Taking Harm Reduction into the Clinic

David Konopka, MS I

Should we teach abstinence-only sex education or pass out condoms in our schools? Should we impose harsher penalties on heroin users or should every major city have a syringe exchange program? What about prostitution? Is it better to crack down harder or to legalize it?

Every one of the questions in the previous paragraph is an example of harm elimination versus harm reduction. They are public policy debates. These are huge issues that we as medical professionals do not have to deal with on a daily basis (though we can, and should, be involved in these debates). Yet the underlying issue, the argument between harm elimination and harm reduction, is something that many of us will deal with on a regular basis.

At first glance, harm elimination, or the cessation of harmful behavior, seems to be the more desirable option. However, it is often unrealistic. We live in an imperfect world. Many teenagers will have sex despite what their parents might want. Men and women will inject drugs, knowing full well that it will harm their bodies and shorten their lives. Women will sell their bodies, even though they are fully aware of the danger that they put themselves into. These are realities of life, and thinking that we can persuade everyone to cease these high-risk behaviors is naïve at best.

Harm reduction is a public health paradigm that recognizes the reality of participation in high-risk behaviors in contemporary society. It addresses the dangerous consequences that these behaviors can have on people’s lives by minimizing the associated harms. Often, the rationale for engaging in high-risk behaviors is far from simple. It includes such factors as economic class, social class, past trauma, social isolation, upbringing, and many others. We cannot hope, in the span of a short office visit, to fully understand their motivation, nor is that even our job.

As practitioners of medicine, our first and foremost objective is to improve and maintain the health of our patients. Some of the time, this will be very simple and straightforward. We will see some patients who take good care of themselves, never smoke, rarely drink, and are in fantastic health. When we see unhealthy behaviors, sometimes it is still easy to confront. We encourage the smoker to quit, recommend a nicotine patch or gum, and send him on his way. If he finds it difficult to quit, but is still willing to try, then we can at least assure him that cutting back to half a pack a day will reduce the harm that he is doing to his body. Even when confronted with a drug abuser who wants to quit, the healthcare system is set up to make our job easy. We write a referral to a rehabilitation clinic, shake her hand, and know that she will get the help that she needs. But what about the patient who does not wish to quit a high-risk behavior? What about the heroin addict that does not want to quit?

Unfortunately, there is no easy answer to that question. However, I would argue that this is precisely the situation where we must apply the principles of harm reduction. Rarely, if ever, can we hope to fully understand the patient’s motivation for engaging in harmful behavior. Perhaps he injects heroin because it is the only way that can escape his isolation. Maybe she drinks alcohol to escape...
from a life that she does not want. Perhaps he has sex with multiple partners because the rush is the only thing that enables him to feel as if he is alive. These are unhealthy behaviors, but we cannot force them to quit. We can, and should, urge the cessation of such behavior, but eventually we must accept that there are things we cannot control.

This is when we must remember that our primary goal is to improve or maintain the health of our patients as best we can. We must work with our patients to find ways to minimize the harm that they do to themselves. If a patient does not wish to try to quit smoking, then we can at least encourage the use of filtered cigarettes. We could even urge him to switch to smokeless tobacco, which, while still harmful, does not appear to have as many adverse health effects as cigarettes.

Harm reduction has been gaining acceptance in the public health field for years. Some of its more well-known—and successful—efforts are the Designated Driver campaign and the rise of syringe exchange programs. Its presence in medical practice, however, is far less obvious. There are certainly some aspects of modern medicine that use similar principles. Physicians often work with patients to reduce their risk factors for certain diseases. Whether it is losing weight, lowering their blood pressure, or avoiding the sun more, these are behavior modifications made in an effort to avert a harmful outcome.

Unfortunately, our medical education does not focus on harm reduction. We simply learn that being obese is a risk factor for diabetes, and that losing weight reduces that risk factor. We do not learn the principle behind it, and we are not taught how to apply it, beyond a few examples given above. I would, therefore, urge each and every medical practitioner to do some more research into the subject and to keep these values and theories in mind. Harm reduction is not a final goal; it is a beginning. Think of harm reduction as a way of helping your patient until they are ready to truly help themselves and cease their harmful behavior. When confronted by a patient engaging in risky and harmful behavior, purposely and intentionally think about not only how to convince the patient to cease the behavior, but also how to help the patient minimize the harm done by the behavior. It can only help to improve their health.

All My Love Always
Ashley Weber, MS1

I was my grandfather’s “best girl”. Technically, we all were his best girls; he often said that his favorite was whoever was standing in front of him. He was a retired fire chief of La Habra, California and had worked at Armored Transport on his off-days. As his family grew, the walls of his house, the tabletops and even the coffee mugs became decorated with pictures of my cousin Lauren at the zoo or baby Jack on the day we picked him up from Guatemala. Papa instilled in his children a strong value of family and a Protestant work ethic. He never raised his hand and rarely raised his voice. It was unnecessary; each of us would have

“My grandfather was not defined as the frail person in need of a warm blanket, and nor was anyone else”

rather died than hear him express his disappointment. During holidays after saying grace, he would retreat to his armchair and listen to the lively and often chiding conversation. He was the safest there. The kind old firefighter had managed to raise three headstrong women who were soon joined by their three precocious daughters. He was outnumbered. Papa’s sock drawer hid a penchant for Snickers bars. He liked the History Channel and loved his irises.

This is the man I remembered when I walked into Mission Hospital on Sunday. The hospital is a familiar place, with the white walls, uniquely stringent yet stuffy smell, and the appropriately friendly nurses. I had walked into hundreds of hospital rooms before, always to greet patients with the
same polite smile. They all seemed similar, my former patients. They all wore the same uniform of faded cotton, their grey hair pushed back off their face as they waited for the physician. I had recognized that each was unique, but my appreciation of their individuality was limited to being in their presence. This time, however, when I walked into the room and saw the old man with labored breathing, his head tilted to one side from a poorly positioned pillow, it was not just another patient in white. He wasn’t just another somebody-else’s-grandfather with chapped lips and a Foley catheter. He was my grandfather, with an IV tapped into my blood, whose fears were my fears, and whose burdens were my own to carry. Looking at him, I began to understand my conviction to be a physician. The patient was not just a body with a problem to be solved. They were a product of God’s own creation in need of help so that they could continue as that special individual doing whatever it was that occupied their life outside the hospital walls. My grandfather was not defined as the frail person in need of a warm blanket, and nor was anyone else. This was simply a situational limitation on an otherwise whole and complex human being. It was seeing my grandfather as a patient that allowed me to see my patients as grandfathers, sisters and friends.

I had always felt sorry for the nurses when they went in to reposition a patient. I understood it was their job and that it was necessary to the patient’s health, but I never felt excited to help brush someone’s teeth or bathe someone. I viewed it as a child might view emptying the garbage, a necessary chore that mattered but could be put off. It was Papa’s stubble that caught my attention. “Who shaved Papa’s face?” I had asked, knowing that he had been in the hospital for seventeen days. “A nice young man named Cleveland,” my mother answered. Apparently, the hospital had a group of aides trained to attend to the hygiene of patients. Cleveland had spent the better part of an hour taking care of my grandfather, joking with him about the attractive nurses on his last day of consciousness. I never realized how strong a comfort it would be that my grandfather died clean, with his face shaved and his teeth brushed. It meant that someone cared about his dignity even in his delirium; that his human right to cleanliness was never overlooked. It was another radical change of my perspective. While treating the disease of a patient is urgent, their daily needs of hygiene, entertainment and human contact are just as important. Without them, the patient suffers.

There was one other thing I noticed while waiting with Papa. When the nurse came in to increase the dosage the third time, she brought with her atropine drops and a scopolamine patch. The atropine was to decrease his saliva production because he couldn’t swallow, but what caught my curiosity was the scopolamine patch for nausea. Papa had been unconscious for 24 hours. The idea of him feeling nausea was almost ludicrous, yet the doctors and nurses were careful to prevent any potential discomfort. I sat there thinking about how unusual it was to watch someone die this way. I wondered if the doctors who had prescribed the morphine had ever sat in my seat. Had they ever sat with a patient, from the moment they were first put under until their last breath? Someone must have observed long enough to hear the sounds of the uncleared mucous and remembered the powerful feeling of nausea. I wanted to be the physician who sits with patients and waits to understand each procedure. I want to see a colonoscopy before I tell a patient that they need one. I want to watch a dialysis treatment before I recommend someone to a clinic. After the impression made by watching my grandfather pass, I am committed to understanding what I am asking of my patients with my orders of CT scans and chemotherapy.

I arrived in Papa’s room shortly after 8pm on Sunday, after his doctor had already begun the morphine drip. It was the anticlimactic end to an odyssey of attempts to treat his emphysema, chronic bronchitis and pneumonia that together made breathing impossible. I had never seen someone die before. Watching the slow process of labored breathing, first the change in quality to painfully huge gasps that upon release caused his chest wall to reverberate like a recoiled spring, followed by the gradual decline in frequency, was life-altering. Part of my soul rebelled, stubborn to let go. The other part trusted the doctors and the heart-wrenching sorrow in my mother’s voice as she described his terror during fits of short breath. The feeling of suffocation petrified him. He was tired, he had said his goodbyes and he was ready to go. We waited another twenty hours, all eight of us huddled around his bed in chairs, sometimes crying, at other times laughing aloud at a story someone had told. Twice, the nurses came in to quiet us down. Papa would have told us to ignore them. “If they had a problem, they could stick it in their ear.” He never raised us to follow the rules.

My grandfather died as he lived, working hard, surrounded by family, love and laughter. We each carry different parts of him with us, my mother his skin, my cousin his name, and in myself a deeply felt duty to serve others. From the man who taught me how to make ice cream sundaes, carve a turkey and slide down a fire pole, I learned a deeper meaning to being a physician. I learned to really listen, to be sure to understand my patients’ points of view. They are unique, important, and precious. Thank you, Papa, and all my love always.
Light at the End of the Tunnel

Jyoti Sharma, MS III

For as long as I can remember, I’ve always wanted to be a doctor. I never knew what doctors were or what they really did, but I did know that my mom was one and that I wanted to be like her when I was a big girl. Fast forward some twenty or so years to my first and second years in medical school. I couldn’t believe what I had gotten myself into! Is this really what doctors learn: metabolic pathways, random parasites that are seen in third world countries and multiple choice tests on menial information from lectures?! Gosh, this isn’t what I signed up for. Whatever happened to stethoscopes and patients and trying to figure out what is wrong with them? What happened to feeling like you were helping someone by making them feel better? All I knew was that I wasn’t helping anyone with anything by sitting in the lecture hall listening to someone lecture about some minute metabolism pathway.

I was quite disappointed for a while, thinking to myself that I had made the wrong career choice. As philosophical and corny as it sounds, I wanted to help others and make a difference in peoples’ lives. I wasn’t trying to spend my time sitting in classrooms and the library memorizing random details that I would probably never need. I should have just followed my interests from undergrad and become a journalist. Gee, this wasn’t what I signed up for.

Well, was I wrong. Reality check – year 3 of med school. I had survived the basic science years of medical school and now I was off to the clinical world of medicine. I finally got to look past my books, use my stethoscope, and interact with patients. I realized I was doing what I wanted to – helping people feel better. My friends always joke around with me because I’m happy being a third year med student even when we are not always treated ideally, to say the least. The majority of our work is so-called ‘scut’ work, but then I think about the patient who told me I made her hospital stay so much more pleasant. Getting up every morning, without fail, I came in to see her at 5:30 AM. Or the patient who was diagnosed with a brain tumor only two days ago but was only concerned about my well being and how much sleep I was getting as a medical student! Then I think about the four year old boy with a terminal diagnosis with whom I played ping pong in the afternoons, allowing his parents to rest. These experiences have proven to me that, although I am not at the level in my training to provide full medical care, I do have the ability to use my knowledge, personality, and love for helping others to make someone else’s day just slightly better. Now I know that all those hours that I spent in the lecture halls and library were for a purpose. Without understanding the pathogenesis of the illnesses my patients were suffering from, I would not have been able to provide them with answers to questions that they asked regarding their health. I wouldn’t have been able to provide comfort to families by relaying, honestly, that their loved one would be O.K. in the end. After numerous such encounters with patients and their families over these past months, I now know, whole heartedly, that I made the right decision by entering med school.

And I write this not as an advocate for the third year of med school, but more so to help those struggling with their decision at this point in their training. Been there, done that. Please realize that things do get better, it’s just a matter of time! And until they do get better, be sure to surround yourself with good people who you can talk to and, most importantly, who can take your mind off of things. Continue your hobbies, whatever they are. Just because you’re in medical school doesn’t mean that you have to give up all your other interests. And last but not least, find yourself a mentor in the hospital- someone who will listen to your thoughts and advocate your best interests. There’s a bunch of them around, just take the time to contact one. Before you know it, you’ll begin to see the light at the end of the tunnel and wonder what happened to the last few years of your life. And FYI, all those random metabolic pathways are actually important, as illustrated by my very first patient in medicine – G6PD deficiency!

I Am Dignified

and So Are You

Nicolai Wohns, MS I

We see it everywhere. In anatomy, we are told to respect the dignity of the deceased. In end-of-life care it is to preserve “dignity in death.” We are instructed during clinical skills sessions to avoid violating their sense of dignity. It’s not unusual to nod along with the instructor with a vague, intuitive sense of their reference.

It is also omnipresent in major international human rights declarations. Common examples are the Preamble of the Charter of the United Nations (“faith… in the dignity and worth of the human persons”) and the Preamble and Article 1 of the Universal Declaration of Human Rights (dignity is “inherent… to all members of the human family,” and that “All human beings are born free and equal in dignity and rights,” respectively).

Despite the frequency of its appearance, sculpting dignity into a rationally palatable concept is a thorny undertaking. There have been efforts to separate its usages, thereby elucidating its meanings, and we will take a brief look at the culprits. Not only is the very definition in a tornado of critique, however, the primary locus of application is also under question. Should the concept of dignity be applied primarily to the individual or rather to uphold the integrity of humanity? But first, let’s consider whether dignity has a meaning of its own. ▶
Consider an extreme example, that of torture. It is incontrovertible that torture demonstrates a violation of human dignity. It somehow desecrates a sense of, well, dignity. But what does this mean? What is the essence of human dignity?

For one, Ruth Macklin of Albert Einstein College of Medicine has prominently declared dignity a useless concept due to its use as either a vague restatement of other more precise notions or as a mere rhetorical slogan. Her argument appears to hold water as further scrutiny reveals that its usage largely overlaps with the concept of autonomy, basically the capacity for self-legislation. Macklin cites a rare definition in a report by the Nuffield Council on Bioethics entitled *Genetics, freedom and human dignity*. The report makes a presumption that:

...one is a person whose actions, thoughts and concerns are worthy of intrinsic respect, because they have been chosen, organized and guided in a way which makes sense from a distinctively individual point of view.\(^1\)

This capacity for rational thought and action, however, leaves us gasping for air with nothing more than the principle of respect for autonomy. So is dignity simply a reconceptualization of autonomy, in which case why not just use the term autonomy and save everyone the headache?

Yet, now is not the time for despair, Oh Dignity-zealots, for there is recourse to a place as yet unexplored. Sure, autonomy has been validated to claim a slice of dignity’s elusive pie, but that is not the whole picture. In the words of Roberto Andorno, “respect for persons is just the consequence of human dignity, not dignity itself, in a similar way that the bell’s sound is an effect produced by the bell, not the bell itself.”\(^3\)

To save the day, Suzy Killmister, rather than banishing the meaning of autonomy, restyles it into what she calls “aspirational dignity,” something between an aristocratic comportment and an embodiment of the moral virtues. It “is necessary conditions for true human flourishing”\(^5\) and continues by thoughtfully delineating requirements: moral virtue, appreciation of beauty, awareness of oneself as a unique individual, participation in human community, receptivity to the natural process, and personal agency. He writes particularly pleasingly of beauty:

It is good to enjoy (and to be able to enjoy) the beauty of a sunset or the work of Monet… It is good to experience great literature, the graceful movements of a ballet dancer, or the grace of a power forward in the low post. Handel’s *Water Music* is a very good thing to enjoy, especially the second suite. It is good that people write poetry (at least some of the time). The Eiffel Tower is beautiful at night, and appreciation of that beauty is itself a good.
Nonetheless, the taste is familiar: we start to notice a rehashing of the meritorious “aspirational dignity” outlined by Killmister, with one notable exception.

Consider age retardation. The technique would restore one’s body to an earlier age, as well as prolong health. Taken on an individual basis, you would be hard pressed to convince someone that, given that we are not demanding the right to such a technology, obviously one should be allowed to do as they wish in this regard. The principle of dignity, on the other hand, would (counter-intuitively) proclaim age retardation immoral: it violates one of the goods cited by Jordan, receptivity to nature, i.e. the idea that there is greater value if nature takes its course.

And here lies the exception: the principle of dignity, argues Jordan, should be applied not to the individual but rather to humanity. Dignity makes no claim to protect individual rights. Instead, the abstract set of non-quantifiables refers to the integrity of humanity, to a human capacity for good, and not to individual abilities. In order to properly assess a given dilemma using this formulation, the perspective of an impartial viewer must be adopted and the following question asked:

All things considered, is a world where age retardation technologies are widely available... one in which the prospects for genuine human flourishing are enhanced or one in which they are jeopardized?

To conclude, I would like to posit a riposte to the objection that human rights laws are akin to cultural empiralism. In this view, moral principles are thought to be reliant on social and historical circumstance. Although one may draw the origins of the modern conceptualization of human rights from the French and American Revolutions, this by itself does not invalidate the claim that people should be entitled to basic rights. In a similar vein, Adorno points out that:

Merely pointing to moral diversity and the presumed integrity of individual cultures does not, by itself, provide a philosophical justification for relativism or a sufficient critique of universalism.

A complete discussion of the debate between moral relativists and universalists is outside the scope of this article. Nevertheless, along with the ideas proposed above, one might argue that the idea of inviolable dignity is present, in whatever form, in every human society.

In question is whether dignity, a term that accounts for the “rich texture of the human experience”, is sufficiently clear to shed light on real moral problems. Regardless of whether Macklin is right in her declaration that dignity is a useless term, it behooves the concerned to deliberate carefully on similarly employed terms - autonomy, beneficence, justice - before exploiting them in rhetorical combat. Public discourse will be the better for it.
FEATURE

Richie

Jim Withers, MD

Since 1992, we’ve been making “medical rounds” at night to the street homeless of Pittsburgh. I’ve seen a lot of remarkable people in that time, but there are a few I can never forget. One of them was my friend, Richie.

Homeless people are everywhere these days. But ironically, some of them are very difficult to find. In terms of our work, these are often the folks who are the most vulnerable, and therefore, important to locate. One night as it was getting late, we were walking through a warehouse section of the city and I glanced over towards the loading docks of an abandoned business. Something told me to climb up and check to see if anyone was there. Behind an immense pile of trash, I could see a grey form curled up in a ball. We scrambled over. Gently, we woke him and he introduced himself as Richie. He was a bit intoxicated and surprised that someone had found him. After a few quick questions, we left him with some water and food and went on to finish our rounds.

What really impressed me about Richie’s situation was how lonely it was. He literally lived behind a mountain of garbage. That section of town was quite remote, and it was as if a wounded animal had crawled into a corner to die. Richie’s death was not imminent, but that was what was slowly happening. In subsequent visits, Richie was very happy for our company. I noticed a nasty cough, but he declined to seek care. I sure wanted to get a chest x-ray. But if the classroom of the streets taught me anything, it was the need to work with people on their terms. For now, it was about Richie singing songs and sharing his “home”.

Clearly, Richie was depressed. His drinking seemed more a way to cope with deep loneliness than anything else. Our visits were easing his pain, but nothing I could say convinced him to let go of it, or his bottle, or his little corner of hell. It’s in such dark places that we are forced to grasp for the deeper roots of healing. Easy enough to walk away and blame him for his own fate, but the problem now was that I really cared about him. He wasn’t just a bum. He was my friend. I could see how, if I hadn’t had the love of family in my toughest times, I might have ended up like Richie.

The reason I began visiting streets at night was not really about taking care of homeless people. As a teacher and physician, I was seeking a classroom where we could learn the lessons not available in our world. To find the roots of healing, I was convinced I needed to seek out those for whom the system did not work. To honestly look at their lives as closely as I could - from their perspective - and deal with that reality. What I found were hundreds of discarded human beings, struggling with their failures, their losses, and their very survival. But they were surviving. They were surviving despite tremendous obstacles, often doing it with courage and a sense of humor. Don’t take my word for it. You have to get to know them to understand. If there was a fault in their disconnection with the medical world, that fault was largely our inability to reach out and connect with their world. We need to “learn to learn” from those we have failed. I went out on the streets to help physicians.

What finally dawned on me about Richie was that he had begun to think of himself much as the garbage in which he was sleeping. Like the rest of us, he had come to believe that the homeless such as him were worthless, beyond redemption. If we were to connect with Richie, to begin the healing process, we would have to go to that place in Richie’s heart. How could I help him to see himself as more than another pile of dirty rags?

One night it was raining heavily. Nobody wanted to walk our usual long journey from bridge to bridge, camp to camp, alley to alley. It was then that I got the idea. What would happen if we were to try to change how Richie felt about himself by changing the space where he slept? So instead of making our rounds, we gathered 21 large garbage bags, some gloves, and headed to Richie’s loading dock. With Richie holding a flashlight, we filled and loaded away bag after bag. Slowly a bit of order came to his little corner. Before leaving, we laid down an old piece of carpet and sat with him to admire the results.

Two days later, our nurse gave Richie a haircut and a tetanus shot. On the next visit, he showed us old photos of his family. A bottle appeared on his little shelf not filled with beer, but some handpicked wild flowers. We learned he had a beautiful singing voice. In about a month, Richie accepted housing and eventually a full physical exam – including that chest x-ray. I would visit him on occasion and share dinner with him.

A few months later I asked Richie about the photos of his family. He thought about it for a while and decided they must still be back at his old sleeping place. We drove there and climbed over the remaining trash to the place he had called home. After a search, he triumphantly held up the photos. Happily, we turned to leave, but then he stopped abruptly and stared at his old bedroll. Finally he looked me in the eyes and asked, “Doc, how could a human being live in a place like this?”

It was then that I realized the healing that had taken place in the most important part of Richie’s body – his heart. It also gave me a lesson I would never forget.

Dr. Jim Withers continues to provide medical care to the unsheltered homeless population in Pittsburgh, PA through his organization, Operation Safety Net. Today, OSN is recognized as one of the first targeted full-time street medicine programs, helping to launch a global Street Medicine Movement, and continues to set the standard for this unique form of health care.

For more information, visit: www.pmhs.org/operation-safety-net
New Professionalism
Sunny Sahajwani, MS I

As health care providers, it is our knowledge that saves lives. Understanding, recognizing and treating illnesses are skills acquired from arduous graduate and post-graduate training. We often think it is our medical skills that enable us to best treat our patients. Nonetheless, it is professionalism that is the link between technical skill and interacting with patients and society. As students we are charged with the duty of becoming professionals, but what does that mean?

One of the criteria the Liaison Committee on Medical Education (LCME) evaluates is how well a medical school ensures its students are developing “explicit and appropriate professional attributes...behaviors, and identity.” 1 This allows each school to select those qualities that they deem an appropriate reflection of professionalism. As a result, there is no clear consensus on the true criteria for professionalism. To provide examples for any confused medical educators (for, as we will see, this topic can be quite confusing), LCME references The American Board of Internal Medicine (ABIM) Physician’s Charter and the AAMC who list a milieu of the following traits as defining professionalism: altruism, accountability, excellence, duty, service, honor, integrity, and respect for others2. Most medical schools, including Penn State, incorporate a similar list in their description of core graduate competencies, representing the traditional ‘trait-based’ approach to transforming its graduates from laymen to professionals.

The focus here is clearly on the individual and their qualities. Yet this approach is not the last word on what it means to be a professional. As a diffuse listing of characteristics, the traditional “trait-based” approach, while setting measurable values, prescribes finite boundaries and prevents a deeper understanding of the varying ways a professional functions in different societal contexts (political, legal, socio-economical)3. The murky concept of a professional has been a hotly debated topic in academic medicine.

A newer perspective is from medical sociology. One of their approaches to defining professionalism draws from structural-functionalism. (Structural functionalism is a sociological concept that tries to understand society by reducing it to its multiple functional elements, its customs, institutions, and traditions)3. Rather than being defined by abstract qualities expressed by an individual, they argue that medical professionals function within this societal infrastructure in a defined, unchanging role, i.e. for the “collective societal well-being rather than self-interest.” In this model, the professional has no political or cultural loyalty and functions with a balance of objectivity and empathy, what is known as a “detached concern”. As James M. Gustafon put it, professionalism “involve[s] a sense of suffering with the client or patient... while at the same time maintaining the perspective of the disinterested observer... interpreting the circumstance from his or her professional [prospective].”4

When considering the many forces that are influencing medicine today, including market demands and bureaucratic regulations, the trait-based and structural-functionalist models seem disadvantageous due to their inflexibility. It does not account for varying societal contexts. For example, medical educators are finding that medical students are less willing to make career decisions based on altruistic motives, a call that is seen as a method to exploit the students by faculty and patients5. Rather, they are searching for a balance between lifestyle and their call for service. A traditionalist, who compares new students to a static professional framework, would lament the end of a golden era of altruism and call for a revitalization of professional education. An emerging concept, in contrast, is to recognize professionalism as a multi-dimensional faculty and to examine professions as a state of mind that changes with varying social pressures.

Today, medicine is becoming increasingly transparent to the public, opening itself to greater public scrutiny. Embracing this new state of mind, Sir Donald Irvine is leading the way to change medical culture with the concept of “new professionalism”. Put simply, change should come from “a social and political consensus between the public and the profession” on expectations of a medical practice. Through collaboration, physicians should not feel exploited nor the patients neglected. He rejects the practice of separating the public from physicians through the professional’s notion of mastery, privilege, and self-regulation. He suggests a new attitude, which incorporates the patient in medical committees and certification boards. From this perspective, professionalism may be explained as the physician behaviors that are in tune with the public’s expectation of health care. New professionalism proclaims that as expectations change so should the profession, an idea that contrasts with structural-functionalism2,5.

While Irvine’s ideas may not be the complete answer, there is no question that the professional culture of medicine must change with the new legal and social climates. The public is increasingly skeptical of the medical systems functionality, and bureaucracy is placing increasing pressures on the autonomy prized by physicians. Instead of working against the forces at large, a debate on the new frontiers of medicine must swim with the tide and focus on the positive acculturation of its new professionals.

Sources Cited:
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