

Professing and Living the Oath: Teaching Medicine as a Profession

[APM Views]

Coller, Barry S. MD; Klotman, Paul MD; Smith, Lawrence G. MD

Dr. Coller was Chairman of the Department of Medicine at Mount Sinai School of Medicine from 1993 to 2001 and currently is the David Rockefeller Professor of Medicine and Physician-in-Chief of The Rockefeller University Hospital. Dr. Klotman is the Murray M. Rosenberg Professor and Chair of the Department of Internal Medicine at Mount Sinai School of Medicine. At the same institution, Dr. Smith is the Internal Medicine Program Director and Dean for Medical Education.

Outline

- [THE MEDICAL STUDENT PROFESSIONALISM DISCUSSION GROUP](#)
 - [Defining "Profession"](#)
 - [Comparing the Business Ethic and the Professional Ethic](#)
 - [Corollaries that Derive from the Professional Ethic](#)
- [EXPERIENTIAL COMPONENTS OF THE MEDICAL PROFESSIONALISM CURRICULUM](#)
 - [Reflections on Humanism in Medicine](#)
 - [The Home-Visit Program](#)
 - [Residents as Teachers and Role Models in the Community](#)
 - [Developing a Culture of Recognizing and Rewarding Humanism and Altruism](#)
- [SUMMARY](#)
- [ACKNOWLEDGMENT](#)
- [REFERENCES](#)

Graphics

- [Table 1](#)
- [Table 2](#)

Medical educators face enormous challenges in teaching students and housestaff the knowledge and skills that are required to become a physician. More important, however, is the responsibility to mentor students as they make the cultural and personal identity changes necessary to insure their transition from "lay person" to "professional." This transition involves two related but distinct processes. The first is recognizing the great powers they exercise as physicians and understanding that those powers are predicated on their assumption of an equal level of responsibility when they voluntarily professed an oath to place their patient's interests above their own. The second is not only accepting responsibility for their own actions, but also accepting responsibility for the medical profession as a whole; each physician insures that all physicians in the profession serve the public good with distinction and integrity.

Role modeling, targeted discussions, and experiential programs are important elements in a comprehensive approach to teaching medical professionalism. Most importantly, there is no substitute for each faculty member exemplifying the principles of professionalism and adhering to the highest ideals of the profession on a daily basis. It is, however, also valuable to provide students and housestaff with a conceptual framework of professionalism and specific experiential opportunities for enhancing their sensitivity to issues of medical professionalism. At Mount Sinai School of Medicine, we developed a program that includes a 1-hour luncheon small group discussion of the elements of medical professionalism with the department chair during the third-year internal medicine clerkship. It also includes a series of experiences during the medical residency focused on the major themes of altruism and sensitivity to the patient's perspective in the physician-patient relationship.

The centerpiece of the experiential component is participation in a medical care home visit program for patients in our community who are unable or unwilling to come to an ambulatory care facility. These visits are conducted under the supervision of faculty mentors who have a special interest in medical professionalism. Other activities include group exposure to art, literature, theater, and cinema related to medicine, followed by group discussions that focus on the physician-patient relationship as seen through the eyes of the patient. To complement these activities, residents are encouraged to participate in service to our community, emphasizing the resident as a role model for community children. The goal of these exercises is to convey a balanced sense of the extraordinary powers and responsibilities that come with being a member of the medical profession, as well as the unique opportunities for service and personal satisfaction that membership in the profession makes possible.

THE MEDICAL STUDENT PROFESSIONALISM DISCUSSION GROUP

Defining "Profession"

Students are encouraged to express their understanding of the meaning of the word "profession" as it applies to medicine. They are asked to identify unique features of medicine that differentiate it from other activities in society. Most student groups have difficulty identifying truly unique features of being a physician, tending to focus on physicians working long hours and assuming life and death responsibility. With prompting, they recognize that many jobs in society require hard work and may involve life and death decisions. The essential elements of a profession-as viewed from a sociologic standpoint-are reviewed; these elements include the existence of a body of knowledge, control over a prescribed curriculum for trainees, a certification process at the end of training that includes assessing both competence and adherence to a code of ethical behavior, and mechanisms for continual review of both competence and ethical behavior, as well as disciplinary power. As viewed from the perspective of its members, the profession must exercise control over these elements to insure that its members achieve and maintain high standards of competency and integrity to protect the public.

Others in society have different perspectives, however, and so it is important that physicians also understand how these persons view the medical profession. Thus, some believe the rigor and the length of medical training have less to do with insuring the maintenance

of high standards of excellence than with limiting access to a career in medicine, so as to preserve physicians' power, status, and economic advantage (1). Others in society challenge the validity of the medical body of scientific knowledge and offer in its place "alternative" or "complementary" therapies. Physician trainees cannot assume that others will automatically share their views about the importance of organizing medicine as a profession.

Most students do not have a full understanding of the powers and privileges that society, through state and federal laws, grants to physicians and how these powers and privileges derive from societal expectations that physicians will adhere to the tenets of their oath. These powers and privileges are reviewed in detail in the discussion group, where it is pointed out that in addition to being granted the privileges of taking medical histories, performing physical examinations, and, where indicated, performing invasive procedures and surgery, physicians are also granted the privileges of writing prescriptions, declaring patients disabled or in need of institutionalization (even against their will), and declaring a patient dead.

Government has a responsibility to protect the public, and so the special privileges that it confers on physicians and the limited autonomy that it grants to the medical profession can only be justified if individual physicians and the profession as a whole use these privileges for the public good. When government becomes concerned about physician competence or ethics, it has a duty to act to limit physician autonomy. As early as 1760, governmental concerns about physician competence in New York led the lieutenant governor and the general assembly of colonial New York to pass an act to require governmental licensing of physicians in the city of New York based on an examination (1,2). The trend toward loss of professional autonomy continues today as governmental agencies, regulatory bodies, and third-party payers each impose their own requirements on medical education, physician credentialing, and disciplinary actions. These limitations on professional autonomy reflect concerns by these parties about the ability of the medical profession to set and enforce high standards. They also reflect the particular interests (economic and otherwise) and constituencies of these groups.

These background considerations provide the necessary context in which to appreciate that the social contract between society and the medical profession relies absolutely on the oath that physicians take to put their patients' interests above their own. It is the oath, with its moral imperative, that distinguishes medicine from other functions in society, and that provides the rationale for the organization of medicine as a semiautonomous, self-monitoring, and self-disciplining profession.

One way to highlight the centrality of the oath to medicine is to consider the origins of the sources of authority involved in conferring titles and privileges on physicians (Table 1). Students become "doctors" when they are granted a degree by an accredited school of medicine. The first Doctor of Medicine degree was conferred in North America by King's College (now Columbia University) 232 years ago (2), and the first Doctor of Medicine degree from Mount Sinai School of Medicine was conferred only 32 years ago. Students become practicing "physicians" when they are licensed by the state in which they practice. The state of New York is approximately 224 years old and state licensure of physicians in its current form by the Board of Regents is 110 years old (3). Finally, students become members of the medical profession when they "profess" the oath, which in one form or another is more than 2,400 years old.

Title	Conferred by	Years since originated
Doctor	Medical school	≤ 232 years*
Licensed practitioner	State	≤ 226 years†
Medical professional	Voluntarily professing an oath to humankind	≥ 2,400 years

* The first degree of Doctor of Medicine was conferred by King's College (now Columbia University) in 1770 (2).

† In the City of New York, formal licensing of physicians actually extends back 242 years ago to colonial New York, with "An Act to regulate practice of Physick and Surgery in the City of New York, June 10, 1760." (2) However, as early as 1664, immediately after the British took possession of the Colony, the Duke of York promulgated a law to protect the public from "any act contrary to the known approved rule of art in each mystery or occupation . . ." by "chirurgeons, midwives, physicians, or others . . ." It also required that medical treatment only be given with the "consent of the patient or patients if they be mentis compotes . . ." (2)

Table 1. From Student to Physician in the United States

It is especially important to emphasize to students that unlike a license to practice medicine, which is an agreement between the physician and an individual state, the oath is a voluntary commitment made by the physician to all of humankind. This distinction is crucial, as history is filled with painful examples of situations in which governments have exploited the knowledge or the respected status of physicians to serve the government's interests. When government makes a demand that physicians believe violates their oath to humankind, it is their responsibility to resist the demand, regardless of the personal consequences (4).

Comparing the Business Ethic and the Professional Ethic [+](#)

One pedagogic device that helps students focus on the unique aspects of being a member of the medical profession is to compare the values and expectations of the professional ethic driven by the tenets of the oath with those of the business ethic, the product of our market economy (Table 2). The purpose of the exercise is to identify the dynamics that shape decision making under each ethic and the points of potential tension between these ethics. It is important to emphasize, however, that highly ethical individual and group behavior is possible under both ethics.

	Business ethic	Professional ethic
1. Oath required:	No	Yes
2. Expectation of purchaser/patient:	<i>Caveat emptor</i>	Informed consent
3. Responsibility:	Limited	Broad
4. Response to expectation:	Suspicion	Trust
5. Peer interactions:	Competition	Collegiality
6. Accountable to:	Investors	Individual patient and humankind
7. Obligatory oversight:	External	Internal and external
8. Goal:	Profit	Health
9. Position viewed as:	Job	Calling

Table 2. Select Elements of the Business Ethic and the Professional Ethic

Caveat emptor versus informed consent. The expectation of someone entering into a business agreement is *caveat emptor*, "let the buyer beware." In contrast, the oath places the burden on the physician to disclose to the patient all potential benefits and risks involved in a given course of action as part of the process of informed consent. To illustrate the difference between these ethics, ask students to describe their visceral response when purchasing a used car and compare that with their response when going to their physician's office.

Limited warranties versus extended responsibility. Differences in the extent of responsibility between the business ethic and the professional ethic provide another point of contrast. In a business relationship, responsibility is limited; thus, businesses usually have strictly defined hours and provide a formal limited warranty or similar document. The physician, however, has nearly opened responsibility, including availability 24 hours a day year-round, and an obligation to contact a patient whenever new data become available that may be important to the patient's health. In fact, the physician's 24-hour responsibility extends beyond established relationships with patients, because by using the formal title "doctor" in all situations, not just medical, the physician undergoes an identity transformation rivaling that of members of the clergy. The status conferred by this new identity comes with the responsibility to act in an exemplary manner to safeguard the reputations of both the physician and the profession.

Suspicion versus trust. It follows from these considerations that even the very best business relationship with a highly ethical businessperson inevitably contains a significant element of suspicion. Professional relationships that are based on the oath, however, will build trust between patient and physician. In fact, without a patient's trust, physicians cannot be effective because so much of the doctor-patient relationship involves sharing confidential and sensitive information.

After establishing that patient trust is the core element in medicine, different methods of delivering and paying for health care can then be judged based on whether they enhance or diminish that trust. Students are encouraged to identify the economic incentives under fee for service, different physician salary arrangements, and various forms of capitation that either reinforce or discourage professional behavior, and thus affect patient trust. As a homework assignment, students are asked to devise a method of compensating physicians that will most reward professional behavior.

Competition versus collegiality. A striking contrast between the business and professional ethics derives from the operative principle of competition in business and collegiality among professionals. This contrast is high-lighted by asking the students what course of action they would take under each ethic if they made a great discovery. In business, the goal is to maximize the economic return to the investors. Therefore, one would calculate the competitive advantage to be gained either by keeping the discovery (such as a soft drink formula) a trade secret, which may provide an indefinite advantage but risks that others will learn the secret, or by patenting the discovery, which provides absolute exclusivity for a limited period in exchange for fully disclosing the discovery. Under the professional ethic, collegiality requires an absolute commitment to rapid dissemination of new information so that patients worldwide can benefit. Patenting is not intrinsically antithetical to the professional ethic, however, as it does not necessarily prevent rapid dissemination of knowledge. Moreover, patenting a discovery may be required to attract the capital investment needed to convert it into a drug or device that will improve health.

Oversight-external versus internal. Although many businesses have comprehensive internal review policies, they are not obligatory; therefore, oversight in the business world is primarily external, through auditors, governmental laws and agencies, and groups designed to maintain business standards. Medical professionals are also extensively regulated by external groups, but it is the essence of medical professionalism that physicians commit to internal review and quality improvement through mutual education. Physicians have a positive obligation to identify (and help) physicians who are not practicing medicine according to high standards, because the oath dictates that the physician's highest duty is to the patient.

Goals and identity. The "bottom line" differs markedly between the business ethic and the professional ethic, with the former focused on profit and the latter on maximizing health. Self-perception is also profoundly affected by the dominant ethic, because most people in business think of their employment as a job, whereas physicians operating under the professional ethic view medicine as a higher calling.

Corollaries that Derive from the Professional Ethic [+](#)

A number of corollaries derive directly from considering the professional ethic. Because patients are entitled to the most advanced medical care, physicians must commit to lifelong learning. Also implicit in the professional ethic is respect for patients and other members of the health care team, including a commitment to help other physicians and team members. The ability to both give and

receive constructive criticism about physician performance is another essential element of professionalism. Finally, it is crucial that physicians participate actively in the professional review of other physicians so that the public is protected and so that physicians receive counseling or remediation when necessary.

EXPERIENTIAL COMPONENTS OF THE MEDICAL PROFESSIONALISM CURRICULUM [+](#)

Reflections on Humanism in Medicine [+](#)

Residents in our training program are taught that medicine rests on the twin pillars of science and humanism, and that the effective integration of these components is the hallmark of the great physician. Medical humanism stems from the appreciation by physicians of the common humanity they share with their patients. To paraphrase the physician's prayer ascribed to Maimonides (5), the resident should not consider the patient a "vessel of disease," but rather a fellow human who is suffering. In the course of medical training, it is inevitable that trainees increasingly view the patient-physician relationship from the physician's perspective. That view often results in trainees not recognizing the enormous powers they exercise, not realizing how a patient's fears and hopes can be profoundly affected by their slightest comments or even by just their body language. It is important to remind trainees that their comments during their daily hospital room visit will be repeatedly revisited in the thoughts and discussions of their patients and their families. Some years ago, Elie Wiesel, with extraordinary insight and perceptiveness, exhorted fourth-year Mount Sinai School of Medicine students at their commencement to continuously think about what their eyes are conveying to their patients, as patients look deeply into their physician's eyes, desperately searching for reason to hope while fearing they will find reason for despair.

Many of the elements of modern hospitals and ambulatory care facilities reinforce the physician's power relative to that of the patient and make it more difficult to establish a physician-patient relationship based on mutual recognition of shared humanity; these elements include high-technology equipment, poorly fitting and never properly closed hospital gowns, physician uniforms and stethoscopes, and cold sterile examining tables. We have found that one powerful antidote to these serious impediments to resident-patient bonding on a human level is to have residents visit patients in their homes, where the patients are surrounded by the people and objects important to them.

The Home-Visit Program [+](#)

Three young faculty members in the Department of Medicine started the Home-Visit Program 7 years ago. Motivated by both educational and altruistic goals, they initially developed a pilot program to augment care delivered by visiting nurses to homebound patients in the area near Mount Sinai Hospital. As a result of its success in providing both outstanding medical care and a unique learning environment, the program has grown to become one of the largest physician home-visit programs in the United States, now serving more than 400 patients. The program provides services to homebound patients throughout Manhattan, but its primary focus is the underserved, indigent patient population in east and central Harlem.

The program is staffed by attending physicians, nurse practitioners, a full-time social worker, a translator and escort, and a registered nurse who coordinates care. Each second-year resident spends 1 month working with the home-visit team. In addition to visiting the patients in their homes, there are one-on-one discussions with the attending physicians on the trips to and from the patients' homes, allowing time for trainees to reflect on what it means to experience illness. During this month, residents participate in a Literature in Medicine curriculum, reading works of poetry and prose that reflect human aspects of medical care. These shared literature readings—as well as group attendance of plays, movies, and other cultural events—are followed by informal group discussions. At the end of the month, the residents are required to express their feelings about the challenges of being a physician, patient, or caregiver. They are given wide latitude in the method of expression, including, for example, keeping a journal, writing about an interesting patient's life story, writing a poem about a patient or about the resident's feelings, creating a work of art, or taking a photograph. The only ground rule is that the chosen method must attempt to explore the human experience. Many of these works are profoundly moving because they capture the essence of medical humanism—shared humanity. It is particularly satisfying that residents have consistently ranked the home-visit program as their favorite educational experience in their training.

Residents as Teachers and Role Models in the Community [+](#)

During their home-visit experience, residents teach a junior high school science curriculum to underprivileged students in a local public school. During the first 2 weeks, the residents work with the science teacher to create a lesson plan that fits into the curriculum. The residents then teach the lesson to the seventh grade classes over the next 2 weeks. After each session, they talk informally to the students, share their life experiences, and encourage the students to pursue excellence as their goal. This program has been enthusiastically received by the students, many of whom immediately begin to emulate the residents, and the residents express great satisfaction in being viewed as role models. The experience also helps the residents gain a better appreciation for the difficulties faced by disadvantaged inner city youths studying in a school with limited resources.

Developing a Culture of Recognizing and Rewarding Humanism and Altruism [+](#)

Reflecting its core values, the department makes a determined effort to recognize and reward residents and faculty who demonstrate a commitment to professionalism, humanism, and altruism. The chair, program director, and other faculty members publicly praise and recognize residents who have distinguished themselves in their service to patients and to the community. A few well-chosen words at morning report or attending rounds makes clear the department's priorities. One specific departmental goal is to balance the cases involving physician error that are presented as part of our morbidity and mortality conferences with cases involving extraordinary medical successes by residents and attending physicians as a result of their commitment to medical professionalism. The educational value of cases reflecting medical successes can be as great or greater than that of cases reflecting errors in medical judgment or knowledge. Furthermore, high-lighting examples of medical professionalism affirms the department's values for trainees.

SUMMARY [+](#)

Medical school and internal medicine residency curriculums are filled with scientific and practice-related information that needs to be mastered to be a competent physician. Professionalism, humanism, and altruism also need to be integrated into the curriculum to help physicians advance beyond competence to excellence, and to help the medical profession sustain the trust of the public. Providing a framework for conceptualizing the importance of these elements to a career in medicine, recognizing and rewarding trainees and faculty members who demonstrate a commitment to these goals, and creating opportunities to convert these principles into actions that benefit patients and the community will not only help students and residents retain the spark of idealism that led them to choose a career in medicine, but will also guide them along the journey to becoming a member of the profession of medicine.

Barry S. Collier, MD

Paul Klotman, MD

Lawrence G. Smith, MD

Dr. Collier was Chairman of the Department of Medicine at Mount Sinai School of Medicine from 1993 to 2001 and currently is the David Rockefeller Professor of Medicine and Physician-in-Chief of The Rockefeller University Hospital. Dr. Klotman is the Murray M. Rosenberg Professor and Chair of the Department of Internal Medicine at Mount Sinai School of Medicine. At the same institution, Dr. Smith is the Internal Medicine Program Director and Dean for Medical Education.

ACKNOWLEDGMENT

We wish to acknowledge Drs. Laurent Adler, Jeremy Boal, and David Muller, who initiated the Mount Sinai Doctor home-visit program, and Dr. Jennifer Koestler, who has led the resident high school teaching program. They represent the best in medical professionalism. We thank Dr. Gary Rosenberg, Mr. Barry Freedman, and especially the late Mr. David Ott of Mount Sinai Hospital for their active support of the home-visit program. We also thank Dr. David Muller for critically reviewing the manuscript.

REFERENCES

1. Starr P. *The Social Transformation of American Medicine*. New York: Basic Books; 1982. [\[Context Link\]](#)
2. Bosworth FH. The doctor in Old New York. In: Goodwin MW, Royce AC, Putnam R, Brownell EP, eds. Half Moon Series, Vol II. New York: GP Putnam's Sons; 1898:277-317. [\[Context Link\]](#)
3. *A public trust: a message to licensed professionals practicing in New York State*. New York: The University of the State of New York, the State Education Department; 2002. [\[Context Link\]](#)
4. Levine AM. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136:243-246. [\[Fulltext Link\]](#) [\[Medline Link\]](#) [\[BIOSIS Previews Link\]](#) [\[Context Link\]](#)
5. Collier BS. Introductory remarks on the Code of Maimonides. *Mt Sinai J Med*. 1996;63:432-433. [\[Context Link\]](#)

Accession Number: 00000439-200206150-00016

Copyright (c) 2000-2003 [Ovid Technologies, Inc.](#)
Version: rel6.0.0, SourceID 1.7240.1.123