MISCELLANEOUS

THE MEDICAL PROFESSION'S RESPONSIBILITIES TODAY

The concept of responsibility towards society was even in ancient times clearly understood by doctors. Hippocrates gave us a prophetic definition, from the ethical point of view, of the universal attributes of sound medical practice. Its wisdom lay in his acute conception of man's gift of life, as well as man's infinitely complex relationship with his environment and even with the Cosmos.

But in every country, medical progress and its economic repercussions, and the development of laws for social welfare, have profoundly changed the doctor's responsibilities and set a whole series of new problems. Moreover, this progress today implies a surprising power to intervene and makes of us, as the great biologist Jean Rostand said, " Gods even before we deserve to be men "

Development of social laws has given rise to a new duty for the doctor, that of assuming responsibility in the conflict which may oppose the patient's requirements to the interests of society. The doctor is called upon to take part in decision making on socio-hygiene expenditure for which economists alone cannot be the sole adjudicators.

In addition, the medical profession itself has been transformed. This is what the World Health Organization had to say on the occasion of World Health Day :

Medical education is the acquisition of knowledge that makes it possible to utilize scientific judgement in interpreting the indications of disease, in deciding on treatment and in forming an opinion as to the outcome. It is difficult and long, requiring a minimum of six years' university level education and perhaps four more of specialization.

There must be time for a strict training in ethics: changing nature by nurture. The medical man comes to know much that is intimate about his patients and can do great harm if he is not trustworthy. The Hippocratic oath that every physician takes is 2500 years old. Medicine and religions grew together and led to the establishment of universities.

Only a few centuries ago medical education was mainly apprenticeship. Formal training gradually became the rule, shorter at first and lengthening with the advance of the sciences on which medicine is based. These advances have been particularly rapid in our times. Fathers of the present generation of doctors did not study microbiology at medical school: radiology is new, and techniques such as electrocardiography have quite recently become part of medical practice.

As knowledge advanced and it became clear that no one should be allowed to practice medicine unless he had learned all the basic essentials, medical education became essentially the same in all countries. There is still room, and need, for familiarity with locally prevalent diseases, but the scientific basis of medicine is universal. There can be only one medicine—that which enables its practitioners to use the best possible scientific judgement.

The responsibilities of medicine, and its intellectual, human and material rewards have for thousands of years attracted some of the best men of their time. While these attractions are still strong, other equally challenging and satisfying careers are now open, some of which are less expensive to study, less exacting and bring quicker and larger financial rewards. Many people who might have gone into medicine are now drawn to the technological sciences: others become research workers, sometimes after they have studied medicine.

This expansion of knowledge has had other results, for a medical student cannot now learn everything that medicine has to offer, nor can his studies be any longer than they are. In any case others can perform functions that do not require full medical education but are based on medical knowledge. The separation of pharmacists and dentists from medicine is relatively old. The separation of nursing as a profession dates from about a century ago. Later still other professions were recognized, optometry, physiotherapy,

X-ray and medical laboratory technology. Sanitation, which is the application of principles of environmental hygiene to protect man's health, has become another profession, represented by the sanitary engineer and the sanitarian. Sometimes these are all grouped together as the medical professions. They have been also called " medical and allied subjects ", " medical and paramedical professions " and collectively, the " health professions ".

Whatever the term used, the fact remains that the care of health and the prevention and cure of disease have become a team affair rather than the responsibility of the doctor alone. The number and quality of the services he can perform depends to a great extent on the number and quality of the persons who share his responsibilities. In many cases some of the functions of each of these professions can be delegated to persons with more limited training called auxiliaries. There are auxiliary and assistant nurses, dental aids, sanitation inspectors, laboratory technicians. There are medical auxiliaries to whom a doctor can delegate certain functions in the diagnosis and treatment of common diseases. The greater the number of persons practising the paramedical professions and the more auxiliaries there are, the better the service a doctor can give. This service is of a nature that he alone is able to provide.

It is common to judge the services available by comparing the number of doctors to total population. Some countries are relatively well provided for : Austria, Czechoslovakia, France, Israel, Scotland, the United States of America and the USSR have one doctor for between 500 and 1000 people. The proportion is very small in many others, especially some new independent countries like Mali, Niger and others, with one doctor for over 50,000 people.

This ratio gives only a rough indication of the situation. Doctors may be concentrated in one part of the country, very often in cities where hospitals are to be found. If communications are good, people far away from a doctor may be better served than those nearer, but less accessible. The nature of the prevalent diseases in a country also makes a difference. Diagnosing and treating malaria or yaws is much less time-consuming than heart disease, cancer or mental illness. In places where the latter are common, people are more likely to call the doctor, for in such countries the preventable

diseases have been reduced and the average age of the population has increased. It also makes a difference whether, in the main, the population depends on the private practice of medicine or whether medical care is part of the public and community health services.

In fact, the ideal is difficult to define. Medicine is no exception to the economic rule that the satisfaction of one need creates other needs more difficult to satisfy. The demand for physicians increases with the development of the health consciousness of the population and the sophistication of the services it demands. In the United States of America, for example, it has been stated that America is not likely to ever be able to produce enough physicians to satisfy growing national needs.

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Needs increase therefore at the same time as responsibilities ; and the greatest of these shouldered by the doctor is the preservation of life. For centuries rules were as clear as the science was rough and ready ; They were founded solidly on the tradition of the art of healing by trial and error. However, technical progress bringing new power to therapy together with medicines which are both a power for good and at the same time often dangerous, has shaken the moral foundations of the medical profession.

How can the risk of effective therapy and the legitimacy of bold intervention be measured? How can the protection of the human person and his dignity be ensured at a time when the doctor, in the name of his vocation, finds himself shouldered with new responsibilities?

To these questions which arise everywhere, in towns and in countryside, in hospitals and in the laboratory, the second " Congrès international de morale médicale ", meeting in Paris last May, tried to reply. The Congress theme " Medical responsibility " was considered from two angles : the legal and the moral. The rapporteurs studied the new events on the ethical tradition of certain therapeutic processes which yesterday were unthinkable and, in addition, the insertion of the medical profession into the social welfare system.

During the inaugural session, Mr. Jean Guitton of the Académie Française, recalled the link between society and the individual, and between fellowship and solitude. Between the patient and the doctor, the man who suffers and he whose first duty is to help him, there is a

profound connection, one which governs intercourse between two consciences.

" Together " he said " we are one body, cast in the same moral. In these historic times, more than ever, I am responsible for myself, you for me, all for me, me for all. And to remedy past evils, to make up for time lost, we have a single collective responsibility which calls upon us to search our hearts unceasingly in solitude, but also requires us all to go forward on a converging path towards a single infinite objective —ever more solitary but with ever greater fellowship ".

With confidence in the same hope, one of the rapporteurs, Professor Jean Bernard, expressed his opinion to the Conference that the fears that medicine might become an impersonal affair are groundless. He concluded : " All medicine involves research. The help to a patient is a fundamental duty but contribution to the progress of our knowledge is also an imperious obligation. The two are inseparable. It is a matter of honour that we endeavour to unite them ; it will be to our merit to succeed. Medicine concerns both the individual and mankind."

It is true that at this international meeting where discussions involved human medicine, the medicine of the body and of the mind, moral responsibility, hospital lay-out and equipment, the problem of the dehumanization of medicine was raised by others in a less affirmative manner. If there is an evolution of this kind, what measures must be taken to prevent it and preclude the dangers to which it gives rise ?

In an account of the Congress published in a series of five studies by La Presse Médicale [1], *Mr. Monnerot-Dumaine quotes several factors which in his opinion tend towards this dehumanization : the convertion of medicine to a social service, the multiplication of specialization and technical progress, automation methods in medicine, a decline in medical responsibility, lack of consideration for the doctor and for human dignity. He recalled certain necessities to ensure a remedy and particularly the awakening of a sense of responsibility. We believe our readers will be interested in some of the ideas here expressed :*

There is yet another important remedy to the dehumanization of medicine: training and a sharpening of that sense of responsibility which is the duty and the honour of our profession. A few

[1] Paris, December Nos. 55, 56, 1966 ; Nos. 1, 2, 3, 1967.

theoretical *ex cathedra* courses will not suffice. It is during hospital training at the patient's bedside and during external consultations as well as during clinical lessons that the teacher must seize every opportunity to convince future doctors that—in the words of J. R. Debray—" medicine is a mission going beyond techniques "; he must bring home to them the difficult choices which will confront them, the questions of conscience they will have to solve always being aware of the fact that it is the client's welfare which is supreme. It must be engraved on their minds that negligence in the medical profession is a sin, a breach of trust, and that the patient is entitled to meticulous examination and care. To raise the moral level of doctors is to fight against that indifference by the doctor which is so detrimental to the patient-doctor confidence and relationship.

There is not only the ethical aspect, the moral responsibility, to be considered. " The sociological consequences of prodigious progress in medicine are not dealt with in any university education " (Prof. Debray). The concept of collective economic and civic responsibility, of public health organization and the functioning of social medicine is often ignored by doctors, engrossed in the daily practice of a difficult profession.

Hospital conditions today are much better than they used to be, but there is still room for improvement. In many countries the full-time presence of doctors in hospitals makes for closer contact between doctor and patients, earlier observation and treatment, and reduces waiting periods which seem interminable to hospital inmates and during which they feel neglected or forgotten, thereby increasing their anxiety. A full-time doctor can give daily consultations to patients in his office, talk to them of their ailments and treatment, instead of leaving them in absolute and worrying ignorance of their condition as used to be the case.

The hospital for children in Boston now being built will include a hotel and a motel run on commercial lines. This will enable parents of children who live some distance away to stay close to the hospital. Children not requiring constant attention will be able to stay with their parents.

It seems that growth in the size of hospitals is not without its drawbacks. English doctors have protested against the disappear-

ance of the smaller hospitals, so convenient for patients not requiring complicated treatment and where a friendly family atmosphere can easily be maintained. Oversize hospitals become like factories. With too many doctors in attendance, the patient does not know which one to trust and may at times be worried as a result. It is not merely the size which should be limited, but also the scope. Some planners—having a tendency to megalomania, to our mind—look upon the hospital as a regional nerve centre in medical matters. Not only does it shelter and heal; it instructs medical students, it engages in applied research but launches out into basic research, it increases external consultations, and clinics for controls, preventive medicine and rehabilitation. It even spreads into the town by setting up district medico-social centres and into the countryside through rural infirmaries, to act as feelers to seek out patients for the hospital. Such a totalitarian type of hospital with its pervading tentacles we would accuse of monopolizing medicine to the detriment of outside doctors, especially the general practitioners whose function is no more than to sort out the patients. Strange way of rehabilitating the family doctor, a species which will soon become extinct. And thirty years hence this hospital will be fully automated at every stage from the patient's admittance to his departure on convalescence, with diet, examination and treatment all ordered, programmed, carried out, timed and controlled by machines. According to Dr. Thomas Hale, of Albany, the day will come when the doctor will not even have to go to his patient's bedside ; " televising rooms " will give the doctor life-size and natural colour projections of his patient. Just like direct television documentaries to an audience.

And yet, thanks to—or in spite of—scientific progress, the personal touch need not be eliminated from the hospital.

The impetus of socialization, the proliferation of specialization, increasing demand for medical treatment, automation and an undoubted decline in moral values (from which the medical profession is not spared), medicine is suffering from a process to which the human touch is slowly being sacrificed. What medicine gains from scientific and technical progress, it loses, we might say, in ethics and humanity. A disturbing tendency ; but is it ineluctable ? Must the doctor and the patient be resigned to be no more than

cogs in the social security machinery of huge hospitals operated by an impersonal administration processing facts, figures and data, instead of treating individual human beings ?

Not if the medical profession is roused, if it desires to play an important part in conceiving and directing the course of medicine tomorrow (J. R. Debray), and if it is determined to make up for leeway. The remedies are to hand ; they are known. They are not so much administrative, technical or planning remedies as moral, spiritual and intellectual. Reliance must not be placed on the issuing of Acts and regulations, but rather on what is best in the hearts of Hippocrates' successors.

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Here then is the second reference to Hippocrates in this account. Could this not also be the place to recall that if one of the essential Red Cross principles, that of non-discrimination, does not figure in the famous Greek doctor's Oath, it is, on the other hand, contained in the Code of medical ethics from which it derives. This Code drawn up by the World Medical Association was adopted by its General Assembly in 1949.[1] *It lays down the general duties of doctors, duties towards the sick and obligations between doctors. It also reflects modern notions on man's condition by insisting on the fact that " considerations of religion, nation, race, political views or social standing " should not intervene. Furthermore, it is known that the World Medical Association recently adopted a Declaration at Helsinki which must serve as a moral guide in clinical research.*

By way of conclusion, it should also be recalled that " the Red Cross is in fact closely allied, if not with medicine, at any rate with doctors and with all those whose work it is to treat the wounded "[2]. *Doctors and the Red Cross have the same end in view ; it is the alleviation of suffering and their collaboration can never be too close. If the Red Cross counts in all countries on the support of doctors, these on the other hand owe it a legal status which protects them in the exercising of their activities on the international level.*

[1] See *Revue internationale de la Croix-Rouge*, December 1955.

[2] J. P. Schoenholzer, *" The doctor in the Geneva Conventions of 1949 "*, see *Revue internationale de la Croix-Rouge*, February and March 1953.

In time of war, the Geneva Conventions impose duties on doctors, but at the same time give them rights of which some are directly attributed to members of medical personnel itself and others take the form of an obligation incumbent on a hostile Power. They also stipulate that persons whom they protect shall be treated " without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria ". In this way doctors can play an important role by knowing and spreading this knowledge of the Geneva Conventions and by insisting on their application. By doing this, they will be acting in accordance with the Red Cross spirit. Similarly, when treating the sick, they will be basing themselves on a certain number of rules arising from the intangible respect for the individual.

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IN MEMORY OF AN ICRC DELEGATE

To honour the memory of Georges Olivet, who died whilst on active Red Cross service,[1] the " Union des Suisses d'Afrique centrale " has had set in a commemorative block of granite a bronze plate with the inscription:

A Georges Olivet,
délégué du Comité international de la Croix-Rouge,
tombé dans l'accomplissement de sa mission à Elisabethville,
le 1.12.1961, à l'âge de 34 ans.

This monument is in the grounds of the " Maison suisse " at Mont Galufa in Kinshasa. It was inaugurated in the presence of all the Swiss residents of the Congolese capital. The Swiss Ambassador and the Chairman of the UNION spoke in moving terms recalling the memory of the deceased.

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[1] See *International Review*, January 1962.