appointed by the state. Their spiritual services ought never to be considered market commodities on sale alongside other consumer goods. The professions all contribute to the common good by virtue of the unique and specialized services they provide and by professing altruistic motivation. The professions also serve a critical function in critiquing and maintaining balance among the various institutional pillars of modern democracy, helping guard against potential excesses.

This model is based more on an Aristotelian political theory than on the social-contract theory normally invoked in thinking about the social role of the professions. I have described the
important place the professions hold in the set of organic conditions necessary for a healthy pluralist society. There is no assumed quid pro quo among the citizens in a hypothetical bargain.

Citizens are conceived of as intrinsically social rather than as irredeemably self-interested rational maximizers. The notion of the common good that I have in mind is not the summative model of utilitarianism and contemporary economics—by which the common good is merely the sum of all individual citizens’ goods—but an integral notion of the common good, by which the good of each individual is partially constituted by the good of the whole. Social-contract models of the professions are part of the problem, not the solution, when it comes to the woes experienced by today’s health care professionals.

The Proletarianization of the Medical Profession

The 21st-century deprofessionalization of medicine in the Western world has effectively meant the proletarianization of physicians, meaning that the social forces I outlined earlier and physicians’ responses to these forces have changed the way the public at large, employers, private insurers, drug and medical device manufacturers, the government, and patients view physicians. Physicians have also changed how they view themselves. The idea of medicine as a profession, as understood according to Flexner’s criteria, has been effectively undermined.

The ends of medicine are in sustained, unresolved dispute among patients, practitioners, and policymakers. Medicine’s knowledge base is increasingly scientific and technical, and the bedside art is no longer a set of techniques passed down from one generation of physicians to the next. Physicians no longer readily see themselves as a self-correcting moral community, and
external regulators have stepped into the vacuum. Society has signaled to physicians that their professed altruism is a lie, and now physicians self-consciously choose to define themselves nonaltruistically.

Increasingly, physicians, like the classical coal miners of the proletariat, form unions, engage in collective bargaining, and threaten strikes and other job actions. Other physicians are seeking refuge in concierge medicine, returning to the pre-Hippocratic, preprofessional notion of the physician as a salesperson in the marketplace, hawking medical goods and services to those who can afford to pay.

Physicians are increasingly either agents of the state or of the market, often employees of corporations that either are for-profit or act as if they are for-profit institutions. Market competition in medicine is now so fierce that both charitable health care institutions (even if religiously established) and academic medical centers all behave as if their primary purpose were making profit, even if only to maintain enough of a bottom line to survive.

For instance, they advertise on billboards and radio, a practice once considered in violation of professional ethical norms but which can no longer be prohibited since it would constitute, according to a Federal Trade Commission ruling, illegal collusion to fix markets and restrain trade. Therefore, competition is now encouraged, leading, paradoxically, to the duplication of services of questionable benefit (who would go to a hospital that did not have “state-of-the-art robotic surgery”?).
Rather than resist such practices, physicians actively participate. Looking for cost containment, payers push physicians to see more patients, profile their patient-satisfaction scores, and deploy financial incentives to decrease health expenditures and increase customer volume. Physicians who jointly own their small-group practices are no different in spirit than employed physicians: they push each other to see more patients and try to develop routine procedures or referral patterns that will increase profit, such as internists learning to give Botox injections, or small-group physicians making frequent referrals for MRI testing at centers where they are also co-owners.

Trying to contain costs, private insurers impose huge bureaucratic hurdles on all physicians regarding the use of various tests and treatments. The case of closed drug formularies provides one common example. Insurers cut deals with pharmaceutical companies to keep certain drug prices down. Beyond simply requiring the substitution of generic drugs when available (which is certainly reasonable), many insurers annually renegotiate their contracts with pharmaceutical companies to make one drug within a class the drug of choice for that year, at a considerable discount, but providing a locked-in market share for the pharmaceutical company.

For example, atorvastatin (Lipitor) may become the drug of choice for elevated cholesterol for the year instead of simvastatin (Zocor). Even if a patient were doing well on simvastatin, the physician would be forced either to change the drug prescribed for the patient or to ask the patient to pay huge out-of-pocket costs. To make the drug substitution, however, requires testing and adjustment to find the correct dose of the new drug, which sometimes takes 12 months, just enough time to face a new formulary change, starting the process all over again.
To appeal to keep the patient on simvastatin and continue to provide coverage, the physician must call a 1-800 number and speak with a clerk who has no medical or nursing education but is equipped with a rote checklist of requirements designed to block the appeal and weary the physician. Since formulary changes are estimated to affect 30 percent of patients annually, such appeal fatigue becomes the rule rather than the exception.

The federal and state governments, though the long reach of Medicare and Medicaid, now employ similar techniques. For instance, physicians are now only allowed to prescribe medication from predetermined lists, as federal and state governments have closed drug formularies, utilization review, prior authorization, and physician cost profiling just as the private insurers do. Some have outsourced this cost-control work to private insurers through Medicare Managed Care. Moreover, the government uses fraud and abuse regulations and investigations as instruments of cost control, seeking to deny payments based on bureaucratic technicalities as much as on true fraud.

For example, for several years, until the practice was made public, if a patient were enrolled in hospice care (which requires a clinical judgment that the patient has six months or less to live) but actually lived more than six months, physicians were being accused of fraud. Superimposed on these cost-control bureaucracies are a host of regulations regarding the prescribing of narcotics and other controlled substances, informed consent for testing and treatment of specific diseases such as breast cancer and HIV, privacy of patient information (some of which interferes with communication between practitioners regarding patient care), and limits on who is permitted to perform simple clinical tests. The estimated effect of this hodge-podge of private
and governmental bureaucracy is that 25 percent of the cost of being hospitalized in the United States is administrative, while in Canada the figure is 12 percent.

Medical-professional organizations have largely accepted these conditions as facts and have found ways to work with them to maintain what they can of their income. In some instances, a gap is growing between these professional organizations and their individual members, who do not perceive the professional organizations as representing them as members of a self-correcting professional moral community but rather as overgrown bureaucracies.4

Some practitioners have decided to take an “if you can’t beat ‘em, join ‘em” approach by abandoning traditional professional commitments to justice and altruism by shunning the public and private insurance bureaucracies in favor of concierge practices, in which patients pay cash retainers for remaining in the physician’s practice and pay cash for services in return for more time and availability from physicians. This market-based solution may be an understandable reaction, but it excludes the poor from access to care and unfairly shifts the burden of caring for the most difficult and least financially rewarding patients to fellow practitioners, undermining Flexnerian claims that professionalism requires altruism.

Academic medicine is now enormously dependent on private corporate funders (such as the pharmaceutical industry) to pay for research and teaching, compromising the academy’s ability to maintain independence from the market and to serve as a correcting and balancing social institution. Disclosure of a researcher’s ties to industry allegedly serves to dispel all suspicion
about compromised objectivity, and the federal government has passed the *Physician Payments Sunshine Act* to require such disclosure.

Nonetheless, considering that a member of the medical profession can author an article in the *New England Journal of Medicine* exploring the pros and cons of a particular drug and can shamelessly list in the fine print 41 corporations from which he or she has received grant support or payment for speaking or advising, something is seriously wrong. Disclosure, under such circumstances, becomes meaningless.

Moreover, a number of medical educators now dismiss Flexnerian notions of professionalism as “nostalgic,” urging medical students and practicing physicians to just learn to manage their many conflicts and the apparently paradoxical demands placed on them. New physicians are now being explicitly taught to abandon 2,500-year-old notions of medical professionalism as unfit for a society in which medicine is no longer a cottage industry. The end result has been a dramatic destabilization of one of the major pillars of a modern democratic polity: medicine. And with medicine playing so significant a role in the idea of professionalism, the destabilization of medicine effectively means the destabilization of professionalism in society.

**Renewing the Role of Physicians as Citizen Members of a Public Profession**

Society faces a cacophony of conflicting calls for how physicians ought to exercise their citizenship. Some would deny physicians any special role as citizens other than to act as profit-seeking members of a market and to participate in charitable acts or the political process as they choose, just as any other citizen might. Others call on physicians to act as agents of the state in
controlling health care costs. Still others urge physicians to take on explicitly political advocacy roles over issues such as the legal limitations of the caloric content of foods, or the proscription of certain forms of interrogation of terror suspects.

To address these less-than-salutary and contradictory trends and to establish a healthy structure in which physicians might once again exercise their proper roles as citizens, it is necessary to restore the idea of medicine as a profession. Unless physicians are recognized as members of a profession, their contributions as citizens will be neither special nor robust. Restoring a vigorous sense of medicine as a true profession would redound to the good of patients, practitioners, and society as a whole.

Effecting such a change is no easy task. It would begin with changes in language and thinking about what medicine is. Physicians and nurses would once again be called “physicians” and “nurses” (in recognition of their distinct professional identities) rather than “providers.” Patients would no longer be called “clients” or “consumers” but “patients,” in recognition that this word does not describe a duty to remain calm in the waiting room, but etymologically denotes “one who suffers.”

Physicians (and other health care professionals) would need to restore their own views of their profession as a self-correcting moral community, redoubling their efforts to root out wrongdoing, cultivating virtue among practitioners and students, and legally freeing them to set their own internal, high standards of morality. The role of professions as independent of both state and market must be reaffirmed in attitude and policy.
Physicians would also need to recover their self-conception as professionals. This task is far more spiritual than political. Physicians need to seriously reinvigorate their own spiritual lives, reaffirming their sense of medicine as a vocation and rededicating themselves to the altruism that characterizes a true profession.

**Being Good Citizens within the Medical Profession**

For medical professionals, being a good citizen begins within the profession. It is not enough merely to take good care of patients (although this remains the primary task). One has duties, when necessary, to assist other colleagues as a consultant in the care they provide. One also has duties with respect to the knowledge base of medicine. While not everyone must be a researcher, physicians have duties to be life-long learners and to keep up to date on developments within the field. Beyond this, physicians also have a duty to promote research (provided the research is morally conducted) by contributing samples and data and by referring patients or even answering surveys.

One additionally has duties to share one’s own knowledge and discoveries with one’s fellow physicians. Newfound cures that are not shared, or patents that are used to extract high profits or exclude other practitioners (and their patients) from reasonable access, are contrary to the Flexnerian spirit of professionalism. Importantly, physicians have duties to see themselves as members of a self-correcting moral community—to correct, admonish, or even discipline members who violate fundamental moral tenets of the profession.
There is a constant temptation to act as a member of a trade union might and to “protect one’s own.” To the extent that physicians fail in this role of self-correction, pressure mounts from the outside to fulfill this regulatory role. Finally, just as some physicians will need to devote much or even all of their time to research as a way of fulfilling their duty to advance medical knowledge, so too will some physicians need to step forth to provide leadership for the profession. Such leaders must be guided by the concerns of patients and a devotion to upholding the integrity of the profession rather than self-advancement or protecting the interests of physicians in a narrow, self-interested manner.

**Being Good Citizens with Respect to the Public at Large**

The cornerstone of exercising good citizenship with respect to the public at large is the responsible practice of medicine. For instance, physicians have duties, on behalf of individual patients and the common good, to promote the use of vaccines. Far before any consideration of rationing, physicians have a duty to not waste medical resources. Overly exuberant use of antibiotics, for instance, can breed bacterial resistance that harms the common weal. Excessive testing and treatment can lead to physician-caused illness and injury, such as cancers from excessive exposure to X-ray radiation.

No physician owns medicine or the knowledge base of medicine. Medical knowledge is a good under professional custody, ordained to the common good. Consequently, physicians also have duties of service to the community, especially the medically indigent. For some, this duty can be fulfilled by providing service in their own practices, either on a sliding scale or even for free for those who cannot afford it.
Group practices can decide whether to allow each member of the practice to decide how and when to do so or may elect to adopt a group policy regarding service to the poor. Alternatively, individual physicians can do pro bono work at free clinics, perform overseas medical missionary work on an intermittent basis, or provide free health education to the community. Those who do not repay their communities in some way are negligent in their duties as citizen members of a public profession.

While many will regard it as quaint, a fully restored sense of medical professionalism would also entail holding physicians to a higher moral standard than that of the general public. This is not elitist. Having a particular social status does not make one better than other people. Nor does it reflect a naive assumption that four years of schooling can make one a better person.

But medical schools can be, and should be, schools for virtue. The public expects more of professionals, and professionals should expect more of each other. The enormous trust that patients must place in physicians when they offer up their personal secrets and even their lives entails an assumption that physicians are morally upright persons who are worthy of that trust.

The Hippocratic Oath states, “In purity and holiness I will guard my life.” That text, however much it may have been debunked in the last few decades, needs to be retrieved and lived out again in the 21st century. Fully reprofessionalized, morally upright physicians not only garner patient trust but also serve as role models for young persons, a widely neglected role in contemporary culture.
Being Good Citizens in a Modern, Pluralistic, Representative Democracy

Physicians do have duties, both individually as citizens and collectively as a profession, to constructively contribute to the political process. This will require professional medical organizations. Only about 20 percent of US physicians are members of the American Medical Association (AMA). The reasons for declining membership are numerous, including the fact that specialization has led to greater identification with specialty societies than with this umbrella organization representative of the profession as a whole. But one important reason for declining membership may well be the failure of the AMA to represent a moral high ground, having opted instead to act more as a self-interested trade union than as a virtuous organization of genuine professionals.

For medicine to have a political voice as a profession, the professional self-identity of these organizations will need to be reinvigorated. These organizations can then serve as major vehicles for setting professional standards for clinical practice, practitioner morality, and the self-regulation of the profession. This must be done vigorously and transparently to renew the public’s trust in the profession.

Among the pressing tasks these organizations also face will be disentangling physician research, physician teaching, and the funding of professional organizations from private medical industry support. It is only possible for a profession to serve the critical function of balancing and critiquing industry if it is truly independent of the other institutional pillars of a democratic polity, including the free market. This does not entail a negative judgment about the morality of
markets but rather an understanding of what it means for a profession to be distinct from the free market and to exercise a distinct role within the structure of a vibrant democracy.

The word “advocacy” is now often used to describe physicians’ role as citizens. This meaning is rarely made explicit. There are at least three kinds of advocacy in which physicians can engage, with distinct moral parameters applicable to each.

First, physicians have a widely recognized duty to advocate for their patients to receive appropriate care within the constraints of the system in which the patient and physician find themselves. For example, if an insurance company denies coverage for a treatment that is clearly medically necessary for a patient and there is an appeals process through which this treatment might legitimately be covered, a physician has a duty to advocate for the patient through this appeals process.

This duty, however, is constrained by a moral duty to never willfully misrepresent the patient’s condition to obtain resources provided by the government or a private insurer. This advocacy could extend to a willingness to testify in court proceedings on behalf of a patient or to provide information necessary for a patient to have workplace accommodations for a medical condition such that the patient could continue gainful employment. Within the constraints of integrity and a duty not to endanger others for the sake of one’s patient, one has a duty, as a physician, to engage in advocacy of this sort.
A second kind of advocacy is that of professional organizations on behalf of the profession. The goals of such advocacy should be focused on advancing the care of the sick and the health of the public. Any attempt to advocate for the profession’s interests independent of the necessity to provide optimal care for patients or to promote the health of the public would be illegitimate. This is one of the major ways that professions can serve a citizenship role within democratic polity.

When government regulation becomes so onerous as to interfere with the physician-patient relationship or so constrains the medical choices available to patients and physicians that government regulation endangers the health and well-being of the sick, professional medical societies should be able to advocate effectively against the overreach of the state into the professional sphere. Professional medical organizations can also provide critical information needed for debates about such matters as how to best assure equitable access to health care, how much money should be budgeted for health care or biomedical research, how best to constrain health care cost inflation, and other thorny political issues related to medicine. It should be noted, however, that the medical profession provides only one voice, however important, in such debates and that the results of a vigorous political discourse about health care may not exactly be those that the medical profession would favor.

Some conceptions of what is entailed in professional advocacy will include stands regarding issues that are morally or politically controversial within the profession. In such cases, however, professional organizations should be wary about public advocacy. The political role of professional organizations should include informing the public and advocating about issues for
which the organizations can genuinely claim to be expressing the general will of their members. In addition, when engaging in public, collective advocacy, the professional medical organizations should recognize and respect the legitimate limits of what aspects of human experience are properly within the ambit of medicine.

The third sense of advocacy involves individual practitioners’ political activity as citizen members of a public profession, beyond the physician-patient relationship. This advocacy entails the most limited sense of duty in terms of what may be asked of physicians *qua* physician-citizens. One begins, however, with what may be asked of physicians *qua* citizens *simpliciter*.

Physicians have generally not been as politically active as they should be as individuals, often citing the pressures of work. A smaller percentage of physicians cast election ballots than other professionals such as lawyers, or even compared with the general public, and this is a nation in which remarkably small numbers of citizens bother to vote at all. It would seem that, *de minimus*, the same duties required of all citizens—to keep informed and to vote—should apply to physicians, and that physicians should do better in this regard.

In addition to voting and keeping informed, physicians, as a class, have other political duties as citizen members of a public profession. While increasing numbers of physicians now run for office—there were 20 physicians in the 113th Congress, including 3 senators—as a rule, physicians have not been very politically active.
While it is not necessary that all physicians engage in political activity, given that health care accounts for 17 percent of US GDP it seems important that some of them should do so. Beyond partisan politics (and physicians certainly disagree about the proper political and economic remedies for what ails health care today), all physicians do have duties, as citizen members of a public profession, to enrich the health care debate by bringing their experience, data, and opinions about health care into the public arena.

Conclusion

Forces internal and external to medicine have combined to place enormous pressures and burdens on today’s physicians, and the status of medicine as a profession has eroded enormously. This has destabilized the body politic, since vibrant and independent professions are one of the pillars of a modern, pluralistic, representative democracy.

The restoration of a Flexnerian sense of professionalism will therefore be required as a first corrective step and this, in turn, will require changes in the attitudes and practices of physicians, organized medical societies, government, private industries supporting the health care enterprise, and the public at large. With such changes in place, the conditions will be set for understanding the role of physicians as citizen members of a public profession and exercising that citizenship within the profession, toward the public at large, and within the political arena of a pluralistic, representative democracy.
About the Author

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Notes

4. A case in point is the marked negative reaction to the American Board of Internal Medicine’s recent promulgation of new rules for Maintenance of Certification in 2014. More than 17,000 internists have pledged to boycott these rules as onerous, costly, and of unproven efficacy in protecting patients from incompetent physicians, but likely to bring substantial new income to the board.