



The practitioner as endangered citizen: a genealogy

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Abstract

Medical practice has always involved at least three roles, three complimentary identities. Practitioners have been at once clinicians dedicated to a patient's care, members of a professional organization promoting medicine, and informed citizens engaged in public debates on health issues. Beginning in the 1970s, a series of social and technological changes affected, and in many cases restricted, the practitioner's ability to function equally in these three identities. While others have discussed the changing realities of medical practice in recent decades, none have commented on their effect on their effect on rights of practitioners as citizens. Here several cases begin an analysis of the manner in which those changes have limited the physician's right to act conscientiously and speak publicly in the face of organizational agendas and political priorities.

Keywords Ethics · Bioethics · Conscience · Physician rights · Medicine in society

1 Introduction

In recent decades a series of economic, social and technological changes have fundamentally altered, and diminished, the clinical and social status of health professionals (Brill et al. 2019). While others have noted their effect on the doctor-patient relationship (King 1991), and the role of the practitioner generally (Koch 2019), the effect on the practitioner as an engaged citizen, and thus society-at-large, has been rarely discussed. Here it is argued that changes have not only limited the practitioner's traditional Hippocratic focus—the best care of the individual patient—but also an implied Hippocratic focus on the physician's duty as a vocal citizen in society. As a result, otherwise presumably guaranteed rights of conscience and public engagement for all citizens are being restricted.

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Here four cases are used to begin a kind of Foucauldian “genealogy,” a critical “history of the present,” with its focus on forms of power, the channels it takes and the effective result (Kearins and Hooper 2002). This is part of the larger Foucauldian methodology that seeks to unravel existing conceptual systems resulting in action and identity in a cultural system. The resulting “archipelago,” to use Michel Foucault’s metaphor, reveals a series of related histories creating a single, integrated cognitive structure (Foucault 1980).

While some may dismiss these cases as exceptional, insisting on a more formal analysis, here they are presented as symptomatic events to be understood in a broader context. There is no simple way to prove that supposition but they are at least indicative and the failure of governments and professional organizations to see them as critical is, at the least, suggestive. Together they demonstrate the manner in which practitioners’ traditional obligations to public interest, an assumed duty to social and professional ethical goals, and their rights as citizens have been diminished.

2 Four cases

2.1 Carolyn Strom: a public voice

After her grandfather’s death in February 2015 a Saskatchewan nurse, Carolyn Strom, posted on Facebook a critical review of his care at a local, long-term health facility. In it she identified herself as a nurse and then described care deficits she observed. The goal of the post, which did not name individuals, was educational rather than shaming. “I challenge the people involved in decision making with that facility, to please get all your staff a refresher on the topic [of care standards] and more to those who made Grandpa’s last year’s less than desirable, Please Do Better Next Time!” (Canadian Press 2019).

A complaint was filed in response with the Saskatchewan Registered Nurses Association, the organization charged in law with overseeing professional conduct and standards. In 2016 it ruled her posts injured the reputation of nursing staff at the institution and thus undermined public confidence in the profession-at-large (Pfefferle 2019). The penalty for this “professional misconduct” was a \$1000 fine and the costs of the disciplinary hearing. In addition she was ordered to submit a “self-reflective essay” and complete an online course in ethics.

The judgment was appealed and later upheld in 2019 by Saskatchewan’s Court of Appeal whose justices ruled the judgment of the nurses association was reasonable (CCF 2009; Martin 2019). By that was meant that the Nurses Association’s review procedures were within its lawful mandate as the organization charged in law with professional governance in the province. The decision did not comment on arguments by her lawyers and others that Strom’s conviction violated a Canadian citizen’s rights of free speech. Nor did it note Strom’s post was directed at institutional decision makers, not the nurses alone. The Association’s view that identifying herself as a nurse meant she acted in a professional role that restricted public commentary was not considered and thus not adjudicated. In argument, lawyers for Strom

drew a parallel with a previous case in which a charge of professional misconduct against a Saskatchewan nurse protesting at a Planned Parenthood office was rejected on the basis of his protected right to freedom of expression (Martin 2019).

2.2 Mary Ellen Waithe: the ethicist's role

In 1997 Dr. Mary Ellen Waithe, then director of advanced studies in bioethics at Cleveland State University, approached Carmen Marino, the first assistant prosecutor for Cuyahoga County, Ohio, on a matter of “grave concern” (Kolata 1997). A student in her bioethics class, Peggy Rickard Bishop Bargholt, worked at that time for the graft organ transplant and retrieval program at the Cleveland Clinic. She asked Waithe's opinion of proposed protocols approving the administration of two drugs (Heparin and Regitine) whose purpose was not patient care but to facilitate organ transplantation through the speedy death of the patient. Bishop Bargholt asked Waithe if this was not helping kill persons who might otherwise survive, albeit in a restricted state.

The subsequent investigation focused on a definition of “brain death”—not unique to this institution—in which a persistently unconscious person with cardiac function could be a suitable candidate for organ transplantation (Carlson 1997). A review made clear, Marino said, “The ultimate motive for declaring [brain] death comes into play—to harvest organs.” In other words, death was to be pronounced for pragmatic reasons in patients who might otherwise have survived, albeit with profound cognitive deficits.

The investigation became a national *cause célèbre* when the TV documentary show *60 Minutes* ran the story on national television (Sixty Minutes 1997). Cleveland Clinic ethicist George Agich and his predecessor Dr. George Canoti expressed outrage at Bargholt's and Waithe's referral to the county prosecutor (Kolata 1997b). Professional courtesy required discussion with them rather than a public investigation. When asked about this Waithe told television interviewers that when one observes a suspected crime one has a duty to report it to authorities, not discuss it with the perpetrators.

In her view it was her duty as a teacher to consider a practical problem presented by a student. As a medical ethicist, she was obliged to evaluate the procedures critically. As a citizen, she was required to notify authorities of what appeared to be tantamount to illegal euthanasia.

Waithe was broadly criticized both by the Cleveland Clinic ethicists, and others worried her story might adversely affect voluntary graft organ donations and thus the U.S. organ transplantation program. After all, the “brain death” definition was widely accepted at US hospitals. After the public disclosure and debate the hospital adopted a less controversial, non-beating heart protocol (Smith 2016). Under withering, heavy institutional fire, she left the university and bioethics, eventually finding a job teaching philosophy and religion.

2.3 Nancy Olivieri: physicians and research

In 1995, researchers at Toronto, Canada's Hospital for Sick Children signed a contract with Canadian drug company Apotex to investigate a new treatment of children with Thalassaemia Major, an inherited blood disorder resulting in the production of abnormal haemoglobin (Viens and Savulescu 2004). The contract for supervised trials of the drug deferiprone included a clause requiring researchers to treat as confidential all data collected until three years after the termination of the trial.

During the trials, however, the team's lead researcher Dr. Nancy Olivieri developed misgivings about the drug's effectiveness. More critically, she came to believe it caused a potentially dangerous progression of liver fibrosis in some patients. It thus would not serve as a substitute for more traditional treatments with the chelation medication deferoxamine.

Dr. Olivieri reported her finding to hospital officials and to the company. Despite the confidentiality clause in her contract she thought it important to present the team's findings at medical meetings and in journal articles. This led to a series of disputes within the hospital, with the company and eventually in the courts: "The Company threatened to sue Olivieri if she publicly revealed her fears about the inadequacy of their drug, deferiprone. She sued them for libelling her; they sued her (\$20 million) for libelling their drug" (Shafer 2015).

At the time, the University of Toronto where Olivieri held an appointment and the Hospital for Sick Children reportedly were negotiating a large donation from Apotex. Not surprisingly, perhaps, neither institute supported her. Instead she was dismissed, although eventually reinstated, and reported to the Canadian College of Physicians and Surgeons for research misconduct. Later, many would criticize both actions (Baylis 2004). "Things have come to a sorry state," wrote one, if scientists who tell the truth run the risk of professional dissolution" (Weatherall 2005).

The very public nature of the dispute, widely reported in newspapers, magazines, and professional journals was seen as a test case of academic freedom and the commercialization of medical treatment and research (Pauly 2015). Largely unremarked was its reference, on Olivieri's behalf, to the traditional duty of practitioners to put patient care and public safety before commercial or institutional interests. Her insistence that adverse test results demanded public and professional dissemination echoed the sentiments of Waithe before her and Strom later, in Saskatchewan.

2.4 Politics and the hospice

In January, 2020, cancer patient Clint Gossard applied for a bed at the Irene Thomas Hospice in Delta, BC, a suburb of Vancouver. He also wanted the hospice to permit his medical termination. While "medical aid in dying" (MAiD) is legal in Canada, hospice officials informed Mr. Gossard that it was not performed in their facility although it was available literally across the street at Delta Hospital. After his death Mr. Gossard's widow complained to Minister of Health Adrian Dix, who in response ordered the hospice change its policy or lose provincial funding (Steuck and Wood 2020).

In reply, hospice officials argued MAiD not only violated the hospice's internal policies but the guidance of both the Canadian Hospice Palliative Care Association (CHPCA) and the Canadian Academy of Palliative care Physicians (CAPCP). In a joint statement in 2019, both stated categorically: "National and international hospice palliative care organizations are unified in the position that MAiD is not part of the practice of hospice palliative care" (CHPCA and CSPCP 2019).

That, and appeals to conscience rights protected in Canadian law, should have ended the matter. In general, the collective rights of practitioners require that where conscience prohibits a practice that systems of counselling and referral are available to safeguard a patient's autonomy (Charo 2005a, b). In this case, both counselling and as importantly MAiD were readily available at the hospital next door. Ignoring this, Mr. Dix ordered the hospice to change its policy or lose its \$1.5 million provincial funding. That accounted for 47% of its funding because hospices are required to raise substantial parts of their budgetary needs. The hospice refused to change its policy and was closed in February 2021 when its patients were transferred to other institutions.

Here I note in passing that at hospices this same debate has arisen repeatedly in other provinces where I have served. In most cases, administrators and attending physicians have decided to at least perform MAiD assessments if not also the practice itself.

3 Genealogies

3.1 Accuracies

There is a long history of public engagement by practitioners—doctors and nurses—in issues of public health and care. These have been political, as members of legislative bodies (Koch 2011a, b, 35; 36), as journal and public authors, and as researchers. Among the things that distinguish that history from these cases is that the participants in the first three cases might be termed "whistle blowers" acting out of a sense of indignation at a wrong and a perceived, personal need to make things right (Elliott 2019). The first question must be the accuracy of their comments. If they were wrong then censure would certainly be appropriate.

With her posting Strom sought to urge administrators at her grandfather's nursing home—and by extension those at other long term care facilities—to recognize and work to limit observed deficiencies in patient care. Neither the Saskatchewan Nurses Association nor the nursing home denied her criticisms were justified, only that their public airing reflected badly on the nursing home's staff and thus on the profession-at-large. In the same vein, in October 2019 the British Columbia Nurses Association warned a nurse that "defamatory" comments criticizing a proposed contract would result in a charge of unprofessional misconduct (McKeen 2019). For their part, nurses critical of the contract argued its failure to deal with staffing shortfalls adversely affected the care they could provide and thus broader public health.

At the heart of the issue were facility policies and programs in which limits to staffing were critical determinants of patient care quality. This became a major issue in 2020 when staffing limits and a ration-oriented funding scenario were seen as major contributors to COVID-19 outbreaks in long-term care facilities (Howlett 2021). In these cases, however, the nurses and their profession were not blamed for lack of care but, instead, the staffing policies and programs of the institutions, especially those run for profit.

The issues Waithe raised were clear and the issues—legal and ethical—similarly legitimate. The only question was whether she should have taken her student's concerns to the prosecutor and then the press. Similarly, nobody questioned the quality of Olivieri's research or the importance of adverse reactions to the drug in question. Finally, the issue of the Delta hospice battle dealt less with issues of medical termination than the nature of hospice and palliative care. In this case the views of the professional organizations representing Canadian hospice care and palliative physicians were simply ignored. Nor, for their part, did those organizations leap to the public defense of the hospice whose policies were in accord with their statements.

In each of these cases the whistle blowers sought only to speak publicly about issues of public care and safety. "We speak far too little of how the health care system is changing—even in the way it delivers care to the insured person" (Zolath 2001, p. 34). Safety in healthcare policies and programs were, in each case, the subject raised. And in each case the facts were without dispute. In all, the penalties levied were unchallenged publicly.

3.2 Public vs. private

The real issue in these cases was the public nature of their presentation. The question then becomes: were there other options? Strom might have complained to both the facility's administrators. But ... to what end? In arguing the specifics she spoke to a more general problem of care standards and staffing in long term care facilities. Would she have been more professional if her observations had been published as a nursing journal article or a newspaper opinion piece?

Had Waithe and Bishop Bargholt raised their concerns with Cleveland Clinic's ethicists they likely would have been referred to a general bioethical and clinical acceptance of brain death as a death criterion. It was first formulated in the *Belmont Report* a signal event in the development of bioethics as an ethical arbiter in medicine (Veatch 2009; Koch 2011a, b, pp. 60–64). That was the problem, however. The protocols were weighted to identify potential organ donors, not to protect fragile patients (Bishop 2011, p. 114). More recently a range of studies using have demonstrated the inadequacy of brain death as a simple criterion (Sade 2011).

"The uncomfortable conclusion to be drawn from this literature," as Truog and Miller admitted in 2008, "is that although it may be perfectly ethical to remove vital organs for transplantation from patients who satisfy the diagnostic criteria of [brain] death, the reason it is ethical cannot be that we are convinced they are really dead" (Truog and Miller 2008, p. 674). Whether the procedures were legally defensible, let alone ethical, was thus at best debatable (Fins 2015, pp. 29; 38; 40).

3.3 Olivieri

Similarly, Had Olivieri simply ended her participation in the drug trial and reported her findings to the company and the hospital there would have been no problem. But in that case researchers involved elsewhere in similar trials would not have been alerted. And, of course, there was no guarantee her findings would not simply have been ignored by the company in its final report to federal drug agencies. “Every week seems to bring some new scandal involving drug company suppression of negative data: think Prozac [Eli Lilly], Vioxx [Merck] and Celebrex [Pfizer]” (Shaffer 2015).

For Olivieri, the issue was not simply her obligation as a citizen and researcher but as a physician under the Hippocratic ethic that puts patient and community care first. Conscience and duty, in this sense, required she disclose her findings to other researchers and professionals even if, in doing so, the hospital’s and university’s funding might have been affected.

Distinctly, the issues around the nature of hospice care and palliative medicine focused upon a government decision with public consequences. It demanded acceptance of procedures that hospice administrators and palliative care physicians at the hospice rejected as appropriate in that setting. At issue were the right of practitioners to determine appropriate and best practices. “Accepting a collective obligation [in this case to medical termination] does not mean that all members of the profession are forced to violate their own consciences” (Charo 2005a, b). There may be an obligation to referral to other facilities but that was not the issue in this case. Simply, it was whether those practitioners were mere functionaries without voice or educated professionals arguing the public nature of the medicine they practiced.

4 The practitioner in society

It is perhaps insufficient, and perhaps simplistic, to say these cases identify the diminution of the practitioner’s right to self-expression and public comment. At the least, they demonstrate an essential conflict between practitioner roles as citizens with an interest in public health and safety, employees beholden to corporate policies, researchers limited by contract obligations, and members of professional organizations with supervisory licensing powers.

4.1 Hippocratic traditions

These conflicts are relatively new; a result of the late twentieth century’s evolving “tissue economies” in which commercialization and commodification of medical practice and research have become the norm (Waldby and Mitchell, 2006). The result has been a diminution of the traditional Hippocratic focus, in which “care should be proportionate to illness and not wealth” (Waltzer 1983, p. 86). That distributive logic reflected a broadly social as well as narrowly clinical agenda. As Peter Singer put it, in a different context, in the Hippocratic world “they could not

conceive of themselves as living apart from, or in opposition, to this community, with all its customs and forms of social life” (Singer 1983, p. 8). Patient care thus was inseparable from the broader society in which patient and physician lived.

There is thus a long tradition arguing a collective obligation towards the general good. It requires the practitioner—educator and ethicist, nurse or physician—to act first in the best interests of the patient and so for the public good. Historically, physicians frequently spoke publicly about the health needs of the community; actively joining legislative bodies and local health boards (Koch 2011a, b, pp. 35–36). For example, like his contemporary eighteenth century physician Samuel Latham, Dr. Benjamin Rush decried social inequalities and the burden of disease that resulted for the poor. A signatory of the U.S. Declaration of Independence, Rush established a public dispensary serving the health needs of low income patients (Cassedy 1984, p. 27).

In nineteenth century England, General Registrar Office official William Farr argued there was a public “duty to health” and that medicine was not a commodity but a civic obligation to be promoted by practitioners (Hamlin 1998, p. 131). Other physicians similarly railed publicly against the deleterious health effects of overcrowded tenements whose impoverished residents were often ill or injured in workplace accidents. “Medicine is a social science and as the science of man,” and as such, as Rudolph Virchow put it, the practitioner “has a duty to perform in recognizing these [structural] problems as its [society’s] own” (Nuland 1989, pp. 314–319).

4.2 The change

The Hippocratic vision of the socially active and focused practitioner endured into the 1970s. The goal of research and indeed of medical practice was first patient care rather than commercial advance. Famously, Fredrick Banting refused to add his name to the patent for insulin because he believed it unethical for a physician to benefit from a discovery that saved lives. The patent was eventually sold to the University of Toronto by Banting and co-discoverers Charles Best and James Collip for a symbolic one dollar (Science Hist. Institute 2017).

Dr. George Gey, the physician who harvested Henrietta Lack’s “immortal” cervical cancer cells made them freely available to any researcher who requested them, mailing them at his own expense (Skloot 2010, p. 57). For him they were a critical boon to cancer research rather than a means of personal enrichment. Similarly, in the 1960s researchers discovered but did not patent a simple blood test for phenylketonuria (PKU), in newborns, “a selfless decision and one rarely made today” (Yeager 2019).

Beginning in the late 1970s, however, as neoliberalism gathered force, this view was challenged by a neoliberal political agenda. With the election of Ronald Regan in the United States and Margaret Thatcher in Great Britain public health and patient care came to be described as first and foremost an economic problem whose answer would be found in bureaucratic initiatives relying on entrepreneurial initiatives (Koch 2011a, b, p. 134).

In service of this new agenda the Hippocratic ideals had to be challenged, ignored, or disavowed. This was a primary task of a new class of practitioner, bioethicists (Veatch 2012). Beauchamp's and Childress's landmark text, *Principles of Biomedical Ethics*, recognized the history of a prior, Hippocratic tradition while asserting its inadequacy in the face of technological advances in medicine and its practice. Other bioethicists asserted, without supportive evidence, that not only was an older ethic outmoded but that physicians were at best clinical technicians whose opinions beyond a limited arena of expertise should carry little weight (see McCullough 1983). The result advanced more or less utilitarian agendas that privileged the needs of society over that of the patient (Callahan 1987), changing the practitioner's role from advocacy to subservience in the face of official and organizational agendas (Etzioni 2011).

The resulting diminution of the practitioner's prestige and public voice was reinforced by the rise of "professionalism" as a principal focus of medical education and policy (Sohl and Bassford 1986; Cruess and Cruess 2008). Practitioners were reduced to mostly silent and secondary partners in a metaphorical social contract with corporate and political participants dominating a commercially oriented health-care system (Brill et al. 2019). While some believed that a traditional medical ethic could exist in the new environment (Pellagrino 1995, 1997), the result in many jurisdictions has been less collaborative than coercive, with the role of employers (state or private) dominating as the sole appropriate voice for concerns over care and treatment. Where active, many professional organizations have been largely silent in the face of ethical disagreement or, as the Strom case suggests, complicit. Their role as advocates for practitioners and a more traditional social ethic varies, obviously, country to country and, in some nations, by province or state.

4.3 Conscience

One sees the effect of these changes in the contemporary debate over "conscience" and the practitioner's right to determine what are medically inappropriate or, for them morally objectionable procedures. Influential bioethicists like Canada's Udo Schüklenk and Great Britain's Julian Savulescu recently argued patients need to be *protected* from morally grounded physicians exercising conscientious objections—or even informed opinions—on the advisability of specific procedures (Savulescu and Schüklenk 2017). Simply, they argue, that if it is legal then there is a duty to its performance. "If this leads to feelings of guilty remorse, or them dropping out of the profession, so be it" (Blackwell 2016). And yet, as others have noted, "The mere fact that something is illegal or legal does not make it immoral or moral" (Blumenthal-Barby et al. 2021). Legalities change and physicians have the right, and some would say obligation, to follow both personal ethics and professional guidelines in their practices.

In each of the cases earlier presented the practitioners spoke publicly as informed professionals concerned with issues of public health. It was, however, precisely *because* they spoke publicly as practitioners that they were penalized. But it was because they were knowledgeable practitioners that their comments were important.

If similar questions had been raised by others without that background ... who would listen? As their public standing was diminished, so, too, was the right to conscience, to object publicly to procedures, policies and programs perceived as inappropriate. Practitioners were thus reduced to silent functionaries whose sole responsibility was to bureaucratic superiors and their policies irrespective of the effect on patients and public health. As a result the relational nature of medicine, of decisions made by practitioners in association with and for patients, is subverted (Deutscher et al. 2019). Increasingly the argument is, as Hastings Center cofounder and bioethicist Daniel Callahan long argued, in a work earlier cited, they must first be “stewards” of diminished health resources rather than advocates for patients in need or society at large.

5 Postscript

This type of critique and review is, to social and political science, what a differential diagnosis is to medicine. It identifies and then organizes symptoms and tracks where possible their origins across a particular history to a conclusion. It presents a snapshot of systems that are not immutable, creatures of a history that can be changed. The advancement of organizational concerns advanced by a utilitarian, body politic can be challenged and perhaps transformed. The role of practitioners to voice concerns on the basis of experience can be lauded rather than challenged as, at best, inconvenient. That would require, however, a concerted focus on those political and social arenas where the activist voices of practitioners are currently being most restricted. And that is, I suggest, a stasis that can only be lamented.

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