Presidential Address: Sleeping With the Enemy

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Dr. Adrian Flatt, 31st president of the American Society for Surgery of the Hand, in his Presidential Address took "great pride in being the first immigrant to be elected to this post." As the second immigrant president of this Society, the first born in a Latin American country, I echo the following words from Dr. Flatt's presidential address: "My election was a fine example of the tolerance and the attitudes that have made this Nation (and I may add this organization) great."

This occasion to address the society's annual meeting provides its president with a unique opportunity to voice concerns that would be difficult to express under any other circumstances. I have lived in this country most of my adult life, and all of my independent professional life. During these years, I have become aware of a gradual change in the ethical behavior of many in our profession. This has been particularly disturbing to me, for in some cases those implicated were close to me, while in other instances the result of their behavior had a direct effect on matters related to *my* professional life. Indeed, I found myself and my profession "sleeping with the enemy."

When I left Argentina for the first time, and a few days later arrived in this country, I did not know that we were entering an era that was to radically change the very soul of this United States of America. The decade of the fifties had just ended. Disneyland had opened its gates in California in 1955, a fitting symbol for this era of good will and trust in the goodness of our society.

It was during the fifties, however, that the elements of a foundation for later change were laid. The nation became wired for television, the development of the birth control pill began, and there was an increasing awareness of matters social, particularly as they related to race and gender. The sexual revolution, civil rights, and the fights for equality followed. On August 28, 1963, Dr. Martin Luther King, Jr, delivered his "I Have a Dream" address in Washington, DC. Thirty years ago, President Lyndon Johnson signed the Civil Rights Act of 1964. The war in Vietnam escalated. The Tonkin resolution ignited a fierce battle among Americans. Many believed that the government had lied to the American public. Anti-war activism, the counterculture, and the Free Speech Movement became part of our vocabulary. The flower children entered the national scene, young adults reverting to the illusions and security of childhood, in a world they thought could no longer be trusted.

America lost a great deal of its innocence—and the feeling that came to be called "Camelot"—on November 22, 1963 the day of the assassination of President John F. Kennedy. And in spite of incredible technical achievements, like the Apollo mission, it was hedonism and self-indulgence that came to define the 1960s.

These changes were reflected in how the country educated its children. A model for education called *decision-making* was introduced at the elementary and high-school levels. Decision-making replaced an older model called *character education*, which had been in place in our schools until the 1950s.[1] Character education was based on a relatively simple premise: that children ought to know certain traits and characters, that they learn these by example, and that once familiar with them, children will need to practice them until they become second nature. The movement's key assertion is that specific, universal standards of conduct exist that ought to apply to everyone, regardless of ethnic or racial background or religion. Character education was sometimes heavy-handed, and often liable to abuse, but seemed to serve our culture well over a long period of time. The shift from character education to a

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decision-making model occurred with the best of intentions, and was proposed to help students to think more independently and critically about values. Behind this model was the belief that children would be more willing to accept knowledge learned from self discovery than knowledge force-fed by adults. However, curricula under decision-making required students to discuss and exchange opinions over matters for which they had no prior guidance. It was believed that this would enhance the students' abilities to truly be educated, rather than indoctrinated. Instead, confusion—or at least a lack of clear vision—resulted in students' minds, as they were unable to question or discuss that to which they had not been exposed.

Many centuries ago, Plato observed that it is much more important for young people to learn what was then called "a love of virtue" than to argue about it. Arguments and discussions were fine, but reserved for a later, more mature stage. William Kirkpatrick, in his book "Why Johnny Can't Tell Right From Wrong," agreed with Plato: it is difficult to question that which has not been taught. Right and wrong were no longer absolutes.[1] Kirkpatrick referred to this generation as morally illiterate, attuned only to their own feelings. This rather damning statement is, I believe, too inclusive. However, it is apparent that, whether directly caused by decision-making education or not, the roles of teachers, administrators, and adults in general has become diminished and the attempt to create a nonjudgmental attitude about values has succeeded (Table 1).

I am not sure that there is such a direct relationship between decision-making education and these changes in the learning environment, but I am not a professional educator. However, the literature in the past 10 years seems to substantiate the case for character education.

After the 1960s came the narcissism of the 1970s, and then, the greed of the 1980s. Medicine was also changing; no longer a pure service profession, it became increasingly a business.[2] These changes found our profession ill prepared to deal with the ethical problems to which other professions had long been exposed. Toward the end of the 1980s, when it became clear that the financial rewards that attracted many to medicine were dwindling, this problem exacerbated. Lower reimbursements, strains in doctor-patient relationships, and the introduction of nonphysicians into our practices forever changed medicine as many of us knew it.

Table 1. The Seven Greatest Threats to Discipline in Our Classrooms

1940	*Today*
Talking out of turn	Drug abuse
Chewing gum	Alcohol abuse
Making noise	Pregnancy
Running in the halls	Suicide
Getting out of line	Rape
Wearing improper clothing	Robbery
Not putting paper in the wastebasket	Assault

(From Kirkpatrick,[1] with permission.)

Physicians became increasingly troubled and unhappy. A 1987 AMA survey of 3,183 medical doctors older than 40 or in practice for at least 5 years, asked, "Given what you know about medicine as a career, if you were in college today, would you go to medical school?" An astonishing 44% responded no.[3] A similar survey of lawyers by the American Bar Association in 1984 found only 15% somewhat or very dissatisfied. This discontent is reflected in the advice doctors give their children; as many (58% in a 1990 poll[4]) do not encourage them to enter the medical profession.

Steven A. Schroeder, MD, president of the Robert Wood Johnson Foundation in Princeton, NJ, in 1992 observed: At some point in the past 15 years, a profound change occurred in the way doctors felt about their profession. There is now serious dissatisfaction among practicing physicians.[5] The further along we found ourselves in a cost-conscious economy, the more our relationship with our patients suffered. The process saw the intimacy between physician and patient become a disposable item. After all, to establish a communion with patients requires time and is labor-intensive, and therefore not cost-effective.[6] Greed was substituted for caring, and ethical barriers were lowered.

The Problem

The measure of a man's real character is what he would do if he knew he would never be found out.

Thomas Macaulay

The concern with ethical behavior transcends medicine and pervades all levels of society: business, law, government, and, yes, even the police, the media, schools, the clergy, and charitable organizations. A recent issue of *Financial World* was dedicated to ethics in business. In that issue, *Financial World's* editor, Geoffrey N. Smith, pointed out that over the past several years, CEOs across the country seem to have rediscovered ethics.[7] Ethics credos and guidelines and ethics training permeate the corporate ranks of America.

General Electric, involved over the last few years in a number of ethical problems, has, paradoxically, one of the most extensive ethics programs in corporate

America—extensive, but apparently ineffective. James Helmer, an attorney who has been a thorn in GE's side, states that General Electric's written policies are as good as any, but "the problem that I keep running into is they talk the talk but don't walk the walk."[8] The savings and loan crisis, the BCCI caper, and insider trading are other examples of wholesale fraud in business. Even golf does not escape. A recent "attitudinal study" by Hyatt Hotels and Resorts found that nearly half of 401 executives agreed that "the way a person plays golf is very similar to how he or she conducts business affairs." Of those polled, 55% admitted cheating at golf at least once. This included moving the ball to get a better lie, not counting a missed tap-in, taking an extra tee shot, intentionally miscounting strokes and, in an incredible 6%, secretly producing a fresh ball while pretending to look for a wayward one in the woods! One-third of those who confessed to cheating on the links admitted to pulling fast ones on the job.

Attorney Sol M. Linowitz was admitted to the bar more than 50 years before he wrote an article entitled "It's legal, but it's rotten!"[9] In it he bemoans changes in his profession. When he entered the practice of law, he recognized that his responsibility would be to serve as an advocate on behalf of his clients—but first he would be the advocate for law and lawfulness. He finds now that too few young lawyers are willing to carry forward the legacy of his idealism. "The great majority of them look upon their license to practice law as a hard-earned and well-deserved entry into the world of wealth and status." Sound familiar? Just substitute "law" for "medicine." He recalled that long before there was a United States, Edmund Burke was encouraging King George III not to listen to some of his legal advisers. What should guide him was "not what a lawyer tells me I may do, but what humanity, reason and justice tell me I ought to do." A couple of centuries later, the distinguished statesman and lawyer Elihu Root said it rather succinctly when he advised a client: "The law lets you do it but don't; it's a rotten thing to do."[9]

I always believed that physicians are held to a higher ethical standard than other professions. Therefore, it came as a painful surprise to find that the body of traditional medical ethics was wanting, and that there was little awareness in medicine that other professions had long dealt with such issues. In his book *Medicine, Money and Morals* Rodwin states that as a result, doctors are held to lower standards of conduct than other professionals.[10] Rodwin points out that the law considers lawyers, federal government officials, and certain professionals in finance to be *fiduciaries*; that is, individuals obligated to work for the benefit of others and held to the highest legal standard. Many today refer to doctors as fiduciaries espousing a fiduciary ethic and thus held "accountable to their fiduciary ideals." The difficulty lies, of course, in establishing enforceable fiduciary ideals. The unfortunate fact is that we physicians are seen by the public at large as working for our own benefit rather than for the benefit of others. For instance, escalating costs in health care are strictly linked to physician's alleged misconduct, particularly by those in the media. Dr. Raymond Scalettar, then the chair of the AMA Board of Trustees, recalled a conversation with a writer for one of the country's major newspapers.[11] Dr. Scalettar was asked. "Isn't it true that the real reason health care costs have gone through the roof is because of physician greed and fraud?"

Describing the AMA's annual National Political Education Conference in Washington, DC, last year, *Time* magazine states: "Watching 600 or so doctors troop up the steps of Capitol Hill, it was tempting to assume they had come to defend their right to earn six times as much money as the average American family and still play golf on Wednesdays."[12] Clearly, our image is tarnished.

Within our own ranks, there is widespread uneasiness, due in part to a perceived increase in ethical misconduct and dishonest behavior. Some of us may agree that there is a problem with dishonesty, with greed or even with fraud, but will argue that the problem is minimal. A few of us may recognize the problem as significant, but would decry any attempts at discussing it in public for, after all, our profession is already in a state of siege, and there is no useful purpose in providing more ammunition to the enemy. The fact is that a profound hostility is developing in some quarters against the medical profession, and that the public's approval rate for us, their physicians, is in continuous decline. Surprisingly, it is not physicians' incompetence that rattles public confidence, but rather their insensitivity and lack of compassion, creating a resentment that some believe we have largely brought on ourselves.[13]

In the privacy of our hospital lounges across the country, and in conversations in the operating rooms, we have been exposed to horror stories of doctor's misconduct, coming not from attorneys, or patients, or the press, but from our own colleagues. As Pogo, Walt Kelly's cartoon character said in response to the Watergate scandal: "We have met the enemy, and he is us."

Ladies and gentlemen: I do not believe that the enemy is us, but I do believe that at the very least, we are guilty of tolerating unethical conduct, that we have been sleeping with the enemy. To paraphrase Rabbi Abraham Heschel's dictum: some may be guilty, but all are responsible. I want to use this time to share with you concerns that have weighed rather

heavily on my mind. Some are more distrurbing than others, some overt, some subtle, but all conform to a pattern of conduct that in many cases can only be termed fraudulent.

Fraud is a criminal act, involving deception and misrepresentation for the benefit of the deceiver, when gains are accrued for a service that has not been provided or should not have been provided. Fraud, unlike good deeds, is newsworthy. California's fight against fraud became national news on "60 Minutes" and in *Reader's Digest*. This suggests that the impact of unethical behavior is fueled by the lay press and is a misperception. The contrary is true. At a recent AMA Leadership Conference panel discussion, Edward Lueckenhoff, the FBI's Health Care Unit chief, said that health care fraud is second only to violent crime on the FBI's priority list.[14]

This puts to a test my long-held belief that misconduct involves only a fraction of physicians. Do not take me wrong. I will defend to the bitter end our right to be reimbursed in a manner that is commensurate with the many years of training and with the significance of the work we do. Criticism is due, at least in our profession, when a doctors' charges are beyond the value of the service provided, when income has not been earned. This is a point that is still missed. This is why unbundling, upcoding, and constructive billing have been under attack.

Last year, the AMA adopted a set of Principles of Medical Ethics. So did the AAOS. The second principle for both organizations states: "A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception."

The Council on Ethical and Judicial Affairs of the AMA stated that "a physician should not charge or collect an illegal or excessive fee. A fee is judged to be excessive when, after review of the facts, a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee." Jim Strickland, in his discussion on "The deterioration of fee for service ethics,"[15] observed: "For the most part, these increased charges are paid by the powerless carriers, and the system rewards the dishonest handsomely. Once remunerated at a higher level, the surgeon now believes that the fee was rendered legitimate by payment." As we have learned in the last couple of years, carriers are anything but powerless. Those of us who have attempted to maintain an ethical billing practice, however, are powerless. There has been an inevitable backlash to the abuses by some, but the backlash has been indiscriminate, and has swept us all, the honest and the dishonest, under the same rug.

Robert M. Tenery, Jr, a Dallas ophthalmologist and past president of the Texas Medical Association, pointed out that there is a new type of physician, whose medical business comes ahead of his patient's care, who is competent and frequently technically above average, and who represents a much greater threat to the profession than the traditional "quack."[16] The patient is not harmed directly, for the care received is usually excellent. But the public develops a sense that their doctor is too concerned about monetary matters. This perception is extended to the profession in general, viewed then as one from which medical care is purchased, and results essentially guaranteed. This small minority exerts an influence much beyond its numbers.

In January 1994, *Plastic Surgery News* carried an item on accurate coding, prompted by the intent of the American Board of Plastic and Reconstructive Surgery to examine coding practices as part of the analysis of the ethical behavior of candidates for membership.[17] The article ennumerated four actual examples of abuse:

- The use of six codes for a single trigger finger release;
- The use of five codes for a routine carpal tunnel release;
- Billing as an "advancement flap" a closure following the excision of a 1-cm skin lesion of the trunk;
- Billing for "myocutaneous flap" for the simple closure of a wound, "perhaps with a little undermining."

Here are some actual examples of fraudulent charges, with which I am personally familiar.

- Nine operations over almost 2 years, and $53,000.00 for surgical fees, for the treatment of an open intra-articular fracture of the distal joint of the nondominant little finger of a laborer.
- Four fingertip injuries. Thirteen procedures listed under "operation," $4,700.00 in charges.
- Malunion of a fracture of the distal radius, billed $29,500.00 for a closing wedge osteotomy of the radius, excision of distal ulna, *neurolysis of all three major nerves to the hand,* and flexor tenosynovectomy.
- Release of a carpal tunnel and four trigger fingers: $17,500.00.
- Bilateral carpal tunnel syndrome "secondary to hypertrophic tenosynovitis of flexor tendons within the carpal canals": $16,000.00.
- Excision of mucoid cyst, removal of osteophytes referred to as "resection arthroplasty," and application of a full-thickness skin graft: $3387.00.

There are many more examples of egregious charges in my possession. It is more important, however, to consider what it is that we, as individuals, as physicians, and as an organization can do to correct these problems.

The Solution

Blanketing an entire profession with rules aimed at catching those who are not living up to their professional standards does not improve quality.

Hillary Rodham Clinton[18]

As part of the Socratic dialogues, many centuries ago, Meno asked the Master:[19]

Can you, Socrates, tell me, is human excellence (virtue) something teachable? or, if not teachable, is it something to be acquired by training or, if it cannot be acquired either by training or by learning, does it accrue to men at birth or in some other way?

Today, we are still struggling with the same questions, and the answers still seem to elude us.

Are there, indeed, solutions? To believe that none exist is a guarantee that none will be found. There are solutions, but they are complex, and in many cases clearly beyond our reach. Let us explore the role that institutions and society, and ourselves, can play in finding answers to the problem.

The Role of Society

Many problems that we perceive as professional are basically societal, and need to be addressed by society at large. These include the viability of our schools, the abdication of parental responsibility, the tolerance for violence, teachers who are poorly prepared to teach, or lack motivation, or are not our best, for this is a society that is willing to spend more on cosmetics, liquor, and drugs, than on schools, teachers, and the education of children. Fortunately, this is beginning to change. In 1992, alarmed by cheating and violence, a growing number of educators began to teach the basics of ethics. Character education was emphasized again. "Core" standards were stressed: honesty, responsibility, compassion, perseverance, respectfulness, cooperation, courage, and citizenship.

Although cheating in college, lying, and stealing take the headlines, in reality, codes of conduct are on the rise—and it's often students themselves who are pushing them. Variations on rules of conduct that had been used in some military academies are now embraced by 100 or so institutions of higher learning, ranging from schools such as Washington and Lee, to Princeton and Rice, and to the University of Maryland, which has 38,000 students.

The Role of Organized Medicine

In 1846, a convention met in New York City to plan a national medical association, which would eventually become the American Medical Association. Only 2 years earlier, in 1844, the state of New York had repealed all licensing statutes, denying the orthodox profession state protection against sectarian and untrained practitioners.[2] Doctors felt obligated to rely on their own, providing the impetus for the adoption of a code of professional ethics designed to control those practitioners. Predictably, this turned out to have little impact. The "irregular" physicians accused the AMA of attempting to monopolize medical practice, and instead of disappearing, they thrived.

The same pattern of publication of codes of ethics, followed by infrequent or unreliable success, has since continued in medicine and all the other professions. When John Dean, of Watergate fame, was asked whether taking an ethics course in college would have averted his participation in the Watergate cover-up, he replied that it would not, since he knew beforehand that what he was doing was wrong.[1] The fact is, that to expect significant changes in conduct to be achieved through ethical guidelines alone, at this level of professional life, is bound to be as sterile as to expect a successful crop after seeding an unprepared, sterile field. The emphasis should be on sterile, for a field that has been prepared will be receptive.

There is, therefore, a place for codes of ethics. The American Society for Surgery of the Hand has published one, as well as a volume on ethical billing practices. This approach may only be cosmetic, and is bound to affect only those that are amenable to correction rather than those for whom the guidelines were intended in the first place. This alone, however, should be enough for us as an organization to continue these efforts.

Our Role as Educators

Integration into the fraternity of medicine should not dehumanize the student. We all understand that the rigors of training and the long hours are meant to make us better doctors, but let us not forget our humanity in the process. At the same time, we need to ensure that those we choose to join us in our profession will adhere to the highest standards. To this end, we should look for guidelines to assist us in the selection, for we all know that there is no better time to eliminate an apple bound to rot than before it enters the common sack. Unfortunately, and much to my disappointment,

the experts point out that the only reliable predictor of professional behavior is a negative predictor: cheating. Those who cheat in school will cheat in practice. Neither school grades, medical knowledge, clinical judgement or technical expertise, nor interpersonal clinical relations or personality, have been good predictors of performance,[20] but the capacity for moral reasoning was.[20,21] High moral reasoning virtually excludes the possibility of poor performance. Conversely, the highest level of clinical performance was rarely achieved by those at the lower levels of the moral scale.

A second factor found to be closely correlated to excellence was the need to understand.[22] This is defined as a cognitive style variable related to curiosity, cognitive complexity, and intellectuality, representing inquiring, curious, analytical, exploring, probing, logical minds. Moral judgement and the need to understand are, however, only two factors, others being emotional make-up, ego strength, and the willingness to act on a decision.

Assuming the adoption of such improved selection criteria we must then teach these students. Unfortunately, the pressures in academia actually detract from this very academic function. Teaching, in many instances, takes a second seat to publishing and research. Publish or perish. It reminds me of Walker Percy's "Prayer of a scientist if he prayed, which is not likely."[23]

Lord, grant that my discovery may increase knowledge and help other men.

Failing that, O Lord, grant that it will not lead to man's destruction.

Failing that, O Lord, grant that my article in Brain [or in the Journal of Hand Surgery] be published before the destruction takes place.

I understand that difficulties arise from the struggle to secure funding, for research, or for clinical endeavors. The imperative is to remain at the very edge of research and clinical practice, lest one's position be thwarted or eliminated. However, if we have academicians involved in research, or as full-time clinicians, who is left with the dedication, the time, and the energy to teach students? It has been proposed that we recognize teaching excellence in clinical medicine as a valued academic function by restructuring promotion and tenure guidelines. In some institutions this may be best accomplished by developing a two-track system, one that recognizes research productivity, the other that rewards effective teaching, investment in clinical activities and curriculum development.[24,25]

Our Role as Physicians

In a profession such as ours, where a "mistake" implies incompetence, or even negligence, we should strive for maintaining a kinship with our students, whereby they may learn from our experience, from our success as well as from our mistakes.

We must conduct ourselves, individually and collectively, in a manner beyond reproach. This will allow us to challenge the public's perception. Let us reemphasize that our patients are of paramount importance. We must renew our commitment to our professionalism, which states that our rewards should come from only those services we ourselves provide, and second, we must identify and speak out against those who transgress. Ethics should stand higher than the law, and to settle for a lesser standard will serve us poorly.

Although our hands may be tied by antitrust restrictions and regulations applied to medicine, we should remain vigilant for otherwise we may experience further loss of autonomy, not only to profit-seeking organizations that are effectively taking over the administration of health care, but, more ominously, to the government. There is an assumption that, unless closely regulated, physician's conduct will change to misconduct. This has led to a humiliating pattern of disclosures, enforced by government and third-party payers, to ensure that our approach to reporting, and care giving, is honest. Arbitrary, institutionalized systems to grade doctors according to performance are being implemented. There is now a doctor's report card for Blue Cross of California, the fourth major United States health care company to publish a review of the quality of care delivered by doctors. At the federal level, the Federal Register of March 16, 1989 announced the establishment of an Office of Scientific Integrity.[26]

Must the government intervene to assure ethical behavior? Must the law assure it? In 1992, James S. Todd, then executive vice-president of the AMA, undertook to answer these questions.[27] He was saddened by those who believe the only solution to maintaining "ethical" behavior is the imposition of laws and regulations. He observed that morality has never been successfully legislated.

Fortunately, antitrust barriers are being challenged, and many are disappearing.[28] Let us proclaim again that the medical profession is ethical, and competent, that those physicians who do not measure up will not be tolerated. None of us should be offended by a reaffirmation of professionalism and integrity in medicine.

Our Personal Role

Medicine is very demanding of our time. It is extremely difficult, if not impossible, to adequately address our obligations to our patients and our families. The April 6, 1990, issue of the *Wall Street Journal* reported that on the average, American parents spend less than 15 minutes a week in serious discussion with their children. For fathers, the amount of intimate contact with their children is an average of 17 seconds per day. We must emphasize to our children what is right, rather than what is expedient; that the ultimate goal is not to be a successful human being at any cost, but to be a good human being: success will follow.

We should become, once more, role models, for it has been pointed out that the question for a child is not "Do I want to be good?', but 'Who do I want to be like?"[29] The role model differs at different stages of maturity, and not infrequently, a new model at a higher level is needed before progression to that stage can occur. Many of us may remember the importance of role models in our own profession, for we came to medicine to emulate the local physician of the small town, whose concern for patients and the community impressed us. Just like most other social parameters, however, role models have changed. People in sports and entertainment came to occupy this privileged position. This is fraught with potential problems, as recent events involving several of our best- known athletes demonstrate. To admire an athlete for feats within his or her field is fine. Anything beyond is dangerous. These are high salaried entertainers, admired not for their virtues, but for their success. We need to make more of a positive impact again.

As I finish this address, I also come to the end of my year as your president. I have been privileged over the past several years to be part of this Society's Council and Committees, and am convinced that in our many young members, and in those that preceded and will follow me at this post and within our Council and Committees, there is a continuum of outstanding individuals, simply representing the best of the hopes and achievements of the ASSH.

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