

Try to become not a man of success, but  
try rather to become a man of value.

—Albert Einstein

# Physician Integrity

## *Why It Is Inviolable*

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To deem itself civilized, a society must protect the personal integrity of its citizens. Without such protection, the integrity of the society itself unravels as more and more effort goes into protecting individuals against the chicanery of their fellow citizens. Perhaps this is why Plato called integrity “the goodness of the ordinary citizen.”

If integrity is the characteristic value for the ordinary citizen, then it’s even more important for those whose social roles are defined primarily in terms of personal trust—doctors, lawyers, ministers, and teachers. Ordinary citizens cannot be healed—or provided with advocacy, spiritual counsel, or learning—without trust in these helping professions. (Unfortunately, history recounts how some physicians in every age have failed in the trustworthiness integral to medicine.) When such professions lack integrity, those who need their services will seek to protect themselves by assuring greater individual or public control over their relationships with these professions.

For a variety of reasons, this is what is happening in medicine in today’s complex societies—especially now that medicine’s power to alter human life is unprecedented. The result is that the center of gravity for individual decisions has shifted sharply away from the physician to the patient. That power shift has been reinforced in law

(witness the burgeoning of malpractice lawsuits and insurance) and public policy as well. However, one may rightly ask: Is the good of the patient better served when he takes charge and directs his own care, or does the erosion of trust in the physician’s integrity put the patient in danger of being morally abandoned by the physician?

I contend that autonomy gives patients the moral right to reject care and protects their human dignity, but that patient autonomy need not interfere with the integrity of the physician—*unless* that right is expanded in such a way that patients can demand and even direct the details of clinical care. But if autonomy is understood as a right to demand care, it not only violates the integrity of the physician, it also endangers the care of the patient. For the benefit of both patient and doctor, patient autonomy must be understood in such a way that it can coexist with physician integrity.

### **The Nature of Integrity**

Classically, personal integrity has been understood as a person’s commitment to live a moral life. The woman or man of integrity is honest, reliable, and without hypocrisy. He will admit mistakes, be remorseful, and accept the guilt that follows wrongdoing. The person of integrity fulfills the obligations of his private and his professional life, which are consistent with each other. He or she follows his conscience reliably and predictably. This pursuit is intrinsic to the person’s identity. To violate it is to violate that person’s humanity.

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In the patient-physician relationship, *both* parties are entitled to protection of their personal integrity. However, the values, beliefs, and norms that comprise integrity may well be very different—and present different challenges—for doctor and patient. The physician needs to contend with an increasingly pluralistic society that can create pressure to compel him or her to accommodate patients' differing religious, cultural, or personal beliefs. Also, the special nature of the patient-physician relationship (which derives from the fact that being sick and being healed are predicaments of special vulnerability), the growth of personal freedom of choice, the systematization of patient care, and the trend toward legal resolution of moral conflicts promise to increase the demand for personal and/or public control of the physician's clinical decisions. All these factors encourage erosion of the physician's personal integrity.

On the patient side, the sick or injured person—in a state of distress, pain, and suffering—is compelled to seek out and depend on the physician who professes to know how to help. The sick person and his family are asked to make choices among therapies, choose when life support may be discontinued, and decide how vigorously the terminally ill patient shall be treated. Throughout all this, the patient and family must trust the physician—or more likely a team of physicians, nurses, social workers, chaplains, etc.—each offering a slightly different rendition of the choices. Often, the physician and other caregivers are of different minds, and none may know what the best choice is. This uncertainty leads to lack of trust and may prompt the patient and family to go in desperation from Internet site to Internet site, and to nontraditional healers or marginal practitioners, in search of answers and of someone they think they can trust. Because, in the end, someone must be trusted.

## The Empowerment of Autonomy

Vulnerable patients have always worried about whether their physicians possessed the competence they claimed and could be trusted to use it wisely and well. Until recently, however, they had little power to challenge the authority and sometimes authoritarianism of their physicians. Today, we live in a time of self-assertion. Autonomy, the most quoted principle of bioethics, empowers patients to challenge physicians' knowledge and judgment. Patients now have the moral and legal rights to be informed and to give or withhold consent. Increasingly, patients and surrogates understand autonomy as empowering them to demand the care they want. Autonomy has expanded to the point that it conflicts with the physician's moral or professional judgments.

The effect on the physician-patient relationship has been profound

Without sanctioning obvious harm, they should yield to patients who choose a less effective treatment, or a treatment of no proven use, or even one that violates the physician's beliefs about what is right and good. Furthermore, some physicians believe that in the name of patient autonomy they must protect all confidences even when others may be harmed—for example, not reporting the incapacitated driver who is a public danger, or not revealing HIV infection to sexual partners. Others may take it as an act of beneficence to exaggerate the severity of disease or disability to increase the patient's insurance coverage.

More subtle—but perhaps more important—is the physician's growing reluctance to urge the course that he or she believes is preferable for *this* patient. Despite protestations that they know what is best for themselves, patients do make wrong choices. For the physician to suggest otherwise is to fail to respect the trust he

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and complex. On the one hand, it has made that relationship more open, more adult, more transparent, and more attentive to the patient's values and wishes. Some of the edge has been taken off physician arrogance and self-assurance, and the patient's dignity as a person is better respected. These benefits have, however, been accompanied by trends that are dangerous to the patient and unjust to the integrity of physicians. For one thing, many physicians feel they are required to satisfy patient or family demands or be guilty of "paternalism"—the original moral sin of modern bioethics.

To avoid paternalism, some physicians and ethicists argue that physicians should be morally neutral.

has promised. Refusing to "bias" the patient's choice by revealing one's own choices—and perhaps persuading the patient to change his mind is not a true violation of autonomy. Rather, *not* to do so violates the principles of beneficence and trust. Beneficence does not equal "paternalism," which relies on deception, treating the patient as a child, or coercing a choice and is itself maleficent. To cooperate in a wrong choice is complicity with what is wrong, and leaving the patient to decide difficult issues about which the physician himself may be uncertain is complicity in harm. Rather, what the patient needs is a physician who protects the moral right of patients to reject any or all treatment after the options have

been frankly disclosed, and who will not use deception or ill-placed emphases to change the patient's mind.

### **Overriding Physician Integrity**

The desire for autonomy and unhindered freedom of choice has led to law and policy that override the physician's objections to certain procedures, including abortion, assisted suicide, euthanasia, some methods of assisted reproduction, and embryonic stem cell research and therapy. This is not the place to argue the ethical issues of these practices. However, refusing to participate in them is essential to the moral and professional integrity of many physicians. Manipu-

lating law and policy to make providing them mandatory by threatening loss of license or specialty certification is an assault on the very person of the objecting physician.

The trajectory of efforts to compel health professionals to provide care they find objectionable is toward relaxation or abolition of conscientious objection privileges. At this writing, there are organized attempts in the courts to block a new federal regulation that protects health workers who refuse to provide objectionable care. The ultimate goal seems to be to eliminate legal protections of conscientious objection entirely.

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### ★ Policy Implications ★

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As we approach another round of health care reform, the medical profession and the public must together find the balance that preserves both patient autonomy and physician integrity, for the benefit of both patients and physicians. Given how essential trust is in medical and health care encounters, we cannot trust physicians who shun responsibility, and we do not want patients abandoned in the midst of critical health and medical care decisions. For a morally viable relationship in a democratic society, both autonomy and integrity must be sacrosanct. ★