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# Professionalism and the Medical Association





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## Introduction

Medical professionalism, and an examination of exactly what it means to be a professional in today's society, have received significant attention in the medical, scientific and lay press over the past few years. The accelerated development of medical and communication technologies, improvements in access to medical information for the public and direct to consumer advertising, have all changed the way in which physicians and their patients interact. While at times this change has been positive (for example, through its empowerment of patients to make medical decisions on their own behalf), at other times the impact has been negative, with many physicians feeling pressured to prescribe medications or order tests they might not have otherwise chosen.

In some locations, the very nature of the medical system itself forces physicians to assume an entrepreneurial role and encourages them to aggressively promote their own medical services. These types of activity may be seen as being incompatible with the traditional role of the physician as an altruistic and selfless healer.

These changes and others have caused a broad re-examination of the nature and meaning of medical professionalism, what it means to be a physician in today's society and culture, and the dynamic of the doctor-patient relationship.

Traditionally, nearly all of the focus of the discussion and debate in the literature on medical professionalism has been centred on attempts at arriving at a definition of the concept of professionalism, the particular obligations of *individual* physicians and the "social contract" between medicine and society. In contrast, nearly no attention has been given to a consideration of medical professionalism from the point of view of organized medicine (1), in particular the National Medical Association (NMA).

The intent of this paper is to briefly review the current literature and thinking on medical professionalism, to highlight some of the various roles played by different medical organizations, and to examine the intersection between medical associations and professionalism. Finally, specific areas are proposed where representative medical associations might become involved in setting guidelines or developing policies in order to assist the collective profession, and by extension its individual members, maintain and enhance medical professionalism for the benefit of patients and the profession alike.

## Medical Professionalism: Where do we stand?

Over the past few years, several articles have been published that have helped to re-focus the debate and discussion on medical professionalism (2-8). The reason for this renewed interest generally varies by situation and locality. Certainly in some instances, it has been triggered by high-profile medico-legal cases involving physician misconduct or clinical misadventures and a subsequent public perception that there exists a desire by the members of the profession to “protect their own” in these situations. In other cases, the technological revolution and resultant change in access to medical information have caused physicians and others to re-examine the nature of the physician-patient relationship and the interactions between these two parties. In still others, discussion has focused on the duty of physicians to society, and the need to establish an updated and modernized “social contract” between society and the medical profession.

While a simple definition of medical professionalism that satisfies everyone’s requirements does not appear to exist, for the purposes of this document it will be defined generally as follows:

*Medical professionalism* describes the skills, attitudes, values and behaviours common to those undertaking the practice of medicine. It includes concepts such as the maintenance of competence for a unique body of knowledge and skill set, personal integrity, altruism, adherence to ethical codes of conduct, accountability, a dedication to self-regulation, and the exercise of discretionary judgment. Professionalism is also the moral understanding among medical practitioners that gives reality to what is commonly referred to as the social contract between medicine and society. This contract in return grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation.

In February of 2002, the *Annals of Internal Medicine* published an article entitled “Medical Professionalism in the New Millennium: A Physician Charter” (2) written by Canadian, European and American physicians. This document has engendered much discussion, and the reaction to the concepts it proposes has been both positive and negative. The essential premise of the Charter (2) is that professionalism is the basis of medicine’s contract with society, which demands placing the interests of patients above those of the physician, setting and maintaining standards of competency and integrity and providing expert advice to society on matters of health. It lays out 3 fundamental principles (primacy of patient welfare, patient autonomy and social justice) and 10 professional responsibilities (commitments to: professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients, improving quality of care, improving access to care, a just distribution of resources, scientific knowledge, managing conflicts of interest and professional responsibilities including self-regulation).

While several bodies and organizations have adopted this Charter (see Appendix 1 for a complete list), others have been equally quick to point out its shortcomings (9-10). However, few would be likely to argue that it has not had a positive effect in renewing and reinvigorating the debate and dialogue on the topic.

Recent developments in Britain are perhaps especially illustrative of much of the present public and professional discourse on this complex issue. They also serve to highlight the relatively large and diverse number of relevant groups and stakeholders with an interest in the issue, including physician representative bodies such as National Medical Associations. These developments have included, among others, the following:

- The King's Fund published a discussion paper in 2004 entitled "On being a doctor: Redefining medical professionalism for better patient care" (11). This document argues that the medical profession as a whole needs to demonstrate better its duty to serve patients' interests in order to show its ability to respond to changing public expectations. It notes that the "compact" between physicians, the health care system and patients has changed since the inception of the NHS in 1948, and suggests that a new compact is required that will show a higher level of responsiveness to patient interests and a focus on identifying professional standards that are more in tune with current values and expectations.
- Subsequently, the Royal College of Physicians published a working party report in December 2005 entitled "Doctors in society: Medical professionalism in a changing world." (12) The aim of this working party was "To define the nature and role of medical professionalism in modern society". They define medical professionalism as a set of values, behaviours and relationships that underpin the trust the public has in doctors. The values identified as being of particular importance are integrity, compassion, altruism, continuous improvement, excellence and working in partnership with other members of the health care team. They suggest that these values should form the basis for a new moral contract between the profession and society.
- In 2006, the British Department of Health released a report authored by the Chief Medical Officer, Sir Liam Donaldson, entitled "Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients" (13). This report is aimed particularly at the topic of regulation of the medical profession, which in Britain is performed under the auspices of the General Medical Council (GMC). It notes that in the early 1990's, a series of highly public medical scandals in the United Kingdom gave rise to mounting public concern.

The report itself was commissioned following the fairly scathing report of the Shipman Inquiry, chaired by Dame Janet Smith (14), which was extremely critical of the GMC in arguing that its culture, membership, methods of operation and governance structures were too likely to support the interests of doctors rather than protect patients. The Donaldson report notes that the current global trend is a move away from pure self-regulation to regulation in partnership between the profession and the public. The report recommends a regular assessment of physicians' clinical skills, a reshaping of the role, structure and functions of the GMC and an extension of medical regulation to the local level to create a stronger interface with the health care system.

For many in the medical profession, the Donaldson report represents much of the current angst with respect to the potential weakening or total loss of physician self-

regulation, which for the majority of doctors is one of the key pillars of medical professionalism. There appears to be a concerning trend in many parts of the world whereby governments and others are challenging and eroding the concept of physician self-regulation (and indeed the self-regulation of other professions as well).

- The British Medical Association (BMA) released a report on “Regulation of the medical profession” in March 2007 (15). It is critical of both the Donaldson report and the resulting government White Paper, “Trust, Assurance and Safety: The regulation of health professionals in the 21<sup>st</sup> century” (16) which was published in February 2007. The government document contains a series of proposals that, according to the BMA, would add up to the loss of professionally-led medical regulation. These proposals include: removal of the adjudication function from the GMC, having GMC Council members appointed rather than elected, and a new composition of the GMC Council with 50:50 lay and medical members. The BMA argues that with a state owned medical system (the NHS), and an appointed regulatory body, physicians might find themselves compromised in their ability to use their clinical independence to ensure optimal patient management, thus diminishing their medical professionalism.

It is against this backdrop of recent publications and events, and ongoing developments in the United States, Europe, Canada, Australia, New Zealand, Hong Kong and elsewhere, that the roles of the various bodies and stakeholders in medicine and health care will be considered.

## Organisational roles: Who does what?

The number and types of organisations involved in educating, licensing, regulating and representing physicians vary significantly depending on the individual country or geographic region. In some locations, in spite of the obvious challenges and potentially significant conflicts of interest, the same body or organisation assumes several of these roles. In general, one or more organisations are involved in the following areas of activity:

- 1) Education: Educational standards and curriculum setting are required for undergraduate medical education (i.e. medical schools) and postgraduate medical education (i.e. internship and residency training). In some places the same organization will be involved in both, while in many places these roles are separated. As well, many countries have bodies that oversee and accredit continuing medical education (CME) initiatives that help to ensure that practicing physicians have access to educational resources throughout the life cycle of their careers. Educational organizations may also administer examinations to ensure the adequacy of the knowledge and clinical skills of the physician-in-training, and may grant certificates of general or specialty designations on successful completion of the training programme and examinations.
- 2) Licensing: After physicians have completed their training, most places require them to obtain a license for the practice of medicine, usually within a specific field or area of expertise. The requirements for licensure (and training background) may vary significantly by country or region. In some situations, extensive testing and examination requirements will also exist. In some countries, a separate license is required to practice in different parts of the country, with different standards in each region and no transportability of licensure.
- 3) Regulation: The licensed, practicing physician is generally held to a certain standard that they must meet in an ongoing fashion in order to continue to practice medicine. This standard, and the way in which it is enforced, may also vary significantly. The specific body involved in regulation may also vary both between and within countries

Traditionally, as for many of the “learned professions”, physicians have been held responsible for professionally-led self-regulation, which many see as a privilege that must be continually earned. In practice, this requires physicians to form organizations that will receive allegations of professional misconduct or clinical negligence, investigate the complaints, render a judgement and impose a penalty. This activity and process is generally separate from the legal or civil litigation systems of that country.

The rationale for self-regulation is that physicians, by virtue of their extensive educational requirements and their unique grasp of a complex body of medical knowledge, obtained through years of training and experience, are felt to be in the best situation to be able to judge their peers.

The argument against self-regulation is that it may be perceived as being overly self-serving and that the majority of the members of a profession will inherently want to “protect their own”, so that physicians who misbehave or under-perform clinically

will not be properly censured or reprimanded by their peers. As a result, many countries have developed a system of regulation whereby lay members of the public participate actively in the process. In almost all cases, these public members make up a minority of the total membership of the regulatory bodies.

Many regulatory bodies have also assumed the role of ensuring that physicians remain up-to-date in their clinical knowledge and skills. This “revalidation” activity varies significantly by country. In some situations, it is a matter of providing proof that a physician is participating in CME activities on a regular basis, while in others the practicing physician may be required to repeat in-depth testing and examination on a regular basis in order to maintain their license to practice. Where no evidence exists to link the particular standard of revalidation to quality of patient care and outcomes, this activity may understandably be of some concern to physicians.

- 4) Representation: In nearly every country, there exists an association or organization that represents the interests of physicians (as exists for most professions). Some countries may have one or more competing organizations of this type. Most commonly (although not always), this body takes the form of a National Medical Association, whose name generally consists of the name of the country followed by the Medical Association designation (for example, Chilean Medical Association, Indian Medical Association, Russian Medical Association and so on).

Some have argued that the roots of modern representative medical associations date back to the formation of guilds in the 12<sup>th</sup> and 13<sup>th</sup> centuries (17). The features of guilds at that time included the power of association and self-regulation (including training), control over the means of production or workplace, control of the market and power over relations with the state. However, it may be more accurate to say that today’s medical associations represent the concept of freedom of coalition that evolved following Napoleon’s dissolution of the guilds and his introduction of a democratic system in the early 1800’s.

The type and degree of specific activity in today’s medical association can vary. In many instances, they provide specific benefits to their members, including the ability to connect with a network of their peers. In some countries, the NMA is involved in advocacy activities on behalf of its membership. This can include lobbying governments for improved working conditions and health care system reform, and often includes lobbying on behalf of patients to improve the level and quality of the care they receive.

In other countries, the NMA also acts as a bargaining body for its membership so that it negotiates contracts and fee structures on their behalf. In some situations, the association may actually have an official “union” designation. Other NMA’s have also assumed various educational and regulatory roles.

Given the large number of roles undertaken by the NMA’s of some countries, it is not surprising that conflicts occasionally arise in the course of their activities. For example, an association that is actively advocating on behalf of its membership might not be seen as being able to also assume a regulatory role that requires it on occasion to publicly censure some of its members, or remove their license to practice medicine. In the case of those NMA’s that negotiate contracts on behalf of their membership, some have questioned whether they can

also be legitimately involved in setting standards of professional behaviour and codes of conduct.

The next section of this paper will explore the intersection between medical professionalism and the representative medical association.

## Professionalism and Medical Associations

The following quote probably best summarizes the concerns that most commonly arise at the intersection of representative medical associations and medical professionalism (1):

“ Medicine is, in essence, a moral enterprise, and its professional associations should therefore be built on ethically sound foundations. At the very least, when physicians form associations, such occasions should promote the interests of those they serve. This, sadly, has not always been the case, when economic, commercial, and political agendas so often take precedence over ethical obligations. The history of professional medical associations reflects a constant tension between self-interest and ethical ideals that has never been resolved.”

Most would agree that representing the economic, commercial and political interests of physicians and organized medicine as a whole is a legitimate and important undertaking, and likely one best done by a body with democratic representation of the profession. In many cases (though certainly not all), this representation and the resultant advocacy also serve to further the cause of patients and improve the care that they receive.

The greater concern arises when the actions (or inactions) of an NMA appear to serve *only* their own self-interests. If individual physicians have an obligation to put the care of their patients above all else, should this obligation extend as well to their representative associations? If we are to say that altruism and integrity are key values for the medical professional, are they by extension key values for the professional's association as well?

The argument has been made (1) that:

“...effacement of self-interest is the distinguishing feature of a true profession that sets it apart from other occupations....When physicians form associations, they should make this promise collectively.... Without such a commitment, they easily degenerate into self-serving trade associations, lobbies or unions....In a properly conceived professional association, physicians should associate to improve the care of the sick, to advance the health of the public, and to ensure that their fellow associates are faithful to that mission...Associations should be aware of the dangers of focussing attention on the economic concerns of their members at the expense of their more important public and professional responsibilities.”

According to this argument, physician associations should make an active and considered decision: to represent the vested interests of their members, or of their patients, but in general probably not both, as the interests of the two groups will too often be mutually exclusive.

All professions are represented in some way by a body or organization that serves to further their particular needs and interests. Without this, that particular profession would soon disappear from the horizon as members of other more organized and more ably represented professions, slowly (or rapidly) eroded its place in the social order. It is patently impossible to make the argument that physicians do not require collective representation. Like all other professions, they will be legitimately concerned about their work environment and safety,

educational and promotional opportunities, salary levels, and all the other things employed persons need to care about.

However, medicine is substantively different from most other professions, and the fundamental difference is its commitment to the welfare of the individual patient, and the tradition of placing the interests of this patient above those of the medical practitioner. How can we reconcile these competing principles? Can a medical association serve both its members and the patients they care for?

The 1991 President's Address to the Annual Meeting of the House of Delegates of the American Medical Association (AMA) (18) by Dr. John Ring provides some direction in this regard. The address states, *inter alia*:

“The new AMA has chosen the right road for medicine: the course of professionalism, of patient advocacy, and of personal sacrifice. It is the way of helping doctors be better doctors – not necessarily richer, not necessarily more powerful, not necessarily more authoritative – but better doctors...

The new AMA is a confluence of professionals whose clear agenda is the health of the American people. ... We are a doctor's organization, working for the good of our patients, rather than a pressure group aiming for political power as a way to build organizational predominance, to create personal prestige, or to line our own pockets...

Professionalism is our very identity as doctors. And the basic act of professionalism is a doctor looking after a patient: the doctor-patient relationship. We can accept nothing that threatens this relationship by trying to turn medicine into a mere trade, a dispassionate business venture, an impersonal public utility.”

Dr. Ring goes on to describe a new AMA initiative examining the issue of access to care. Clearly, the interests of both patients and physicians are served by improving access to care. He uses this as a prototypical example of where the AMA should be focusing its efforts. From this, we understand that organized medicine has a legitimate claim at representing its own interests, and that this representation can and should be done by a representative medical association. However, these interests, like those of the individual physician, should not supersede or replace the interests of patients in the collective.

Perhaps the vision statement of the Canadian Medical Association (19) best captures the preferred approach. In describing its vision, it lists only two aims: “A healthy population and a vibrant medical profession.” The promotion of both ideals can and should coexist in the same representative medical association. But the rank ordering of these priorities, which is clearly not random, should not change.

The next section will examine specific issues and areas where medical associations can set guidelines, policies and standards to advance the professionalism of the association and its members while also striving to serve the best interests of patients and society.

## Potential areas of activity

There are several potential areas where representative medical associations might become actively involved in promoting and enhancing professionalism within the association and for their membership. What follows is a discussion of some of these areas, recognizing that others are likely to exist as well.

### 1) Pandemic and disaster preparedness

Since the experience with the Severe Acute Respiratory Syndrome (SARS) epidemic of 2003, there has been much discussion in the medical literature regarding issues of professionalism and medical care during a crisis situation, be it pandemic or otherwise (20-23). Although it is generally accepted that physicians and other health care workers have a duty to provide care in such a situation, several important questions have been raised as part of the broader discussion. These include:

- What exactly is the obligation of health care providers during a pandemic? Is it to provide care to all those in need regardless of the level of personal risk?
- Do physicians and others have a right to refuse to provide care when their own health (or that of their family) is at risk?
- Is the provision of services during a pandemic based in whole or in part on the obligation of governments and others to provide reciprocal services to physicians? If this reciprocity is not honoured, are physicians then absolved of their obligations?

Clearly, these are questions not easily answered. While some have argued that physicians and other health care workers appear to have an absolute obligation to provide care regardless of the circumstances in which they find themselves (24, 25), others have argued that this obligation may vary depending on the particular situation and circumstances (26-28). There are clearly compelling arguments to be made on both sides. The professional obligations of physicians in this situation are also well set out in various codes of ethics and regulatory documents.

Traditionally, physicians have respected the principle of *altruism*, whereby, throughout history, they have set aside concern for their own health and well-being in order to serve their patients. While this has generally manifested itself primarily as long hours away from home and family, and a benign neglect of personal health issues, at times more drastic sacrifices have been required. During previous pandemics, physicians have served selflessly in the public interest, often at great risk to their own well-being (although it should be noted that there are also isolated historical exceptions of physicians who have fled from such situations; Galen and Sydenham both fled from patients with contagious epidemic diseases) (29).

Since the experience of SARS, the concepts of reciprocity and reciprocal obligations have received significant attention from physicians and others both in and outside of the health care field. During this crisis, many health care workers found themselves assuming great

personal risk, sometimes with very little support and assistance from governments, hospitals, health districts and others. Several physicians and nurses contracted the virus, and some of these died as a result. It has become increasingly clear that more support will be expected during the next public health crisis, particularly in developed countries that have the necessary resources to provide this support.

As the University of Toronto Joint Centre for Bioethics report, “We stand on guard for thee” (30), states:

“(The substantive value of) *reciprocity* requires that society support those who face a disproportionate burden in protecting the public good, and take steps to minimize burdens as much as possible. Measures to protect the public good are likely to impose a disproportionate burden on health care workers, patients and their families.”

Some of these reciprocal obligations, which should be undertaken by governments, hospitals, and others, might include:

- Physicians and the associations that represent them should be more involved in planning and decision making at the local, national and international levels. In turn, physicians and the associations that represent them have an obligation to participate in these discussions.
- Physicians should be made aware of a clear plan for resource utilization, including:
  - o clearly defined physician roles and expectations, especially for those practicing outside of their area of expertise;
  - o vaccination/treatment plans – clarification of whether health care workers (and their families) will have preferential access based on the need to keep caregivers healthy and on the job;
  - o triage plans, including how the triage model might be altered and plans to inform the public of such.
- Physicians and health care providers should have access to the best equipment needed and should be able to undergo extra training in its use if required.
- Physicians and health care providers should have access to up-to-date, real time information. They should be kept informed about developments locally and globally.
- Resources should be provided for backup and relief of physicians and health care workers.
- Physicians and health care providers should receive financial compensation to cover expenses such as lost wages, lost group earnings, overhead, medical care, medications, rehabilitative therapy, and other relevant expenses in case of quarantine, clinic cancellations or illness.
- Families should receive financial compensation in the case of a physician family member who dies as a result of providing care during a health care crisis.
- Physicians should be given expanded liability coverage as required, particularly for those practicing outside of their area of expertise.
- Psychological and emotional counselling and support should be provided in a timely fashion for physicians, health care providers, their staff and family members.

It should be noted that meeting these reciprocal obligations might not be possible in less developed countries which lack sufficient resources to do so. For example, in countries with few resources and poor infrastructure, even providing soap for all health care workers might be difficult. In this case, *situational reciprocity* must be ensured; that is, health care workers

should be provided with whatever resources are available in order to optimise patient care and the safety of the workers.

### **What NMA's can do on the issue of disaster and pandemic preparedness**

National Medical Associations can develop guidelines on disaster and pandemic preparedness that will specifically outline for their membership exactly what is expected of them in such a situation, and what their professional obligations entail. They can also assist their members, and the public, by helping ensure that governments, hospitals and others understand and meet the reciprocal obligations (as outlined above) that will be critically important for ensuring the care and safety of patients and physicians alike during a pandemic or other public health emergency.

### **2) Conscientious objection**

In this context, conscientious objection is a term generally used to refer to a situation where a physician or other health care worker refuses to provide treatment or therapy on the grounds that such provision would violate their strongly held moral principles. The concept originated during wartime tension between religious freedom and patriotic obligations (31) and was subsequently co-opted during the reproductive rights debates of the 1960 and '70s.

The most common examples in the literature and in day-to-day medical practice continue to involve reproductive medicine: specifically, the provision of therapeutic abortion services and access to contraceptive devices and medication. More recently, the issue of access to post-coital contraception and abortifacient options has garnered much attention, from both the physician and pharmacist perspective, with reports of pharmacists refusing to dispense emergency contraception dating back to 1991 (32). The past several years have seen an increase in legislative initiatives, particularly in the United States under the current Republican administration, designed to protect health care providers who refuse to participate in specific reproductive procedures or practices (33).

Other less common issues sometimes referred to during a discussion of conscientious objection include euthanasia, physician assisted suicide, assisted reproductive technologies, assistance during executions and experimentation on human embryos (34).

A recent New England Journal of Medicine article has served to highlight the scope of the issue, at least in the United States (35). According to a survey of 1144 physicians, most physicians (63%) believe that it is ethically permissible for physicians to outline their moral beliefs and objections to their patients. The majority (86%) also agree that physicians must present all options regarding specific therapies and treatments to their patients – which of course means that a sizeable minority of 14% of physicians are not providing all the information required by their patients. In addition, 71% of physicians feel that a doctor has an obligation to refer a patient to another clinician to obtain a service to which the referring physician is morally opposed.

There are several possible advantages in allowing physicians to invoke the concept of conscientious objection as a reason for refusing to participate in certain procedures or therapies. It allows the physician to stay true to their morals and values; in general, society

does not require professionals to forsake their morals upon entry into a particular profession. It allows medical professionals to exercise their independent judgement. And the right to refuse to participate in acts that conflict with personal, ethical, moral or religious convictions is generally accepted as an essential element of a free and democratic society (33).

There are also several possible downsides when physicians invoke the right of conscientious objection. This practice may limit access to care and consequently have a detrimental impact on the health of patients. It can serve to impose the values and personal morals of the physician on the patient. It may be in direct opposition with the obligation of the physician to provide care without discrimination. Furthermore, professional autonomy is not without its limits and the interests of the patients are generally held to take precedence over those of the physician. Finally, the practice can introduce elements of inefficiency, inequity and inconsistency into a medical system (36).

While there are clearly arguments to be made on both sides of the issue, some authors have particularly strongly held beliefs. In a recent article in the British Medical Journal, Savulescu (36) claims that:

“A doctor’s conscience has little place in the delivery of modern medical care. What should be provided is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient’s good and the patient’s informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care because it conflicts with their values, they should not be doctors.”

There seems to be general agreement in the medical and ethics literature, current Codes of Medical Ethics and legislative approaches on several issues. First, it would appear that physicians and other health care providers have at least a limited right to refuse to participate in certain procedures or therapies if these are in opposition to their values and beliefs. However, one needs to distinguish this right from the right to refuse to refer a patient to a clinician who will provide these services. While there is some debate about this issue, the majority of the current literature, if not current policy and legislation, appears to support the obligation to refer (33, 36, 37, 38).

From the perspective of the National Medical Association, this issue would appear to provide fertile ground for policy development and professional guidance.

### **What NMA’s can do on the issue of conscientious objection**

It is suggested that policy development in this area should consider and address at least 6 aspects of the issue:

- 1) The concept of conscientious objection, its history and its current use should be carefully and comprehensively outlined.
- 2) In general terms, there appears to be agreement that physicians have a right to stay true to their personal values and morals and to exercise their independent professional judgement. They also have the right to inform their patients of such, but not in a way that is unduly coercive or argumentative.

- 3) Physicians should understand that they should not refuse to provide urgently needed care by using the concept of conscientious objection. A distinction must be made between an acute situation where immediate care is required to save a life or maintain health, as opposed to a less acute situation where there is time for a patient to seek medical services elsewhere.
- 4) Physicians should not obstruct, actively or passively, patients from receiving care from another clinician. Although health professionals may have a right to object, they do not have a right to obstruct (33).
- 5) Physicians should provide their patients with all the information they require regardless of the personal values of the physician. For patients to give valid informed consent, they have to be informed of the relevant alternatives and their risks and benefits in a reasonable, complete and unbiased way. This concept is one of the central tenets of modern medical ethics and cannot be undermined based on conscientious objection.
- 6) NMA's should address the issue of whether or not the conscientious objector has a duty to refer the patient to another clinician for services the objector will not provide. Clearly worded guidance in this area will be of benefit to patients and physicians alike.

While some NMA's may elect to include this information within the context of a related policy (for example, a policy on therapeutic abortion), because the concept of conscientious objection can apply in several different types of clinical situations, it is suggested that it is preferable to develop a separate policy that can be used in multiple circumstances.

### 3) Self-regulation

The general concept of self-regulation has been outlined above in the section on organizational roles. In some parts of the world, the term "self-governance" is used interchangeably with self-regulation, while in other areas the regulatory function is felt to be one part of the overall governance function. For ease of understanding, the term "self-regulation" will be used in this document.

It is fair to say that the vast majority of representative medical associations, if not all of them, support and encourage the concept of self-regulation of the medical profession. From a physician standpoint, it would not be advantageous to have their actions or clinical decisions evaluated by lay people and members of the public who are not likely to have the necessary training or experience to make those judgements. In addition, this is an area where individual physicians can demonstrate their collective sense of responsibility rather than through sometimes abstract principles or declarations.

From the standpoint of the general public, they need to have confidence that the regulation of physicians is fair, open and transparent and that physicians are held liable for any clinical or professional transgressions in a significant and meaningful way so that such transgressions will not be repeated in the future. They need to be confident that self-regulation does not mean self-protection. Some degree of public involvement in regulatory bodies is now generally well accepted, but physicians usually become concerned when consideration is

given to having these organizations constituted with a public majority, meaning that decision making will then be outside the control of the profession.

According to the website of the College of Physicians and Surgeons of Ontario (39), the self-regulatory body for physicians practicing in this Canadian province, the relationship between the College, the profession and the public is as follows:

“The College of Physicians and Surgeons of Ontario governs the practice of medicine in the public interest. It does not exist to protect the medical profession. The profession's interests are well represented by other bodies, including the Canadian Medical Association.

The medical profession has been permitted by legislation to play a leading role in the protection of the public. It does this through the College. This is what is meant by "self-regulation." Self-regulation should never be confused with professional autonomy. The profession, through the College, is always accountable to the public.”

It is not uncommon for there to be a somewhat strained relationship between representative medical associations and those organizations involved in physician self-regulation. While the public may see regulatory bodies as occasionally overly protective of physicians and not always acting in the best interests of the public, some physicians find them unnecessarily intrusive, interventionist and restrictive when it comes to regulating the day-to-day practice of medicine. However, in order to preserve the privilege of self-regulation, the medical profession must be clearly seen to be acting in the best interests of the public and not of the profession itself.

The concept of self-regulation of the medical profession presents a situation where representative medical associations may find themselves with a choice to make, between representing the desire of their membership for more freedom to practice medicine in a fully autonomous way with little “unnecessary” regulatory intrusion, versus supporting the public desire to strengthen the regulatory oversight of physicians and increase the transparency of the system. As suggested previously, and for reasons outlined above, the interests of the public and patients should take precedence in this type of situation.

### **What NMA’s can do on the issue of self-regulation**

This does not mean that NMA’s should acquiesce to any and all demands of regulators and the public. It does mean that they should support, through policy, advocacy and action, legitimate efforts to improve the quality of medical care and outcomes through regulatory oversight of their physician members.

Unduly intrusive activities that have not been shown to improve the quality of patient care are not necessarily appropriate. Efforts at revalidation of physicians should not simply be exercises intended to reassure the public and legislators, but should truly strive to improve the quality of medical practice, and should be based on solid evidence demonstrating that the means used will be efficient and effective. It may be up to NMA’s to help ensure that this evidence exists and is incorporated in a meaningful way.

NMA’s should develop policy or position statements clarifying their support for self-regulation and outlining the importance of this concept to the maintenance of medical

professionalism. They should assist their members in understanding that self-regulation cannot be perceived as being protective of physicians, but must maintain the support and confidence of the general public.

#### 4) Interactions between physicians and industry

Perhaps nowhere in medicine today is the potential for conflict of interest greater than in the interaction between physicians and private industry. These industries can include pharmaceutical companies, medical device manufacturers and makers of other products like baby formulas. In short, any private interest whose income generation depends on physician prescription or approval of their product.

From a business standpoint, the model is fairly simple. In most businesses, the product is marketed directly to the public through means such as advertising and word of mouth campaigns. However, in medicine, the companies must go through the “middle man”, the physician. The physician must prescribe a product, usually a medication, which is then purchased by the consumer, their patients. Sound and accepted business practice means that the companies will mount marketing and advertising campaigns to influence physician prescribing patterns in favour of their company, thereby increasing their income and market share.

The pharmaceutical industry has traditionally denied that they attempt to influence physician prescribing behaviour, instead insisting that their marketing efforts are simply intended to educate physicians on new products in order to ensure that their prescribing choices are well-informed and based on the latest available scientific literature. However, there is now much evidence to the contrary.

To start with, the information presented to physicians is usually extremely biased, often inaccurate, and intended to portray the target product in a favourable light. A Spanish study revealed that 44.5% of the information provided by pharmaceutical representatives to family physicians is factually erroneous and is biased towards their own products (40). An Argentinean study (41) concluded that 46% of references given in literature distributed by industry representatives did not concur with the claims made in the company’s literature. A German study (42) found that 94% of the information in brochures for doctors had no basis in scientific evidence; while many brochures had cited publications that could not be found, the majority of information found in them did not accurately reflect the publications that they cited.

This mounting body of evidence hardly supports the industry argument that physician education is the true intent of its information dissemination. Clearly the purpose is instead to provide information in such a way that physicians will view the product in a more favourable light and be more likely to prescribe it to their patients.

Secondly, a significant number of former pharmaceutical representatives and industry insiders have recently come forward to reveal the internal machinations of the business. One states: “An unofficial, and more accurate, job description for a sales rep would be: Change the prescribing habits of physicians.” (43). Another says: “It is my job to figure out what a physician’s price is...everything is for sale and everything is an exchange” and “It’s my job to constantly sway the doctors. Doctors are neither trained nor paid to negotiate. Most of the

time they don't even realize that's what they're doing." Perhaps most concerning, this same former representative (43) went on to write:

"The concept that reps provide necessary services to physicians and patients is a fiction. Pharmaceutical companies spend billions of dollars annually to ensure that physicians most susceptible to marketing prescribe the most expensive, most promoted drugs to the most people possible. If detailing were an educational service, it would be provided to all physicians, not just those who affect market share. Every piece of information provided is carefully crafted, not to assist doctors or patients, but to increase market share for targeted drugs."

Finally, an increasing number of studies are revealing that pharmaceutical marketing *does* impact physician prescribing habits (44-48). The old argument that "it just doesn't affect me" does not hold water anymore, nor does the assertion that "It may influence my colleagues, but it does not influence me".

Given the current lack of public funding for CME events and medical research, and the resulting reliance of these important activities on private industry funding, most physicians seem to be in agreement that banning all forms of contact between physicians and industry is not feasible or perhaps even desirable. However, there is clearly a need to develop policies and guidelines in this area to help regulate the relationship in order to avoid the appearance or presence of real or perceived conflicts of interest.

The bodies setting these policies can vary and may include some or all of the following:- government and legislators, medical regulators, physician representative associations, medical specialty groups, and the industry itself. The argument is made here that these policies should be developed and led by the profession, should be clear and transparent and should ensure that any interactions taking place between physicians and industry will be only for the clear benefit of patients, not of for physicians or industry.

### **What NMA's can do on the issue of interactions between physicians and industry**

National medical associations can and should develop clear and comprehensive policy in this area to ensure that their members do not find themselves in a position of conflict of interest. They should widely distribute these policies to their membership and others, and undertake educational initiatives to clarify their importance, intent and content. They should use their advocacy capabilities to help ensure that these physician-led guidelines become the accepted standard for all the other participants involved, including industry.

At a minimum, these guidelines should address the following topics:

- a clear explanation of the issue and the concept of conflicts of interest
- gifts to physicians, including social science literature on gift giving
- drug samples and their impact on prescribing behaviour and drug costs
- educational and promotional materials aimed at physicians

- CME events (including electronically-delivered CME) and sponsorship, including physician payment for participation
- physician participation and patient enrolment in industry-sponsored research trials, including physician payment for participation
- disclosure obligations for physicians submitting research or providing educational sessions
- physician participation as medical advisors or on advisory boards, and the distinction between these activities and marketing
- peer selling and direct physician promotion of individual products or companies
- how medical students and residents should approach the issue

Those NMA's without sufficient resources to develop their own policy in this area may wish to adopt the policy of other NMA's or of the World Medical Association (49).

Physician representative associations should also give careful consideration to developing stringent internal policy for governing relationships between the organization and third parties. This will serve to set an example for the membership and ensure that the association itself is able to avoid situations of conflict of interest (a lesson learned painfully by the American Medical Association during a brief sponsorship deal with Sunbeam in the 1990's).

## 5) Interprofessionalism

Traditionally, and until relatively recently, health care had been delivered in what can best be described as a multidisciplinary model of teamwork. In this model, each member of the health care team fulfilled a certain well-defined and predetermined role with little or no overlap between the activities of the team members. Ultimate decision-making authority rested nearly always with the physician.

More recently, this model has evolved into one of interdisciplinary team care (or "interprofessionalism") whereby the members of the team work collaboratively together to help ensure optimum patient care and outcomes. In this model, there may be some overlap between the roles and responsibilities of the team members, based on what is in the best interests of the individual patient at that particular point in time. For example, a speech and language pathologist might prescribe a specific dysphagia diet based on their clinical assessment, or a pharmacist might renew a prescription without consulting the physician. Unfortunately, studies have shown that even in this model the provision of health services is still often fraught with interprofessional conflict, dissension and misunderstandings (50).

In the current context of limited health human resources, and particularly limited physician resources, it makes inherent sense to take full advantage of the abilities of each member of the health care team. These members can include, but are not limited to, physicians, physician assistants, nurses, nurse practitioners, pharmacists, occupational and physical therapists, psychologists, speech and language pathologists, social workers and dieticians.

In general terms, the move towards interprofessionalism has particularly impacted on the role and responsibilities of the physician, as many of the expanded roles of team members have been into areas traditionally occupied by the physician on the team. While physicians have by and large accepted and sometimes actively embraced such changes, particularly where they have been shown to impact positively on patient care and outcomes (although it should be noted that such an impact has not been conclusively proven) (51), they have also shown well-placed concern when warranted. Although physicians have been often criticized as “defending their turf” or being unwilling to relinquish complete control over patient care, there are justifiable reasons to approach interprofessionalism with caution. It should also be noted that the assumption of traditional physician duties by other professions is not a new concept, as witnessed by the undertaking of surgery by barbers and the medical treatment of patients by apothecaries.

It is at times unclear as to who has ultimate responsibility for patient care. If everyone is responsible, then no one is truly responsible. In addition, when physicians provide direct medical care and there is a mishap, then medico-legal liability, once established, is usually fairly straightforward. In an interprofessional model of care, the physician may not be constantly aware of services or recommendations being provided by other team members, yet the patient and their lawyers may expect the physician to assume ultimate liability for this care if harm occurs. Where individual liability ends and group liability begins might not always be clear.

Different professions may have different Codes of Ethics with different values, standards and priorities. As a recent example, while the American Psychiatric Association (52) has clearly stated that sharing clinical knowledge for the purpose of using this information to torture or gain admissions from terrorism suspects is unprofessional and unacceptable behaviour, the American Psychological Association has elected not to take this stance (53, 54). When competing principles of various team members occur during patient care, how are we to determine which one will win out?

There are professional divisions based on demographics, gender composition, class of origin of members, educational attainment, status and relative size and source of primary income; these have all been cited as obstacles to the development of interdisciplinary collaboration in the health field (51). Medicine is a long-established and fairly large profession whose members come mostly from a well-educated, small, upper class and earn a high income. Thus, it is argued that:

“The raw power of medicine, combined with a high degree of professional self-confidence developed by doctors and consciousness of these differences in prestige among other occupational groups, contributes to a degree of mutual wariness and defensiveness as each occupation attempts to defend its own territory. For most of the twentieth century the health division of labour has been organised and hierarchically structured around the dominant profession of medicine. However, over recent decades medicine’s claims to autonomy and dominance have been increasingly challenged by non-medical groups.” (51)

Interdisciplinary relationships are also often political. Different occupational groups attempt to establish clear professional demarcations and demand that their expertise be recognized. They construct their own distinct codes and standards and advance what they deem to be their own ethical theories (for example, “medical ethics” versus “nursing ethics”) (55).

Different professions may use different standards to judge the acuity of a case or situation. When other professionals then apply their own frames of reference to make sense of a situation, they may differ intensely over the priority the case is assigned (51). This may be a source of significant conflict amongst team members.

Professional differences may also have been reinforced by various court decisions. For example, decisions by the English courts in the early twentieth century emphasized the responsibility of medical practitioners and the subservient nature of nurses (56). Although more recent court decisions have not been quite as harsh, there are those who feel that the earlier approach still has some influence on attitudes to the responsibilities of those offering care to patients (51).

Unfortunately, relationships between health care professionals remain fraught with organizational, status and value differences (55). An Australian survey of hospital admissions reported that problems with professional interactions were the most common cause of preventable disability or death in the intensive care unit, and were twice as common as those due to poor medical skill (57).

There is a significant body of work on the topic of interprofessional education and training at the medical school and undergraduate level (58 - 61) but relatively little guidance when it comes to educating postgraduate trainees or practicing physicians. While tomorrow's physicians may be well equipped to work in collaborative practice models, today's physicians may require extra guidance and training in this area, as many of the skills and concepts required are not necessarily inherently known.

### **What NMA's can do on the issue of interprofessionalism**

In spite of the many challenges of interprofessionalism and interdisciplinary models of care, it is clearly a concept that is becoming firmly entrenched in today's patient care settings. In order to optimise patient care and outcomes, physicians must be able to work collaboratively with a wide variety of health professionals in different settings. Representative medical associations can assist their members (as well as their patients and other health care professionals) by developing policy and guidance in this complex area. Such policy should ideally include:

- a review and definition of the concept of interprofessionalism with attention given to both the medical and non-medical literature
- a clarification of the relevant medico-legal liability issues, including the need for all team members (and not just physicians) to carry liability insurance; this may need to be done in partnership with local and/or national medical malpractice insurance carriers where appropriate
- an approach towards education in this area for medical students, postgraduate medical trainees and physicians in practice, as well as other health care professionals who will be working in the team setting
- an integrated or separate policy or document outlining the issue of scopes of practice for the various health care professions, including the fact that roles and scopes must

be in keeping with the relevant training and expertise and should not exceed the capabilities of a given field (for example, professionals not trained to provide a diagnosis should not be licensed to do so; this is not in keeping with clinical or ethical standards and is a potential threat to patient care and well-being)

- a clarification on potentially competing ethical principles and Codes of Ethics to ensure that physicians understand their individual obligations in this regard

## 6) Clinical practice guidelines (CPGs)

Clinical practice guidelines or CPG's, are systematically developed statements that aim to help physicians and patients reach the best possible health care decisions (62). While they have been in existence for a long time, recent years have seen an explosion in their numbers. They go beyond systematic reviews of the literature by recommending what should and should not be done in specific clinical circumstances.

Generally, CPG's are developed by a group of writers with representatives from clinical medicine, research, and epidemiology, among other disciplines. The body or organization sponsoring their development may vary significantly, from an uninterested third party (rare), to a medical society or association (more common) to a disease specific organization (perhaps increasingly common). The funding for each type of group may also vary, with differing degrees of private and public sponsorship. Private sponsorship usually comes from parties with a vested interest in the outcome of the process, particularly the pharmaceutical industry (and less commonly the insurance industry). Pharmaceutical companies can benefit from the outcome of a CPG either through the recommendation of a specific therapeutic agent or a lowering of the threshold required before the use of an agent. Sometimes the source of financial sponsorship is made transparent, but it is not uncommon for it to remain relatively anonymous (or hidden).

Not only the process itself, but also the actual participants in the process, may also be subject to potential conflicts of interest. This has been the focus of much debate in the medical and scientific literature as of late (63-65). Two recent publications have helped to outline the scope of this problem. One study (66) notes that 87% of authors of CPG's had some form of interaction with the pharmaceutical industry. Fifty eight percent had received financial support to perform research and 38% had served as employees or consultants for a pharmaceutical company. Only 2 published CPG's out of 44 examined made declarations regarding the personal financial interactions of individual authors with drug companies. Another report (67) on more than 200 CPG's from various countries deposited in 2004 with the United States National Guideline Clearinghouse found that more than one third of the authors declared financial links to relevant drug companies with nearly 70% of panels being involved, and almost half of the CPG's providing no information about conflicts of interest.

It is increasingly clear that the problem of conflicts of interest in the development of CPG's is widespread and under-reported. While there are those who argue that it is not possible to develop CPG's without using authors linked to industry, since these authors are experts in the field and are sought both by the companies and the bodies producing the CPG's, some organizations have taken steps to remedy this situation. Various guidelines have been developed to ensure that any possible conflicts are declared to all those involved in the process of CPG development and that those with conflicts are given reduced or modified

roles. For example, since 1999 the National Institute for Health and Clinical Excellence (NICE) has provided guidance on appropriate clinical practice within Britain's National Health Service. NICE has taken steps to avoid situations arising from potential conflicts of interest, requiring members of its advisory bodies to declare financial and other interests. If a conflict is identified, the individual will be required to step down and not take part in the decision-making process (68).

Other criticisms of CPG's have included the fact that some leave little room for deviation in the case of individual patients whose needs may differ, that they may present physicians with difficult medico-legal situations if CPG's are held to be the standard of care, and that they may provide reasons for insurers to deny coverage.

While National Medical Associations have not been traditionally involved in the actual development of CPG's, there may well be an important role for them to play in the process of ensuring the highest standards of care based on the use of recent, high quality, unbiased CPG's by practicing clinicians. There are some good examples of NMA's who have become involved in this area.

The American Medical Association, together with the Agency for Healthcare Research and Quality and the American Association of Health Plans, initially assisted in the development of the National Guideline Clearinghouse in the United States ([www.guideline.gov](http://www.guideline.gov)). The National Guideline Clearinghouse is a comprehensive database of evidence-based clinical practice guidelines and related documents. Its mission is "to provide physicians, nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use" (69).

The Canadian Medical Association, on its website at [www.cma.ca](http://www.cma.ca), provides its membership with access to a service called CMA Infobase. This site provides access to CPG's which are produced or endorsed in Canada by a national, provincial/territorial or regional medical or health organization, professional society, government agency or expert panel. In addition, the CMA and one of its provincial divisions, the Ontario Medical Association, have combined with the Ontario Ministry of Health and Long Term Care to form the Guidelines Advisory Committee (GAC) (70). For selected topics relevant to clinicians, patients and the health care system, the GAC identifies, rates and endorses the best available guideline (71). The GAC uses the Appraisal of Guidelines, Research and Evaluation (AGREE) tool to assess the quality of CPG's. The AGREE tool was created and validated for physicians to use in rating guidelines according to their process of development by identifying the factors that are considered important in judging their quality (72). On the CMA website, a rating of the quality of the guideline development process for those guidelines that have been reviewed by the GAC is included.

### **What NMA's can do on the issue of clinical practice guidelines**

Providing physicians with access to recent, high quality, unbiased CPG's will enhance medical professionalism by increasing the quality of patient care and outcomes and ensuring that patients everywhere receive the same high standard of care. Although it is probably not

reasonable to expect NMA's to participate in the production of the guidelines themselves, given the relative intensity of resources required to do so, they can assist in the process by:

- actively screening guidelines for their membership using a validated tool such as AGREE
- providing a quality rating for each guideline based on a validated tool such as AGREE
- organizing the many thousands of CPG's into areas of clinical content and relevancy
- selecting the most appropriate and relevant guidelines for use by their members (for example, there are over 300 English CPG's on the management of high cholesterol, and NMA's could review these and choose the highest quality 2 or 3 CPG's)
- providing a clearinghouse for the screened and selected CPG's with membership access on its website or other location (which also provides a direct benefit of membership in the association)

## 7) Organizational ethics and professionalism

Organizational ethics has been defined as “the articulation and application of the consistent values and moral positions of an organization by which it is defined, both internally and externally” (73). It is generally articulated via values statements, mission and vision statements, organizational codes of ethics, policies addressing specific ethical issues, and especially through its effects on the attitudes and activities of everyone associated with the organization.

This represents in many cases a relatively new approach to the consideration of ethics in organizations, particularly healthcare organizations. With the Enron scandal (74) and other recent developments in the business world and elsewhere, organizational ethics have become increasingly important both in practice and to reassure stakeholders and others that an ethics framework is in place.

While the medical literature in this area focuses on healthcare organizations such as hospitals, health care districts and health maintenance organizations (HMO's) (74-76), the general principles of this approach can be applied to representative medical associations as well. While these associations serve an important role in helping to guide their individual member physicians in professional and ethical standards; as outlined in previous sections of this paper, having robust internal policies will also help to set a high standard of behavior and provide an example of professionalism from within the organization.

There are four important strategies that can be used to help build a solid ethics infrastructure in a medical organization (77). These include:

- 1) Conducting a formal process to clarify and articulate the organization's values and link them to the mission and vision statements. This should include building the mission, vision and values statements into the introduction of the strategic plan, involving all employees in the design of the mission, vision and values statements, using facilitated group approaches to discuss these statements and using team building strategies to enhance organizational values.
- 2) Facilitating communication and learning about ethics and professionalism. Specific strategies include:

- a. placing mission and vision statements in highly visible locations throughout the organization
  - b. offering training programmes that encourage interaction about the organization's values
  - c. using role playing, case studies and lunchtime educational sessions to facilitate communication about ethics and professionalism
  - d. engaging employees in values clarification techniques
- 3) Creating structures that encourage and support the culture. These structures should be multiple, interconnected and diffused throughout the organization, and ideally should include an ethics infrastructure with sufficient dedicated staff and resources.
- 4) Creating processes to monitor and offer feedback on ethical performance. Specific strategies include:
- a. using ethics and professionalism audits
  - b. examining processes and/or outcomes of ethical decision making
  - c. regular evaluation of the organization's mission, vision and values statements

The American Medical Association has published a document entitled "Organizational ethics in healthcare: toward a model for ethical decision-making by provider organizations" (78). While the document specifically notes that its focus is on organizations that provide health care to individual patients, and not other organizations such as associations of health care professionals, several of the principles reviewed are of relevance. For example, the document discusses in some detail the prioritization of competing principles to help organizations understand that patient health is their ultimate priority, regardless of other competing considerations. The paper also provides an overview of various sources of organizational ethics for provider organizations, including business ethics, professional accountability and law and social context.

### **What NMA's can do on the issue of organizational ethics**

It is very important that a representative medical association exhibit strong organizational ethics. Not only does this assist with ensuring the proper prioritisation of association objectives and strategies, it also helps demonstrate to the physician membership the importance the organization places on ethics and professionalism. An NMA cannot expect its membership to respect and follow the ethical codes and policies it produces without first setting the same high standards for the NMA itself. Associations can do this by:

- developing thoughtful and well-articulated mission, vision and values statements that are produced with input from association staff and physicians
- developing internal organizational policies and codes which address specific ethical and professional issues (for example, harassment in the workplace, individual and organizational conflict of interest, and professional interactions with outside third parties)
- making efforts to promote the above policies and documents, including them both during orientation of new staff, and in an ongoing manner through retreats and educational sessions

- measuring and evaluating the impact of these policies, and keeping them updated in an ongoing fashion
- ensuring that the physician membership of the association is aware of these internal policies via mailings, journals and websites

## Summary

In many respects, medical professionalism is currently at a crossroads. The nature of the physician-patient relationship continues to evolve, as physicians struggle to redefine their role in an ever-changing society that is in the midst of a technological revolution. Threats to medical self-regulation and evolving physician scopes of practice have caused many practicing doctors to question whether the profession itself will ever be the same.

At the same time, change often represents opportunity. Many have seized this chance to try to redefine the concept of medical professionalism and refocus attention on the sanctity of the physician-patient relationship. New social contracts have been devised to help physicians understand how to balance their competing priorities and roles. Task forces have been formed, reports have been written and hands have been wrung. Whether all this activity will have a lasting impact remains to be seen.

Representative physician organizations are in a unique position. They serve in many instances as the public face of the profession, and help make known and understood the views of physicians on important matters. They also have the opportunity to be standard-setters for the profession, to help shape and mould the ongoing evolution and development of medical professionalism. While the literature to date focuses with near exclusivity on the roles and obligations of individual physicians, there is much that medical associations can do, both internally and externally, to advance and promote the concept. Whether this is done in isolation from, or together with, other relevant medical and non-medical bodies will vary depending on individual circumstances.

The objective of this paper has been to examine medical professionalism through the lens of the representative medical association rather than the individual clinician. Through providing both general and specific, concrete suggestions and examples of current and future potential activities which might be undertaken, it is hoped that it will add in a positive and constructive way to the preservation of what most doctors consider to be at the core of medicine: the role of the physician as healer and professional.

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## Appendix 1

### Organizations that have endorsed the Physician Charter:

Accreditation Council for Graduate Medical Education  
Administrators of Internal Medicine  
Alliance for Academic Internal Medicine  
American Academy of Allergy, Asthma and Immunology  
American Academy of Dermatology  
American Academy of Family Physicians  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Orthopaedic Surgeons  
American Academy of Otolaryngology—Head and Neck Surgery  
American Academy of Pediatrics  
American Academy of Physical Medicine and Rehabilitation  
American Board of Medical Specialties  
American Board of Allergy and Immunology  
American Board of Anesthesiology  
American Board of Colon and Rectal Surgery  
American Board of Dermatology  
American Board of Emergency Medicine  
American Board of Family Practice  
American Board of Internal Medicine  
American Board of Medical Genetics  
American Board of Neurological Surgery  
American Board of Nuclear Medicine  
American Board of Obstetrics and Gynecology  
American Board of Ophthalmology  
American Board of Orthopedic Surgery  
American Board of Otolaryngology  
American Board of Pathology  
American Board of Pediatrics  
American Board of Physical Medicine and Rehabilitation  
American Board of Plastic Surgery  
American Board of Preventive Medicine  
American Board of Psychiatry and Neurology  
American Board of Radiology  
American Board of Surgery  
American Board of Thoracic Surgery  
American Board of Urology  
ABIM Foundation  
American College of Dentists  
American College of Medical Genetics  
American College of Obstetricians and Gynecologists  
American College of Physicians  
American College of Radiology  
American College of Surgeons  
ACP Foundation  
American Orthopaedic Association  
American Osteopathic Association  
American Psychiatric Association  
American Society of Anesthesiologists  
American Society of Clinical Pathologists  
American Society of Plastic Surgeons  
American Urological Association  
Association of Academic Physiatrists  
Association of American Medical Colleges

Association of Physicians of Ireland  
Association of Physicians of Malta  
Association of Professors of Medicine  
Association of Program Directors in Internal Medicine  
Association of Subspecialty Professors  
Austrian Society of Internal Medicine  
Belgian Society of Internal Medicine  
Clerkship Directors in Internal Medicine  
Chinese Medical Doctors Association  
College of Physicians and Surgeons of British Columbia  
Council of Deans, Association of Canadian Medical Colleges  
Council of Medical Specialty Societies  
Czech Society of Internal Medicine  
Danish Society of Internal Medicine  
Estonian Society of Internal Medicine  
European Federation of Internal Medicine  
Federation of Royal Colleges of Physicians of United Kingdom  
Federation of State Medical Boards  
Finnish Society of Internal Medicine  
French Society of Internal Medicine  
German Society of Internal Medicine  
Hellenic Society of Internal Medicine  
Hungarian Society of Internal Medicine  
Icelandic Society of Internal Medicine  
Israeli Society of Internal Medicine  
Italian Society of Internal Medicine  
Latvian Society of Internal Medicine  
Lithuanian Society of Internal Medicine  
Luxembourg Society of Internal Medicine  
Medical Council of Canada  
Ministero della Salute  
Netherlands Society of Internal Medicine  
North American Society of Radiologists  
Polish Society of Internal Medicine  
Portuguese Society of Internal Medicine  
Residency Review Committee for Internal Medicine  
Royal Australasian College of Physicians and Surgeons  
Royal College of Physicians of Edinburgh  
Royal College of Physicians of Ireland  
Royal College of Physicians of London  
Royal College of Physicians and Surgeons of Canada  
Slovak Society of Internal Medicine  
Slovenian Society of Internal Medicine  
Society of Neurological Surgeons  
Society of Nuclear Medicine  
Society of Thoracic Surgeons  
Spanish Society of Internal Medicine  
Swedish Society of Internal Medicine  
Swiss Society of Internal Medicine  
Turkish Society of Internal Medicine

**Table 1 – Summary of potential areas of NMA activity**

<b>Potential area of activity</b>	<b>What NMA's can do</b>
1) Pandemic and disaster preparedness	<ul style="list-style-type: none"> <li>- develop guidelines on disaster and pandemic preparedness that will specifically outline for their membership exactly what is expected of them in such a situation, and what their professional obligations entail</li> <li>- assist their members, and the public, by helping ensure that governments, hospitals and others understand and meet the reciprocal obligations that will be critically important for ensuring the care and safety of patients and physicians alike during a pandemic or other public health emergency</li> </ul>
2) Conscientious objection	<ul style="list-style-type: none"> <li>- outline the concept of conscientious objection, its history and its current use</li> <li>- assist members to understand that they should not refuse to provide urgently needed care by using the concept of conscientious objection</li> <li>- assist members to understand that they should not obstruct, actively or passively, patients from receiving care from another clinician</li> <li>- address the issue of whether or not the conscientious objector has a duty to refer the patient to another clinician for services the objector will not provide</li> </ul>
3) Physician self regulation	<ul style="list-style-type: none"> <li>- support, through policy, advocacy and action, legitimate efforts to improve the quality of medical care and outcomes through regulatory oversight of their physician members</li> <li>- help ensure that efforts at revalidation of physicians are not simply exercises intended to reassure the public and legislators, but truly strive to improve the quality of medical practice, and are based on solid evidence demonstrating that the means used will be efficient and effective</li> <li>- develop policy or position statements clarifying their support for self-regulation and outlining the importance of this concept to the maintenance of medical professionalism</li> <li>- assist their members in understanding that self-regulation cannot be perceived as being protective of physicians, but must maintain the support and confidence of the general public.</li> </ul>
4) Physician-industry interactions	<ul style="list-style-type: none"> <li>- develop clear and comprehensive policy in this area to ensure that their members do not find themselves in a position of conflict of interest</li> <li>- widely distribute these policies to their membership and others, and undertake educational initiatives to clarify their importance, intent and content</li> <li>- use their advocacy capabilities to help ensure that these</li> </ul>

	<p>physician-led guidelines become the accepted standard for all the other participants involved, including industry</p> <ul style="list-style-type: none"> <li>- give careful consideration to developing stringent internal policy for governing relationships between the organization and third parties</li> </ul>
5) Inter-professionalism	<ul style="list-style-type: none"> <li>- develop policy and guidance in this complex area, including:</li> <li>- a review and definition of the concept of interprofessionalism</li> <li>- a clarification of the relevant medico-legal liability issues</li> <li>- an approach towards education in this area for medical students, postgraduate medical trainees and physicians in practice, as well as other health care professionals who will be working in the team setting</li> <li>- an integrated or separate policy or document outlining the issue of scopes of practice for the various health care professions</li> <li>- a clarification on potentially competing ethical principles and Codes of Ethics to ensure that physicians understand their individual obligations in this regard</li> </ul>
6) Clinical practice guidelines	<ul style="list-style-type: none"> <li>- provide physicians with access to recent, high quality, unbiased CPG's by:</li> <li>- actively screening guidelines for their membership</li> <li>- providing a quality rating for each guideline</li> <li>- organizing the many thousands of CPG's into areas of clinical content and relevancy</li> <li>- selecting the most appropriate and relevant guidelines for use by their members</li> <li>- providing a clearinghouse for the screened and selected CPG's with membership access on its website or other location</li> </ul>
7) Organizational ethics	<ul style="list-style-type: none"> <li>- develop thoughtful and well-articulated mission, vision and values statements that are produced with input from association staff</li> <li>- develop internal organizational policies and codes which address specific ethical and professional issues</li> <li>- make efforts to promote the above policies and documents</li> <li>- measure and evaluate the impact of these policies, and keep them updated in an ongoing fashion</li> <li>- ensure that the physician membership of the association is aware of these internal policies</li> <li>-</li> </ul>