

Professionalism: Looking For Your Blind Spots

Robert K. Kamei,¹MD

In 1996 a major breakthrough was reported in the medical literature. A 5-week ectopic pregnancy was re-implanted into the uterus via the cervix, and the fetus was successfully carried to term. Dr Malcolm Pearce, Senior Lecturer at St. George's Hospital Medical Centre was credited with this medical achievement. The event was published in the *British Journal of Obstetrics and Gynaecology*, on which Pearce served as an assistant editor. The second author was Professor Geoffrey Chamberlain, who at the time was the head of Dr Pearce's department at St George's, President of the Royal College of Obstetricians and Gynaecology, and editor of the journal. In the same issue of the *British Journal of Obstetrics and Gynaecology*, Dr Pearce published the results of a 3-year, double blind randomised clinical trial, in which 191 women, prone to miscarriage, were treated either with the hormone human chorionic gonadotrophin, or with placebo.

After the results of the 2 studies were published, a physician at St George's Hospital questioned the research, wondering how it could have been possible that she had not previously heard of the studies. A subsequent investigation could not find the patient with the ectopic pregnancy, or the patients in the randomised trial. Professor Chamberlain stated he did not know the paper was fraudulent, because he was not involved with the research or writing the paper, but he had agreed to sign as an author because Dr Pearce had asked him to do so. It was further discovered that 3 other studies by Pearce were fraudulent. Because of the scandal, Professor Chamberlain was forced to resign from his prestigious posts, bringing an unfortunate end to his otherwise illustrious career.

Unfortunately, the medical profession in Singapore is not immune to such publicised lack of professionalism. For several weeks in August 2006, newspaper headlines reported to the Singaporean public about some physicians inappropriately selling buprenorphine (Subutex, used to help rehabilitate drug addicts) to patients expressly for profit.

When one thinks about professionalism in medicine and science, these dramatic examples are what usually leap into

mind; these instances have tremendous implications not only for individual patients but also for society in general. As patients lose faith that physicians will act in their best interests, their respect for the profession fades. Without this respect and trust, caring for patients becomes more challenging and less enjoyable. Patients may reject treatments that are in their best interest, or demand therapies of little benefit and potential harm to them. Published studies based on fraudulent data may convince physicians to utilise treatments that do not help, and may even harm their patients.

While it is easy to criticise these individuals and distance ourselves from these "bad apples", perhaps there are reasons why we should not feel so smug.

A study by Todd et al¹ in 1993 looked at the use of analgesics for isolated long bone fractures in an emergency room in the United States. They compared the dose and class of analgesics used for white patients compared to Hispanic patients. They found a huge disparity in that 25% of the time white patients did not receive any form of analgesia, compared with Hispanic patients who, 54% of the time, did not receive any analgesia. White patients received narcotic (i.e., opioid type) analgesics 68% of the time, compared with Hispanics, who only received them 45% of the time. How can we explain these differences? Even if you take the likely assumption that the physicians in this study were well meaning, radical differences were found in the care provided to the 2 races.

Unfortunately, health disparities defined by race (ethnic origin) are a well-established phenomenon in the medical literature. In 1999, Schulman et al² showed videos of standardised patients who were identical in all aspects except for race and gender to 720 physicians. The African American patients were rated as having a lower income, despite having the same occupation as white patients. African-American patients were 40% less likely to be referred for cardiac catheterisation; the lowest rates of referral were for African-American women. Lurie et al³ reported that one-third of cardiologists believe there are racial or ethnic discrepancies in the care of heart patients;

¹ Duke-NUS Graduate Medical School Singapore

Address for Correspondence: Dr Robert K. Kamei, Vice Dean of Education, Duke-NUS Graduate Medical School Singapore, 2 Jalan Bukit Merah, Block 5, Singapore 169547.

Email: robert.kamei@gms.edu.sg

whereas only 12% felt that these discrepancies occurred in their own hospital or clinic and, only 5% believed that such disparities existed in their own practice.

In 2000, Wazana⁴ reported, in an analysis of 29 published studies on physicians and the pharmaceutical industry, that those physicians accepting gifts believe that the pharmaceutical representatives have no impact on their prescribing behaviour. However, being provided with professional samples from the pharmaceutical industry, in general, was associated with positive attitudes toward the industry. Also, physicians who accept drug company sponsor funds to attend a symposium, for example, correlated with the physicians' writing more prescriptions in favour of the sponsor's drug.

What are the lessons that we should learn from these studies? Should we assume that the physicians in all of these studies were somehow different than us? Instead I suggest the opposite: that these studies demonstrate that physicians are indeed like everyone else, and that we all have our own blind spots. No one is immune to these blind spots, and to deny that these blind spots exist because we "can't see" them, is both ludicrous and dangerous.

Cohen⁵ points out many different current threats to medical professionalism. The unwelcome changes in medicine have made physicians feel that "The promises made to them at the beginning of their careers have been broken. Maintaining a commitment to the values of a profession that one believes has reneged on its promise is understandably difficult." Some of the valuable improvements in medical practice, as shown by commercial marketplace techniques (focus on patient satisfaction, quality improvement techniques), as well as recent US regulations for trainee work hours ("time-clock medicine"), can lead physicians to the unjustified conclusion that medicine is "just a business". Professionalism suffers when commercialism is used as the primary ethic, rather than the responsibility of acting first for the patient's benefit before one's self interest ("First do no harm").

These studies do not prove that US physicians are unprofessional or racist. That conclusion would be too simplistic. Instead, they speak to the fact that physicians are no different than the rest of humankind. We all have our blind spots. Unprofessional acts in everyday practice are

much more subtle than the ones that make newspaper headlines.

So how do we recognise these blind spots? We need our physician colleagues to help us visualise these blind spots. The recent conference on "Professionalism in Medicine", organised by Singapore General Hospital provided a critical opportunity for an open discussion with colleagues from various perspectives. This Conference, and others like it, requires physicians to take time out of their busy patient care practices to reflect on what they do in everyday practice.

Other people more easily see a person's blind spots. For example, as a relative newcomer to Singapore, I see the practice of physicians filling their own patients' prescriptions in their offices as something not done in the USA or the UK, and as a potential blind spot for those practitioners. A set of ethical and professional guidelines that have been debated and agreed upon can be of great help to physicians looking for their own blind spots.

Professionalism is of the highest importance to the entire field of medicine; we have much to lose if the public questions our professionalism. I applaud the efforts to feature this important subject for physician self-reflection and to encourage future public discussion. The time spent working on professionalism may not seem to improve daily clinical productivity, but the rewards can be greater than imagined: better care for your patients and an even more satisfying practice for yourself.

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