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DEFINING THE ROLE OF THE PHYSICIAN: MEDICAL EDUCATION, TRADITION, AND THE LEGAL PROCESS

Robert L. Schwartz*
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I. INTRODUCTION

Physicians today are facing numerous and powerful attacks on the exercise of many of their most basic functions. If asked to identify one source most responsible for these challenges, many physicians would name the legal profession. Legal intrusion into the medical profession goes beyond challenges to the physician’s income; it threatens what many physicians believe to be the traditions that maintain their profession as a learned one and that distinguish it from other less principled and less socially responsible callings. Added to this are the incessant comments and questions issuing from yet another group, that new breed of philosophers, the bioethicists¹—a group which, unlike the legal profession, need not confront day-to-day professional ethical problems.

The professional conflict and animosity that have developed between the legal and medical professions are symptomatic of something that is basic and disturbing to the traditional science and practice of medicine. Even a cursory review of the literature will reveal that physicians, lawyers, philosophers, and others (with greater or lesser degrees of insight and awareness) are currently engaged in serious reevaluations of such concepts as the definition of medicine as science and/or art, the structure and administration of effective medical curricula, and the goals of the medical profes-

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¹ The discipline of bioethics has developed out of the disciplines of philosophy, law, medicine, anthropology, sociology, history, psychology, and politics, largely over the past decade. A good introduction to the development of bioethics is found in Callahan, The Emergence of Bioethics, in SCIENCE, ETHICS, AND MEDICINE (H. ENGLEHARDT, JR. & D. CALLAHAN EDs. 1976). An early and scholarly account of the nature of bioethical debate is contained in J. MONOD, FROM BIOLOGY TO ETHICS (1969).
sion itself. Such analyses require not only that physicians evaluate what they ought to be doing, a problem often relegated to economists, health planners, sociologists, and philosophers, but also that they evaluate what they are capable of doing. It is in defining this second kind of limitation that the traditional views of medical science, education, and profession, so carefully preserved and transmitted by physicians teaching and practicing at all levels, come into conflict with those of the legal profession. It is disconcerting that this redefinition of the medical profession is so little discussed by medical academics, and that a tradition-bound and possibly anachronistic definition of the medical profession, which ignores the substance of much of the contemporary debate, is so fundamental to medical education itself.

While the philosophical and legal intrusions into the medical profession are not themselves the sole causes for erosion of traditional medical authority, the specific and highly visible conflicts they provoke are instructive for uncovering the actual reasons for the current discomfort and confusion experienced by some physicians. In this year’s Shattuck lecture, Daniel Callahan offered an explanation for the resistance which many physicians have developed to the new interest in bioethics:

To be sure, physicians and medical researchers have on many occasions been resentful of the new laws and regulations to which they have been subjected. They have correctly perceived that the public’s discussion of ethics has been one important cause of that development. And they have not always been pleased to find lawyers and those called “ethicists” wandering about, often causing trouble, in territories they once considered their private preserve . . . I suggest that the primary reason for resistance is simply that, if ethics is taken seriously at all, it must force an examination of fundamental goals and assumptions. That is never a very pleasant enterprise, whether the impetus comes from ethics, the law, or any other sources. It is difficult enough to practice any complex discipline, even when agreement exists on its goals and purposes; there will still be some moral problems. But when moral problems are combined with uncertainty concerning professional purposes, the stage is set for considerable anxiety, suspicion, and resistance.²

If insecurity and anxiety are likely to be heightened by the

philosopher’s inquiry into the foundations and goals of the medical profession, it ought not be surprising that the lawyer’s inquiry into which professional goals might be beyond the professional competence of a physician has posed an even more immediate and personal threat to many doctors. Without question there is a high degree of personal as well as professional animosity between individual physicians and lawyers. The uninformed discussion of malpractice lawsuits by physicians who have heard rumors about them, as well as the ignorant discussion of physician error by lawyers who have spoken only with complaining patients, has added an unreasoned, sometimes hysterical, and almost mythical quality to the debate between the professions.

Because of the concrete nature of medical malpractice lawsuits, and because they are so often found to be without merit, doctors’ complaints about lawyers have most often been heard in the form of complaints about such legal actions.3 These complaints, which have come to be known collectively as “the malpractice crisis,” have been heard in the state legislatures across the country. Many state legislatures have assumed the “malpractice crisis” to be the problem of a tort law system which allows the greedy lawyer to prey upon the helpless physician (and, of course, upon the physician’s liability insurer).4 In acting to help the apparently disadvantaged physicians, legislatures have limited the time in which malpractice actions can be brought against doctors,5 the

3. For a popular account of these complaints, see Malpractice Nightmare, TIME, Mar. 24, 1975, at 62. See also Rubsam, Medical Malpractice, SCIENTIFIC AM., Aug., 1976, at 18. For a good summary of early academic and political analyses of the “crisis,” see U.S. DEPT OF HEALTH, EDUCATION, AND WELFARE, APPENDIX TO THE REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE (1973).

4. Every state legislature has fashioned some kind of legislation to deal with the perceived crisis. In every case this legislation has changed the normal tort law process, but only as it operates in actions brought against health care providers in their professional capacities. See White & McKenna, CONSTITUTIONALITY OF RECENT MALPRACTICE LEGISLATION, 12 FORUM 312 (1977). Interesting case studies of five state legislatures’ actions to deal with their malpractice crises, each written by a state legislator, can be found in GEORGETOWN UNIVERSITY HEALTH POLICY CENTER AND THE NATIONAL CONFERENCE OF STATE LEGISLATURES, A LEGISLATOR’S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 27-55 (1976). For a good analysis of the alternatives available to states willing to tamper with the tort compensation system, see Comment, An Analysis of State Legislative Responses to the Medical Malpractice Crisis, 1975 DUKE L.J. 1417. See also Abraham, Medical Malpractice Reform: A Preliminary Analysis, 36 Md. L. Rev. 489 (1977).

5. See, e.g., IND. CODE ANN. § 16-9.5-3-1 (Burns 1976); LA. REV. STAT. ANN. § 9:5683 (West Supp. 1981). The American Medical Association has sought to have state legislatures limit the time during which medical malpractice actions can be commenced. See 3 AMA, STATE HEALTH LEGISLATION REPORT 3 (Oct. 1975). For a general discussion of the various
amount of damages that can be awarded, and, in at least one state, the amount that can be recovered in fees by a successful plaintiff's attorney. Just as doctors resent legal trespass into what they have considered to be their sacred preserve of doctor/patient relationships, lawyers who practice in this area have deeply resented the medical profession's intrusion into their own traditionally private sphere of competence, the regulation of the private legal relationships established by the centuries-old tort system of compensation.

This focus on the most immediate and concrete area of physician/lawyer conflict—the battle over the legal treatment of medical malpractice—might suggest that the real problem between doctors and lawyers rests in their pocketbooks and not in their professional egos. But this is not true. The most bitter defendants in malpractice actions are not those physicians who lose their cases and are forced to watch their insurance carriers pay large judgments. More significant is the resentment of that large majority of malpractice defendants who successfully defend the lawsuits and are thereby vindicated. They resent the effrontery of being challenged in their ways the malpractice “crisis” could be ameliorated by modification of state statutes of limitation, see Comment, supra note 4, at 1429-1436.

6. A great number of states have limited the maximum dollar amount of recovery available to plaintiffs in medical malpractice actions. See, e.g., N.M. Stat. Ann. § 41-5-6 (1978), which essentially limits a plaintiff's recovery from physicians who come within the Act to $500,000 plus medical expenses. In some states such dollar limitations have been struck down by the courts. See, e.g., Wright v. Central DuPage Hosp. Ass'n., 63 Ill. 2d 313, 347 N.E.2d 736 (1976). See generally Redish, Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications, 55 Texas L. Rev. 759 (1977).

7. See, e.g., Ind. Code Ann. § 16-3.5-5-1 (Burns Cum. Supp. 1979), which limits the attorney's contingent fee to 15% of any recovery over $100,000 in most medical malpractice cases. In Pennsylvania an attorney who successfully prosecutes a medical malpractice claim may not recover as his fee more than 30% of the first $100,000, 25% of the second $100,000, and 20% of the remainder. Pa. Stat. Ann. tit. 40, § 1301.604 (Purdon Supp. 1980). In Tennessee any contingent fee in a malpractice action must be evaluated by the court and determined to be properly based on the “time and effort devoted to the litigation by the claimant's attorney, complexity of the case claim and other pertinent matters in connection therewith," and, in any case, it cannot exceed one-third of the recovery. Tenn. Code Ann. § 29-26-120 (1980).


9. As Dr. Edward D. Henderson, chairman of the Professional Services Committee of the American Academy of Orthopedic Surgeons, pointed out:

Physicians are not, by and large, insensitive and callous. They are trained carefully to make decisions which are hard and are trained not to show their emotions. It has not been recognized generally that being sued by a patient . . . is a devastating occurrence. All of us have seen what it does to our colleagues. Even when
own professional domain by those who do not share the special knowledge and social obligation that is traditionally imposed upon physicians.

Although some physicians see themselves economically threatened by the "crisis," such a perception is really more a consequence of the myth than any financial reality. Although insurance companies have dramatically increased their reserves to cover the malpractice avalanche which they still await, there is no evidence that the crisis has had any real impact upon the earnings of physicians. Members of both the legal and medical professions seem to be thriving. Whomever it may disadvantage, the "malpractice crisis" has been used to great advantage by health care insurers. Roberta Ritter, speaking about the "malpractice crisis" to a group of plaintiffs' attorneys, suggested that attorneys ought to be creating as much outcry over the $1.3 billion of health insurance premiums Blue Shield has kept, as the physicians did over the increase in malpractice action filings some years ago. That the increase in filing of malpractice actions may incidentally have some impact upon the income of either doctors or lawyers remains unproved and, even if it were proved, the impact would surely be shown to be insubstantial.

More important is an understanding of the two kinds of issues over which physicians and lawyers typically disagree. The first is that in which the medical and legal professions both claim exclusive competence and social responsibility, and where each profession's asserted expertise is simply inconsistent with the other's. These include, to one degree or another, the establishment of a standard for civil commitment of the mentally disabled, the determination of eligibility for payments based on medical disability, the determination of competency of criminal defendants to...
stand trial, the establishment of a standard for professional malpractice, and the treatment (or punishment) of drug addicts and alcoholics who participate in socially unacceptable conduct. To the physician, these are medical problems and their resolution requires medical expertise; to the attorney, these are questions the legal structure is erected to answer. These battlegrounds have made the harshest and most obvious inconsistencies in the legal and medical professions' self-images apparent. Here the distribution of authority between the professions, and thus the accommodation of the expertise of each profession, has been uneasy and incomplete.

The second class of conflicts includes those in which lawyers insist that doctors do not have the competence or expertise claimed for themselves. Examples are the attempts to limit the power of the Food and Drug Administration and state licensing agencies and to permit such medically unacceptable treatment as laetrile therapy and acupuncture. Other conflicts of this type involve refinement of the doctrine of informed consent, development of such "patient's rights" as the right of access to medical records, and, more generally, distribution of medical decisionmaking authority in such a way that the patient is the primary decisionmaker and the physician only an adviser. In discussing these issues, lawyers do not claim that physicians have usurped the lawyers' role, but only that these are public policy issues and not concerns of the medical profession alone. Although the first class of medical-legal conflicts involves more obvious and direct inconsistencies between the spheres of competence claimed by the medical and legal professions, the second group may be viewed as a more piercing attack on the foundation of the medical profession—the expertise (and the social obligation) to do all within the profession's power to make sick patients healthy. In essence, some physicians believe that they are being required to forego exactly that which they are ethically obliged to do. They see themselves as being reduced from the guardians of the community's health to something more like health technicians.

Although an occasional bioethicist is accused of redefining (and defiling) the role of the physician, the medical profession more often acts as if the legal profession itself has unilaterally acted to forbid physicians from ministering at the altar at which they were ordained. Physicians find it frustrating to be legally denied the right to do that which they are honor bound, by a long and sacred tradition, to do. It is this bind that is primarily responsible for the depth of the animosity between the legal and medical professions.

II. Medical Science, Education, and Profession

Much of the animosity directed at challengers from outside the medical profession stems from physicians' uncertainty about themselves and their own profession, which only increases proportionately as they avoid current debates in philosophy of science and biomedical ethics. There is at present a well-developed, ongoing process of reevaluating medicine on at least three levels. The first level is theoretical, in which the conceptual confusion in medicine is often pointed to as evidence for the need to reconsider the philosophical underpinnings of science as it contributes to medicine. While this level of analysis and criticism clearly precedes the other two, among physicians it is undoubtedly the least understood and appreciated of the three. The second topic of debate involves the education of doctors, in which serious doubts are being raised about the present system of structuring and administering medical education on the model of "hard sciences first, clinical activity second." Much is being written on this subject, and authors are beginning to realize that the root of their problem is the probably anachronistic model of science that is still uncritically accepted as the rationale behind most medical curricula. In spite of such insights, little real change is occurring in the majority of medical schools throughout the United States. Finally, writers are questioning the professional aspects of medicine, in which practicing and teaching physicians are facing a genuine challenge.

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16. Refer to text accompanying notes 20-27 infra.
17. Refer to text accompanying notes 28-30 infra.
to the traditional role they have been educated to assume.\textsuperscript{18} It is at this level that conflicts with other professions are most visible. Nevertheless, the defensive posture physicians assume, and their surprising vulnerability at a time when science and technology are perceived as having produced amazing victories over sickness and disease, can be understood and explained only when all levels of the debate are brought into focus and incorporated into the analysis. Physicians must study and contribute to what until recently was left mainly to philosophers—the philosophy of science and the analysis of medicine's place within and outside of science. Only on the basis of such a clear and sound understanding of the proper nature of medicine can a sensible and effective medical curriculum be established. And only within this context can a definition of the appropriate professional role of the physician be reconstructed.

A. Medicine as Science

As we have seen, physicians feel that the sanctity of physician-patient relationships is no longer respected; they are somewhat appalled at the presumptuousness of others who challenge the privilege of medical knowledge and profession. Often they are frustrated at not being able to persuade others that they, as physicians, are not only capable of, but obligated to define what is truly a "medical" problem, as opposed to legal, economic, and social concerns. How does one define "medicine"? What conceptual skills do physicians bring to a highly theoretical debate over the nature and limits of scientific knowledge? Recent discussions in the philosophy of medicine\textsuperscript{19} have emphasized the need for developing a new epistemology and metaphysics of medicine\textsuperscript{20} that recognizes medicine not only as a species of the biological sciences but as a member of the class of the human sciences as well.\textsuperscript{21} Such philosophical inquiry must precede any redefinition of medicine and its parts (such as concepts of disease, sickness, and health), and will

\textsuperscript{18} Refer to text accompanying notes 31-36 infra.

\textsuperscript{19} An entire journal, The Journal of Medicine and Philosophy, is devoted to learned discussion of this issue. Recently an entire issue was devoted to "Understanding and Explanation in Medicine" and other topics related to the issue of scientific method in medicine. \textit{5 J. Med. \& Phil.}, 1-97 (1980).

\textsuperscript{20} Spaeth & Barber, Homocystinuria and the Passing of the One Gene-One Enzyme Concept of Disease, \textit{5 J. Med. \& Phil.} 8 (1980) [hereinafter cited as Spaeth & Barber].

have direct bearing on the practical and clinical dimensions of effective patient care.\(^\text{22}\)

To this end, some philosophers have revived the distinction between “explaining” (Erklären) in science and “understanding” (Verstehen) as a useful paradigm for studying the several kinds of science embodied in medicine.\(^\text{23}\) “Explanation” is usually taken to mean causal explanation, as is found in discussions of the natural sciences. Implicit in these discussions is the underlying assumption that the events in natural sciences are “lawlike (nomological), that is, that there [are] universal, or at least general, laws or patterns in terms of which individual cases could be accounted for, or taken as instances of these laws.”\(^\text{24}\) Certainly to the extent that medicine is based on biology, chemistry, and the laws of physics in general, explanations or diagnoses made in this manner are legitimate. “Understanding,” on the other hand, emphasizes that human behavior and/or states (the proper object of study for the human or social sciences) are never fully comprehensible or explicable in terms of lawlike or mechanistically causal phenomena. Intentions, agency, consciousness, choice, self-awareness—phenomena outside the domain of the natural sciences—must be considered, and the account that results will be in terms of “reasons” rather than causes.\(^\text{25}\) As one writer notes:

In a clear sense, medicine stands at the center of this methodological distinction and exhibits the differences aimed at in interesting ways. Thus, on the one hand, the physician as a natural scientist may infer a patient’s condition from such nonsubjective data as blood count, pulse, and the whole range of objectively measurable or examinable properties of the organism qua organism. On the other, the physician as an interpreter of other human beings may come to know a patient’s condition by a sort of empathetic sense or experientially developed intuition of what the condition feels or looks like (as, e.g., in clinical judgments arrived at from

\(^{22}\) Spaeth & Barber, supra note 20, at 8.

\(^{23}\) The terminology derives from a distinction first introduced in the latter half of the nineteenth century by George Simmel, Wilhelm Dilthey, Max Weber and others—theorists who were attempting to redefine the nature, scope, and standing of the sciences and disciplines which focused specifically on the human milieu as distinct from those which focused specifically on the nonhuman sphere of physical nature. In this, they were reacting against the prevalent trend of their times, one which continues to the present. Wartofsky & Zaner, supra note 21, at 1.

\(^{24}\) Id.

\(^{25}\) Id. at 2.
the way a patient looks, or a patient's expression, or even from some kinesthetic or proprioceptive insights which the physician brings to bear as a human being "understanding another human being.)"

Physicians participating in an analysis such as the one just presented may be persuaded to reappraise their own philosophy of medicine as science, and to experiment with other models which suggest a more interpretive, less deductive and authoritarian approach—models which acknowledge that the uniqueness and individuality of concrete cases (i.e., patients) as opposed merely to their statistical significance, ought to be a primary concern of medical science. Appreciating the limits of the traditional hypothetico-deductive model of science as applied to medicine does not automatically limit the physician's ability to provide scientifically justified and sound care for the patient. Indeed, quite the opposite is true. By abandoning, for example, disease theories which are no longer adequate, (e.g., the "single cause" theory), and by investigating alternative problem-solving and decisionmaking models, the domain and power of science are actually expanded. Furthermore, before physicians can respond successfully to challenges that would limit their capacity to define the substance and boundaries of medical issues, they must have a clear idea of just what such a definition must contain. Such an idea requires knowledge of the proper domain of medical science, as well as its limits. Physicians must realize that knowledge of one's own limits contributes significantly to one's power, and to one's ability to explain and persuade.

B. Medical Education

The passing on of the traditional definition of medical science as Erklären is perhaps nowhere more complete and thorough than in most medical schools in the United States. The works of Abraham Flexner, noted author of medical education studies, are often cited as the reason for this. A brief look at most medical curricula supports the truth of the proposition:

The basic sciences are the first instruction given to medical students: they are regarded as the essential foundation for later professional competence. Medical students are allowed to proceed to

26. *Id.* at 3.
clinical studies only when they are deemed to have learned the science subjects. And they are taught to hold science in the highest regard, the progress of medicine in the 20th century viewed as a consequence of the spectacular development of physics and chemistry in the 19th.\textsuperscript{28}

Most of these students, admitted into medical school because of a previous commitment to and training in the basic sciences, are not even aware of the philosophical/scientific debate over alternative medical models, and there is scant evidence that significant curricular changes are occurring as a result of that debate.

It is generally acknowledged that the practice of medicine is at least as much art as science, practice as theory. In fact, many argue that medicine as practiced successfully is largely a problem-solving, decisionmaking enterprise involving not only explanatory devices delineating causes, but managerial decisions involving choices among a number of treatment therapies for specific individuals. Yet, courses that address these activities in detail are nearly always added on (usually in the last two years) rather than made a central and governing feature of the standard medical curriculum. Faculty members are hired, retained, and promoted according to this hierarchy of values; funds are available more often for basic science research; and medical students, notorious for the importance they place on rolemodeling, perpetuate the tradition accordingly:

The spirit of medicine is that of service, one that is not foreign to the technologist but to which the scientist gives only a grudging allegiance. In the medical endeavor, science and technology, rightly used, are only hired servants. There are clear signs that the servants are taking over control in the master's house.\textsuperscript{29}

As a result of their education, the relative values placed on the several dimensions of medical practice, and the kinds of skills emphasized as most important for success as a physician, new physicians often find themselves without the conceptual tools and information necessary to understand and resolve the conflicts that question their competence and authority to practice their profession as they were taught. Rather than anticipate, they are prepared

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\bibitem{28} Editorial: Medical Science, Medical Service and Medical Education, 14 Med. Educ. 1 (1980).
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only to react to each challenge as it arises. It is no wonder that physicians feel trapped in a never-ending series of legal and social skirmishes that continually encroaches upon their traditional domain.

C. Medical Profession

To repeat, physicians see their profession as under attack from sources external to medicine. We have shown the degree to which internal confusion and uncertainty contribute to the vulnerability of the medical profession, but there has unquestionably been a shift in the public’s perception of the nature of the profession as well. Most would agree that medicine, and perhaps science itself, has become a “socially accountable institution,” a fact physicians regularly acknowledge with varying degrees of resentment and resignation. In fact, the largest medical and legal professional organizations have recently been engaged in rewriting their codes of ethics, suggesting that both professions recognize that their roles in this society have changed.1

The American Medical Association’s House of Delegates has done far more to recognize the new professional role of physicians in the Principles of Medical Ethics promulgated this year.2 In this document the organized profession clearly, albeit reluctantly, shows the scars of its encounters with the courts, and the profession does make an attempt to resolve some of the internal professional conflicts that depend upon the definition of the role of phy-

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31. Attorneys have been chastised by physicians and others for their roles as mere mouthpieces in the resolution of social problems. Not surprisingly, then, the Commission on Evaluation of Professional Standards (the Kutak Commission) has drafted a report for the American Bar Association that would alter the formal professional standards adopted by that organization to focus more on the role of an attorney as an officer of the court, with obligations beyond those imposed by the whim of a paying client. Despite the modifications that might be imposed by the new code, the role of the lawyer is still based primarily on the obligations defined by George Sharswood 125 years ago: “The lawyer who refuses his professional assistance because in his judgment the case is unjust or indefensible usurps the function of both judge and jury.” G. SHARSWOOD, LEGAL ETHICS 84 (1854). Indeed, many believe that the Kutak Commission has done a successful job of clarifying the ethical rules of the lawyerly road without changing the course of that road at all. See Luban, Professional Ethics: A New Code for Lawyers?, 10 Hastings Center Rep., June 1980, at 11.

sicians. Although some time ago the AMA abandoned the strictly paternalistic role it established for itself in its first set of ethical principles, promulgated in 1847, which demanded that medical doctors “study . . . in their deportment, so as to unite tenderness with firmness, and condescension with authority,” the new principles provide a more radical reappraisal than most physicians expected. The newly adopted Principle IV, for example, provides that “a physician shall respect the rights of patients, of colleagues, and of other health care professionals, and shall safeguard patient confidences within the constraints of the law.” Not only does this principle mark the AMA’s first formal adoption of the “rights” language of the law, it also recognizes that as a matter of principle, the ethical physician must act in accord with whatever the law may require. Conflicts between what is traditionally required of a good physician, and the requirements of law, are to be resolved in favor of the law. This change in the medical profession’s self-image is a consequence of the realization, first stated in an early publication of the committee established to draft the Principles of Medical Ethics, that “[t]he medical profession is no longer perceived as the sole guardian of the public health, and consequently the traditional paternalism of the profession is in conflict with society.” That this substantial alteration in the medical profession’s self-concept should be so consistent with the legal profession’s challenges to the doctors’ view of their own competence is not merely fortuitous. The legal profession is in great part responsible for changing the self-image and the role of physicians.

III. LAWYERS, THE LAW, AND THE DEFINITION OF PROFESSIONAL MEDICAL COMPETENCE

The conflict between doctors and lawyers goes to the heart of the role to be played by each profession. It strikes at the epistemology, traditions, and moral requirements each profession imposes upon its practitioners, and is much more than a simple economic disagreement.

Because of the long tradition within the medical profession of viewing the calling as something much greater than a simple business, coupled with a strong yet little understood faith in the power

33. Id.
34. Id. at 17.
35. Id. at 18.
and glory of medical science, the lawyers' attack on the professional rights and obligations of physicians stings at least as painfully as would an attack on the financial rewards of the profession. Roscoe Pound, Dean of Harvard Law School and a great scholar of the legal profession, defined "profession" in such a way that it was clearly differentiated from the economic incentives of commerce:

By a profession, such as the ministry, medicine, law, or teaching, we mean much more than a calling which has a traditional dignity and certain other callings which in recent times have achieved or claimed a like dignity. There is much more in a profession than a traditionally dignified calling. The term refers to a group of men pursuing a learned art as a common calling in the spirit of public service—no less a public service because it may incidentally be a means of livelihood. Pursuit is the primary purpose. Gaining a livelihood is incidental, whereas in a business or trade it is the entire purpose. Thus, if an engineer discovered a new process or invented a new technical device, he may obtain a patent and retain for himself a profitable monopoly. If, on the other hand, a physician discovers a new specific for a disease or a surgeon invents a new surgical procedure, they each publish their discovery or invention to the profession and thus to the world. Historically there are three ideas involved in a profession: organization, learning, i.e., pursuit of a learned art, and a spirit of public service. These are essential. A further idea, that of gaining a livelihood is involved in all callings. It is the main if not the only purpose in the . . . money-making callings. In a profession it is incidental.36

Perhaps recognizing that many might be pulled astray by financial incentives, Dean Pound suggested that "pursuit [of riches] is held down by traditions of a chief purpose to which the organized activities of those pursuing the calling are to be directed primarily . . . ."37 This suggests that what defines the profession is not the rights accorded to learned societies, but rather the obligations imposed upon them by the traditions of their calling's "chief purpose." As the "chief purpose" of the medical profession becomes less clear, and as the traditions which define it are more often subject to successful attack, it is not surprising that many who practice the profession have felt the insecurity demonstrated by the new Principles of Medical Ethics.38 If doctors can no longer fulfill

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37. Id. at 5.
38. Refer to text accompanying notes 31-36 supra.
the requirements of their traditions, is their calling reduced to a trade, no different than plumbing or automobile repair? That insecurity, not financial instability, is perceived as the real threat to the profession.

It is not surprising that the legal profession's attempts to define the limits of medical competency have been only weakly opposed by physicians, who are uncertain about their own professional role. First, the "rights" language that has passed from the law to medicine provides an easy way to analyze many of the problems that the medical profession cannot otherwise resolve simply. After all, "it is far easier simply to talk about the rights of individuals to make their own decisions or about the establishment of public procedures to adjudicate among contending values and interests than to talk about what individuals ought to do when they make personal moral choices." The medical profession has been seduced by the legal profession's more persuasive definition of the role of physicians; it has taken the easiest cure for its insecurity even though that cure may require that it limit its own professional realm and leave unresolved the basic problems.

This new image of a more limited profession has not found its way into medical education, which remains within the private control of the organized profession and still inculcates in its students the traditional notions of the substance of medicine and the role of the physician. The absence of courses taught by attorneys (or other professionals) in the curricula of most medical colleges has insured that the interaction between doctors and lawyers which has pervaded the practice of medicine does not reach medical students. In turn, this has insured that each new generation of doctors must confront anew conflicting definitions of the doctor's professional role. While the AMA has redefined the role of the doctor to be consistent with legal requirements, students at medical schools

39. Callahan, supra note 2, at 1230.
have been told that they have the power that traditionally was claimed by the medical profession—the mastery of disease and pain, and the obligation to treat disease and pain as they are taught is appropriate.

This is not to say that the model of the ethical physician that still serves to define that role to medical students is an anachronism, nor that the medical profession has completely capitulated to the law in allocating the authority to define medical professional ends. Indeed, the AMA's decision to restructure the Principles of Medical Ethics does not indicate that the profession has succumbed to legal pressure to abandon all of the profession's fundamental tenets. Where the medical profession has found a legal resolution of a problem to be inconsistent with the most basic requirements of traditional ethical practice, it has refused to accede to the legal demands. For example, at the same meeting at which the AMA was reworking the Principles of Medical Ethics, it strongly opposed medical participation in the imposition of capital punishment by intravenous drug injection, even though several state legislatures had found that method of execution to be more "humane" than any other alternative. The flat refusal to sanction medical participation, which might be necessary to perform the lethal injection, was based on the essential inconsistency between such participation and the traditional injunction that the physician must "do no harm."\footnote{The authors contend that medical participation in capital punishment by administration of such injections is inconsistent with international ethical principles such as those contained in the Declaration of Tokyo, adopted by the World Medical Association in 1975. The Board of Trustees of the American Psychiatric Association has taken the formal position that "active medical participation in capital punishment would violate [the principles of the Declaration of Tokyo]. The physician's serving the state as an executioner, either directly or indirectly, is a perversion of medical ethics and of his or her role as healer and comforter." Position Statement on Medical Participation in Capital Punishment, 137 AM. J. PSYCH. 1487 (1980).}

Opposition to legal intervention in the doctor/patient relationship has sometimes resulted in the reaffirmation of the traditional paternalistic model of that relationship. For example, psychiatrists have successfully fought attempts to equate involuntary commit-
ment of the mentally disabled with incarceration of the criminally convicted. Their constant and almost unanimous opposition to the imposition of the "beyond a reasonable doubt" standard of proof in such cases was finally vindicated when the Supreme Court held that the Constitution requires that commitment standards be met by "clear and convincing evidence," a less demanding burden than the "beyond a reasonable doubt" standard employed in criminal cases.  

Last term the Supreme Court announced that the constitutional process due to a child involuntarily committed to a mental hospital could be satisfied by a physician making a medical judgment. Indeed, the debate fostered by the legal attack on the abuses of civil commitment procedures has caused psychiatrists to suggest creative statutory schemes which formally sanction medical paternalism while they also claim to protect the legally defined interests of the patients. The attempt to find a way to vindicate both the traditional medical model and the restraints imposed by the lawyers' "rights" model is surely encouraging, and we might expect similar attempts at accommodation of the professions' differing principles in the areas of medical evaluations of legal disabilities, determination of competency of a criminal defendant to stand trial, and determination of parental fitness in child custody matters, just to name a few areas. Unfortunately, because the determination of competence has not traditionally been considered to be part of the role of the physician, these issues are rarely within the curriculum at medical schools.

The least successfully opposed legal intrusion into medical decisionmaking has been in the allocation of authority to make treatment decisions. Because the notion of patient-controlled healing is now so well established as a matter of law, the issue has been raised most often in a context of decisionmaking for the incompetent patient. In the now famous case, In re Quinlan, for example, where the court removed some decisionmaking authority

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46. Indeed, this is the whole purpose of the doctrine of informed consent. It is founded on the premise that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). It has been recognized in virtually every jurisdiction.
that had traditionally rested with the physician, the court also formally recognized the importance of having physicians participate in decisions in ways that do not call upon their technical and engineering expertise, but instead require them to make essentially ethical decisions. In *Quinlan*, the Supreme Court of New Jersey concluded that the lower court correctly held that "the nature, extent, and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of a physician. What justification is there to remove it from the control of the medical profession . . .?" In that watershed case the ultimate decision was not to be a judicial one, because reallocating medical decisionmaking would constitute a "gratuitous encroachment upon the medical profession's field of competence . . . ." The decision was left to the guardian and family of the patient, the patient's physician, and a hospital ethics committee. Just what the ethics committee was to do remained unexplained, and the decision was widely (and correctly) viewed as a formal, necessary, legal determination that removing Karen Quinlan from a respirator would be proper. In other words, by providing a formal legal procedure for approving such determinations, the court turned what had been a medical decision into a legal one, even though it claimed that it did not do so.

The Massachusetts Supreme Judicial Court, which has been the single most important force in developing legal standards to be applied to bioethical issues over the past few years, has not been certain where to locate the power to make bioethical decisions. Three years ago the court said that questions of life and death were not to be left to the medical profession because they "require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility . . . and is not to be entrusted to any other group purporting to represent the 'morality and conscience of our society' . . . ." Two years ago in

48. Id. at 48, 355 A.2d at 668.
50. 70 N.J. at 50, 355 A.2d at 668.
the celebrated Chad Green case,\textsuperscript{53} the court did find an independent "state . . . interest in protecting the ethical integrity of the medical profession, and in allowing hospitals the full opportunity to care for people under their control."\textsuperscript{54} This legally recognized state interest in maintaining whatever ethical standards physicians set for themselves is apparently entirely independent of the patient's interest in otherwise desirable treatment.

Today the Massachusetts court is willing to admit that treatment decisions for incompetent patients might be just the kinds of decisions that require medical participation. In the case of Earle Spring,\textsuperscript{55} the family of a terminally ill dialysis patient sought to have the patient, who had grown unable to recognize even his family, cease dialysis. This surely would (and did) lead to his death.\textsuperscript{56} The court, although deciding that the termination of treatment would be appropriate, announced that the case need not have come through the courts at all; it said that this was just the kind of decision a family ought to be able to make, at least if the decision also comported with the expectations of generally accepted medical morality.\textsuperscript{57}

So, while the law has indeed taken it upon itself to determine what a physician is competent to do, and while the law has been willing to define that competence in terms of the public policy allocation of decisionmaking authority, the courts are also willing to recognize a social interest in allowing physicians to act ethically, as physicians define ethical conduct. This kind of resolution of the problem—a legal recognition of a sphere of medical expertise that goes beyond technical expertise—would surely be enhanced by the dispassionate and academic discussion of the role of physicians and their relationship to the role of attorneys. Unfortunately, there is no such discussion at medical schools today because medical educators do not view resolving such problems as being within the professional scope of the physician. Once again it appears that the professional animosity between doctors and lawyers can be traced to the medical school curriculum.

Professor Robert Burt suggests that both the legal and medi-
cal models of medical decisionmaking are built on the premise that the sick person is one in need of protection, and each simply offers a different kind of protection.\textsuperscript{56} Both doctors and lawyers are acting on a model of benevolence to the sick. But, asks Burt in his introduction, “whose claim of benevolence towards diseased people is to be believed?”\textsuperscript{59} He answers that “[n]o one’s claim should be wholly believed or disbelieved, whether the claimant is physician or law reformer, judge or the diseased person himself.”\textsuperscript{60} The question of how problems are to be resolved remains, however. What should be done when a patient and a physician disagree on a course of treatment? Professor Burt suggests that the resolution lies in an understanding of each participant’s position. In the end, he implies that where the medical model would dictatate treatment (or its absence), and the patient and his family oppose treatment, there can be no resolution. Without consensus, nothing ought to be done.\textsuperscript{61} Perhaps serious dialogue between the legal and medical professions, like Professor Burt’s presumed dialogue between doctors and patients, would yield the discovery that both are sometimes attempting to apply the same model, and that, properly understood, both are seeking the same end.

However, as every doctor/patient confrontation in court reveals, doctors and patients sometimes have genuinely inconsistent interests. These same confrontations also demonstrate that the legal and medical models for resolving these disputes are not only different, but sometimes inconsistent. Ultimately, the resolution of these problems is squarely within the mandate of the court, and the legal profession will be called upon to resolve these problems in cases which do directly attack a doctor’s decision or proposed decision. These are the cases that get to court and into the lawyers’ hands. Ultimately, then, it must be the legal model that will, at least in these cases, define the role of medical professional competence.

This should not be disconcerting to the physician. The point that the angriest physicians have not observed is that the law is willing to give great weight to the physician’s principled arguments

\textsuperscript{58} R. Burt, Taking Care of Strangers: The Rule of Law in Doctor-Patient Relations (1979).
\textsuperscript{59} Id. at vi.
\textsuperscript{60} Id.
\textsuperscript{61} Id.
defining the role of medicine. That the decision is, finally, a legal one, does not mean that it does not involve physicians, nor that the physicians' view of their own role will not prevail. Physicians must be able and willing to participate in the debate, however, and must consider it not only part of their professional responsibility but within the unique competence of the medical profession as well. Since exposure to the various philosophies of medical science, art, and responsibility are systematically excluded from a doctor's professional education, it is not surprising that most new doctors do not view participating in social policy and legal debates, especially those which seek to redefine their professional role, as within their competence. Even more disconcerting to the doctor is the manner in which such debates are conducted; challenges, questions, and debate are fundamental to the legal process, but are foreign and patently threatening to physicians whose professional identity is closely linked to the traditional (albeit unexamined) medical model. Many physicians consider the debated issues to be contrived and mischievous, or at least peripheral in significance. For these issues to be resolved, however, and for doctors to be satisfied with the resolution, doctors must participate in the debates. They must realize that these issues, far from being peripheral, are generated at least as much from within medicine as from without; and they must recognize that participation in the debates is indeed part of their professional competence. Medical education must focus on the substance of these issues, and physicians must arm themselves with the intellectual tools necessary to direct public discussions of the philosophical, ethical, and legal dimensions of their profession with the same degree of confidence, expertise, and facility with which they diagnose and treat medical conditions.
