

2007 Leffingwell Memorial Lecture

Professionalism: My Profession, Part II

By Peter L. McDermott, M.D., Ph.D.

Peter McDermott, M.D., Ph.D., is an esteemed past president of the ASA and CSA, and currently is a Lecturer in History at Cal Lutheran University. He is admired and acknowledged for his creative, scholarly, and entertaining wit. Peter's 2007 Leffingwell Lecture was an endearing and engaging historical commentary and thought-provoking erudition replete with ample Pete "McDermottisms."

Medicine finds itself today in a conflict between two possible orientations: medicine as applied sociology and medicine as applied science. What are the implications for professionalism in either of these two choices? As science continues its advance, doctors are increasingly filled with "therapeutic self-confidence." In the course of this, their sense of humanity, primacy, and respect for the patient as a person risks becoming subordinate, even unnecessary, to effective treatment. Surely a profession or a specialty that defines itself by procedures, therapies, and "successful" outcomes needs to at least consider another look at its identity.

Atul Gawande, a Boston surgeon many of you know of, in an article in *The New Yorker* described changes in obstetric practices and asked, "Is medicine a craft or an industry? If medicine is an industry ... you seek reliability." Increasingly, standardized procedures, total quality management, and the expectation of successful outcomes define the patient's encounter with the physician. Medical care also comes to be seen as an entitlement. Outcomes increasingly match expectations, anything less is unacceptable, and medical practice becomes a commodity. The spectacular accomplishments of the last several decades come with consequences that have broad implications.

Many doctors don't dwell on this sort of thing. It's too cumbersome and ill-defined. They are busy trying to survive in the worst of both worlds—the world of government and other regulatory pressures on one side, and that of third party payers on the other. More and more doctors today don't primarily identify with the "medical profession" except as it is manifested in their specialty practice or society. This is true of most specialists, not just anesthesiologists. How do you share an identity with people who are so different from you? We are not the dons of a medieval university, we are not the gentlemen of Tudor London. We are not even the physicians of the same profession I joined in 1956 when I entered medical school. My class had two Asians, four women, 98 white men, and no blacks. Look at your medical staff or county medical society today and rejoice. I knew that becoming a physician was to

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inherit the dignity and status of generations of professionals. Respect unearned, but valued nonetheless.

When I began medical school in 1956 we had a grueling schedule of anatomy lessons, very few lectures, but many hours of dissection. One of our instructors was a volunteer surgeon from the community, Dr. Benjamin. He was gruff and authoritative, powerful and intimidating. One morning he asked one of his post-op aortic aneurysm patients to come to class, and, having had the man drop his pants and pull up his shirt, he described the operation while we looked at the man, his scar, and his naked self. When he was done, Dr. Benjamin walked to the door, leaving the man bare and hesitant, not knowing what to do. I would ask you to reflect for a moment on the ways in which professionalism is portrayed and conveyed by the example of elders to the young such as this one. Many of the attitudes concerning what faculty or other role models actually believe about professionalism is not best taught by didactic sessions, oath ceremonies, or physician charters. As useful as they may be, the message is more compellingly conveyed by the tacit learning embedded in the hidden agenda in education.

There is evidence that medical students lose some of the elements of professionalism during the course of their exposure to the curriculum. Values expressed by faculty and other health care providers sometimes speak louder than the unfurled flag of ideals. In learning to be objective, in learning detachment, in learning to listen rather than to express ideas, empathy may be lost. In the fragmentation of learning in the medical curriculum, in the wariness, distrust of emotions and skepticism that goes with training a doctor, there is the risk that idealism and altruism are adversely impacted.

Jay Jacoby, my old chief, is a good example of professionalism. He practically met medical students at the front door the first day of class. He was involved in their education throughout the basic sciences and early clinical experiences. He was passionate about anesthesiology as a medical specialty and zealous in demonstrating how much it had to offer both to patients and other specialties. Besides his excellence as a teacher and as a clinician, he truly cared about people and never thought that to choose anesthesiology as a specialty was in any way to abandon what we sometimes call "patient contact." I remember one Friday afternoon in the operating room during residency when a number of surgeons and anesthesia staff were dealing with a drunken vagrant who was admitted with multiple gashes inflicted when he fell down with a bagful of bottles. He had a full stomach and was a difficult awake intubation. After a series of brutal attempts to secure an airway, and a wrestling match with the combative patient, someone asked if Jay was still in the building. I got him and watched as he took charge. I will never forget the transformation that then occurred: Jay

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began to talk to the man. He explained what he was trying to do and why. His tone was gentle and respectful, and, by treating the man with dignity, he changed a dangerous situation into a cooperative endeavor in which a grateful patient practically inhaled the naso-tracheal tube. There was no doubt in my mind from that time on that techniques and procedures occupied a secondary universe in the practice of medicine: It was the patient that must be cared for, not dealt with, not treated, not managed—cared for.

Our specialty has come a long way in the last 50 years; and, as a profession, it was not prepared for many of the changes, nor has it responded coherently to them—changes such as the influx of women and minorities, foreign or international medical graduates, truly bright and gifted students anxious to become anesthesiologists.

Because a profession is a community of shared values, we might be better off interrogating the present rather than the past. History is not there to be exploited by the present, to serve the interests of mythmakers or entrenched interests. We might ask the new among us what they see as professionalism, or if it matters to them. In many ways the process of selection serves to define the profession: in medicine, people who are good at science test well, like to solve puzzles, want a good income and time off, are willing to work within a system, and do not require the approval of ordinary people to validate their worth—sorry to be so harsh—perhaps these are the characteristics of the new physician. Whatever the balance between an appetite for science or for service, there is a danger to the young in the hidden agenda or silent curriculum of the medical institutions they enter.

I believe that what drew most of us elders to medicine is not what attracts the young. Vandam seemed to see this coming back in 1973 when he said, “I wonder what will remain of anesthesia to attract neophytes when predictive monitoring of vital signs is combined with the expected arrival of the nontoxic, selective, centrally acting intravenous anesthetic or some physical means of achieving anesthesia, such as electronarcosis or acupuncture. I raise these questions because there is undoubtedly a life and death—or metamorphosis—going on in all of the medical specialties ... reflection a generation from now may reveal little that is recognizable as anesthesia now—in the drugs and methods used and those who administer them.”

Each generation needs to discover and define itself. It ought to respect the values of the past for what they are, not for the inflexible demands of another day. The profession must be redefined to accommodate the views of the majority, the views of those present today, not by the sacerdotal remnant of times-gone-by guarding a guttering flame.

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If medicine has become a commodity within a service industry, and new physicians see themselves as providers in a delivery system, less as ministers of care than managers of modalities; if it is treatment, not care, that is being dispensed; and if health care is being packaged and distributed by teams and departments and institutions—well, that's something to think about. There may be less personal reward or blame in being a cog in a delivery system. The satisfaction to the individual becomes the accomplishment itself, not the expression of gratitude or respect from the beneficiaries of their professional care. But this should pose no threat to a professionalism that is confident and robust.

If scientific knowledge becomes intellectual property, if patient education becomes advertising, if promises to provide coverage and care become exclusive contracts, if departments and privileging and medical staff membership becomes an opportunity for those who got there first to exploit those who follow, can anyone wonder that the medical profession doesn't look the same, precisely as it did, because it isn't? I asked a friend, a retired TV journalist, if journalism was a profession and he shot back "No!" It is not licensed or regulated; it has no agreed-upon standards of ethics, no educational or performance requirements, no peer-reviewed curriculum, no oath, and no requirement for postgraduate education and proficiency assessment. Maybe, by comparison, we're not that bad off; but I'm not any happier being better off than journalists than I would be out-professionalizing lawyers.

When I started medical school in 1956, American medicine was the most highly respected occupation besides Supreme Court justices. At the beginning of the 20th century it had been in disarray—its educational processes a mess, and its credentialing system an embarrassment. Having these deficiencies corrected by legislation and state oversight, a burst of new science empowered physicians in a way that had never occurred before. A conjunction of factors made the 1950s, by some accounts, the Golden Age of American Medicine. The improved system of medical education, the development of surgical procedures and daring, anesthesia education and certification—and new drugs and techniques had been coming along for some time. But look at the then-new developments—antibiotics, vaccines, transplant surgery, fluoride chemistry, psychotropics, insulin and electroshock therapy, steroid therapy, treatment of deficiency diseases.

Add to this health insurance as a tax-free benefit of employment; fee-for-service self-employment as the predominant mode of medical practice. The replacement of the old Marcus Welby kind of doctor with the new scientifically programmed and engineered practitioner. We also have seen the rise of high tech medicine wedded to complex relationships with governmental agencies

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and industries such as pharmaceutical companies, and the growth of sophisticated and expensive research facilities in universities and industry. The astonishing power of the medical-industrial complex has given rise to great progress and great concerns. During this time, the 1950s, the state was relatively passive, following policies and enforcing regulations established by professional associations. Privileged status was granted by the state and affirmed by the Supreme Court, saying medicine was not a trade or business and granting exemption from anti-trust laws, allowing it monopolistic control over practice. Doctors had control over licensing and were effective in controlling scope of practice for other practitioners. An alliance of medical organizations, insurance companies, drug and manufacturing industries prevented national health insurance for many years. Hospitals were controlled by their medical staffs—doctors ordered and nurses and administrators obeyed. Nurses: When I was a medical student I remember coming into the nurses station and the head nurse, easily old enough to be my grandmother, **stood up** out of deference to the medical profession. In the later years of my practice, I remember being told by a nurse's aide to go away from the nurse's station—they were having report. Not that much had changed about me, but times had changed. This is what medicine looked like when I entered medical school.

Another difference in the 1950s, the standard of care was the community standard, not that of some authoritarian hot shot or migratory testifier. The standardization of care and a uniform measure of outcomes is increasingly a fact of life, but this should pose no threat to a sense of professionalism that is confident and robust.

The escalation of therapeutic possibilities as new drugs and procedures came on line put pressure on the people paying the bills and on insurance companies to evaluate the usefulness of new modalities, and to assess the outcomes of both new and traditional therapies. Reimbursement was the stick they had at hand. Collective insurance of groups of industry employees or governmental employees gave bureaucrats and regulators a responsibility to account for the annual rise in expenditures as well as the power to economize. I do not deny the impact upon the practice of medicine of economic constraints and regulatory burdens. It has often been said that the practice of medicine is beset by challenges beyond its control. System managers and consumers have changed the practice of medicine, but they have changed everything else in the social landscape as well.

At the same time (since the 1950s) there has been an erosion of public respect for and confidence in all American institutions: professional, commercial, and political. While some might conclude that my entry into the profession is strangely coincident with this, I deny any responsibility. There has been,

paradoxically, a rejection of traditional ideas and therapies at the same time that medicine was offering the rewards of science and unheard-of personal health benefits. Alternative therapies, herbal medicine, acupuncture, and personal responsibility for health decisions have accompanied a new awareness of the relationship between the individual and the environment. Alternate providers and consumer choice have been embraced by politicians as well. New technologies and technicians push for recognition, licensure, and direct reimbursement by insurance plans. I don't minimize the consequences to autonomy and professionalism these pose, but I do suggest that medical professionalism is defined by its own values and behavior, not by those of others. Autonomy in medical practice has never been an absolute; its ability to preserve its limited autonomy has recently been compromised by specialization and other disunifying factors that have fragmented the political force of organized medicine.

Some of the public transgressions of physicians have weakened the bonds between us and those we serve—guilt by association. This has had a tarnishing effect on the larger community of physicians who are honorable and dedicated. Some of today's professionals will evolve into privileged technical workers as knowledge becomes a commodity and its application a service. Still, for those who serve, there continues to be a “deep and broad respect for medicine as a discipline, even if not as an organized profession.” If we no longer have a monopoly on a body of specialized knowledge and technical skills, and if we are held accountable for our decisions, and if the trust reposed upon us is tentative and contingent, professionalism is still not yet lost.

Matthew McEvoy, an anesthesiologist from South Carolina, and his colleagues have looked at the explicit teaching of professionalism and the adoption of consensus papers, charters, and position papers. They conclude that they are not generally successful. Professionalism is strengthened and sustained by the values of moral communities **external** to the profession itself—those traditions of virtuous conduct that, by their narratives and examples, establish some sense of the value and the ends of human life. A commitment to altruism and social justice begins with critical self-exploration and character formation. There is no one path to professionalism in medicine or any other activity; an “open pluralism,” many paths to participation in an ethical community of practitioners, should be the direction a profession takes. Conscience formed by knowledge of—and admiration for—virtuous behavior and personal excellence, however arrived at, should be the sinew and strength of professionalism. A healthy concern about professionalism should not degenerate into pessimism or the false nostalgia of the golden age. Emerson, whom I've quoted before, warns against the urge of mankind to “with reverted eye,

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lament the past, or, heedless of the riches around him, stand on tiptoe to see the future.”

I read recently that optimism in America is at an all-time low. About 25 percent of people think things are going well or getting better. It should surprise no one that, in this climate, concerns about the erosion of professionalism are expressed. I believe that a certain optimism is in order. If institutions and individuals were unaware of the problems or indifferent to the consequences of letting things go their own way, we would be in trouble. However, the CSA and ASA, many visionary leaders in medical education, and many laborers in the field **are** aware and determined to preserve the best of the past in the service of the future. Professionalism is not a legacy or a lost tradition. It is the soul of the commitment we make when we accept the privilege of serving our fellow man.

The sociologist Eliot Freidson said, “Serving only the immediate political, economic, and popular interests cripples both the intellectual development of disciplines and their distinctive moral position. True professionals consider the use of their knowledge in light of values that transcend time and space.”

I have seen so many examples of professional excellence in my lifetime—many of them in this very society, people in this very room—serving their specialty and the medical profession by their commitment to serving the needs of others. My old partner, Kay Belton, who began my engagement in serving in professional organizations, and who suffered through virulent gender discrimination during the years of her life as a physician, spoke glowingly to me of Forrest Leffingwell. She served this society and her specialty with distinction as its first woman president, and she brought an uncompromising commitment to excellence to everything she did. Her strength consisted of intelligence and personal virtue—the very stuff of professionalism. Her funeral 27 years ago was memorable for two reasons: the leaders of both CSA and ASA were in attendance, and she had made and carefully frozen the hors d’oeuvres served to the mourners at her house. Such a nifty last touch!

My brightest students want to become doctors. They work hard in my history class and strive for excellence. Those of you who actually teach medical students and residents must be happy for the reminders of your own thirst for knowledge and the privilege of witnessing their development of skills and confidence. Should I tell my students that medicine is not a worthwhile choice? That there are too many problems and it’s not worth the effort? Should I tell them that one day they’ll cease to grow in abilities, that they will stop learning, that the challenges they embrace today will become either stress or boredom? If they survive their education, bring healthy values with them on their journey,

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and if they continue to renew themselves, I believe they will develop the feature of professionalism I have described.

Professionalism is gained and maintained by successful persuasion. That persuasion is made meaningful in the examples and the narratives of the best among us. I urge you to share your stories of the lessons you have learned with others. Consider how far we've come and how much we have to offer. Quantification has its place, but many of life's greatest treasures can't be weighed and measured. Nourish and encourage the idealism that you see in the young. Rekindle it in your own lives. It can only make things better.

I thank Mark Singleton for giving me this opportunity to speak to you. I am grateful for your attention and deeply honored to belong to this profession. Thank you.

Dr. McDermott would like to acknowledge Eliot Freidson, Ph.D., who wrote some of the materials upon which he relied in preparing his lecture.

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