The Price of Professional Integrity—Ethics of the Physician-Patient Relationship

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Historically, the science of medicine has met a great deal of social rejection, if not outright hostility. Through the years physicians have had to maintain a delicate balance between the norms and values established by societies and the dictates of their own conscience of what constitutes the best interest of their patients. Confronted by the dilemma of facing social ostracism or defying their duties as stated in the Hippocratic oath to be "bound by a stipulation and oath according to the law of medicine, but to none others (Information for Research on Euthanasia, 2003)", physicians have often faced difficult ethic quandaries. It is a hotly debated issue whether the duty of physicians is to assess every individual case and act solely according to their own best judgment or act in line with the rigid norms and social structures imposed by the community. Issues such as euthanasia, abortion and organ transplantation present the very essence of this controversial bioethical debate.

It is interesting to note that the spectrum of what is socially accepted has been changing steadily through the centuries of human history. It is important to remember the times when blood transfusion, for example—a routine and life-saving procedure in modern medicine—was associated with sorcery and witchcraft in medieval Europe. In 1492, however, when Pope Innocent VIII in Rome had an apoplectic stroke and went into a coma, his physician advised a blood transfusion as a therapeutic measure. Employing crude methods, however, the Pope did not benefit and died by the end of that year (Bloodbook, 2003). This anecdote clearly illustrates the historical disconnect between the public view of medicine as a dark and dubious science and the potential real benefits that it could offer for people's health and well-being.

In fact, the very advance of medical science has been an agonizing process whose progress has been continuously met with social stigma and stern opposition, and many a physician have met their grim end attempting to advance this most humane of sciences. During the second century A.D., a Roman physician named Galen performed numerous animal autopsies drawing conclusions on human physiology. Soon thereafter, however, Christianity pervaded in the West and autopsy was forbidden by a Papal decree (South Africans for the Abolition of Vivisection, 2003). The study of human anatomy through autopsy—a crucial phase of the development of medical science—was regarded by the church as a desecration of the body, preventing the spirit's ascent to heaven. The same attitude was applied to a number of other medical practices through history, such as the origins of brain surgery, the study of schizophrenia, hysteria and other psychiatric ailments considered for a long time to be God's just penalty for human sins, and as such, were not to be interfered with. While the norms of society have dramatically changed since, the interests of patients have remained the same—mainly the preservation of their lives, health, and the improvement of their well-being.

Many physicians have asked the question of what is the definition of doctors' duties to their patients. Dr. Harry Osmond, for example treats the medical profession as a combination of three basic components: medical competence, charismatic authority and moral guidance (Osmond, 1980). The importance of medical competence is a requirement that needs no elaboration. However, scientific mastery, Osmond claims, is not enough. Another basic component is the moral guidance of the physician whose main objective is to help the "patient in a [way] which is socially good, avoids any inequities and is individually beneficial." The need for moral guidance of the patient is considered paramount in the physician-patient relationship and is best summarized by Dr. Franz Ingelfinger in his book *Arrogance* published posthumously in 1980 (Ingelfinger F.J., 1980). The third component is the ability of physicians to establish a link with their patients that will allow them to serve the patients' best interests and be their advocates for health and wellbeing. Of course, clear distinction between these three components defining the doctor-patient relationship is impossible.

Thus, in the case of pernicious social conventions, which are in obvious contradiction with patients' best interests, "civil disobedience," if we are to employ vocabulary from the science of jurisprudence, on the part of physicians should be considered the antidote. This, however, is not to argue that widespread breach of societal rules and laws should be encouraged since that would eventually lead to anarchy and disorder. Rather, every case should be considered in light of its very particular circumstances. The physician's judgment in that respect is vital. Physicians, however, are imperfect creatures, too. Thus, the accord between patient and physician is what should be regarded as the pivotal component of medical ethics, and ultimately, the doctor-patient relationship.

From a personal perspective, all these questions have a special significance for me since I had to understand their urgency by facing the desperation of a seemingly hopeless situation. I still remember my happiness when my

younger brother Damian was born on Christmas day, 1980. Unfortunately, no one could have predicted what would happen only five years later, on a beautiful Saturday morning in the spring of 1986. My family had just arrived at our summerhouse in the Balkan Mountains of Bulgaria for the weekend. As I played outside, my mother struggled to put Damian to sleep. She was worried since the boy had been crying all day and seemed to have difficulty breathing. Soon after we got home that evening, Damian experienced violent seizures and lapsed into a coma. My parents, hysterical, rushed him to the hospital and we stayed there late into the night, watching through the windows of the emergency room as doctors tried frantically to save his life.

Unlike many other young Bulgarian children at that time, my brother lived, but only to embark on a long and agonizing struggle for survival. Damian's immune system had been severely compromised by radiation from the nuclear meltdown in Chernobyl a few days earlier and was in desperate need of urgent bone-marrow transplantation, an expensive and cutting-edge medical procedure in Bulgaria then. He would also need continuous immunosuppressive medications to sustain him for the rest of his life. My parents were trying to do everything in their power to ensure the best possible care for Damian but their options were very limited in Bulgaria's totalitarian system, where only Communist Party members were entitled to the benefits of the latest medical therapies or to travel abroad for treatment. Unfortunately, neither one of my parents were such and that seemingly sentenced my family to the torture of watching Damian's slow and agonizing demise, unable to do anything to help him.

And when every last resort was exhausted and everything seemed lost, a glimmer of hope appeared in the face of a physician—Dr. Markov, a pediatric oncologist—who had incidentally heard of my brother's case in Sofia's Children's Hospital. He had traveled to a transplantation conference in the US the year before and was familiar with the resources available in this country for the treatment of similar cases. He said that it was not a routine procedure by any standard and there were substantial risks involved, but in America there were entire centers that specialized in this type operation, an operation that meant the difference between life and death for my brother. The doctor also said that for Damian to travel abroad and be admitted to such a center in the US, a Bulgarian doctor familiar with the procedure had to refer him and explain why the patient was unable to receive therapy in his home country. That also meant that the doctor had to fight against the entire system of communist party-line favoritism and put his own professional career on the line in order to save a child's life. Dr. Markov, however, never mentioned these risks, nor that his whole family may suffer the consequences of his professional decision. But my parents knew very well what that meant for him and the burden he, a stranger, was taking to help their child. They could not believe that someone would do that for their son and could not accept this extraordinary generosity.

But for Dr. Markov the issues were clear and separate in his mind, he explained. He viewed his duty to his patients as his ultimate priority, a duty defined by his full commitment and advocacy for them. And he viewed as patient anyone whose health and life depended on his decision as a physician. Therefore, my brother, although not previously assigned to him by the hospital, had become his patient the moment Dr. Markov took interest in his case and realized that he could help him. He also said that his wife was aware or his professional ethic and had accepted the burdens that their family may have to endure as a result. Finally, he could not in good conscience go on to practice medicine knowing that he had failed to protect a patient who needed his assistance and had thus forfeited his professional integrity. So you see, his ethical values maintained his moral foundation as a human being as well, and in that respect did, in a way, simplify his life, although the harsh reality of the matter was far more complex and dreadful.

A month later, my whole family arrived in the US and my brother received an urgent bone marrow transplant in Boston's Children's Hospital. At the time, I did not place too much thought on what Dr. Markov had done for our family. All I knew was that my brother was going to be helped and have a chance at life and normal childhood again. Years later, however, I remembered the kind doctor and tried to contact him and personally thank him, as well as ask him about the consequences of his selfless act to himself and his family. After long searching and many discouraging leads, I finally managed to get in touch with his son who had taken after his father and had also become a physician. I explained who I was and briefly recounted the story of his father's gracious deed that had saved the life of my younger brother. When I asked for Dr. Markov, Sr., there was a dreadful moment of silence at the other end of the line. His son then explained in a quiet voice that one week after his father had helped my family to emigrate, Dr. Markov was dismissed from his position as chief of pediatric oncology in one of Bulgaria's biggest hospitals and was "blacklisted" by the communist party as a "dissident" who was banned from legal employment anywhere in the country. Members of his family were ostracized and some of them interrogated by the secret police. After numerous unsuccessful attempts to find other jobs and sustenance for his family, even abroad, Dr. Markov fell prey to severe clinical depression and several years later suffered a stroke and died in the hospital. Ironically, he had lost his life at the same place where he had given life to so many of his patients.

I felt horrible at the news of what had befallen the kind doctor and his family as a result of helping my family. But his son reassured me that Dr. Markov never regretted his decision, even at the price he had to pay. The young doctor understood his father's professional and personal

ethics and said that if he were faced with the same situation, he would have done the same thing—a clear proof that he was truly his father's son.

When I hung up the phone that day, I felt a mixture of deep sadness and intense surge of inspiration. Coincidentally, that was the year of my candidacy to medical school, a fortuitous twist of fate, which influenced tremendously my decision to get on the road to become the best possible physician I could be. Such a decision, I realized, would not be a light burden, but like Dr. Markov, I understood that a solid and unwavering ethical foundation is crucial for the practice of medicine, especially in present times, when this noble profession is faced with so many new ethical and moral challenges stemming from today's rapid progress of science. Therefore, it is vital for every physician to have a touching stone on which to base his or her personal values and professional integrity, a professional "Bible" of sorts, which would spell out the rules of medical ethical conduct and which would define the duties and responsibility of the physician to his or her patients.

It would not be a far-fetched simile to state that the Hippocratic oath is such a professional Bible, a constitutional text whose contemporary interpretation is of great significance to the function and ethics of today's medical profession. While the use of language and the connotations of words have changed, one thing remains invariably the same—to focus on the essence, rather than on the specifics, of the art of practicing medicine. Thus, certain aspects of this age-old professional sermon have been revised and interpreted differently through the years—and "this art …[is no longer imparted] …without fee or written promise. (2003, The Internet Classics Archive)" Perhaps, other aspects, such as abortion and euthanasia—both proscribed in the oath—are open to revision as well and should be adapted to the contemporary needs of our society. Perhaps, the statement "never do harm" can be examined in the broader perspective of what truly constitutes the best interest of the patient in the context of his or her desires which might, in certain cases, endorse either abortion or euthanasia.

To make matters even more complicated, the recent accelerating development of science has presented today's medical profession with increasingly complex ethical dilemmas. In an age where cloning and stem cell research are the latest scientific breakthroughs, it remains an open question whether people are prepared to answer some of the quandaries posed by these powerful, yet controversial, technologies. The very boundaries of the medical profession have come into question. Where does human power end and divine intervention begin? What are the limits, if any, of humans' capacity to save life? Should we stop advancing our knowledge in the prospect of meddling with God's affairs, as someone has put it theologically? These questions become especially acute for societies with strong religious ethos.

The answer to these anxieties perhaps lays in a better interaction of the medical establishment with the wider public. Just like the essential practices of blood transfusion and autopsy earlier, many of today's quandaries of biomedical ethics, such as stem cell research and cloning, if properly regulated by laws, may substantially decrease human suffering and eliminate many human diseases. The rewards seem promising enough not to risk the discomfort of addressing these pressing issues outright. Silence, history has proved, is no answer, and human intellectual curiosity thrives best when challenged. Thus, it is in our best interest to push the boundaries of our knowledge, while regulating new technologies and practices carefully whenever possible.

NOTE

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