

PROFESSIONAL ETHICS IN MEDICINE

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INTRODUCTION

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Ethics is generally defined as the science of human feeling, thoughts and actions relating to duty or morality; or it is the science of right conduct. Medical ethics embodies the rules or principles governing the professional conduct of medical practitioners.

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Chauncey D. Leake states that the term "medical ethics" is really a misnomer. Based on Greek traditions of good taste, it refers to the rules of etiquette developed in the profession to regulate the professional contacts of its members with each other. The average physician of today also interprets the meaning of medical ethics in a like manner. Medical ethics should be concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole, and it should include a consideration of the will and motive behind this conduct. The term, medical etiquette, should be used to imply the conduct of physicians toward each other, and it embodies the tenets of professional courtesy. Medical ethics, then, is largely a moral issue to the physician, while medical etiquette is really a professional courtesy.

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Leake, in contrast to many other writers on medical ethics, has attempted a philosophical analysis of the principles of the ethical theory. He states that the two chief ethical positions are idealism, which stresses the interests of humanity as a whole, and hedonism, which emphasizes the interests of the individual

self. Hedonism is usually concerned with personal pleasure and attainments; idealism, with the furtherance of the welfare of society.

The ethical basis for the professional system of etiquette is primarily hedonistic, since it is designed to promote dignity and pecuniary advancement of the individual physician and of the profession as a whole. On the other hand, the ethical basis for the professed attitude of medicine toward the sick and toward the public is idealistic, since it presumes that every professional act of the physician is motivated by rational and sincere concern for the ultimate welfare of society. The ultimate path of conduct that a physician chooses is a compromise between these two issues, according to the individual's temperament and moral interpretations.

Professional men have many moral issues confronting them, many delicate and yet vital relations with their patients, many issues which rules cannot be made to cover. He must make a choice between acting in the ideal interests of humanity or in the practical interests of self, which the complexity of responsibility, honor and prestige will exert the greatest influence. As a result it is convenient for the physician to find refuge in utilitarianism, the greatest good for the greatest number, which is really calculated hedonism.

Indeed, the present day expense of gaining a medical education, equipping a suitable office, and in the upholding of the

social status, that is traditionally expected of a physician, may cause him to fail to elevate true idealism to the moral plane that it should attain. The physician has a right to reap ample returns, to compensate for the time and money he has had to consume. He not only owes a debt to himself, but to his parents, his family, as well as to society.

Nevertheless, when one reviews the principles underlying the moral responsibilities of medical men as enunciated by physicians themselves, one feels that medical ethics is not based upon the utilitarianism but on idealism, primarily. From the Hippocratic oath to the latest revision of the Principles of Ethics of the American Medical Association, it is implied by all of the medical ethical writers that the ideal end in the interests of humanity are the real bases for their remarks, and that these must be compromised only as little as possible in the interests of self.

The first clause in the "Principles of Medical Ethics" ⁽³⁾ is exemplary of idealism and it represents a standard set forth by many of our best physicians of today. It reads as follows: "A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession, an individual assumes an obligation to conduct himself in accord with its ideals."

Formerly, statutory regulation of medical morals was

quite prevalent. Severe restrictions and penalties were placed upon physicians by social forces regarding fees, technical conduct, and moral deportment. Now society has left to the medical societies and individual members the responsibility of deciding for themselves the conduct they should practice. Naturally, there are weak willed and morally unstable men in every profession and it is through the action of these that many ill reports are circulated.

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J. N. Jackson, former president of the American Medical Association, writes as follows: "Our profession occupies a rather peculiar position among the professions and vocations among men. More than any other it rests fundamentally on the base of faith. Individually our relative ability as physicians is not susceptible of obvious proof. The merchant exhibits his wares on the counter and shelf, and since they are material things, the prospective purchaser can judge adequately for himself of the quality and of the price. The realtor has like advantages. The lawyer in his arguments and briefs proves his knowledge of law and his powers of logic. The preacher in the pulpit proclaims his teaching in words and oratory, which please our ear or persuade our minds. The ability of a medical man, however, cannot be proved by words of logic or eloquence, nor displayed in any material way. The logic of our science cannot be judged by the mind untrained. We must be accepted or rejected therefore by our ability to influence the faith of our followers. The consequences of medical treatment are not proof whether good or bad. The judgment whether wise or unwise is difficult enough for the expert in a matter in which so many varia-

bles enter. Trust and faith of our patients become, then, the necessary foundations of our profession."

HISTORY OF MEDICAL ETHICS

The oldest code of laws in the world were formulated
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by Hammurahi, a king of the First Dynasty of Babylon (about 2250 B.C.) and in it is contained nine sections dealing with medicine. These sections refer to the fees of the physician and the punishment to be enacted in case the treatment of the physician results in injury or death, the fees, and the punishment being influenced by the financial and social state of the patient - a practice followed more or less by physicians ever since. The essential features of these laws are based on personal responsibility and the jus tilionis.

Similar codes were in force among the Persians, and
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according to Friedenwald, the ancient Jewish laws concerning medical treatment also invoked the principle of the lex talionis. Dr. John D. Comrie in a lecture upon Medicine Among the Assyrians and Egyptians in 1500 B.C. speaks of the court physician, the Rah-mag or Nah-Mugi, as he was called in days of Babylon, and who stood at the head of the medical profession. The following translation of a letter from Aradonana, a consulting physician to Esar-haddon, is interesting chiefly from the standpoint of the position of medical etiquette of that period. "as regard the patient who had bled through the nose the Rab-mag reports: Yesterday, toward evening, there was a good deal of hemorrhage, the dressings have not been properly applied. They have been placed outside the nostrils, oppressing the breathing and coming off when there is hemorrhage. Let them be placed inside the nostrils, and then the air will be excluded

and the hemorrhage stopped. If it is agreeable to my lord, the King, I will come tomorrow and give instructions; meanwhile let me know how the patient is."

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It is remarkable that the Greeks, during the period of Grecian greatness, had no specific laws regulating the practice of medicine, the general Greek view of morality rendering it quite unnecessary. Customs and religious tradition, however, served satisfactorily in their place. These lofty and noble conceptions of the duties and responsibilities of the Greek physician are contained in the celebrated oath of Hippocrates. Hippocrates, who was born in 460 B.C., bound his followers together by this oath, which with its high moral precepts, has been the bond and banner of our profession through the ages to the present date. All systems of etiquette and ethics since then have only been enlargements of the principles set forth by Hippocrates.

It is significant to note that the Greeks did not bother about the details of ethical practice. The guiding principle was that the physician should help or at least do no harm to suffering humanity. Modern etiquette protects the interests of both patient and the profession, and is enforced by penalties of various degrees of severity, exercised by the organized profession. Greek etiquette protected the patient where the law was not effective, and appealed to the artistic instinct without imposing penalties.

It is probably that the famous oath of Hippocrates was influenced or resulted from the practice of several groups of

teachers at the Asclepieia and Iatreia (the health temples and public medical centers) to require an indenture of persons training for the practice of medicine, in order to be certain of good character on the part of physicians. The chief provisions of the Oath are that the physician should call a consultant if in doubt, be reasonable in fees, lead a pure and moral life, respect and honor his teachers, should not give nor sanction the giving of a poison, cause nor encourage abortion, use his position to debauch a patient, nor any member of his household, divulge information about a patient, whether acquired professionally or otherwise, advertise in any manner, annoy patients with noise or odors, especially those of wine, or assume ostentation in dress or in any manner. It has been claimed that this is not the oldest oath, but that the Oath of the Hindu Physician was given long before the Oath of Hippocrates.

With the gradual decadence toward the Alexandrian epoch such admonitions, as have survived in the Hippocratic collection, were formulated in the attempt to maintain the old standards. This was about in the year of 350 B.C.

It is also noted that the Romans similarly failed to provide any legal regulations for the practice of medicine. As a result there was no great gulf between quacks and responsible physicians. Neither etiquette nor excellent morality can suppress quackery. As a result in Italy an intolerable situation of quackery made it necessary to clean up the situation. Under Antoninus Pius (86-161 A.D.), an edict was enacted which restricted

the number of physicians practicing in a community and stimulated tests for character and capacity. These "Archiatri" were provided with an annual salary "in order that they may honorably serve the poor rather than basely grovel before the rich". They were further exempt from taxation and from other public duties. This reform, however, with its establishment of state medicine, was short-lived. The empire was rapidly crumbling under Christian influence and the inroads of Germanic tribes. In the stress of these circumstances, medical practice as a profession ceased.

After the fall of Rome in 476 A.D., the lex talionis was again involved in the provisions of the Germanic tribes relating to physicians. In 650 A.D. was formed the Forum Judicum of the Visigoths. It is noted that these early laws of the Visigoths bear a striking resemblance to the Babylonian laws of Hammurahi.

The first extensive law relating to the practice of medicine in Europe was established by Fredrick II in 1224 and 1241 A.D. This specified the type of instruction which a physician was to receive, required an examination and a license to practice, and regulated the fees that might be charged. In addition, the law attempted to control public hygiene, and the sale and adulteration of foods and medicines. It was this law which did so much to establish the preeminence of the School of Salernum in medical education during the Middle Ages. The significance of Fredrick's statute may be judged by the fact that it was re-enacted by Charles IV for the German States in 1347 and for Italy in 1365 A.D.

With Henri de Mandeville in the 14th century, a distinctly hedonistic note crept into the moral precepts of medical writers. Indeed, during the Middle Ages, the generous idealism of the Greeks was in danger of being swallowed up by the meticulous details of professional deportment advised by such scholastics as the Salernitan Archimathaeus. However, the ancient nobility of the profession was strongly emphasized by Guy de Chanlic (1300-1370), Paracelsus (1493-1541), Ambrose Pare (1510-1590), and especially by Sydneham (1624-1689). These men, by precept and writing, attempted to establish an esprit de corps, a tradition of noble bearing and wholesome personal honor in medical practice. In 1452 the Paris Faculty formed an ethical code, which was local for that vicinity. It is interesting that, with the rapid development of medicine, in the Renaissance, the better class of physicians and surgeons began as a group to impose penalties for violations of the traditions, and to demand action by the civil authorities in the elimination of quackery.

Guy de Chanliac compares the influence governing the surgeon of that day to that of the time of Hippocrates. Both advise against taking desperate causes, the French surgeon, because of dread of personal risk, the old Greek physician, not from fear of consequences, but in recognition of the limitations of the medical art.

A consideration of the differences in attitude between the Hippocratist and the surgeon of the Middle Ages suggests the

inference that wherever and whenever the medical profession and medical practice have been most highly organized, the penalties for failure and ill success have been most humane; and wherever they have been less organized, the penalties have been harsher, more vindictive, and often inhuman. In the more highly organized state of medicine, practitioners have been better educated, and more skillful, bolder, surer, yet more cautious amid dangers, more circumspect and therefore more trusted. When the organization has been imperfect, the number of educated physicians and surgeons has been fewer, while quacks and charlatans have been more numerous and more unconscionable.

The Visigoths held the physician to strict accountability, and while the penalties imposed were very drastic in character, the ordinances contain some protective clauses. Similar in intention were the laws of the Franks and Allemanni, the Salic law, the Capitularies of Charlemagne, a mixture of Germanic, Roman and Merovingian codes, and the assyes of the Crusaders. In these ordeals by fire, torture, ocular verification of impotence, and orientation, or the supposed bleeding of a corpse in the presence of the murderer, were regarded as legal tests.

In 1505 A.D. the Royal College of Surgeons of Edinburgh was found. Thirteen years later, during the reign of King Henry VIII, Thomas Linacre founded the College of Physicians of London. In 1851, it became the Royal College of Physicians of

England, which title was confirmed in 1860. The College was originally founded in order that its members by constant association might be improved in learning, in the practice of medicine, and in the morals of their profession. The statutes of the College ordained for the government of its members are explicit and emphatic. They not only declare what shall be the demeanor of its members, but they prescribe that they shall be clothed with gown and other decent apparel when in attendance upon all great meetings, feast of the colleagues, funeral and anatomical administrations under penalty of a fine if delinquent.

In 1525 A.D., the first Latin translation of Hippocrates was published at Rome and a year later, the first Aldine Greek text of Hippocrates was published at Venice.

In 1542-3 A.D. Henry VIII, because of the greed of surgeons who disdained to help the poor, enacted certain acts permitting common persons having knowledge of herbal and folk medicine to minister to the indigent, thus affording a loophole for unqualified practitioners, like the *Kurierfreicheit* of modern Germany. Thirty years before this Henry VIII had granted the Barber-Surgeon Guild a charter which forbade the practice of surgery by anyone except the members of the guild. This practically limited all surgery to the barber-surgeons. They were given rights of training new members and examining applicants for practice. Their early ordinances required scrupulous moral relations with their patients, enumerated the reciprocal obligations of members to each other, and

indicated the attitude to be taken by the members to the public at large.

In 1569, the Ethical Code of Piacenza was printed. Then in the seventeenth century many of the assemblies of the early colonial states passed laws regulating medical fees. Virginia passed such a law in 1636 A.D. Maryland passed an act in 1638 A.D. Massachusetts in 1649 A.D. In 1735, the medical society of Boston was founded.

In Europe, the London Royal Society (1662 A.D.) was organized, the French Academy of Sciences (1665 A.D.) was established and the Royal College of Physicians of Edinburgh was founded.

Percival's Code, which was written in 1775, was dedicated to his son, who was about to engage in medical practice. Percival said: "The relation in which a physician stands to his patients, to his brethren, and to the public, are complicated and multifarious involving much knowledge of human nature and extensive moral duties. The study of professional ethics, therefore, cannot fail to invigorate and enlarge your understanding, while the observance of the duties which they enjoin will soften your manners, expand your affections and form you to that propriety and dignity of conduct which are essential to the character of a gentleman."

Percival's Code was first published in 1807. It is divided into four chapters, with the titles as follows:

Chapter I: Of Professional conduct, Relative to Hospitals or Medical Charities.

Chapter II: Of Professional Conduct in Private or General Practice.

Chapter III: Of the Conduct of Physicians toward Apothecaries.

Chapter IV: Of professional Duties, in Certain Cases which Require a Knowledge of Law.

During the latter part of the eighteenth century many important societies were founded. The Massachusetts State Medical Society was organized in 1781 A.D. and its constitution contained several sections on the principles and practice of medical ethics. The Royal College of Surgeons of Ireland was founded in 1787 A.D. The Royal College of Surgeons of London was founded in 1800 A.D. In 1794 A.D. Benjamin Rush of Philadelphia lectured on the duties of a physician and also at this time, although Percival's Code, was not published, its precepts were in full operation at Manchester Infirmary.

The transition from the broad principles of Greek ethics to the current complicated system was completed in the eighteenth century and early in the nineteenth century. During this period, the philosophical significance of law and order in nature became generally appreciated. Men sought to establish similar immitable, detailed and comprehensive laws for every phase of their activity. With the object of specifically covering all possible contingencies, two results were certain to follow: a growing emphasis on letter in-

stead of spirit, and a conflict in the multiplicity of rules.

It was not until the 19th century that with increasing morale and skill in the treatment of disease, there developed a pride and prestige in the profession which gradually made it unnecessary for civil authorities to regulate minutely the moral deportment and qualifications of physicians.

Thus, we see many codes of ethics adopted during this century. In 1820 A.D. the code of the Kappa Lambda Society of Aesculapius, Philadelphia was established (an abridgement of Percival's Code). In 1823 A.D. the New York State Medical Society adopted a code of ethics drawn by a committee. In 1832 A.D. the British Medical Association was founded. Michael Ryan's Medical Jurisprudence was published and the Medico Chirurgical Society of Baltimore published System of Medical Ethics. In 1836 A.D. Hufeland's Encheiridion Medicum was written and Koon O gata (7) (1812-1863) prepared a famous scroll, a medical code base on Hufeland's Encheiridion Medicum. In the past few years the Japanese have unearthed, reproduced and republished Koon O gata's famous scroll into English in hopes to emphasize the teachings of their own older generations.

In 1847, a universal national code of ethics was adopted by the American Medical Association, which was founded May 5, 1846. This code was divided into three chapters, namely:

Chapter I: The Duties of Physicians to Their Patients.

Chapter II: The Duties of Physicians to Each Other and to the Profession at large.

Chapter III: The Duties of the Profession to the Public.

Dr. Isaac Hays, chairman of the committee to report a code of ethics to the American Medical Association at its organization said: "On examining a great number of codes of ethics adopted by different societies in the United States, it was found that they were all based on that by Dr. Percival, and that the phrases of this writer were preserved to a considerable extent in all of them. Believing that language so often examined and adopted must possess the greatest of merits for such a document as the present - clearness and precision - and having no ambition for the honors of authorship, the committee which prepared this code have followed a similar course, and have carefully preserved the words of Percival whenever they convey the precepts it is wished to inculcate."

In 1903, the American Medical Association, held a meeting in New Orleans, and the House of Delegates unanimously adopted the "Principles of Medical Ethics", a revision of the Code of Medical Ethics, which was adopted in 1847. The "Principles of Medical Ethics" was again revised and adopted at Atlantic City, June 4, 1912.

In 1912, the American College of Surgeons instituted a "fellowship pledge" and a declaration against fee-splitting to which each candidate must subscribe himself before he is eligible

for fellowship. At formal convocations of the College the Fellowship Pledge is recited in unison by the candidates who are admitted to Fellowship.

In 1915, Fellows of the American College of Physicians had to subscribe to a Fellowship Pledge, which is based on the precepts of the Fellowship Pledge of the American College of Surgeons.

SOME RECENT ETHICAL PROBLEMS

FEE - SPLITTING .

If one reviews the current literature of the present day to only a limited extent, he will find the problem of "fee-splitting" discussed by many authors and from many and diverse angles. An article in the Lancet entitled "Dichotomy or Fee Splitting" gives one a sketchy review of the prevalence of this moral problem in America and also some of the opinions of the American medical practitioners. These opinions seem to represent, very closely, the average medical view in the United States.

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The Medical Journal and Record of Boston sent out questionnaires to doctors all over the country and then printed the personal views of many of these doctors, with the following results: It seems clear, that there are many members of the medical profession, especially in the Eastern States and their large cities, who have not come in contact with fee-splitting at all; whereas it is equally evident that, in the Middle West, and still more in the Southern States, fee-splitting is by no means exceptional. A New Orleans correspondent states that in Louisiana it is a common practice; in Alabama, it seems to have been almost a rule 15 or 20 years ago, although it is not so prevalent now; in Ohio, a signed contribution states that it is universal, while a Wilmington practitioner understands in a general way that many of the general surgeons and specialists in Cincinnati split fees with small town doctors who refer cases to them. A Minnesota physician remarks that the

practice is quite inevitable under the present conditions, the larger fees received by surgical specialists being the foundation. The ex-president of the Iowa State Medical Society says, quite frankly, that 75% of the doctors of Iowa and Nebraska want splits. Many such examples as these were received and these few quoted may suffice to give some idea of the relative prevalence of fee-splitting in the United States.

It is also interesting to note some of the comments of the various practitioners concerning different phases of the question of fee-splitting. A New York practitioner states two reasons why fee-splitting is so prevalent. One cause he attributes to the young surgeon who has to offer part of his fee to the family physician in order to build up his surgical practice. Another cause is that some prominent specialists with a large income, takes into consideration the plight of the referring physician and gives him a portion of his fees.

Because of the prevalence of fee-splitting many practitioners take the attitude that now that we can't get rid of it, lets make it legal. A Baltimore physician says that the legal profession can find nothing wrong with fee-splitting. Another physician suggests that there be a division of fee, openly, between the surgeon and general practitioner on the basis of two-thirds of the fee to the surgeon and one-third of the fee to the medical man.

Another suggested that the practitioner should openly charge his fee for examinations and that the surgeon should limit his fee so that the patient can pay the family doctor. Many of the correspondents complain that if the surgeon's fee and the practitioners fee is presented separately, the practitioner is not paid in many instances, and often only after difficulty. Many suggested a collective fee with full knowledge having been imparted to the patient, concerning this fee.

Dr. Thayer, in his presidential address to the American Medical Association in June 1928, believes that there should be a revision of the ethical code and recognize the principles of open ethical fee-sharing as just and equitable. This modification of the code should provide that the specialist's fee shall include the physician's fee and it shall be deemed as much a violation of the code for the specialist to withhold the physician's rightful share as for the physician to demand or the specialist to offer more than the duly established proportion.

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Dr. Franklin H. Martin, president of the American College of Surgeons, in his address to that body firmly upholds the present ethical code. He states as follows: "It was a bold stroke when the American College of Surgeons at the initial meeting declared against the division of fees between the practitioners of medicine and the surgeons. It required courage to discuss the abominable practice which reduced to its ultimate terms, is simply a traffic of patients between these two groups; the buying and selling of patients,

with the highest bidder the purchaser regardless of ability. This vicious practice will cease only when every member of the profession has the courage and the honesty to present his individual bill for services rendered and when the public will insist upon paying each, the practitioner and the specialist, for his individual services."

The chief evils of fee-splitting are:

1. It leads toward incompetent surgery. The practitioner generally does not refer his patient to the most competent men but to the men who will split the most and these are generally the poorer surgeons. Also the practitioner often insists that a certain procedure be carried out and the surgeon does so, even though it is against his better judgment.

2. It leads toward unnecessary operation. Both the practitioner and surgeon tend to make diagnoses without adequate study. Many surgeons think they must operate because the practitioner, who is less able to judge, insists on an operation.

3. Fee-splitting is definitely dishonest and lowers the entire medical profession in the eyes of the public.

I have found the practice not so prevalent among the best surgeons throughout the country. It does exist and until corrected in some definite suitable manner, it will remain a discredit to the medical profession.

LIQUOR PRESCRIPTIONS.

Since the passing of the Eighteenth Amendment, the members of the medical profession alone have been given the privilege of prescribing intoxicating liquors to their patients. There is evidences on all sides that this privilege is being misused. Many doctors never wrote a prescription or prescribed liquor before prohibition and now use at least one book a year. Some statistics were recently published in the Journal of the American Medical Association concerning the number of prescriptions used and I quote as follows: (10) In 1928, there were 68,951 doctors who prescribed liquor. In 1927, there were 48,097 doctors. There are 116,756 doctors in the United States, so over one-half use the prescription books. In 1927, 14,948 doctors used one book, 8,743 used two books, 10,861 doctors used three books and 13,545 doctors used four books. 10% of the doctors used all of the books afforded to them. The total number of prescriptions written, in 1922 were 8 million, in 1925 $13\frac{1}{2}$ million, and in 1927 slightly less than 12 million.

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Dr. Arthur Dean Bevan in a recent article expressed his views as follows: "From the standpoint of personal hygiene and public health, legislation has never been passed that had such possibilities of good as had the prohibition amendment. If it was the power of the nation to legislate out of existence of tuberculosis or cancer, such legislation would be passed over night and be strictly enforced. Drink did more injury under the old order of things than did either of these plagues. Prohibition has done

an enormous amount of good and with better enforcement can accomplish much more for the health and betterment of our people. The medical profession as a whole recognizes this fact and should support the constitution and the amendments. On the other hand a noisy active minority of the medical profession are taking advantage of certain provisions of the amendment and selling their souls for a mess of pottage.

The United States government in the framing of laws under which the prohibition amendment functions, made liberal provisions for the use of alcoholic liquors as medical agents so that these could be prescribed by the members of the medical profession, who believe that such alcoholic liquors are of value in the treatment of disease.

The government regulations permit a physician to prescribe one hundred pints of whiskey every three months or 400 pints per year. In addition he can secure twelve pints of whiskey and five gallons of pure grain alcohol each year to be used in his office. The five gallons of alcohol does not have a special value as a sterilizing agent or in external application over denatured alcohol, which can be purchased at a smaller cost. If he so wished he could make and dispose of eighty pints of synthetic gin, made from this five gallons of alcohol.

The opportunities of taking advantage of this amendment and the chances to make a little money or impress one's patients is too great and the results are deplorable to the medical profes-

sion, especially from an ethical or moral view. Physicians are obliged, according to their medical code and as citizens of the United States, to abide by the laws and constitution of the United States, and, therefore, have no authority whatsoever to issue liquor prescriptions except for medicinal purposes and these incidents are rare.

SURGICAL EDUCATION

One need not visit many of the small towns and cities throughout the state, and I presume throughout the United States, before one is impressed with the knowledge that many of the general practitioners have practically no limitations on their ability to treat the sick. It is true, that we have clinics, composed of specialists, who are doing very fine work, but they are far in the minority and in many cases ignored and hated by the general practitioner. In a small hospital in one of the cities of the state, I know of seven general practitioners who will undertake any type of operation and who have had the minimum amount of surgical education.

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Norman Barnesby, in "Medical Chaos and Crime", summarizes the situation very thoroughly with the following quotations: "Such cases of over confidence or criminal carelessness, and thousand of examples might be added, surely dispose of the idea that the only fault of our system lies in the preparation and training of the surgeon, and that when a high educational standard is set and maintained and all incompetents are weeded out, surgical outrages will be a thing of the past. This based on the assumption that all surgeons are possessed of superhuman attributes and hence should be amenable to now law. Surgeons are but men, influenced by various motives, subject to strong temptations. Granted a license, such as no other body of men possess, and restrained only by general social, and economic laws, and such interpretations as they choose to give to their self-imposed code of ethics, is it to be wondered at that

they assume an arrogant superiority towards the general public, and hence often come to value lightly the health and even the lives of the helpless folks who are so completely in their power? It is true that this very irresponsibility brings out, in some, the noblest and highest altruism, but only too frequently it breeds cruelty and criminal carelessness that is simply appalling to those who know.

It is true that things which were permissible or even commendable under past conditions, are at present high crimes and misdemeanors. With the opportunities now available in morgues and clinics to see and study living and dead pathology there exists no excuse for repetition of our former mistakes. We know that it takes more than the ability to cut and sew to make a surgeon. We know that a recent graduate, except in rare instances, is not competent even to operate. We recognize the wide distinction between the words "operator" and "surgeon". We know that skill, confidence and judgment in any vocation comes from constant repetition. We know that we, as individuals, would not select the occasional operator for ourselves or our families in any matter of serious import. We are capable of protecting ourselves; are not the public entitled to like protection?

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Dr. J. H. Percy presents an example of many young surgeons of today. Quoting from a paper published in the Illinois Medical Journal as follows: "There are too many men going into surgery as soon as they leave the medical school. I met one of them a few years ago. He had had his diploma just two weeks. He was an

average graduate of a medical school with a good reputation. This young man had not prepared himself specially for anything but good average work. He had not had the training of the average hospital interne, he had not served as assistant to a real surgeon, he had not got up his surgical technique by animal experimentation, he knew nothing of the practical application of sepsis or even antisepsis, neither had he learned in the great school of general practice; yet this doctor who was just two weeks out of the opera chair of his medical school, announced to me he was ready to cut anything, and he did. Circumstances favored him so that he got surgical cases, and for a year or two he was literally doing surgery. Is he doing surgery today? No. Surgery has done him. He is in a position now where he has to commence all over again if he was to become a surgeon. But he never will. Some of you say that he was a fool. No, he was not. If I thought he were, I would not have made him a part of this paper. Neither would I have mentioned this case if it were an isolated or uncommon one. But what I have just described is being enacted in scores of places not only in this state, but in every one of our states. If human life and suffering count for anything, as they do, then this is a condition of affairs that to put it mildly is unfortunate for the most desirable and truest advance of both internal medicine and surgery".

This situation can be bettered to a large extent by keeping a high standard in our medical schools, the requirement of a good internship and the teaching of medical ethics in our schools. Hospital privileges should not be extended promiscuously. The Amer-

ican College of Surgeons recommends that a doctor wishing to practice in a hospital should make a written application to the superintendent stating the name of the medical school he graduated from, his internship and his post graduate work. He should name 3 or 5 references in the community where he is practicing or has practiced. He should agree to abide by all the laws of the hospital. The hospital should have a medical staff and the chief of staff or the head of the hospital should consider applications and recommend appointments to the Board of Trustees and have them make the appointments. Appointments should last for one year. The hospitals should keep a record of doctors as to their professional efficiency and conduct.

The American Medical Association has attempted to create an interest in the teaching of ethics in our medical schools. They have sent to each senior of a class A medical school a copy of the "Principles of Medical Ethics".⁽⁴⁾ Jabes N. Jackson, past president of the Journal of the American Medical Association very fittingly describes the purpose and need of the "Principles of Medical Ethics". He states as follows: "The Principles of Ethics as promulgated by our association is an attempt to outline the pathway for conduct in human relationship, which shall make him, who follows it, worthy of that faith and trust on which our real standing must rest. It is a religion which, if understood, proposes to make a doctor a true christian in the discharge of his duties to his fellowmen and in the observation of his relation to his professional co-laborers. Knowledge alone is not enough. A scholar may yet be a scoundrel. One

may be wise and yet not worthy. Education and character must go hand in hand if the ideals of our profession are to be maintained. Is it not, therefore, obvious that our medical educational system should develop character as well as impart scientific knowledge."

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