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LOMA LINDA UNIVERSITY
CENTER FOR
CHRISTIAN BIOETHICS
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Update

Personal and Professional Integrity in Clinical Medicine

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I teach clinical ethics. My teaching focuses on decision-making. This has to do with actions. I encourage physicians to discern right actions and to seek good outcomes. But I may be missing the boat. Right actions flow from good character. Maybe instead of trying to help physicians deal with the question "What should I do?", I should be making them ask and answer the question "What kind of person should I be?" Doing the right thing is not the same as being an honorable person.

What kind of person should the physician be? What constitutes the ideal physician? Is there one answer? Is it the same now as it was 100 years ago? Can it be determined before admission to medical school whether a person has those virtues which are required of a good physician? Can those virtues be taught to student physicians? Does an individual or a university with a religious mission have any unique answer to these questions?

Medicine is a profession in the classical sense. The meaning of the word "profession" has been expanded to include doing something for pay, as opposed to doing it as an amateur. But in the classic sense, being a professional implies a publicly declared vow of dedication or devotion to a way of life. It also implies a special knowledge not available to the average person; thus, it is an unequal relationship. But with that special knowledge comes a special responsibility. It is thus a fiduciary relationship in that the possessor of the knowledge has a responsibility of altruism, and the recipient of the special knowledge may thus trust the professional. In the words of Karen Lebacqz, author of the book *Professional Ethics: Power and Paradox,* a professional is a trustworthy trustee.[1]

The classic professions have been medicine, law and theology. For the sake of argument, and because of my personal bias, let us say that the primary-care physician is the paradigm of the professional. He or she is dedicated to a way of life; dedicated to practicing medicine for the benefit of his or her patients, and the patients may trust the physician to act in their best interests. This is another way of saying that a physician is a person of integrity. What does integrity mean? It means an uncompromising adherence to a code of values. These values are part of the person; they are integrated into the person. Integrity is integrated values. What values are integrated into the person of the physician?

To answer that question, it is helpful to define the purpose of medicine. Seldin argues for a narrowly defined disease model in that he believes medical practitioners should restrict their activities to those medical, surgical and psychiatric conditions for which effective therapy exists.[2] Leon Kass, on the

other hand, proposes a wider model in that he defines the end of medicine to be maintenance and restoration of health, broadly defined as the well-working of the organism as a whole.[3] George Engel likewise proposes a broad scope in what he calls the "biopsychosocial" model of medicine.[4] Loma Linda University has a broad understanding of medicine as reflected in its mission statement and its motto "To make man whole," which adds to Engel's model a spiritual dimension. For the remainder of this discussion, let us assume this broad focus, that the purpose of medicine is to make persons whole.

So what kind of person should the practitioner of medicine be? What characteristics, what attributes, what virtues, what personal ethics should he or she have? And why should physicians have these virtues? Because Hippocrates would be upset? Because the AMA would judge them adversely or take away their membership? In order to avoid other unpleasant repercussions, such as loss of license or medical malpractice claims? No, performing good actions to avoid unpleasant repercussions is not virtuous; it is self-serving. One undertakes the profession of medicine — one becomes a physician — in order to serve one's patients and assist them toward the mutually agreed upon goal of health while remaining loyal to the responsibilities of the science and art of the profession.

The profession of medicine is often traced back to the shadowy figure of Hippocrates in the fifth century before Christ. But he, in turn, referred back to the mythical Greek demigod, Asklepios, son of Apollo. According to Albert Jonsen, medical historian and ethicist, in his new book, *The New Medicine and the Old Ethics*,[5] the focus of Asklepian-Hippocratic medicine was competence in the sense of a disciplined understanding of the science and skilled manipulation of the art. The ancient oath attributed to Hippocrates was the standard for conduct and decorum for centuries. The oath admonishes physicians about what they should and shouldn't do, but not about what kind of persons they should be. Kass, in trying to move beyond the specific do's and don'ts of the oath, analyzes it in detail in his essay "Is There a Medical Ethic: The Hippocratic Oath and the Sources of Ethical Medicine,"[6] and he finds the following virtues requisite for physicians: justice, moderation, self-restraint, gravity, generosity, discretion and reverence.

Much of this sounds pertinent for today and much of it sounds good and noble. However, what was the motivation for encouraging these virtues? If we read the oath closely, we find that the oath is self-serving. The physician swears to not teach medicine to anyone who has not taken the oath. Maybe we should ask medical students to take an oath before starting school rather than at graduation. Immediately after the two strong and clear proscriptions against taking human life it says "In purity and holiness I will guard my life and my art." Not "my patient's life," but my life. And the anticipated result of following the precepts of the oath is clear in the closing sentence: "being honored with fame among men for all time to come." Physicians were admonished to develop these virtues so that they would be trusted and felt to be competent; so that they would be honored and held in high esteem. Karen Lebacqz states, "Professional codes are not a guide to ethics, but simply protect professionals and assure them status and income. They are the products of a guild that has as its first priority maintenance of self."[7]

Professor Jonsen goes on to point out that it isn't until the teachings of Jesus that the Samaritan virtues of compassion and self-sacrifice are first injected into the practice of medicine. Compassion literally means to suffer with. Luke says of Jesus, when He saw the sorrow of the widow of Nain over the death of her son, "His heart went out to her." His actions were preceded by compassion. And when teaching His disciples who was their neighbor, He tells them the familiar parable of the Good Samaritan who also had compassion on a stranger, acted competently and responsibly on behalf of this man, giving of his time, ability and money. Jesus said that this man showed mercy, and the disciples should follow his example. This parable was used in the first centuries of the Christian era and into the Middle Ages to exemplify the duties of the Christian physician; a duty to respond to someone in need, even at a cost to himself.

The essential virtues of the physician were thus laid down early and are the prohibition against patient exploitation and the demand for physician competence of the Hippocratic tradition, and the compassion and non-discrimination of the Samaritan tradition. Altruism before self-interest. A covenant, a mission, a calling. The ethical principles of old which have only in recent years been articulated as principles of medical ethics are (1) beneficence—doing what is good for the patient, and (2) non-maleficence—not doing what is bad for the patient. And when there was a conflict between these two principles, e.g., medicine that makes the patient sick (that's bad) while curing another disease (that's good), it was left to the physician to decide what to do.

For centuries, there continued an informal relationship between medicine and religion. In the Middle Ages, hospices, which were precursors of hospitals, were established along the routes where pilgrims travelled on their way to the Holy Land. They were operated by devoted religious knights as hostels for travelers and places to care for the sick. For several centuries, the practitioners of medicine were Physician-Priests. They did not have a lot of effective interventions to offer. They were long on compassion and short on science. They were able to make some diagnoses and prognoses, and they were able to be with the patients and comfort them through the crises of ill health. Many European and North American physicians were religious men who humbly recognized the sovereignty of God. For example, Ambroise Pare, the sixteenth century French surgeon, is remembered for saying "I bandaged them, but God healeth them."[8] The mysteries of medicine went hand-in-hand with the mysteries of God's interaction with mankind. At that time also, the societal acceptance of biblical teaching recognized that sometimes there is value in suffering. Then, as now, illness made patients vulnerable, and the uncertainty of recovery forced them to trust their physicians and their God. Generally speaking physicians acted virtuously, as taught by tradition. There were times when this was not true. Many physicians

fled the cities and abandoned their patients during the Black Plague of the Middle Ages, but there were many who risked their own lives to care for the dying specifically because they viewed the practice of medicine as a spiritual calling, true Physician-Priests. Altruism before self-interest.

During the Enlightenment, the Age of Reason of the 17th and 18th centuries, came great advances in the physical sciences and the development of a mechanistic view of human life. The human body came to be visualized as a machine which could be studied and understood, and occasionally the course of illness could be altered. At the same time, a shift in philosophical thought formulated the ideals of human dignity and worth which led to the centrality of mankind in the universe, with a coincident decrease in acknowledgment of the sovereignty of God leading to a veritable worship of Man's abilities. In the words of Paul as recorded in the first chapter of Romans, they "worshipped and served created things rather than the Creator."

Thomas Percival was one of the first physicians to write about medical ethics. His book by that title, *Medical Ethics*, was published in 1803. Interestingly, it was inspired by a major turf battle between two groups of physicians in Manchester, England; a controversy where self-interests had taken priority over the patient's best interests. That book is often criticized today as being focused on professional etiquette rather than the hallowed principles of modern medical ethics. However, in the introduction, Percival stated, "It is characteristic of a wise man to act on determinate principles and of a good man to be assured that they are conformable to rectitude and virtue."[9] He claimed that the practices he espoused were the out-working of the virtues of veracity, faithfulness, justice, benevolence and the cultivation of good habits. In spite of modern criticism, his casuistic method worked. His teachings were accepted widely and formed the basis of the first AMA Code of Ethics of 1847. According to Pellegrino's commentary, "a chief characteristic of Percival's life and thought was the close integration of faith and reason."[10] His treatise on medical ethics focuses on the interactions of physicians with hospitals, consultants, apothecaries and the law. He focused on areas of potential conflicts of interest; areas where physicians might be tempted to place self-interest ahead of the patient's best interest. He promoted rules, but the basis of his rules was the concept of a virtuous physician.

In spite of the changes in spiritual and philosophical belief which occurred during the Enlightenment, many in medicine continued to see no contradiction between medicine and religion. Such great physicians as Thomas Browne, William Harvey, and John Gregory joined with Percival in declaring their views on suffering, illness and the role of Divine Providence in healing.

Beginning in the 1830's, the clinico-pathological correlations discovered and taught in the medical schools in Paris ushered in the modern era of medicine. Slowly, the image of the Physician-Priest gave way to the image of the Physician-Scientist. In the last 150 years, physicians have actually been able to do effective and relatively safe surgery, give medications which cured or controlled disease, administer tests which give valuable diagnostic and prognostic information. The competence of physicians has been greatly enhanced. Physicians learned how to perform "miracles." Now there's an oxymoron — perform miracles! Miracles are by definition unplanned, unexplainable, and the result of supernatural intervention in the usual course of nature. Physicians can't "perform miracles"! But it is the perception of patients that modern medicine is often miraculous, and they have developed great expectations. Unfortunately, it is often the perception of the physicians as well that they truly are doing superhuman activities. Thus the genesis of the M.Deity degree, physicians "playing God."

Some of you may be ready to tell me to take off my rose-colored glasses. Yes, I realize that there have been many portrayals of greedy and self-serving physicians and surgeons in classical English (Cronin, Shaw), French (Moliere), and Russian (Tolstoy) literature. I realize that early American medicine was replete with poorly trained physicians, and that the medical profession allowed hucksters and healers to greedily ply their trade.[11] I neither deny nor ignore that. I am merely trying to remind us all of the ideals that have been passed down, the virtues that have been expected in the practice of medicine.

For a long time, the art of medicine continued along with the newly developing science. The newly powerful physician was on a high pedestal. He (usually he rather than she) could do no wrong. He could be trusted. Not only did Robert Young always do the right thing as Father Knows Best, but as Marcus

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Welby he helped convince a whole generation that the doctor always knew and did what was best for his patients. Altruism before self-interest.

The pace of the changes quickened. The complexity of medical practice led to specialization and subspecialization. Patients less frequently had a long-standing relationship with a trusted primary physician. Even when they did have a primary physician who knew them well, their particular medical crisis often happened at night or on a weekend when they received care from an unknown covering physician. The complexity of medical education led to a shift in emphasis from the art of bedside clinical medicine to high-tech research, causing us to take our eyes and hands off the patient and focus our concentration on the electronic monitor or the lab values. All these factors led to a weakening of the trust that the patient used to have in the physician, his trustworthy trustee.

The cost of high-tech medicine led to the development of health insurance in order to share the financial risk of illness. Removing or lessening the patient's contribution to medical costs led to expectations that everything would be done at someone else's expense. Medical technology has become front-page news; usually good news emphasizing good results. Patients have become more sophisticated and have developed very high expectations, some of which are unrealistic. Unmet or unmeetable expectations have further eroded the patient-doctor relationship.

Beginning in the 1960's, the rise of individualism in society and a general questioning of authority broke the spell of the miraculous healer who could do no wrong. The Physician-Scientist evolved into the Physician-Provider. Commercialism, marketing, and for-profit medical practice have further demystified medicine. Unmet expectations and diminished trust have combined in this new professional relationship which is more contractual than covenantal, resulting all too frequently in an adversarial relationship played out in a courtroom.

Physicians have been blamed for the high cost of medical care; they have been criticized for lack of compassion; when high expectations are not met, they are called incompetent. Some of the criticism is justified, some is not. But what has been the response of the dedicated, altruistic servant? He (and now she) has become defensive and often blames the patient, the government, the lawyers, or social changes for the unwelcome state of affairs.

When I was sued for malpractice a few years ago, my first reactions were those of devastation and self-doubt. The patient obviously had a poor outcome. Was I at fault? I honestly wanted to know the professionally correct answer. If I had been at fault I wanted the patient to be compensated. I wanted justice. But by the time the complaint had been filed with its accusations of incompetence and lack of caring, by the time the plaintiff's attorney had deposed and eventually cross-examined me with cunning questions, by the time two highly paid expert witnesses had testified giving exactly opposite opinions, I realized the goal was not justice, the goal was winning. I became defensive; I became angry; I became disillusioned. I had a very difficult time still saying that I wanted what was best for the patient; altruism before self-interest. What had happened to my idealism? What has happened to the idealism of medicine which seeks the good of the patient before the good of the physician?

On top of all this has been the divorce of medicine and religion. Many hospitals retain religious names and maybe even some religious symbols, but the strong bond of the past is mostly gone. No longer is God recognized as sovereign. No longer is the physician a priest on a mission with a covenental relationship to the patient. He or she is a scientist who can do miracles. He or she is a provider who is responsible for the results. No longer is there any purpose to suffering; it can be and must be eliminated. No longer is stewardship something that we humbly owe to a sovereign God; it is a concept of allegiance to Mother Earth or to our fellow-humans. Mankind is in; God is out.

Does this change the ethical underpinnings of the practice of medicine? Beneficence and non-maleficence are still honored precepts. But in the 1960's and 70's we began to hear for the first time that the ethical precept of autonomy, of patient self-determination, should be recognized by physicians. Society rightly demanded a change from the paternalistic physicians of the past making newly possible life and death decisions for patients without inquiring about their desires. The pendulum swung way over from the physician making all the decisions—remember, this is theoretically a physician who is motivated by a mission of caring for the patient—to the patient making all the decisions, and often perceiving the physician as being uncaring, not trustworthy and self-serving. Rapidly the patient's right to autonomy became the most important element in the doctor-patient relationship.

And in the 1980's, because the rapidly escalating cost of medical care had caused many patients to be without insurance and unable to afford even basic care, there arose another banner in medical ethics—that of justice. But this is not entirely new, it is really the resurrection of a concept that was mentioned in both the Asklepian-Hippocratic tradition and in the Samaritan tradition. So now we have the mantra of the modern medical ethicist: Autonomy, Beneficence, Non-maleficence and Justice. These are the generally accepted principles of decision-making in medicine.

But, does application of these four principles change the requisite virtues of the physician? What were those requisites? The prohibition against patient exploitation and the demand for physician competence of the Hippocratic tradition, and the compassion and non-discrimination of the Samaritan tradition. Altruism before self-interest.

Has the complexity of medical practice and the involvement of third-party payers erased the need for maintaining confidentiality? Has the societal acceptance of the sexual revolution changed Hippocrates' proscription against sexual involvement with patients? Has the development and elevation of patient autonomy changed the strong admonition against giving the patient a deadly poison if it is requested? Has the development of managed-care plans in which a physician's income may be decreased if he or she orders more consultations or diagnostic tests changed the duties of the

Samaritan?

Medical ethics has focused on medical decision-making, on patient's rights. It is oriented to right actions and good outcomes. The concern that I am raising is about motivation—about physicians' self-interest *vs* the patient's best interests. This potential for conflict of interest has always been present in medicine. Physicians are human and they have been tempted by human self-interests such as power, greed and lust. Although examples of self-serving physicians exist in medical history, they are noteworthy because they stand out against the tradition of putting the patient's interests first.

Let's look at some of the potential conflicts of interest in modern medical practice. Probably the most important step in maintaining professional integrity is to recognize those situations where there is the possibility of a conflict of interest. Those situations cannot be eliminated. Physicians are, and always will be, faced with situations where they make choices between what is best for the patient and what might be more desirable for themselves.

What self-interests of the physician might he or she be tempted to place before the patient's interests? We could talk about the seven deadly sins of pride, covetousness, lust, envy, gluttony, anger and sloth. But I will reduce it to the three F's of fortune, fame and fun. And I do not mean to imply that money, recognition and recreation are inherently wrong. I am asking us to consider the physician who is motivated by fortune before the patient's best interests; the physician who seeks fame before the patient's good; the physician who believes his or her own fun is more important than his patient's health.

I will offer what may seem like a trivial example to demonstrate the nature of such conflicts. A family physician who is on call has just settled into the bleachers for the beginning of his son's Little League game when he gets "beeped" by a patient whose daughter has a two-inch laceration of her scalp, which is bleeding profusely. This is a patient that he would ordinarily see right away in his office. But he doesn't want to miss the game. He could ask the father to take his daughter to the office after the game, assuming that the bleeding will slow quickly, as scalp wounds usually do. But the patient's father might think him uncaring or incompetent. He could refer them to the E.R., but that would result in a much larger and unnecessary charge to the father or his insurance company. It would be in the patient's best interests to be cared for right away in the physician's office. It would be in the physician's best interests to not miss the game. A conflict of interest. Which interest takes precedence?

Other potential conflicts of interest may not be so trivial. Such issues as fee splitting, physician advertising and patient stealing were major professional and societal concerns in the past. There are numerous potential conflicts of interest in research, in publication and in the practice of military, industrial or prison medicine.

The AMA and the U.S. Department of Health and Human Services have spent innumerable hours and pages in recent months debating the issue of physician self-referral. That is the practice of an individual physician sending one of his patients for an X-ray, lab work or other medical service to a facility in which he has a financial interest and from which he can make a profit. Other concerns involve physicians profiting from the sale and dispensing of medications which they prescribe[12] or in-office laboratories, physical therapy, treadmill testing, etc. These are valid concerns. But they are not valid concerns because there is anything inherently wrong with a physician providing these services. It is a valid concern because some physicians have ordered more tests or treatments than are really necessary, or have unscrupulously profited by charging "what the traffic will bear," or have been careless about the quality of the service provided. Some physicians have put their own interests in fortune before the best interests of their patients.

Emphasizing our professional, philosophical, and theological roots will help us recapture a sense of professional integrity.

Gifts to physicians from the pharmaceutical industry[13] and perks to physicians from hospitals[14] have recently come under scrutiny. The AMA wrote guidelines one year ago outlining what gifts from industry are professionally acceptable and many pharmaceutical companies have volunteered to work within those guidelines.[15] Marketing ploys thinly disguised as clinical research have offered monetary rewards to physicians for starting patients on a new drug. Pharmaceutical sponsorship of continuing medical education may sometimes be aimed more at marketing than at education. Physicians may succumb to such temptations without even recognizing that they are satisfying their personal interests but compromising their objectivity regarding decisions which require keeping their patients' best interests uppermost.

Some physician contracts with managed-care plans offer financial incentives to physicians to limit the number or scope of referrals for testing, consultation, or hospital admission. They may require their contracted primary physicians to refer to the lowest charging specialists even when he knows of another physician who could provide a better service to the patient. Physicians may be expected to place the financial interests of the plan, and ultimately their own financial interests, ahead of the interests of their patients.

There is still professional unanimity that physicians should not be sexually involved with their patients.[16] The argument is not a moral one against adultery, but a professional one because of the inequality of the relationship. The physician is in a position of power and authority over the more vulnerable patient. But recent surveys show that an alarming percentage of psychiatrists[17] and primary physicians have violated this unchanged Hippocratic proscription; they have put their own personal interests before the well-being of the patient.

Some of these conflicts of interest are new and exist because of the current methods of financing medical care. Others have been part of the practice of medicine for gen-

erations or longer. Physicians have always had some control over their own income and ultimately over how much the patient was charged by virtue of how often they asked the patient to come back for follow-up. However, the possibilities for abuse seem more abundant, the costs are much higher, the temptations seem larger. And this is happening at a time in history when individual rights and freedoms have been touted; when religious influence on the moral life has significantly diminished; when personal integrity is not as highly valued as in the past.

Does all this mean that altruism before self-interest no longer needs to be the standard motivation in medicine? Does this mean "every man for himself"? Does this mean "let the buyer beware"? No, I still believe with Drs Pellegrino and Thomasma that medicine is to be practiced *For the Patient's Good,* which is the title of their 1988 book.[18] I still believe that altruism comes before self-interest. If that is still accepted dogma, how do we continue it; or perhaps, how do we recover it? In 1984, after two and one-half years of discussion and study the Association of American Medical Colleges published a report entitled "Physicians for the Twenty-First Century" which has come to be known as the GPEP Report, standing for the panel on the General Professional Education of the Physician. In the introduction, the panel "affirms that all physicians, regardless of specialty, require a common foundation of knowledge, skills, values, and attitudes." They later go on to say, "We believe that every physician should be caring, compassionate, and dedicated to patients—to keeping them well and to helping them when they are ill.

Subsequently, the AAMC established an ad hoc Working Group on Student Professional Ethics. They published their first report in Academic Medicine in December 1991,[19] and they conclude that medical educators have paid insufficient attention to students' development of professional standards. They have started an initiative with three goals: (1) improving the evaluation of candidates for admission, (2) improving the medical school learning climate, and (3) improving communication to students of expectations of professional behaviors and standards.

The Working Group believes that the primary determinant of a medical student's ethical development is his or her stage of moral development upon admission. They cite a report of the Josephson Institute for the Advancement of Ethics which shows an alarming shift in the values of American young adults from traditional moral principles to self-centered values stressing materialism and winning. That report specifically states that over two thirds of college students admit to cheating. The response suggested is tighter security; not enhancement of moral integrity, but tighter security.

If that is the moral climate of medical students, how can we instill in them the concept of altruism before self-interest? It sounds like an uphill battle. The Working Group recommends less reliance of admissions committees on GPA's and MCAT scores and an increased emphasis on interviews, essays and other admittedly subjective, difficult and as yet non-validated measures of the applicants' qualitative attributes.

College students' values are changing. The February 6 *New England Journal of Medicine* contains a special article by Jack Colwill entitled "Where have all the primary care applicants gone?"[20] In trying to sort out why fewer medical students are choosing primary-care specialties he tells of a 25-year study by Astin which had asked college freshmen their life goals each year. A very disturbing X-shaped graph shows that the percentage of students who identified "to develop a meaningful philosophy of life" as either essential or very important had fallen from steadily from 82% to 40% over the 25 years. At the same time there was a steady climb from 40% to 80% for the response "to be very well off financially."

Entering medical students have different values. But, does the medical school experience have any influence on those values and on morals? Baldwin and Self and colleagues recently published the first report of a medical school doing an in-depth cross-sectional analysis of moral reasoning in all four years of its students.[21] They conclude that it does improve over the four years. They recommend longitudinal research on the stages of moral development of entering medical students and the influence of various factors on its further development. The same group of investigators had earlier published an objective study showing that a first-year course in medical ethics did have a salutary effect on moral reasoning of the students.[22]

The second recommendation of the AAMC Working Group is to improve the learning climate of medical students by ensuring that their teachers model ethical behavior. Less competitiveness; more compassion; more concern about the patient's health needs than his DRG category; clear learning objectives and fair evaluation mechanisms to minimize the temptation for students to cheat; assessment of students' integrity and respect for patients in addition to their knowledge and technical skills; clear ethical standards for teachers and censure when they fail to model or teach those standards. Though the Working Group believes medical students' stage of moral development on admission is critical, most commentors place a very heavy responsibility on medical school faculty. To quote Pellegrino, "Many of our habits (remember that word habits) as physicians and what we consider 'good' medicine are traceable to imitation or rejection of some teacher's example."[23] Are medical schools sufficiently diligent about assessing the professional and moral examples of their faculty members, or are they more concerned about their publications, their clinical expertise, or their skills in pedagogy?

The AAMC Working Group's final recommendation is for better definition and communication to students of clear expectations regarding professional behaviors and standards. They suggest that medical schools adopt honor codes with student responsibility for peer conduct, and provide more resources for students to discuss their personal and professional ethical dilemmas. This recommendation raises the long-standing question of whether ethics and professional behavior can be taught. Aristotle taught that knowledge of ethics was not enough; right actions come from the will. He went on to emphasize that development of habits is the only effective route to moral development, and that parents and the law

teach virtue by enforced habituation. Regarding ethical issues in medicine, students can be taught how to identify and analyze the problems; they can learn about ethical and legal precedents, and they can be guided as they come to grips with their own values. Courses in medical ethics cannot make virtuous persons out of morally indifferent or morally vicious students. However, by precept and by example, student physicians can be encouraged and guided in their moral development as professionals.

The report of the AAMC Working Group is the first step in an initiative to help medical schools enhance professional integrity.

We would do well to remember our historical, professional, philosophical and theological roots as we work to recapture professional integrity. The prayer of Moses Maimonides contains some insightful words. The author of this prayer is uncertain, but it has been ascribed to Moses Maimonides, a Jewish physician practicing in Egypt in the twelfth century. It opens saying, "Almighty God, thou hast created the human body with infinite wisdom." It later goes on to say, "Thou hast blest Thine earth, Thy rivers and Thy mountains with healing substances; they enable Thy creatures to alleviate their sufferings and to heal their illnesses." It later makes the following request from God, "Inspire me with love for my art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures." And it closes with a strong affirmation of the need for physicians to rely on God's help in order to benefit their patients.

Does relying on God make any difference? Does being a Christian physician make any difference in how he or she views the patient? Does it make any difference in his or her internal motivation or integrity? Does being a Christian medical student make it any easier to incorporate the idea of altruism before self-interest? Does being a Christian institution make the mission of the institution or the individuals practicing in the institution more patient-centered? Does being a Christian make a difference?

Being a Christian should make two major differences for an individual. First, it makes a difference in eternal destiny. Believing that Jesus sacrificed his life as an atonement for my inability to meet God's high standards and accepting that atonement as a reality in my life gives me surety and peace about my eternal life with God in Heaven. But that belief, that decision, does not make me a different person. It doesn't make me a better physician. It doesn't make me more compassionate. It doesn't make me place the patient's interests before my own.

However, those differences can and should occur as a result of a decision to believe and follow Christ. Being a Christian means not only being assured of a heavenly reward, it means being committed to a way of life; being committed to follow the example and teaching of Jesus. We are to aim for that ideal in our behavior. We are to aim for moral excellence. We are to strive for the humanly impossible. But we are not without help and guidance. Being a Christian, accepting the amazing grace of God, gives us access to the assistance of the Holy Spirit. The Spirit gives us the power to overcome the selfish human nature with which we all continue to wrestle. Those who submit their nature to the Holy Spirit are promised the fruit of the Spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control.

Most patients would like a physician with these attributes. Physicians with these attributes would be trustworthy trustees. They would not have difficulty remembering that altruism comes before self-interest.

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