1996

Ethics or etiquette: the history and epidemiology of professional courtesy in medicine

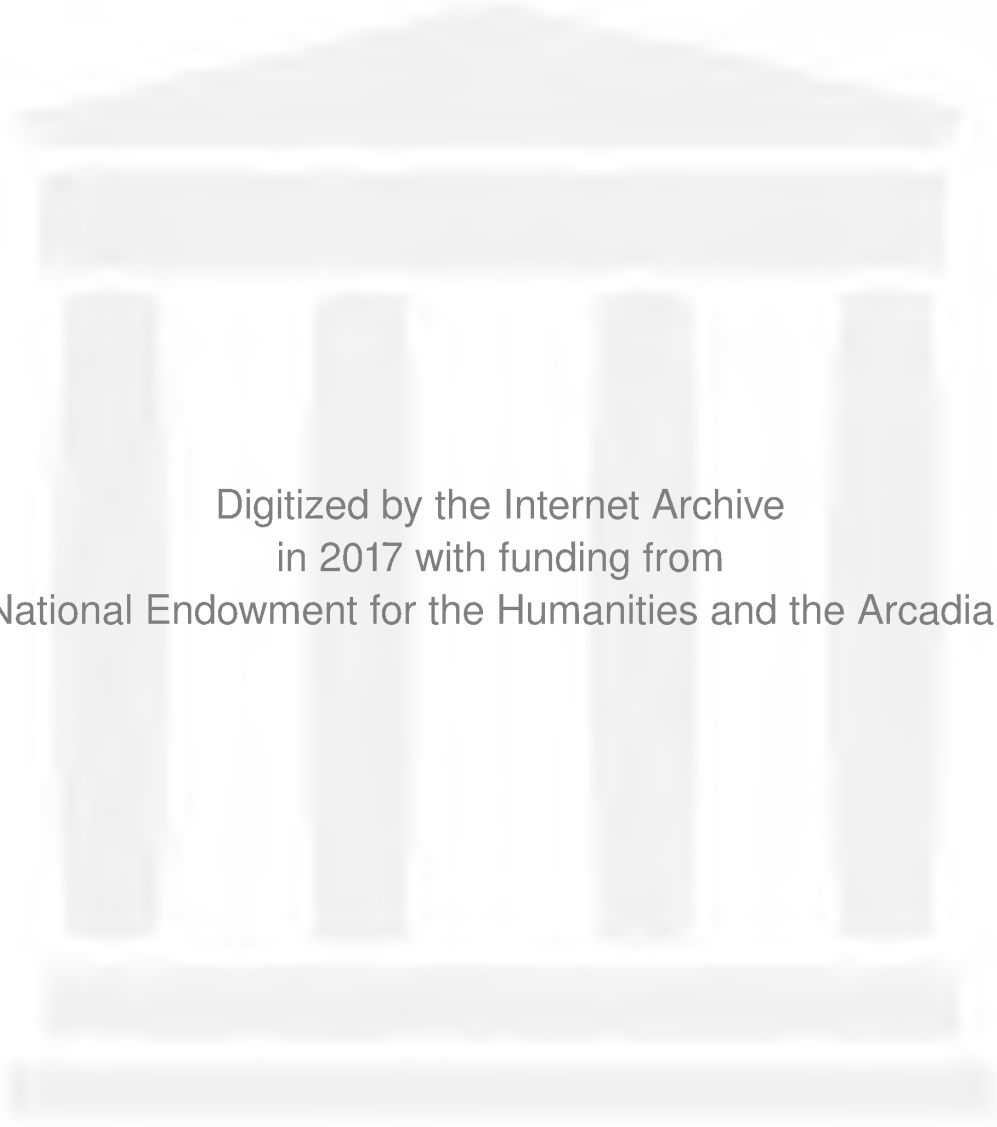
Jeffrey Ian Algazy
Yale University

ETHICS OR ETIQUETTE:
THE HISTORY AND EPIDEMIOLOGY OF PROFESSIONAL COURTESY IN MEDICINE

JEFFREY IAN ALGAZY

Yale University

1996



ETHICS OR ETIQUETTE :

The History and Epidemiology of Professional Courtesy in Medicine

A Thesis Submitted to the Yale University School of Medicine in Partial Fulfillment of the Requirements for the Degrees of Doctor of Medicine and Master of Public Health

by

Jeffrey Ian Algazy

1996

Permission for photocopying or microfilming of ETHICS OR ETIQUETTE : *The History and Epidemiology of Professional Courtesy in Medicine* for the purpose of individual scholarly consultation or reference is hereby granted by the author. This permission is not to be interpreted as affecting publication of this work or otherwise placing it in the public domain, and the author reserves all rights of ownership guaranteed under common law protection of unpublished manuscripts.

Signature of Author

3/21/96

Date

ETHICS OR ETIQUETTE : *THE HISTORY AND EPIDEMIOLOGY OF PROFESSIONAL COURTESY IN MEDICINE.* Jeffrey I. Algazy. (Sponsored by Donna Diers). Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT.

This study is an investigation of the historical origins, epidemiology, and future of professional courtesy in medicine. Professional courtesy is defined as the waiving of all or part of a physician's fee incurred when a colleague seeks medical care. Professional courtesy, as envisioned by physician Thomas Percival in 1803, was originally intended to prevent practitioners from treating themselves or their families. An historical review of the practice was conducted through library and archive research. National surveys on the topic of professional courtesy were reviewed from *Medical Economics*, the *Journal of the American Medical Association*, and the *New England Journal of Medicine*. Research concerning physician self-treatment and treatment of family members was studied to investigate these practices within the medical profession. The historical development of organized guidelines (codes of ethics) on the subject of professional courtesy and the treatment of physician-families was traced from Hammurabi to contemporary medical school oaths. Ethical codes, since their origins in medicine, have never solely dealt with ethics, but have served more as guides to professional conduct and professional etiquette. This study presented evidence that the number of physicians providing professional courtesy has not declined significantly over the past forty years. Over 90% of practitioners today still provide some form of professional courtesy to their physician-patients. Even so, physicians provide inadequate and inappropriate care for themselves and their families. Professional courtesy is no longer the means of preventing such misguided self-treatment. Questions are now raised about the ethics of forgiveness of copayments as professional courtesy (the most common form of the practice). Medicolegal purists may consider this form of courtesy as fraud or an abuse of antikickback statutes. These types of significant changes in medicine will result in the future disappearance of the professional courtesy tradition.

This thesis is dedicated to my family, without whom I could never have made it this far. To my father, who always appropriately questioned my desire to pursue medicine and perhaps in the process broadened my interests, study, and mind. To my mother, who always supported whatever I did "as long as I felt that I did the best that I could." To my sister, who gave me just enough space to pursue my own interests no matter how different they were from her own. Finally, to my grandparents, who provided me with the environment to grow and develop into the scholar that I am today.

I would like to thank Donna Diers for advising the writing of the thesis project and sponsoring its completion in the Department of Epidemiology and Public Health. Finally, I would like to thank Mark Lachs who originally provided me with the research topic and with whom I published an article on the subject.

INTRODUCTION

Literally interpreted, the words professional courtesy would seem to convey something about the tenor of physician-physician interactions. Colloquially, however, it has come to have a specific economic meaning.

Today, in extending professional courtesy, a physician caring for a physician-patient or a physician-family waives all or part of the charges that would normally be incurred in the rendering of health care services. This economic provision of professional courtesy could not be the only aspect of historical professional conduct that continues today. Codes of medical ethics have never dealt solely with ethics, but have been intertwined with notions of professional etiquette and courtesy.

Interest in this subject was prompted by a letter to the editor in response to an article that examined the practice of copayment waiver, or forgiving that portion of a patient's bill not covered by insurance. (Lachs et al., 1990) The author of the letter observed that while physician-patients were probably more able to afford medical care than most, they often benefited from waiver of copayment, which in many offices has become the preferred form of professional courtesy. (Jacobs, 1990) Accordingly, I began a search to discover how this modern variation of the tradition evolved from historical notions of professional courtesy and professional ethics. In addition, I was interested in studying the current and past prevalence of the practice since its historical origins.

Several authors have suggested that professional courtesy is disappearing. They believe that the tradition is no longer practiced by much of the profession and when it is, professional courtesy does more harm than good. These researchers suggest that

physicians who continue to offer the service to their colleagues should abandon the practice. They even offer suggestions on how to inform one's colleagues that they will no longer receive care gratuitously. (Bass and Wolfson, 1980)

Has the practice of professional courtesy actually declined or instead have the types of gratuitous services offered merely changed? I argue the latter, and hypothesize that physician surveys conducted between 1958 and 1993 suggest that professional courtesy is not declining but changing. I further hypothesize that the tradition will still disappear, but due to changes in the medical marketplace not because physicians themselves decide to abandon the practice.

METHODS

An historical review of professional courtesy in medicine was conducted through library and archive research. A study of the origins of medical ethics was also conducted using both primary and secondary sources. The Yale University School of Medicine Historical Library served as a formidable resource for this process. Further historical information was acquired from the American Medical Association archives in Chicago.

National surveys on the topic of professional courtesy were reviewed from *Medical Economics*, the *Journal of the American Medical Association*, and the *New England Journal of Medicine*. Results from these studies were compared and contrasted to trace the prevalence of the tradition in the practice of medicine from the 1950s to the present.

Research concerning physician self-treatment and treatment of family members was studied to investigate physician opinions about these practices within the medical profession. Finally, the historical development of organized guidelines regarding professional courtesy and treatment of physician-families were traced to investigate the profession's past and present beliefs regarding the practices in the changing health care environment.

ETHICAL CODES IN MEDICINE

An essential component of any profession is a code of ethics that suggests how members of the profession should interact with their clients as well as their colleagues. (Reed and Evans, 1987) Guidelines within medical ethics have focused on fee setting, protection of the public (from incompetent practitioners), and encouraging professional courtesy and respect. (Edmunds and Scorer, 1958) Unfortunately, throughout medical history, authors have tended to confuse ethical practice with professional etiquette.

'Ethics' (from the Greek *ta ethika*) means literally, the 'customs' or 'morals' of a people. Medical ethics is defined as : "A system of principles governing medical conduct. It deals with the relationship of a physician to the patient, the patient's family, his fellow physicians, and society at large." (Thomas, 1970)

SUMERIAN ETHICS

The first ethical thoughts were documented by the Sumerians of Mesopotamia. In approximately 2350 BC, Urukagina, ruler of Lagash, a Sumerian city-state "showed great concern for the plight of widows, orphans, and the poor..." where other rulers would have exploited them. (Chapman, 1984) Sumerian kings routinely issued codes which regulated punishment for inflicting wrongful bodily injury, wrongful death, and property damage.

The earliest regulation of medical practice was written in the *Code of Hammurabi* (1727 BC). Among the 282 statues from the first Babylonian Dynasty are nine related to protecting patients from incompetent physicians.

STATUTES 215-223 *CODE OF HAMMURABI* 1727 BC

215. If a surgeon has made a deep incision in the body of a free man with a lancet of bronze and saves the man's life or has opened the caruncle in the eye of a man with a lancet of bronze and saves his eye, he shall take 10 shekels of silver.

216. If the patient is a villein, he shall take five shekels of silver.

217. If the patient is the slave of a free man, the master of the slave shall give two shekels of silver to the surgeon.

218. If the surgeon has made a deep incision in the body of a free man with a lancet of bronze and causes the man's death or has opened the caruncle in the eye of a man and so destroys the man's eye they shall cut off his fore-hand.

219. If the surgeon has made a deep incision in the body of a villein's slave with a lancet of bronze and causes his death, he shall replace slave for slave.

220. If he has opened his caruncle with a lancet of bronze and destroys his eye, he shall pay half his price in silver.

221. If a surgeon mends the broken bone of a free man or heals a diseased muscle, the injured person shall give the physician five shekels of silver.

222. If he is a villein, he shall give three shekels of silver.

223. If he is the slave of a free man, he shall give the surgeon two shekels of silver.

These statutes impose penalties for unsatisfactory outcomes and fee schedules for services rendered. Although these codes are regulations for medical practice, they are certainly not a code of medical ethics. (Chapman, 1984)

HIPPOCRATIC ETHICS

The most significant writings concerning medical conduct are gathered in the corpus ascribed to Hippocrates (about 400 BC). It is commonly felt that the corpus was neither written by one author nor at a single time period. The corpus describes a standard of decorum, a professional etiquette, and distinguishes "regular" practitioners from others. (Loewy, 1989) Etiquette (from the Greek, *euschemosyne*) means literally "being graceful, elegant, manifesting good form or bearing." (Carrick, 1985) Etiquette commonly refers to courtesy and breeding, while ethics is typically concerned with doing what is right. These standards of professional etiquette were probably more important than ethics to the early physicians to whom patient's perceptions were more important than skill. (Carrick, 1985)

The Hippocratic Oath, not a part of the Hippocratic corpus, has been the most influential ethics document to physicians worldwide. There has been a great deal of controversy concerning the origins of the Oath. Scholars note that the Oath of Hippocrates is unlike any other Hippocratic document. Until the writings of Ludwig Edelstein in 1943, most authorities believed that the Oath was based on Aesculapian teachings. Ludwig Edelstein showed that certain ethics in the document were not written by Hippocratics at all, but are Pythagorean in origin. (Chapman, 1984)

Various revisions of the Hippocratic Oath have been used at medical school graduations all over the world. (Appendix I) The Oath, in one form or another, is to be voluntarily taken by the physician on or about graduation from medical school. In an informal survey of medical schools in the United States and Canada during 1990, Drs.

David S. Stasior and John D. Stoeckle, from the Harvard School of Medicine, (Personal Communication, 1992) found that most schools do indeed expect their students to recite oaths and that only a minority of schools choose the classic Hippocratic Oath. In addition, they found that some schools change their oath from year to year.

The original Oath of Hippocrates swears to the pagan gods of health and healing. The graduating physician swears to *primum non nocere* (first, do no harm), to do no surgery, to perform no abortions, and to practice no euthanasia.

OATH OF HIPPOCRATES (Original Translation)

> I swear by Apollo, the Physician, by Asclepius, by Hygieia, Panacea, and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and covenant:
>
> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art--if they desire to learn it--without fee and covenant; to give a share of precepts and oral instruction and all the learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.
>
> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
>
> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.
>
> I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.
>
> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustices, of all mischief and in particular of sexual relations with both male and female persons, be they free or slaves.

> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must noise abroad, I will keep to myself holding such things shameful to be spoken about.
>
> If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

This original translation of the Oath speaks of partnership, brotherhood, and patient care. Physicians swear to treat colleagues as family and to even educate their children as if they were their own. The original oath also provides guidelines concerning the treatment of patients. Many of these guidelines prohibit procedures which are common in today's medical practice. In 1948, a more concise version of the Oath of Hippocrates was written and adopted by medical associations around the world.

OATH OF HIPPOCRATES (Geneva Version 1948)

> Now being admitted to the profession of medicine, I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration. I will hold in confidence all that my patient confides in me.
>
> I will maintain the honor and the noble traditions of the medical profession. My colleagues will be as my brothers. I will not permit consideration of race, religion, nationality, party politics or social standing to intervene between my duty and my patient.
>
> I will maintain the utmost respect for human life from the time of its conception. Even under threat, I will not use my knowledge contrary to the laws of humanity.
>
> These promises I make freely and upon my honor.

The Geneva version of the Oath removes statements prohibiting accepted medical practice while maintaining a notion of collegiality in the ethical document. Modern revisions of the Hippocratic Oath reflect more current beliefs and practices.

In May of 1990, Robert H. Gifford, MD, Associate Dean for Education and Student Affairs at the Yale University School of Medicine, asked Alan C. Mermann, MD, Chaplain, to assemble a working group to update and rewrite a Yale Physician's Oath. In 1994, that Oath was modified again to include "gender" and "sexual orientation" in the Oath's statement of non-discrimination. (Personal Communication, 1995)

YALE PHYSICIAN'S OATH

> Now being admitted to the high calling of the physician, I solemnly pledge to consecrate my life to the care of the sick, the promotion of health and the service of humanity.
>
> I will practice medicine with conscience and in truth. The health and dignity of my patients will be my first concern. I will hold in confidence all that my patients relate to me. I will not permit considerations of gender, race, religion, sexual orientation, nationality, or social standing to influence my duty to care for those in need of my service.
>
> I will respect the moral right of patients to participate fully in the medical decisions that affect them. I will assist my patients to make choices that coincide with their own values and beliefs.
>
> I will try to increase my competence constantly and respect those who teach and those who broaden our knowledge by research. I will try to prevent, as well as cure, disease.
>
> When I am qualified to instruct, I will impart my knowledge gladly, hold my students and colleagues in affectionate esteem, and encourage mutual critical evaluation of our work.
>
> In the spirit of those who have inspired and taught me, I will seek constantly to grow in knowledge, understanding, and skill and will work with my colleagues to promote all that is worthy in the ancient and honorable profession of medicine. I will maintain the honor and noble

> traditions of the medical profession. My behavior will be honorable and thoughtful and reflect justice toward all.
>
> If I fulfill this Oath and do not violate it, may it be granted to me to enjoy life and the practice of the Art. This pledge I make freely and upon my honor. May my faith strengthen my resolve.

Today, most schools of medicine use a dynamic document which is reviewed and modified to reflect the changes and current beliefs in society.

It is ironic that in many cases Hippocratic ethics and the Oath are the only education physicians receive concerning ethical conduct in medicine. Ludwig Edelstein makes clear that "the Oath of Hippocrates is not, and cannot ever have been, a guide to ethical conduct for the physician... virtually none of the Oath's content seems to possess genuinely ethical reference..." unless the physician was a Pythagorean. (Chapman, 1984)

ROMAN AND GREEK ETHICS

It was Scribonius Largus (2 - 52 AD) who wrote what modern scholars would consider the first recorded writings of true medical ethics. He recognized the practice of medicine as a "profession". He wrote extensively on the duties of the physician, including but not limited to their ethical obligations. Scribonius believed that ethics were intrinsic to the practice of medicine and that one could not be a member of the profession without conforming to the duties to the patient, to the state, and to their ethics. (Loewy, 1989)

MEDIEVAL MEDICAL ETHICS

The move toward ethical behavior disappeared during the medieval era. Galen (131 - 201 AD) and others, during this time period, felt that a physician was expected to be an expert in medicine and that morality was not essential. Etiquette was more important to the medieval physician than morals and these beliefs were adopted by the Church. Disease and the healing profession were seen as instruments of God. The role of the Christian Church in medicine and ethics became stronger as it provided care and shelter for the sick and the poor. Physicians were often priests and healing of the soul and body were inseparable acts. Medical ethics of the time were the ethics of the Christian Church. Certainly acts of euthanasia and abortion were unethical for the physician of this time period. (Loewy, 1989)

Medical Ethics separated itself from the Church at the end of the 14th Century. Medicine tightly controlled the institution, licensure, and professional regulation of health care. Though still based on the teachings of the Church, Rodericus à Castro published one of the first works of medical ethics which was distinct from a document concerned with medical etiquette. The book was called *The Responsible Physician or the Duties of the Physician towards the Public*.

The philosophers of the 17th and 18th centuries had the most influence on modern medical ethics. Three scholars, David Hume (1711-1776), Immanuel Kant (1724-1804), and John Stuart Mill (1807-1873), were a few of the most influential of these philosophers. David Hume believed that the general foundation of morals could be attributed to both reason and sentiment. "...I am apt to suspect, they may, the one as well

as the other, be solid and satisfactory, and that reason and sentiment concur in almost all moral determinations and conclusions." (Hume, 1751) John Stuart Mill's Utility Theory, or the Greatest Happiness Principle, "holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure." (Mill, 1863) Finally, Immanuel Kant believed that duty was central to one's moral theory. Duty is "that action to which someone is bound." Kant believed that some duties resulted in an obligation on the part of others, while other duties fulfill an action that is owed. Kantian theory suggests that physicians practice medicine for the love of man, a duty for which he or she expects no obligation on the part of others. (Kant, 1803)

MODERN MEDICAL ETHICS

Modern medical ethics came about to combat the internal friction within the profession of medicine. Physicians struggled to cooperate with one another, and abused other members of the profession verbally and in writing. Some practitioners published lectures on the "qualities of a good physician." *Lectures on the Duties and Qualifications of a Physician* was published by John Gregory, Professor of Medicine at the University of Edinburgh, for medical students in 1772. But, as many guidelines to ethical conduct before it, Gregory's writings provide more of a basis for practical etiquette than professional ethics. His lectures suggest the qualities, manners, and even proper dress of a physician. (Gregory, 1817)

Perhaps, it was medical etiquette that served the need at the time. In 1789, the Manchester Royal Infirmary, plagued with a typhus and typhoid epidemic, doubled its medical staff. Threatened by the additional physicians joining the hospital staff, established practitioners, including Charles White (known for work on puerperal fever) and Thomas Henry, (known for his work with milk of magnesia), resigned from the institution. Physicians at the infirmary failed to cooperate and between 1791 and 1792 Dr. Thomas Percival was asked by the staff to produce a "code of laws" to govern professional conduct in the practice of medicine at the infirmary and other medical institutions. The author was influenced by "an earnest desire to promote the honour and advancement of his profession, to enlarge the plan of his undertaking, and to frame a general system of Medical Ethics; that the official conduct, and mutual intercourse of the faculty, might be regulated by precise and acknowledged principles of urbanity and rectitude." (Percival, 1803)

Thomas Percival's book, *Medical Ethics*, was published in 1803. He borrowed from the writings of John Gregory, the *Statuta Moralia* of London's Royal College, and from Thomas Gisborne's *On the Duties of Physicians Resulting from the Profession.* Like his predecessor John Gregory, he misused the word ethics to refer to his guide of conduct and etiquette in medical practice. Chauncey Leake felt that Percival's *Medical Ethics* was, in fact, "a manual of medical etiquette, an Emily Post guide... to proper professional conduct..." (Leake, 1927) *Medical Ethics* was a guide to physician-physician interaction, the origins of professional courtesy.

Percival's writings had considerable influence in the United States. The Association of Boston Physicians developed their Code of Medical Police in 1807 based on the writings of Thomas Percival, Benjamin Rush, and John Gregory. Later other medical organizations developed codes of practice along similar lines in New York, 1823; Baltimore, 1832; and Philadelphia, 1843. (Chapman, 1984; Hamstra, 1987)

In May 1846, Alden March and Nathan Smith Davis organized a National Medical Convention in New York. The chief purpose of this convention was to form a national medical association later to become known as the American Medical Association (AMA). One of their first tasks was to designate a committee to develop a Code of Medical Ethics. Members from Pennsylvania, Delaware, Rhode Island, New York, and Georgia wrote the code with Isaac Hayes and John Bell, graduates of the University of Pennsylvania. The code was accepted by the National Medical Convention at the Philadelphia convention in May 1847 and was based largely on Percival's *Medical Ethics*. Some sections of the AMA's code were taken from the exact wording in *Medical Ethics*. In studying medical ethics, the committee found that Dr. Percival's writings were clear and precise. The committee "carefully preserved the words of Percival wherever they convey the precepts it is wished to inoculate... in all cases, wherever it was thought that the language could be made more explicit by changing a word, or even a part of a sentence, this has been unhesitatingly done..." At the same meeting, the convention changed the name of the organization to the American Medical Association. (Fishbein 1947, Proceedings of the National Medical Conventions, 1846-7)

PROFESSIONAL COURTESY : THEN & NOW

The practice of professional courtesy, commonly referring to the practice of waiving all or part of a physician-patient's fee, has been a significant part of professional conduct which continues to be offered by many practitioners today. One physician suggests that the practice "... was an age-old tradition chiseled in stone. It was the community norm from which one never considered deviating." (Schiff, 1991) Still, many physicians believe that professional courtesy is disappearing. Medical schools offer few lessons on professional decorum and conduct. Those programs that do teach medical etiquette often limit their training to a few hours of lecture. Medical ethics has become a small part of most medical school curricula. (Howe, 1987)

Third party payment has removed the physician from the true costs of health care. Physicians no longer own their own practices or else have a very business-like and impersonal billing policy. The doctor may not know how much money is being collected for the services he or she provides, but may also not be permitted by their employer to provide professional discounts. Some private practitioners have found that the tradition has become too large a portion of their pocketbook, while others feel that the practice of reducing charges for physician-patients has outlived its usefulness to the profession. (DeLawter, 1992; Schiff, 1991; Peterkin, 1988; Goldman, 1985; Bass and Wolfson, 1978)

It is difficult to ascertain exactly how prevalent the practice of professional courtesy, monetary or otherwise, was before the 1950's, but anecdotes and written accounts of the tradition in medicine appear to suggest that it was common. "When a

doctor treats any member of a colleague's immediate family, neither physician worries about the bill. Except in rare cases, it's tacitly understood there'll be no charge." (Hughes 1958) Several surveys of the practice have been published in *Medical Economics* [1958 - 1990], the *Journal of the American Medical Association (JAMA)* [1966], and most recently in the *New England Journal of Medicine* [1993]. (Appendix II)

MEDICAL ECONOMICS SURVEYS : 1958 - 1962

Although the extension of professional courtesy was so ingrained in the practice of medicine, as early as 1958, doctors and their families protested the practice. An internist in 1962 argued that, "Professional courtesy is a pain in the neck... when I need medical attention myself, I put off getting it because I hate to impose." According to James P. Gifford, writing in *Medical Economics*, this feeling was not unusual. (Gifford, 1962)

In 1962, the magazine *Medical Economics* published a survey of some 3,000 practicing physicians. The published report of the survey provided no further information regarding the survey and its methods. Correspondence with *Medical Economics* and its editors was unsuccessful in obtaining further information about the study design. According to the published report of the survey, 93% of all physicians offered fee reductions to other doctors. (Gifford, 1962)

AMA JUDICIAL COUNCIL SURVEY : 1966

The first academic investigation of the prevalence of the tradition of professional courtesy [no fee] was conducted by the AMA Judicial Council in 1964 and published in JAMA in 1966. The Department of Medical Finance and Economic Research and the Department of Medical Ethics of the AMA worked together to design the questionnaire and conduct the study. A systematic sample of every 35th physician in private practice was compiled resulting in a total of 5,000 physicians. Thirty-seven surveys were undeliverable making an "effective" sample of 4,963. Two mailings in the fall of 1964 resulted in a 79% response rate (3,939).

The AMA survey asked physicians about their own practice as well as what they think physicians should do regarding charging other physicians and their families for health care. A major difference between the earlier *Medical Economics* survey and the survey conducted by the AMA was that the 1966 survey differentiated between fee reductions for services not covered, partially covered, and fully covered by insurance. Most (91.2%) physicians never charged for services rendered to physicians or their families when the service was not covered by insurance. The report of the Judicial Council also stated that physicians believe "that some allowance should be made for especially prolonged illness or very expensive procedures." (Judicial Council, 1966)

Practices varied when the services were partially or fully covered by health insurance. A minority (32.6%) of physicians never charged patients or their insurance company when the service was covered, while 52.4% usually charged in this situation. It seems that physicians did not mind being paid for services rendered, but did not wish to

accept payment directly from the physician-patient. In fact, 93.6% of physicians surveyed never charged for the additional amount when reimbursement was less than the usual and customary fee [waiver of copayment]. (Judicial Council, 1966)

Physicians were aware of the importance of health insurance. Most (86.6%) physicians carried some form of insurance for themselves and/or their family. According to the Judicial Council this number was more than the general population at the time. (Judicial Council, 1966)

Most physicians provided some form of fee reduction to colleagues and the practice did not vary widely by medical specialty. With the exception of psychiatrists, most specialties provided services without charge between 86.8% (dermatology) and 100% (allergy) of the time. Psychiatrists reported in the 1966 survey that 20.5% never charged for services when the service was not covered by insurance. Psychiatrists have argued that their time-intensive medical practice makes the offering of professional courtesy impossible. The tradition can be disproportionally burdensome as physician-patients occupy a greater proportion of their patient rosters. (Judicial Council, 1966)

The survey also investigated other aspects of the tradition. A majority (81.1%) of physicians responded that they usually sent gifts to other physicians who provided them or their families with gratuitous services. Even though the tradition of professional courtesy and gift giving was so widely practiced, 47.3% of physicians surveyed felt that professional courtesy made them hesitant to seek medical care. (Judicial Council, 1966)

MEDICAL ECONOMICS SURVEYS : 1974 - 1990

In 1974 and 1990 the magazine *Medical Economics* again published surveys of physicians regarding their practice of professional courtesy. The 1974 survey, part of the *Medical Economics* Continuing Survey, was conducted using a sample of 9,717 office-based physicians. The 1990 survey utilized a random sample of more than 2,300 physicians. The published reports of the surveys provided no further information regarding the surveys and their methods. Correspondence with *Medical Economics* and its editors was unsuccessful in attaining further information about the study design. The surveys conducted in 1974 and in 1990 by *Medical Economics* showed that 96% and 97% of the physicians respectively offered some form of professional courtesy [no fee, discounts, or waiver of copayment]. (Owens, 1974; Norman, 1990)

The key difference between these *Medical Economics* surveys was that the number of physicians charging no fee to physician-patients dropped from 56% in 1974 to 29% in 1990; 42% of physicians in 1974 waived copayments for physician-patients, while 50% of physicians in 1990 provided professional courtesy by this method. (Owens, 1974; Norman, 1990)

LEVY ET AL. SURVEY : 1993

Levy et al. conducted a survey and published its results in the New England Journal of Medicine in 1993. As with the *Medical Economics* surveys conducted between 1958 and 1990, this survey did not follow the format of previous studies on the tradition of professional courtesy which limits to some degree the comparability of its

findings. The survey sample was derived from the AMA's 1991 master list of physicians (both AMA members and nonmembers). Four hundred physicians were randomly selected by the nth name technique from each of 12 specialties. The sample size per specialty was selected to ensure power to detect a 15 percent difference between specialties. Between August and November 1991, five mailings to the 4,800 physician sample resulted in a total completed response of 2224 (46%). The physicians who responded were white, middle-aged, males in fee-for-service practice. Subgroup responses were compared using the chi-square test for categorical variables and using the Student's t-test for continuous variables. (Levy et al., 1993)

Levy et al. found that 96% of physicians offered some form of professional courtesy (free or discounted care). Male sex, private practice, fee-for-service reimbursement, higher income, and older age were all physician characteristics associated with the tradition. ($P<0.01$) With the exception of psychiatry (80%), greater than 90% of physicians in all specialties provided professional courtesy. Most (95%) primary care specialists and as many as 98% of non-primary care specialists provided their colleagues with some form of professional courtesy [no fee, discounts, and waiver of copayment]. (Levy et al., 1993)

The survey format made it difficult to analyze the most important information gathered by this study, the form of professional courtesy [no fee, discounts, or waiver of copayment] the physicians practice. The survey used a scale [never, occasionally, often, always, and no answer]. Most (75%) of physicians responded that they often or always billed only the insurance company, 49% often or always provided care at no charge, and

23% often or always gave a partial discount. (Levy et al., 1993) Unfortunately, it is difficult to compare these data to the results of the *Medical Economics* studies of 1974 - 1990 since the use of this scaling system does not allow us to determine exactly how often physicians provided each type of professional courtesy [no fee, discounts, and waiver of copayment]. (Appendix II)

Some (23%) physicians surveyed had changed their policy regarding professional courtesy since beginning practice. Physicians changed for various reasons including that colleagues carry insurance, that colleagues' policies on the practice have changed, and that the practice of professional courtesy is too expensive. (Levy et al., 1993)

Levy et al. also investigated opinions regarding the tradition of professional courtesy. A majority (79%) of physicians agreed that "professional courtesy solidifies bonds between physicians." A smaller portion (62%) of physicians felt that "giving professional courtesy is sound business practice." Unlike the AMA survey conducted in 1964 which showed that almost 50% of physicians believed that professional courtesy made them hesitant to seek care, Levy et al. reported that only 15% agreed with the statement that "professional courtesy discourages physicians from appropriately seeking care." Only 14% of physicians felt that the tradition interfered with the doctor-patient relationship while 12% felt that it was too expensive to offer professional courtesy to their colleagues. (Levy et al., 1993)

Levy et al. attempted to compare the results from their study with the AMA survey published in 1966. They determined that "a smaller proportion of physicians offered professional courtesy in 1991 than in 1966 (88 percent vs. 94 percent,

respectively, P<0.001)." The survey showed that the absolute prevalence of professional courtesy has decreased between 5 and 10 percent in just over 25 years. (Levy et al., 1993) It may be difficult to compare these studies because they defined professional courtesy in different ways. The 1966 AMA Survey reported that 96% of physicians offered professional courtesy [never or rarely charged for services rendered to physicians if the service is not covered by insurance and never or rarely charged for the additional amount when the insurance benefit is less than the usual and customary fee]. The 1993 Levy et al. study reported that 96% of physicians offered professional courtesy [offered some form of free or discounted health care].

Professional courtesy is still practiced by the majority of physicians today, but the tradition has certainly not remained static. As the surveys between 1958 and 1993 have shown, although the majority of physicians, excluding psychiatrists, continue to participate in the tradition of professional courtesy, more physicians today merely waive insurance copayments than provide services without charge as they did in the past. Professional courtesy has not disappeared, but merely changed in form.

Courtesy services to physicians are not the only gratuitous services which have changed. Physicians have a long history of providing services without charge to others including nurses, dentists, pharmacists, friends, medical students, office workers, and clergy. Although physicians, patients with the monetary means to pay for their own care, continue to receive professional courtesy, other less able members of the community may no longer benefit from these generous practices.

PROFESSIONAL COURTESY TO NON-PHYSICIANS

Not only did the early codes of medical ethics mention physician-to-physician courtesy, but they also addressed the issue of courtesy to non-physicians. Percival wrote in his book *Medical Ethics* :

> XVIII. Clergymen, who experience the *res angusta domi*, should be visited gratuitously by the faculty. And this exemption should be an acknowledged general rule, that the feeling of individual obligation may be rendered less oppressive. But such of the clergy as are qualified, either from their stipends or fortunes, to make a reasonable remuneration for medical attendance, are not more privileged than any other order of patients. Military or naval subaltern officers, in narrow circumstances, are also proper objects of professional liberality.

The *Medical Economics* professional courtesy surveys conducted between 1958 and 1990 also studied gratuitous services provided to non-physicians.

MEDICAL ECONOMICS SURVEY : 1958

In 1958, *Medical Economics* reported that the typical physician provided special rates to about 2% of his or her patients. One physician reported that he offered fee reductions for as many as 80% of his patients. Physicians claimed that they provided reduced fees as a form of kinship. The practice was also seen as a method of practice-building (especially when provided to referral sources such as pharmacists and nurses). (Sherwood, 1958)

Physicians typically provided fee discounts to non-physicians when the care was reciprocal or when he or she had a business relationship with the non-physician. For example, 62% of physicians provided care at no charge to their own dentists. Physicians

appeared to provide gratuitous services more often if they knew the non-physician personally. For example, 66% of physicians provided care at no charge to nurses they had worked with, but only 24% provided free care to nurses they had not worked with in the past. (Sherwood, 1958)

Whether the physician knew the patient did not appear to be the only variable. During the 1958 survey, physicians provided free care to only 16% of married nurses. Perhaps one New Jersey internist's words reflect the feeling at the time : "I don't see why I should help support another man's wife." A young Louisiana physician reported that he charged based on the woman's looks : "Pretty--no charge. Ugly--full fee. Jealous husband--refuse to see." Many physicians stated that they provided gratuitous services to nurses because they felt a degree of indebtedness to the nursing profession. (Sherwood, 1958)

Another group, medical students, were provided free care almost as often as physician-patients themselves (87%). "It's during this period, more than after they've graduated, that such people are most in need of free care," stated one physician from Massachusetts. Many physicians remembered what it was like to struggle through medical school with a young family. (Sherwood, 1958)

Physicians provided other individuals regularly with gratuitous services : 95% of physicians offered their office workers free care, 90% provided care at no charge to immediate relatives, and 86% did not charge their in-laws for services rendered. (Sherwood, 1958)

Typically, physicians did not provide optometrists, osteopaths, veterinarians, and physical therapists with professional courtesy (12% - 26%). When they did it was "usually in return for services rendered." Generally, physicians provided courtesy more often to non-physicians with whom they had a relationship. Distant relatives, acquaintances, and laboratory technicians did not receive professional courtesy frequently. (Sherwood 1958).

Physicians generally wanted their patients to know when they were receiving courtesy services. They did not appreciate patients who insisted on professional courtesy. Nearly 75% of physicians followed their usual policy whether the patient offered to pay full fee or asked for some form of professional courtesy. (Hughes, 1958)

MEDICAL ECONOMICS SURVEYS : 1962 - 1990

Although physicians continued to provide courtesy to other physicians, they reduced their charity to non-physicians considerably. Nurses were extended professional courtesy by 77% of physicians in 1962, but only 67% of physicians offered free services in 1974. Dentists received courtesy from 63% of physicians in 1962, but only 54% of physicians in 1990. Clergy were offered free services by 76% of physicians in 1962, but only 63% of practitioners in 1990. Even employees of physicians have realized a reduction in professional courtesy. In 1962, 99% of physicians provided services to their own employees for free, while in 1990 only 94% of physicians offered this benefit. (Gifford, 1962; Norman, 1990)

Physicians offer professional courtesy to non-physicians for various reasons. They give free care to nurses and pharmacists because they can be good sources of referrals. Physicians provide gratuity to clergy because they feel that they are underpaid. Finally, physicians provide free care to family members because they expect it. In addition, one physician provides courtesy to family members so as not to upset the in-laws : "I don't much care what my own relations think of me, but I sure don't want to get in bad with my wife's family." (Gifford, 1962)

PROFESSIONAL COURTESY : HISTORICAL ORIGINS

Some writers believe that professional courtesy has its earliest origins in the Hippocratic Oath. Heinrich von Staden, a Yale Professor of Classics, points out that there is no mention of free treatment for physicians or others in the Oath. (Von Staden, Personal Communication, 1995) The Oath pledges to see to the worldly needs of their medical mentors and families as if they were relatives :

> ...to reckon him who taught me this Art equally dear to me as my parents--to share my substance and relieve his necessities if required--to look upon his offspring in the same footing as my own brothers and to teach them this Art if they shall wish to learn it without fee or stipulation.
> (Oath of Hippocrates)

The authors of the Hippocratic Oath, Hippocratics or Pythagoreans, may have been misinterpreted by those who believe it to be the origin of professional courtesy. The Oath only suggests that tuition be waived for the physician's child wishing to learn the art of medicine. Presumably, however, in "looking upon these offspring," a physician would not charge for medical care either. Ironically, while the practice of fee reduction is practiced today, few recent medical graduates can say that their education was procured "without fee or stipulation."

Although the Hippocratic Oath may not serve as the true origin of professional courtesy, other Hippocratic writings may present clues to the origins of physician-physician courtesy if not all charity or courtesy care. In *Precepts*, a part of the Hippocratic corpus, the author asks the physician to consider the wealth of his patients in setting fees :

> I urge you not be too unkind, but to consider carefully your patient's superabundance or means. Some times give your services for nothing, calling to mind a previous benefaction or present satisfaction. And if there

> be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician. And it is well to superintend the sick to make them well, to care for the healthy to keep them well, but also to care for one's own self, so as to observe what is seemly. (*Precepts* VI, Hippocrates I)

This passage appears to suggest that some patients are not expected to pay for services. These courteous services the physician gives, according to the corpus, out of "love of the art."

Thomas Percival, was the first to articulate precisely a suggested policy on the tradition of professional courtesy. In his 1803 text *Medical Ethics*, Percival clarified any ambiguity that might have existed about when and how professional courtesy and other matters of professional etiquette should be rendered, as well as the impetus for these practices. (Percival, 1803) Although European guildsmen had been providing their services to one another without recompense as an expression of solidarity and fellowship since Medieval times, Percival suggested a much less lofty rationale for physician reciprocity in Chapter II - "Of Professional Conduct in Private, or General Practice" of *Medical Ethics* :

> XVI. All members of the profession, including apothecaries as well as physicians and surgeons, together with their wives and children, should be attended gratuitously by any one or more of the faculty residing near them, whose assistance may be required. For as solicitude obscures judgment, and is accompanied by timidity and irresolution, medical men, under the pressure of sickness, either as affecting themselves or their families, are peculiarly dependent upon each other. Distant members of the faculty, when they request attendance, should be expected to defray the costs of traveling. And if their circumstances be affluent, a pecuniary acknowledgment should not be declined. For no obligation ought to be imposed, which the party would rather compensate than contract. (Percival 1803)

Percival proposed physician-physician gratuity because he was worried that the physician treating family or self would render inferior care. Modern day physicians have echoed this concern for unbiased investigation. La Puma and Priest (1992) suggested that "the practice of physicians' treating their own families raises ethical concerns, including when to breach confidentiality... and who to consider the patient and who to consider the family." Professional courtesy, Percival believed, would remove a cost barrier that might dissuade physicians from seeking treatment. It is interesting that Percival suggested that an affluent physician-patient should offer to pay, an idea which seems to conflict with notions of collegiality in the Hippocratic Oath but is consistent with ideas present in the Hippocratic corpus, *Precepts*, suggesting that physicians must set fees based on their patient's ability to pay.

PROFESSIONAL COURTESY : THE AMERICAN MEDICAL ASSOCIATION

In May 1847, the National Medical Convention, later known as the American Medical Association, adopted a code of ethics based on Percival's treatise on professional courtesy. The AMA's Code of Ethics preserved the words of Percival wherever possible. The Code of 1847 had three chapters; 1) "Of the Duties of Physicians to their Patients and of the Obligations of Patients to their Physicians", 2) "Of the Duties of physicians to Each Other, and to the Profession at Large", and 3) "Of the Duties of the Profession to the Public, and of the Obligations of the Public to the Profession." (Proceedings of the National Medical Conventions, 1846-7) The American Medical Association's Code of Medical Ethics, like Percival's *Medical Ethics*, served as more of a code of "professional courtesy" than an ethical code. The section on professional courtesy from the Code of 1847 was published in the Proceedings of the May 1847 meeting of the National Medical Convention in Philadelphia and reads :

> Chapter II : Article II--Professional Services of Physicians to Each Other.
>
> Section 1. All practitioners of medicine, their wives, and their children while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them, whose assistance may be desired. A physician afflicted with disease is usually an incompetent judge of his own case; and the natural anxiety and solicitude which he experiences at the sickness of a wife, a child, or any one who by the ties of consanguinity, is rendered peculiarly dear to him, tend to obscure his judgment, and produce timidity, and irresolution in his practice. Under such circumstances, medical men are peculiarly dependent upon each other, and kind offices and professional aid should always be cheerfully and gratuitously afforded. Visits ought not however, to be obtruded officiously; as such unasked civility may give rise to embarrassment, or interfere with that choice on which confidence depends. But, if a distant member of the faculty, whose circumstance are affluent, request attendance, and an honorarium be offered, it should not be declined; for no pecuniary obligation ought to be imposed, which the party receiving it would wish not to incur.

The AMA guideline concerning professional courtesy was taken almost word for word from Thomas Percival's *Medical Ethics*.

Modern notions of professional courtesy are probably derived from Percival's historical concern for judgment in family and personal care, although it appears that Percival may have merely documented a long shared practice and belief of medical practitioners of the time. Physicians did not charge their colleagues for medical care in order to prevent self-treatment. The Hippocratics, Gregory and Percival all speak of a certain medical etiquette and conduct which underlies the practice of medicine. Perhaps, Percival's justification for the practice of professional courtesy was indeed the origin of the practice. On the other hand, the tradition may have developed as more of an act of collegiality, notions expressed in Hippocratic writings, than for any true concern for physician-patient well-being.

AMA CODE OF ETHICS : 1847 - 1995

The original code of ethics was adopted in 1847 by the National Medical Conference. The code remained unchanged until the membership could be convinced that it needed to be modified to keep up with modern times. In 1876, the President of the AMA first mentioned modifying the almost 30 year old code, but his suggestions were disregarded by most of the delegates. (King, 1983) The President of the AMA stated in an 1876 address that "the code of ethics was violated everyday, not only by rank and file, but by men high in the profession." (King, 1983)

The New York State Medical Society was troubled by stipulations in the association's code of ethics which prevented members from referring patients to or accepting referrals from "irregular" practitioners, homeopaths and practitioners without "regular medical education". In 1882, the state medical society adopted a completely new and much abbreviated code. Until this time, all state medical associations accepted the AMA code of ethics though they were independent state organizations. Dr. Samuel D. Gross, a recognized medical leader, called the action "an outrage which every member of the profession should consider as a deep personal insult, and which the association should rebuke in a most stern and uncompromising manner". (Gross, 1882) The AMA refused to seat the New York State Medical Society delegates at the 1882 annual meeting. (King, 1983)

The New York State Society was politically divided concerning the new code of ethics. The new code had been adopted in 1882 by a vote of 52 to 18, more than the two-thirds majority required for adoption. Opposition within the New York Society attempted

and failed to repeal the new code in 1883. The following year, members who wished to remain affiliated with the AMA organized a new state medical organization called the New York State Medical Association. Adopting the "old" code of ethics, the new association joined the AMA. A motion to repeal the modified New York State Medical Society code was defeated by a vote of 105 to 124 in 1884. As a result of this division, New York had two medical organizations (the society and the association) until 1903. (King, 1983)

The division between "new-code men" and "old-code men" continued through the 1880's and 1890's. "New-code men" were left out of business meetings which only enraged independent physicians. Several recognized medical leaders (J.M. Da Costa, Louis Duhring, Samuel W. Gross, S. Weir Mitchell, William Osler, William Peper, Alfred Stille, Henry P. Bowditch, O.W. Holmes, James C. White, and Francis Minot) signed a resolution condemning the actions of the AMA and refused to participate in the International Medical Congress that the AMA was planning for 1887. Nathan Smith Davis, editor of JAMA, criticized the group for acting like school boys and not suggesting improvements to the process. The International Congress was held in September 1887 and although the meeting was a success, very few distinguished American practitioners attended. (King, 1983)

Finally, in 1892 the AMA recognized the division it had created in organized medicine. The President of the AMA appointed a committee to revise the Code of Ethics which it completed in 1894. The earliest the House of Delegates could vote on the new code was 1895, but the vote on the new code was postponed indefinitely. The actual

adoption of a new code came only after Nathan Smith Davis stepped down from his powerful position as editor of JAMA. Negotiations began, after the turn of the century, among representatives of the AMA, New York State Medical Association, and New York State Medical Society. The two New York groups agreed to unify into the Medical Society of the State of New York after the AMA adopted the new code. A new code of ethics was prepared by William H. Welch entitled, "Principles of Medical Ethics". (Chapman, 1984) The new principles of ethics were adopted in 1903, but the unification of the two New York medical organizations did not become effective until December 9, 1905. (King, 1983)

The Principles of Ethics of 1905 removed not only the section regarding consultations by "irregulars", but revised the section on professional courtesy. The 1905 revision changed the organization of the statement. Instead of the verbose single section, the guideline regarding professional services of physicians to each other was reorganized, reworded, and shortened into three sections as follows :

> Article II. - PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER
>
> PHYSICIANS DEPENDENT ON EACH OTHER.
> Section 1.--Physicians should not, as a general rule, undertake the treatment of themselves, nor of members of their family. In such circumstances they are peculiarly dependent on each other; therefore, kind offices and professional aid should always be cheerfully and gratuitously afforded. These visits ought not, however, be obtrusively made, as they may give rise to embarrassment or interfere with that free choice on which such confidence depends.
>
> GRATUITOUS SERVICES TO FELLOW PHYSICIANS.
> Section 2.--All practicing physicians and their immediate family dependents are entitled to the gratuitous services of any one or more of the physicians residing near them.

COMPENSATION FOR EXPENSES.

Section 3.--When a physician is summoned from a distance to the bedside of a colleague in easy financial circumstances, a compensation, proportionate to traveling expenses and to the pecuniary loss entailed by absence from the accustomed field of professional labor, should be made by the patient or relatives. (Principles of Medical Ethics of the AMA 1905)

This revision of the professional courtesy guideline reorganized the original text and updated the English language used by the organization.

The new Medical Ethics of the AMA were more eloquently stated, but also less enforceable. By changing the name from "code" to "principles" the ethics of the organization became advisory rather than authoritative rules. The principles placed disciplinary action mainly on shoulders of the state and local medical societies. (Chapman, 1984) Traditionally, disciplinary action by state and local medical societies was merely exclusion from the medical society, an action which would not really affect most practitioners at all.

The Principles of Ethics were revised slightly over the next 30 years by the Judicial Council of the AMA. The Judicial Council continued to decide what was ethical in the practice of medicine though many of its decisions were not judgments concerning ethical behavior but etiquette. The statement on professional courtesy was rewritten in 1940 and read :

ARTICLE II.--PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.--Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SECTION 2.--When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SECTION 3.--When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighboring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants. (Principles of Medical Ethics of the AMA 1940)

This rather informal version of the professional courtesy guideline added a new section to the code. It provided guidance to physicians in selecting an attending physician for themselves while retaining the original intent of Percival's statement. This section was revised again in 1949 and reincorporated more formal wording while retaining the format and intent of the guideline. In the 1949 Principles of Medical Ethics of the AMA, the statement on professional courtesy read :

ARTICLE II.--PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.--As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SECTION 2.--When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him.

> When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.
>
> ONE PHYSICIAN IN CHARGE
>
> SECTION 3.--When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants. (Principles of Medical Ethics of the AMA 1949)

The 1949 revision would not be the last change in the AMA's position regarding professional courtesy. First, in December of 1955 an attempt was made to separate medical ethics from medical etiquette (a problem which has plagued medicine from the earliest origins of the profession). Unfortunately, the submitted changes were not accepted by the House of Delegates. Then the Judicial Council and the Council on Constitution and By-laws made a radical change in the Principles of Medical Ethics by reducing them to a brief preamble followed by ten short statements. The councils argued that this was a rational decision and resembled the organization of the United States Constitution, the Ten Commandments, and the Oath of Hippocrates. The shortened ten Principles of Medical Ethics were adopted by the House of Delegates in June 1957. (Appendix V) Accompanying the shortened Principles of Medical Ethics was the longer Opinions and Reports of the Judicial Council. This reorganization of the documents served to divide responsibility for ethical decision making within the AMA. (Judicial Council, 1960)

The revised Principles did not explicitly mention professional courtesy, but Section 1 and Section 2 of the 1949/1955 code were retained under Section 1 of the

Opinions and Reports of the Judicial Council. (Appendix V) This format and wording was retained until 1969 when the format was again revised to read :

> SECTION 1
> Opinions and Reports of the Judicial Council 1969
>
> 12. Professional Courtesy
> The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.
> 1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.
> 2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.
> 3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.
> 4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.

The 1969 revision of the Opinions and Reports of the Judicial Council reflected significant changes within the health care environment. For the first time, the Judicial Council recognized as ethical insurance reimbursement for care rendered to physicians. This radical change reflected what had become common practice throughout the medical profession and a practice which was already deemed ethical by the AMA House of Delegates. As early as 1966, most physicians (93.6%) did not charge for the additional amount beyond that paid by insurance and most physicians (86.6%) purchased some form of insurance for their families. (Judicial Council 1966)

The statement by the Judicial Council had moved from an ethical practice based on preventing self-treatment to one insuring physicians would not be unduly burdened in the process of providing professional courtesy to their colleagues. Unlike previous statements by the Judicial Council concerning the practice, the 1969 Opinion centered not on gratuity but on payment to the doctor's doctor. In 1972, the Judicial Council also included another guideline :

> 13. PROFESSIONAL COURTESY BEYOND FELLOW PHYSICIANS AND THEIR DEPENDENTS
>
> Ethical custom and tradition have suggested the extension of professional courtesy to fellow physicians and members of their immediate families. As a matter of private determination some physicians have extended this practice variously to clergymen, teachers, nurses, assistants to physicians and others in the health care field. The extension of professional courtesy beyond fellow physicians and members of their immediate families is a matter of discretion to be decided by the individual physician in his own practice and in his own community. (Judicial Council 1972)

This same statement was removed only five years later in the 1977 revision of Opinions and Reports. Perhaps, its removal reflected the fact that professional courtesy was less frequently being provided to non-physicians. (Appendix II)

Although professional courtesy is still practiced by the majority of physicians (Appendix II), the tradition has certainly not remained static. The practice of professional courtesy has become expensive in the modern medical industrial complex where physicians must concentrate not only on patient well-being, but on the business of medical practice.

The Judicial Council published a significant revision of Opinions and Reports in 1977. The Principles of Medical Ethics (not revised since 1957) it explained was "an

expression of the AMA House of Delegates." Opinions and Reports of the Judicial Council, on the other hand, reflects the "interpretations, opinions, and statements of the AMA Judicial Council." It may be "expanded, contracted, or modified from time to time to meet changing conditions of medical practice."

In 1977, a number of long-standing statements of the AMA Judicial Council were retained in Opinions and Reports while others were withdrawn. Some statements were removed because they did not reflect current medical practice. Others were withdrawn because they dealt with "outmoded matters of medical etiquette which embraced admonitions that have long been unnecessary and were historical anachronisms for a current publication." The 1972 statement concerning professional courtesy to non-physicians was one such statement that was removed as an outmoded matter of etiquette. Another statement removed by the Judicial Council stated that "when a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness." Finally, the Council removed a statement which suggested that when a physician succeeds another physician he should not disparage or criticize the other physician.

In 1977, the Judicial Council recommended that the House of Delegates revise the AMA Principles of Medical Ethics. The revised Principles were adopted by the House in 1980 (Appendix VI). Opinions and Reports published after 1977 removed the remaining statements referring to the practice of professional courtesy. [This removal of all mention of professional courtesy is interesting because it marks the true removal of professional

etiquette from organized medical ethics. This was the first time that ethics and etiquette would be wholly separated in the profession of medicine.]

For over 10 years there was no mention of the tradition of professional courtesy in the Code of Medical Ethics : Current Opinions of the Council on Ethical and Judicial Affairs (renamed in 1985). In fact, the 1992 edition reads, "Behavior relating to medical etiquette, custom, or **professional courtesy** is not to be addressed in Current Opinions." (Council on Ethical and Judicial Affairs, 1992) Of the thirty-three state medical societies that responded to my inquires regarding their policies on professional courtesy, only four reported having written guidelines on the practice between 1992 and 1993. Those societies that did have guidelines essentially retained wording similar to previous AMA principles and reports.

In June 1993, the Council on Ethical and Judicial Affairs readdressed the topic of "Self-treatment or Treatment of Immediate Family Members." At that meeting, it adopted opinion 8.19 (Appendix IV) which declared that, "Physicians generally should not treat themselves or members of their immediate families." At the same June 1993 meeting in opinion 6.12 "Forgiveness or Waiver of Insurance Copayments", the Council warned that "Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers." This discussion of copayment probably prompted the council to address and adopt opinion 6.13 "Professional Courtesy" in June 1994 after almost fifteen years without organized guidance on the tradition. The Code of Ethics has been once again

corrupted by guidelines concerning etiquette. The preface of the 1994 Current Opinions states that "Behavior relating to medical etiquette or custom is not addressed in Current Opinions with Annotations." This time the 1994 Current Opinions suggests that this form of etiquette may be considered fraud. The opinion stated :

> 6.13 Professional Courtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate opinion 6.12. (Council on Ethical and Judicial Affairs 1994)

It is interesting that this opinion states that professional courtesy is not an ethical requirement (but perhaps a matter of professional etiquette). By stating that professional courtesy is a form of etiquette, notions of collegiality (based on Hippocrates and Percival) have been lost. Physicians are now asked to use their own judgment in providing professional courtesy. Physicians educated under Percival and Hippocratic ethics would have expected free care as members of the honorable profession.

ETHICS OR ETIQUETTE

Various scholars have questioned whether medical codes of professional ethics are truly ethical or whether they are merely a form of professional etiquette. Goffman (1967) writes, "In our society the code which governs substantive rules and substantive expressions comprises our law, morality, and ethics, while the code which governs ceremonial rules and ceremonial expressions is incorporated into what we call etiquette." Veatch describes the necessary elements of any "true professional ethic". He argues that a professional group generates the norms, principles, and correct professional conduct for the profession. He adds that only the profession is capable of adjudicating ethical disputes and imposing ethical discipline. (Veatch, 1981)

Codes of professional ethics sometimes contain provisions that have little to do with ethics, for example, the sections dedicated to the provision of professional courtesy to one's colleagues in medicine. While not specifically relating to an ethical obligation of the profession, the practice may contribute to the overall professional goal. Professional codes of ethics tend to idealize the profession and its responsibilities. While idealizing the profession, several codes of ethics within a single profession (i.e. the AMA Code of Ethics and the American College of Physicians Code of Ethics) may conflict with one another. Unless one code is superior to another, then no code of ethics provides an adequate guide to professional ethical behavior. (Mahowald, 1984)

Ethical codes may be interpreted as a set of rules having legal or quasi-legal function or as simple guidelines or principles of appropriate conduct. (Veatch, 1989) In the 1980 version of the AMA Principles of Medical Ethics (Appendix VI), the Preface

says that the principles "are not laws, but standards of conduct which define the essentials of honorable behavior of the physician." Failure to follow such guidelines though may result in disciplinary proceedings within the association. (AMA, 1980) Obviously, even the American Medical Association is somewhat confused about the role of their own ethical codes.

Veatch argues that the word "ethics" may be misused in medicine. He argues that it is impossible for medical ethics to be founded on custom or self-imposed standards without reference to any higher authority. He suggests that medical ethics is truly a kind of metaethics meaning that ethics in medicine refers merely to what is customary in practice among all physicians. In other words it can be viewed as a theory of relativism, where medical ethics becomes retrospective, merely documenting what is usual and customary within the profession. (Veatch, 1981)

Ethical codes may represent guidelines to their authors, but may be viewed by outsiders as more stringent moral rules. For example, physicians can be held accountable by the courts for malpractice when they fail to uphold the AMA Code of Ethics. (Veatch, 1981) Thus codes may serve as both rules and guidelines. Physicians may be held both morally and legally responsible for their content. (Veatch, 1989)

The function of ethical codes becomes even more ambiguous since physicians do not need to be members of professional organizations in order to practice medicine. One voluntarily becomes a member of an organization and pays dues. In joining the organization, the physician is asked to voluntarily agree to the code of ethics of that organization. This situation poses significant problems for those physicians who either

do not join their professional organizations or choose to join multiple associations. (Veatch, 1989) Are physicians who do not join the organization held to the same moral guidelines or rules as the rest of the profession? Do multiple codes weaken the strength of the moral codes? Which professional codes of ethics supersede other moral codes?

A better question, why do we even need an ethical code in medicine at all? Most physicians do not have any idea about what is discussed in the ethical codes of their professional organizations. Members of the AMA never receive a copy of the Council on Ethical and Judicial Affairs' Opinions and Reports. It may be that physicians are held to a higher standard within society. But, as alternative providers have entered the market and technical medical information has infiltrated the popular press, the separation between physician and patient has been lessened. Physicians no longer need guidelines to dictate common etiquette but need the same guidance on matters of morality which effect every common man or woman.

Does professional courtesy represent a form of "law, morality, or ethics" as Goffman suggests must be inherent to ethics? I do not think so, and suggest instead that professional courtesy, while included in most versions of the AMA Code of Ethics since 1847 and in writings by Percival and others, is a ceremonial rule and expression better governed by "what we call etiquette." One must also seriously question whether medical codes of ethics have ever dealt solely with "law, morality, or ethics" or have been corrupted by codes of etiquette and conduct.

PHYSICIAN AS PATIENT

Thomas Percival's rationale for the tradition of professional courtesy was to prevent physicians from treating themselves or their families. Percival and other physicians believed that the physician was a poor judge of his or her own health care needs. For this reason, practitioners were to offer gratuitous services to prevent self-treatment by their colleagues. But, even with professional courtesy, not all physicians seek care from other professionals. Many physicians resort to treating themselves.

Physicians report that they care for their own health problems because they do not want to bother colleagues, want to remain in control of their care, are embarrassed to seek help from a colleague, and are concerned about confidentiality issues when seeking care from other practitioners. (Anonymous, 1973; Marzuk, 1987) To prevent seeking care for themselves, physicians tend to diagnose and treat their own health problems, obtain "hallway" consultations about their medical symptoms, receive treatment from close personal friends, and delay seeking treatment for their disease. (Stoudemire & Rhoads, 1983)

Physicians argue that with their advanced knowledge of medicine they are in the best position to evaluate and care for themselves and their families. Studies would suggest that these practitioners are wrong. Physicians do not typically practice what they preach. For example, 90% of physicians stated in one study that they urged healthy physical examinations for their patients but 70% of physicians themselves did not seek such examinations. (Pulse of Medicine, 1961)

This lack of regular screening health care and contact may be harmful to the physician. In one study, physicians were shown to have as many undiagnosed diseases as a control group of "well" executives. Physicians required treatment for the newly diagnosed conditions and generally did not receive appropriate care for preexisting illnesses. (Sharpe & Smith, 1962) Other studies have documented a significant delay in the diagnosis and treatment of ill physicians. Robbins et al. (1953) showed that physicians tend to delay seeking treatment for cancer. Pearson and Strecker (1960) showed that physicians delay therapy for psychiatric illness.

Studies conducted over 40 years ago showed how these delays could affect physician health. One study by Benjamin Byrd reviewed the records of 60 physicians between 1925 and 1950 and determined that physicians had ignored alarming symptoms of disease including bloody stools, black urine, recurrent abdominal pain, jaundice, dysphagia, and hemoptysis between 3 and 14 months before seeking care. Of the 60 physicians with cancer, 30 of the neoplasms had metastasized by the time the physicians sought diagnosis and treatment. (Medical World News, 1972) Anecdotes of this type of delay continue even today. One physician with non-Hodgkin's lymphoma delayed seeking diagnosis and treatment for four years. The physician himself was a hematologist/oncologist. (Personal Communication, 1995)

Unfortunately, when physicians do seek care from their colleagues they are not ideal patients. One surgeon was hospitalized for a spondylosis operation :

> After the two-hour procedure was over and the patient had rallied from anesthesia, a nurse steered him off the table to a wheelchair. But the bouncy 45-year-old physician--who's on the Hospital staff--protested that he felt better standing. Disregarding "horror-stricken" nurses, he padded down the hall toward his room, pushing the wheelchair before him. Five nights later, another impulse struck. When all was quiet, he stole down to the staff locker room, removed his neck brace, and helped himself to a shower. It felt salubrious at the time, but when he turned off the water there was a suspicious trickling sensation down his backside (without his brace he couldn't turn to investigate). Out of the shower, mirrors told the story: Sure enough, the water had loosened the dressing and opened "the whole middle" of the wound. Unabashed, Dr. Dillon stood in the shower stall for 15 minutes until the bleeding stopped, then enrobed and slunk unnoticed back to his room. A phone call brought an open-mouthed resident surgeon, who redressed the wound and consented to pretend that nothing had happened. (Medical World News, 1972)

Physician-patients are not always as lucky as the next story illustrates :

> A 30-year old physician had pain in the epigastric area that was sharp, stabbing, intermittent, and persisted over several days. He obtained a "hallway" consultation from a colleague, who, after hearing the patient describe his symptoms, suggested gastritis or possible duodenal ulcer and recommended that, if the pain was not relieved by antacids, he see a gastroenterologist. When the pain persisted and became more severe, he consulted a gastroenterologist "informally" in a hallway who also recommended antacids, and suggested he get an appointment in his office if there was no relief. Approximately 24 hours later, the physician collapsed at home, and despite resuscitation efforts, was dead on arrival at the same hospital in which he worked. A ruptured aneurysm at the site of a repair of coarctation of the aorta was found at autopsy. The patient had had this surgical repair approximately 16 years ago, but had failed to give this history in relating his symptoms to both physicians that he had informally consulted. (Stoudemire & Rhoads, 1983)

Finally, not only are physicians poor patients, not only do they delay seeking formal health care evaluation, but once diagnosed it may be difficult for them to comfortably conform to the "sick role" as the follow case depicts :

> Late one night in early 1966, while still New York Hospital's physician in chief (but on special leave), Dr. E. Hugh Luckey had a myocardial infarction at his home in suburban Bronxville. He had no doubts about the nature of the attack, but he altered his route not a bit. He rose at his usual time, dressed, drove to work (the pain "wasn't too severe," he recalls), walked to the office, and finally told the acting physician in chief he was having a coronary. "He nearly fainted," Dr. Luckey says. "He took an ECG and of course it was true. I'd had an infarct." In spite of the diagnosis, Dr. Luckey was permitted to go to his office and leave instructions with his secretary before reporting to the coronary care unit. (Medical World News, 1972)

What do these three anecdotes show us? Physicians do not make ideal patients. According to Dr. E. Hugh Luckey (who by the way was a cardiologist and vice president for medical affairs at Cornell University Medical College), "They're probably the worst [patients]." (Medical World News, 1972)

Physicians also bring with them issues unique to being physician-patients. Many physicians believe that they are immune to disease. This belief is potentiated by the medical training system. For example, many residency training programs do not provide sufficient sick days for illness in their housestaff. Even when physicians recognize symptoms in themselves, they are apt to deny any existence of illness which delays their diagnosis and treatment. Physicians deny illness for various reasons including that they fear losing patient referrals, they know the limitations of medical technology, and they may feel guilty since others must carry the burden of caring for their patients. (Marzuk, 1987; Stoudemire & Rhoads, 1983)

Care of the physician-patient also poses difficulties in management. Some physicians may be uncomfortable in requesting personal information or examining the physician-patient especially when they know the patient socially. Physicians caring for

physician-patients may avoid embarrassing procedures or questions. According to one Boston doctor, physicians will say to themselves, "Oh, I won't do a rectal exam this time; it would be too uncomfortable." (Medical World News, 1972) History taking from physician-patients may also be challenging because the history may be influenced by the patient's own beliefs or fears. Physician-patients may provide or omit significant positives because of their medical knowledge and understanding. Treatment of the physician-patient presents an extra concern for confidentiality, especially when seeking care in the physician's own hospital. (Marzuk, 1987)

Physician-patients may attempt to retain control of their health care even after surrendering to the care of a colleague. Physicians and patients may become frustrated as physician-patients attempt to deny the existence of their illness. In addition, physicians caring for physician-patients often do not take control in this power struggle. As a result, physician and patient share the provider role, for example, by over-medicalizing the office visit. Discussions of diagnosis and prognosis may be inadequate where physicians may provide too little information for fear of insulting their colleagues or friends. (Marzuk, 1987; Stoudemire & Rhoads, 1983)

Finally, physicians themselves believe that their special medical knowledge and status might provide them with an advantage. Unfortunately, physician-patients all too often succumb to the "VIP syndrome", where the VIP role paradoxically leads to treatment failure. They receive special treatment, but in the process pose a threat to their health care staff. Staff may react to this external pressure with hostility and resentment. The VIP status of the physician-patient may also enable them to demand inappropriate

privileges including chart reviews and prescribing authority. (Stoudemire & Rhoads, 1983) Finally, as might be expected, health care staff may feel awkward and anxious about caring for the physician-patient whom they know personally :

> It is difficult to behave professionally toward a former co-worker, colleague, and friend with whom one shared information, discussed cases, and socialized. This means that the treating professional may be less able to form independent judgments and to enforce his treatment of choice, and the patient may suffer. (Glass 1975)

Therefore, not only are physicians "bad" patients, but doctors who care for the physician-patient may be forced to practice "bad" medicine.

CARING FOR ONE'S OWN

Physician-parents, because of their knowledge of medical science, may feel that they can care for their family members adequately. Unfortunately, because of the closeness of these patients the physician's objectivity is compromised. Physicians' children and spouses tend to receive inadequate health care services. McSherry (1988) suggests that physicians are prone to take inadequate histories and amass poor documentation when treating family members. He describes what he calls the "MD-parent syndrome" which afflicts physicians, their families, and their health care.

The "MD-parent syndrome" occurs when physicians believe they are competent to care for the health care needs of a loved one. The syndrome has three levels of severity, McSherry explains. At the first level, the MD-parent acts as primary care physician for the children. He suggests that these children never have complete physical examinations, have no complete medical record, and may suffer from severe medical neglect. At the second level, MD parents not only designate themselves as attending physicians for their children, but seek personal copies of all of their children's medical records even if their children are seeking medical attention elsewhere. These parents have a need to remain in control. Finally, the most severe form of the "MD-parent syndrome" involves physician parents who actually admit their children to local hospitals and write orders for their care. They exercise power over their children's care at a distance using their children's financial dependence to enforce control. McSherry suggests that the physician-parent must totally surrender all of their children's health care

to a private physician to prevent succumbing to the "MD-parent syndrome". (McSherry, 1988)

Physicians provide inadequate care to their families because the care they require may be outside their specialty:

> One day at lunch a pediatrician commented to his colleagues about how difficult it must be for lay parents to decide whether their baby crying at night is ill or well, "If they could just use an otoscope, as I can, they could tell the child to go back to sleep and they themselves could relax." A neurosurgeon at the table spoke up, "When my children cry in the night I always check their eyes. If their eye grounds are normal I can go back to bed." A surgeon said, "I always examine my children's abdomen." Finally a psychiatrist spoke, "When this happens at my house, I go in and ask, 'What are you dreaming about?'" (Kennell & Boaz, 1962)

At other times it is their advanced knowledge and anxiety that prevents appropriate health care delivery :

> A neurosurgeon's baby had a head somewhat larger than average, which concerned the father, though there were no sings of increased pressure. At an out-of-town meeting the neurosurgeon told a pediatrician that his wife had just called because their son had a temperature of 104°F and lethargy; he expressed his relief that his wife had reported that their son's eyes and fontanel were normal. When the pediatrician asked him what he had told his wife to do about the fever he replied "Good Lord! I completely forgot about that." (Kennell & Boaz, 1962)

Physicians report that they provide services to family members ranging from diagnosis to surgery. In a recent study (La Puma et al., 1991) 83% of physicians reported prescribing medications, 72% of physicians performed physical examinations, and 9% performed elective surgery on family members. (Appendix III)

Services Provided to Family Members

SERVICE	NUMBER	PERCENT
Prescribed Medication	386	83
Diagnosed Illness - Tx	372	80
Performed Physical Exam	334	72
Provided Samples	334	72
Diagnosed Illness - No Tx	311	67
Provided Immunization	146	31
Primary Attending	68	15
Elective Surgery	44	9
Consulting Physician	32	7
Heimlich maneuver	18	4
Emergency Surgery	17	4
Administered CPR	3	1
None	16	3

Source : La Puma et al., New England Journal of Medicine, 1991.

In another study, physicians reported on the pressures they felt to treat family members. Physicians claimed that they treated family because of a sense of responsibility and convenience. They generally have easy access to diagnostics and therapy. These physicians felt that their family's illnesses were too minor to waste a colleagues time. (Boiko et al., 1984) Some physicians did refuse to care for family members when asked. La Puma et al. (1991) reported that most often they refused because they felt that the request was outside their field of expertise (34%), that they had not examined the family member (18%), or that the relationship with the family member was too close (17%). (Appendix III)

Reasons for Refusal of Requests by Family Members

REASON	% REFUSAL
Outside field of expertise	34
Lack of examination	18
Relationship too close	17
Medically not indicated	9
Patient needs own doctor	7
Prefer not to be involved	7
Unethical	4
Legal concerns	3
Family conflict	1

Source : La Puma et al., New England Journal of Medicine, 1991.

Physicians themselves are not the only ones who feel uneasy about doctors treating their own families. The practice raises significant ethical concerns including when to breach confidentiality, how to obtain informed consent, how to assess decision making capacity, and who to consider the patient and who to consider family. (La Puma et al. 1991) In addition, medical societies and the AMA have published guidelines prohibiting members from treating their own families. Organized medicine urges practitioners to avoid dual relationships, including not only relatives but employees, students, supervisees, and close friends. In June 1993, the AMA Council on Ethical and Judicial Affairs revised its opinion on physicians treating their families. (Appendix IV) In the opinion, the Council suggested that "physicians generally should not treat themselves or members of their immediate families." The December 1994 AMA House of Delegates asked the Council to reconsider their opinion concerning physician self-treatment and treatment of relatives at their June 1995 meeting. (AMA, Personal Communication, 1995) At this meeting, the AMA Council on Ethical and Judicial Affairs "reaffirmed its opinion on the ethics of physicians who treat themselves or family members, finding it acceptable only in emergencies or cases of routine care for short-term, minor problems." (American Medical News, 1995)

Insurance carriers also recognize the possible conflict of interest involved in caring for family members. Since 1976, Blue Cross-Blue Shield has not paid for services rendered to immediate relations. (La Puma, 1991) Effective November 13, 1989, Medicare ceased paying for "expenses that constitute charges by immediate relatives of

the beneficiary or members of his or her household." (*Code of Federal Regulations* Title 42 Part 411.12)

Although MD-families are supposed to seek care from unrelated practitioners, like their parents, physicians' children do not make good patients. Pediatricians suggest that physician-parents have easier telephone access, but that they are less likely to call than non-physicians. Physician families also tend to come in less often for acute illnesses and when they do, they are generally sicker. Even though physician families seek care from outside their close relations, physicians often obtain less social and psychological history from the family. In addition, physician families were more likely to alter normal diagnostic, referral, and hospital routine than patients without physician-parents. (Wasserman et al., 1989)

Several physicians have provided suggestions on how to evaluate situations where they are asked to care for family members. Generally, these authors have suggested that family members should have their own private physicians with whom all family members are comfortable. Physician-family members should not prescribe medications, supply a medicine chest, second guess other physicians, or self-refer their family members without consulting the physician to which they have relinquished their family's care. (McSherry, 1988; Kennell & Boaz, 1962)

But, when the physician decides to treat a family member, La Puma and Priest (1992) have suggested a few questions that physicians should ask themselves before treating a family member :

1) Am I trained to meet my relative's medical needs?
2) Am I too close to probe my relative's intimate history and physical being and to cope with bearing bad news if need be?
3) Can I be objective enough to not give too much, too little, or inappropriate care?
4) Is medical involvement likely to provoke or intensify intrafamilial conflicts?
5) Will my relatives comply more readily with medical care delivered by an unrelated physician?
6) Will I allow the physician to whom I refer my relative to attend him or her?
7) Am I willing to be accountable to my peers and to the public for this care?

PROFESSIONAL COURTESY : PROS AND CONS

Hammurabi, Hippocrates, and Percival could not have anticipated several developments that might influence professional courtesy in the provision of modern health care. In the United States, the most notable of these have been the widespread availability of private health insurance since the 1940s, and more recently the rising costs, competition, and market forces more traditionally associated with the provision of other goods and services. These developments have undoubtedly influenced professional courtesy from the vantage of the physician as both patient and provider of care to other physicians.

As the practice and guidelines regarding professional courtesy have changed, not all physicians agree on whether it is an outdated or a time honored tradition. Many physicians regard the provision of professional courtesy as a colleagial tradition based on a premise that physicians should not care for their own families. But, as early as 1958, some physicians and their families began to complain that "courtesy care" was becoming too large a portion of their billable hours. (Sherwood, 1958) Ironically, the reward to the "doctor's doctor"--a skilled physician sought by other physicians for their personal or family care--is a decline in compensation as physician-patients occupy a greater portion of their patient roster. For providers of time-intensive care, notably psychiatrists, professional courtesy can be disproportionally burdensome. (Judicial Council, 1966)

The advent of fee-for-service health insurance in the United Sates introduced a quandary for a physician wishing to offer professional courtesy to physician colleagues. By waiving the copayment normally required by such policies, the doctor's doctor could

recover partial payment from an insurance company for their services without generating out-of-pocket expenses for the physician-patient. In 1951, the AMA Code of Ethics was amended to reflect that the acceptance of insurance as payment in full for services to physicians was ethical. (House of Delegates, 1951)

Technically, however, waiver of copayment is a contractual violation and, in some contexts, considered to be health insurance fraud. (Lachs et al., 1990; Turner, 1991) The contract between patient and insurer obligates the patient to pay a fixed percentage of physician fee in the form of copayment. If the doctor's doctor only charges for the insurer's portion of the bill, the total fee has been theoretically reduced, and the insurer may argue that it is now only responsible for a percentage of the "new" total fee. Carried to its logical conclusion then, only when the doctor's doctor charges both insurer and patient total or nothing is contract language of copayment legally satisfied.

By activating the claims machinery of third-party payors, health insurers have been able to amass claims experience on the health care utilization of physicians. Physicians have rates of utilization that exceed those of many professions and some physicians find it difficult to obtain reasonably priced private insurance coverage. (New York Times. February 5, 1990:A1) Although the increased utilization may reflect better health awareness by physicians or differences in health, it is possible that waiver of copayment itself is partly responsible. (Lachs et al., 1990) Several studies have shown that for non-physician patients, copayments are powerful disincentives to utilization. (Cherkin et al., 1989; Shapiro et al., 1986; Leibowitz et al., 1985; Newhouse et al., 1981) This cost barrier for the physician-patient is removed by waiver of copayment as

professional courtesy, but it is currently not known whether physicians who receive professional courtesy have more personal health care utilization than those who do not receive it.

Another intriguing possibility (and one with far-reaching policy implications) is that the personal experience of professional courtesy by physician-patients influences health care utilization for their nonphysician patients. Ironically, professional courtesy effectively insulates the major arbiter of health care resource allocation from the costs of personal medical care. Thus, the agent who is responsible for making health care expenditure decisions for society may not have had to experience the financial burdens of paying for medical care.

Several physicians believe that professional courtesy may create the feeling that a busy colleague is being imposed upon. In reviewing the history of professional courtesy, Bass and Wolfson (1980) note that several prominent psychiatrists, including Karl Menninger and Sigmund Freud, believed that the practice could make both the doctor-patient and the doctor's doctor uncomfortable, perhaps preventing the necessary and appropriate relationship from developing. Freud insisted on paying for medical care for both himself and his family.

With a sense of imposition, physicians may also feel obligated to continue seeking care from a colleague even when they are unhappy with the services they receive. Many physicians also feel that it is necessary to send gifts in lieu of a fee for medical care. This traditional gift giving may also create problems. When should a gift be given? How much should be spent on a gift? What should be given? One physician has even

suggested rules of etiquette for giving gifts to colleagues. (Fischer-Pap, 1974; Appendix VII)

The practice of professional courtesy may cause other problems for the physician. Another "gift" offered in return for gratuitous services may be a tacit or explicit expectation that the physician-patient would reciprocate by referring other nonphysician patients. (Judicial Council, 1966) Medicolegal purists might depict this offering as an act of physician self-referral and violation of antikickback statutes. An honorable defense of the practice might invoke quality of care arguments; a concerned physician chooses for his patients consultants he would choose for himself or his family.

Finally, critics of the practice of professional courtesy may ask why physicians should be singled out to receive special privileges as patients. Certainly, unlike many of their patients, physicians have the financial means to pay for their own health care. What makes physicians different?

Though there are many more arguments against the practice of professional courtesy, the basic one in favor of the tradition revolves around the notion of preventing physicians from treating themselves or their families. This historical basis of the tradition was first documented by Dr. Thomas Percival in his book *Medical Ethics* though it was most likely a commonly accepted practice. As previous chapters have shown, physicians do often care for themselves and their families (La Puma, 1991) and may tend to deliver inferior care. (McSherry, 1988) Professional courtesy has been argued as a rational solution to reducing the barriers encountered when physicians seek unbiased care for their families.

CONCLUSION : DISAPPEARANCE OF PROFESSIONAL COURTESY

So, is professional courtesy really disappearing? The evidence presented from the 1950's to the present would suggest otherwise. Professional courtesy continues to be offered by over 90% of physicians (Levy et al., 1993), but today most practitioners merely waive copayments rather than the total fee. Professional courtesy is not disappearing but changing. These changes have been driven mostly by significant modifications in the organization and reimbursement structure of the United States health care system. Unlike the physicians of 40 years ago, physicians of the 1990's must concern themselves not only with the provision of care, but the business of medicine. Starting with the rise of third party payers, most significantly Medicare and Medicaid in the 1960's, physicians now see a larger number of insured patients than in years past. Patient out-of-pocket payments for physician services accounted for only 15% of health care expenditures in 1994. (Health Care Financing Administration, 1994) Physicians continue to refuse direct out-of-pocket payments from their colleagues for services rendered. Professional courtesy may have changed in form, but surveys show that it is not disappearing. Although physicians do not extend free services to their colleagues, medical practitioners continue to provide some form professional courtesy as a notion of collegiality.

Physicians do not provide professional courtesy to non-physicians as often as they did in the past. The main reason these physicians have abandoned the tradition is because of the expense of providing free care. Perhaps, non-professional courtesy has decreased faster than physician professional courtesy because physicians and patients lack that

common bond, a sense of collegiality, between the physician and other members of the profession.

It appears from the surveys conducted since the 1950s that though the prevalence of the tradition maybe unchanged, the practice of professional courtesy has been altered greatly. Perhaps, this change was due to the increasing numbers of insured physicians, the changing health care environment, or perhaps a certain aspect of collegiality has been lost over the years. Certainly, the transition of medical practice towards a more business-like environment may be to blame. As physicians concerned themselves more and more with their practice's bottom line, they were more likely to accept insurance benefits than in the past while still participating in the tradition of not accepting out-of-pocket payments from one's colleagues.

Will the tradition of professional courtesy continue to be practiced in the future? I believe that it will not, but not because physicians will voluntarily refuse to offer it. As the health care system continues to change, physicians will no longer have the power or ability to provide gratuitous services to their colleagues. Fewer physicians today are in traditional private solo practice. In 1987, 30% of non-federal physicians were in group practice. (American Medical Association, 1989) Physicians are rapidly losing control over their own practices. Today they are becoming employees rather than small employers. More and more, physicians' practices are being acquired by hospitals, by managed care entities, and by health care networks. No longer are physicians and hospitals alone in charge of patient care. They are joined by alternative practitioners and a much larger health care infrastructure. As patient care and decision making is taken

away from the physician, practitioners no longer have the ability to make decisions concerning who will and who will not be charged for services rendered. In fact, it is already apparent that in practices where physicians do not make billing decisions, professional courtesy is declining. In the 1993 survey conducted by Levy et al. physicians practicing in fee-for-service environments offered professional courtesy 98% of the time, while only 62% physicians in managed care environments were able to offer similar fee reductions. For this reason, I suggest that as the health care system continues to take the decision making about fees or charging away from physicians, professional courtesy will disappear.

Professional courtesy, as proposed by Thomas Percival, was to prevent the problems associated with treating oneself. Unfortunately, the practice may interfere with the physician-patient relationship it was intended to foster. First, the fee discounts may reinforce the "VIP syndrome". Second, the offering of professional courtesy may make it difficult to switch providers if the physician-patient is unhappy. Finally, the receipt of gratuitous services may instill a sense of guilt for taking up the physician's valuable time without reimbursement. (Stoudemire & Rhoads, 1983)

Is the disappearance of professional courtesy good or bad for medicine? For years, academics have argued that the practice of medicine was becoming deprofessionalized. They claim that medicine has become more of a trade than a profession. Professional courtesy may indeed be an "historical anachronism" as the AMA has suggested. Dr. Percival originally envisioned the tradition to prevent physicians from treating their own families. Unfortunately, professional courtesy may

actually promote the very practice which it was supposed to prevent. In the survey conducted by the AMA Judicial Council, 47.3% of physicians surveyed felt that professional courtesy made them hesitant to seek medical care. These physicians treated themselves. (Judicial Council, 1966) It is commonly understood that physicians are poor judges of their family's health care, but professional courtesy is certainly no longer the means of preventing such misguided self-treatment. Perhaps, the medical profession must find alternative means to prevent physicians from treating themselves. Already, Medicare and Blue Cross/Blue Shield will not reimburse physicians or their families for office visits, diagnostic testing, or pharmaceuticals prescribed by a family member. Disincentives like these, not professional courtesy, will be used in the future to prevent self-treatment by health care professionals. Professional courtesy is a tradition which unfortunately has outlived its historical origins of collegiality and has become a solely monetary interaction.

REFERENCES

"Charges imposed by an immediate relative or member of the beneficiary's household." Title 42 *Code of Federal Regulations*, pt. 411.12.1994Ed.

American Medical Association. The environment of medicine. Chicago: American Medical Association, 1989.

American Medical Association. Membership Facts. Chicago: American Medical Association, 1994.

American Medical Association. Code of Ethics of the AMA. Chicago: American Medical Association, 1847.

American Medical Association. Code of Ethics of the AMA. Chicago: American Medical Association, 1901.

American Medical Association. Principles of Medical Ethics of the AMA. Chicago: American Medical Association, 1905.

American Medical Association. Principles of Medical Ethics of the AMA. Chicago: American Medical Association, 1940.

American Medical Association. Principles of Medical Ethics of the AMA. Chicago: American Medical Association, 1949.

Anonymous. Physician Heal Thyself! Virginia Medical Monthly. 1973;100(10):917-918.

Bass, Lee W. And Wolfson, Jerome H. Professional Courtesy. Pediatrics. 1980;65(4):751-757.

Bass, Lee W. And Wolfson, Jerome H. Professional Courtesy is Obsolete. New England Journal of Medicine. 1978;299(14):772-774.

Blue Cross and Blue Shield of Illinois. Immediate relative services excluded. Medicare B Bulletin. 1990;12:10.

Boiko, Patricia E., Schuman, Stanley H., and Rust, Phillip F. Physicians Treating Their Own Spouses : Relationship of Physicians to Their Own Family's Health Care. The Journal of Family Practice. 1984;18(6):891-896.

Carrick, Paul. Medical Ethics in Antiquity : Philosophical Perspectives on Abortion and Euthanasia. Boston: D. Reidel Publishing Co. 1985.

Chapman, Carleton B. Physicians, Law, and Ethics. New York: New York University Press, 1984.

Cherkin, DC, Grothaus, L, Wagner, EH. The effect of office visit copayments on utilization in a health maintenance organization. Medical Care. 1989;27:1036-1045.

Council on Ethics and Judicial Affairs. Code of Medical Ethics, Current Opinions with Annotations. Chicago: American Medical Association, 1992.

Council on Ethics and Judicial Affairs. Code of Medical Ethics, Current Opinions with Annotations. Chicago: American Medical Association, 1994.

DeLawter, DeWitt E. Professional Courtesy : A bygone Era [Editorial]. Maryland Medical Journal. 1992;41(5):367-368.

Edmunds, Vincent and Scorer, C. Gordon. Ideals in Medicine : A Christian Approach to Medical Practice. London: Tyndale Press, 1958.

Fischer-Pap, Lucia. A guide to gift-giving for professional courtesy. Medical Economics. 1974;November 11:143.

Fishbein, Morris. A History of the American Medical Association. Philadelphia: W.B. Saunders, 1947.

Freidson, E. Medical Work in American. New Haven: Yale University Press, 1989.

Gifford, James P. Professional Courtesy : Who gives how much to whom. Medical Economics. May 21, 1962:81-87.

Gisborne, Thomas. An Enquiry into the Duties of Men. London:B&J White, 1797.

Glass, GS. Incomplete role reversal: the dilemma of hospitalization for the professional peer. Psychiatry. 1975;38:132-144.

Goffman, Erving. Interaction Ritual. Chicago: Aldine and Doubleday, 1967.

Goldman, Brian. Professional courtesy: My colleagues will no longer be my brothers. Canadian Medical Association Journal. 1985;132:422-428.

Gregory, John. Lectures on the Duties and Qualifications of a Physician. Philadelphia : M. Carey & Son, 1817.

Gross, Samuel D. [Letter]. Transcripts of the American Medical Association. 1882;33:3.

Hamstra, Kenneth Warren. The American Medical Association Code of Medical Ethics of 1847. Ann Harbor: UMI Dissertation Information Service, 1987.

Health Care Financing Administration. Health United States 1994. Maryland:Health Care Financing Administration, 1995.

House of Delegates. American Medical Association Meeting. Chicago: American Medical Association, 1951.

Howe, KR. Medical Students' Evaluations of Different Levels of Medical Ethics Teaching : Implications For Curricula. Medical Education. 1987;21(4):340-9.

Hughes, Stewart C. When You Give Professional Courtesy... Medical Economics. 1958;May 12:154-166.

Macintyre, Alasdair (ed.). Hume's Ethical Writings : Selections from David Hume. London: University of Notre Dame Press, 1965.

Jacobs, Michael B. Forgiveness of coinsurance [letter]. New England Journal of Medicine. 1990;323:1284.

Judicial Council of the American Medical Association. Professional Courtesy Survey. JAMA. 1966;195(4):159-161.

Judicial Council of the American Medical Association. Opinions and Reports of the Judicial Council. Chicago: American Medical Association, 1960.

Judicial Council of the American Medical Association. Opinions and Reports of the Judicial Council. Chicago: American Medical Association, 1966.

Judicial Council of the American Medical Association. Opinions and Reports of the Judicial Council. Chicago: American Medical Association, 1969.

Judicial Council of the American Medical Association. Opinions and Reports of the Judicial Council. Chicago: American Medical Association, 1972.

Judicial Council of the American Medical Association. Opinions and Reports of the Judicial Council. Chicago: American Medical Association, 1977.

Kant, Immanuel. The Metaphysics of Morals. New York:Cambridge University Press, 1803.

Kennell, John H. And Boaz, Willard D. The Physician's Children As Patients. Pediatrics. 1962;30:100-108.

King, Lester S. IX. The AMA Gets a New Code of Ethics. JAMA. 1983;249(10):1338-1342.

Lachs, MS, Sindelar, JL, and Horwitz, RI. The forgiveness of coinsurance: charity or cheating? New England Journal of Medicine. 1990;322:1599-1602.

La Puma, John., Stocking, Carol B., La Voie, Dan, Darling, Cheryl A. When Physicians Treat Members of Their Own Families : Practices in a Community Hospital. New England Journal of Medicine. 1991;325(18):1290-1294.

La Puma, J and Priest, EF. Is there a doctor in the house? Analysis of the practice of physicians' treating their own families. JAMA. 1992;267:1810-1812.

Leake, Chauncey D. Percival's Medical Ethics. Baltimore: Williams and Wilkins, 1927.

Leibowitz, A, Manning, WG Jr, Keeler, EB, Duan, N, Lohr, KN, Newhouse, JP. Effect of cost sharing on the use of medical services by children: interim results from randomized controlled trial. Pediatrics. 1985;75:942-951.

Levy, Mark A. et al. Professional Courtesy--Current Practices and Attitudes. New England Journal of Medicine. 1993;329(22):1627-1631.

Loewy, Erich H. Textbook of Medical Ethics. New York: Plenum Medical Book Company, 1989.

Mahowald, Mary B. Are Codes of Professional Ethics Ethical? Health Matrix. Summer 1984;II(2):37-42.

Marzuk, Peter M. When The Patient Is A Physician. New England Journal of Medicine. 1987;317(22):1409-1411.

McSherry, James. Long-distance Meddling: Do MDs Really Know What's Best for Their Children? CMAJ. 1988;139:420-422.

Means, James Howard. The Association of American Physicians. New York: Blakiston, 1961.

Mill, John Stuart. Essential Works of John Stuart Mill : Utilitarianism, Autobiography, On Libert, and The Utility of Religion. New York: Bantam Books, 1961.

Newhouse, JP, Manning, WG, Morris, CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. New England Journal of Medicine. 1981;305:1501-1507.

Norman, James. Are You Giving Away Too Much Care? Medical Economics. January 22, 1990:142-158.

Owens, Arthur. See how professional courtesy is changing. Medical Economics. February 4, 1974:79-84.

Pearson, M.N. and Strecker, E.A. Physicians as Psychiatric Patients, Private Practice Experience. American Journal of Psychiatry. 1960;160;915-919.

Percival, Thomas. Medical Ethics: or, A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons. Manchester: J. Johnson, 1803.

Peterkin, Allan. Is professional courtesy disappearing? Canadian Medical Association Journal. 1988;139:425.

Petrie, John T. Overview of the Medicare program; Medicare and Medicaid Statistical Supplement. Health Care Financing Review. 1992;14(SUPP):1.

Pulse of Medicine. Medical Tribune. 1961;2(Aug 7):25-26;2(Aug 14)1.

Quigley, Rosemary. Personal Communication : AMA Council on Ethical and Judicial Affairs Opinion on Physician Self-treatment and Treatment of Family Members. April 11, 1995.

Reed, R and Evans, D. The Deprofessionalization of Medicine: Causes, Effects, and Responses. JAMA 1987;258(22):3279-3282.

Robbins, G.F.; Macdonald, M.C.; and Pack, G.T.. Delay in Diagnosis and Treatment of Physicians with Cancer. Cancer. 1953;6:624-626.

Schiff, Arthur F. Some Musings on the Dying of Professional Courtesy. Southern Medical Journal. 1991;84(11):1297-1298.

Scorer, Gordon. The Moral Values, Law, and Religion. in Scorer, Gordon and Wing, Anthony. (Ed.) Decision Making in Medicine : the practice of its ethics. London: Edward Arnold, 1979.

Shapiro, MF, Ware, JE Jr, Sherbourne, CD. Effects of cost sharing on seeking care for serious and minor symptoms: results of a randomized controlled trial. Annals of Internal Medicine. 1986;104:246-251.

Sharpe, JC and Smith, WW. Physician, Heal Thyself: comparison of findings in periodic health examinations of physicians and executives. JAMA. 1962;182:234-7.

Sherwood, Hugh C. How Much Professional Courtesy for Non-M.D.s? Medical Economics. April 14, 1958:74-82.

Shryock, Richard. Medicine and Society in America: 1660 - 1860. New York: New York University Press, 1960.

Starr, Paul. The Social Transformation of American Medicine. New York: Basic Books, 1982.

Stoudemire, Alan and Rhoads, John M. When the Doctor Needs A Doctor: Special Considerations for the Physician-Patient. Annals of Internal Medicine. 1983;98(Part 1):654-659.

Thomas, Clayton L. (Ed.) Taber's Cyclopedia Medical Dictionary. Philadelphia: F.A. Davis Co, 1970.

Thompson, F. Health policy and bureaucracy : policies and implementation. Boston: MIT Press, 1991.

Turner, Jack C. Professional Courtesy Defrauds, Say Health Insurers. Virginia Medical Quarterly. 1991;188:6.

Veatch, Robert M. A Theory of Medical Ethics. New York: Basic Books, 1981.

Veatch, Robert M. Medical Ethics. Boston: Jones & Barlett Publishers, 1989.

Von Staden, Heinrich. Personal Communication. June 16, 1995.

Wasserman, Richard C., Hassuk, Bruce M., Young, Paul C., and Land, Marshall L. Health Care of Physicians' Children. Pediatrics. 1989;83(3):319-322.

_____. Ethics Opinion Revoked. American Medical News. 1995;December 25:3,8.

_____. Precepts VI. Jones (translations): Hippocrates, I, p. 319.

_____. Proceedings of the National Medical Conventions Heldin New York, May 1846, and in Philadelphia, May 1847. Philadelphia: T.K. and K.P. Collins, Printers, 1847.

_____. The doctor as patient. Medical World News. 1972;13(18 February):56-65.

_____. Webster's New Collegiate Dictionary. Springfield, MA: G&C Merriam Company, 1981.

APPENDIX I

OATH OF HIPPOCRATES (Original Translation)

I swear by Apollo, the Physician, by Asclepius, by Hygieia, Panacea, and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art--if they desire to learn it--without fee and covenant; to give a share of precepts and oral instruction and all the learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustices, of all mischief and in particular of sexual relations with both male and female persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must noise abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

OATH OF HIPPOCRATES (Christian Version)

I affirm by that which I deem holy that, according to my ability and judgment, I will keep this Oath and this covenant;

To reckon them who taught me this Art equally dear to me as my parents and to share my substance with them and relieve their necessities if required; to look upon their offspring as my own and to teach them this Art--if they desire to learn it--without fee or stipulation; to give, by precept, lecture and every other mode of instruction, a knowledge of the Art to my own children and those of my teachers and to disciples bound by covenant and oath to the law of medicine, but to no others.

I will follow those regimens which, according to my ability and judgment, I consider for the benefit of my patients; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman a harmful pessary. In purity and holiness I will guard my life and my Art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of those who are engaged in this work.

Whatever houses I visit, I will come for the benefit of the sick, remaining free from all intentional injustice, from all mischief and, in particular, of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear, in my professional practice or not in connection with it, bearing on the lives of others which ought not be spoken abroad, I will keep to myself, reckoning such things to be secret.

If I fulfill this Oath and do not violate it, may it be granted to me to enjoy life and the practice of the Art, respected by my peers at all times; but, if I trespass and violate this Oath, may the opposite be my lot.

OATH OF HIPPOCRATES (Geneva Version 1948)

Now being admitted to the profession of medicine, I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration. I will hold in confidence all that my patient confides in me.

I will maintain the honor and the noble traditions of the medical profession. My colleagues will be as my brothers. I will not permit consideration of race, religion, nationality, party politics or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life form the time of its conception. Even under threat, I will not use my knowledge contrary to the laws of humanity.

These promises I make freely and upon my honor.

LASAGNA'S OATH (Tufts University School of Medicine)

I swear to fulfill, to the best of my ability and judgment this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say, "I know not," nor will I fail to call in my colleague when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play God.

I will remember that I do not treat a fever chart, or a cancerous growth, but a sick human being, whose illness may affect his family and his economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow men, those sounds of mind and body, as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

OATH (Brown University)

Now being admitted to the high calling of the physician, I solemnly pledge to consecrate my life to the care of the sick, the promotion of health, and the service of humanity.

In the spirit of those who have inspired and taught me, I will seek constantly to grow in knowledge, understanding, and skill and will work with my colleagues to promote all that is worthy in the ancient and honorable profession of medicine.

The health and dignity of my patient will ever be my first concern. I will hold in confidence all that my patient relates to me. I will not permit considerations of race, religion, nationality, or social standing to come between me and my duty to anyone in need of my services.

This pledge I make freely and upon my honor.

YALE PHYSICIAN'S OATH

Now being admitted to the high calling of the physician, I solemnly pledge to consecrate my life to the care of the sick, the promotion of health and the service of humanity.

I will practice medicine with conscience and in truth. The health and dignity of my patients will be my first concern. I will hold in confidence all that my patients relate to me. I will not permit considerations of gender, race, religion, sexual orientation, nationality, or social standing to influence my duty to care for those in need of my service.

I will respect the moral right of patients to participate fully in the medical decisions that affect them. I will assist my patients to make choices that coincide with their own values and beliefs.

I will try to increase my competence constantly and respect those who teach and those who broaden our knowledge by research. I will try to prevent, as well as cure, disease.

When I am qualified to instruct, I will impart my knowledge gladly, hold my students and colleagues in affectionate esteem, and encourage mutual critical evaluation of our work.

In the spirit of those who have inspired and taught me, I will seek constantly to grow in knowledge, understanding, and skill and will work with my colleagues to promote all that is worthy in the ancient and honorable profession of medicine. I will maintain the honor and noble traditions of the medical profession. My behavior will be honorable and thoughtful and reflect justice toward all.

If I fulfill this Oath and do not violate it, may it be granted to me to enjoy life and the practice of the Art. This pledge I make freely and upon my honor. May my faith strengthen my resolve.

APPENDIX II

PROFESSIONAL COURTESY SURVEY : 1958

What the respondents usually charge : dentists

	No charge	Discount	Full fee
Family dentist	62%	26%	12%
His family	45%	34%	21%
Other dentists	31%	41%	28%
Their families	23%	36%	41%

What the respondents usually charge : druggists

	No charge	Discount	Full fee
Known druggists	42%	37%	21%
His family	35%	43%	22%
Other druggists	11%	29%	60%
Their families	8%	25%	67%

What the respondents usually charge : nurses

	No charge	Discount	Full fee
Nurses they work with	66%	28%	6%
Nurses they don't work with	24%	54%	22%
Married nurses	16%	37%	47%
Nurses' families	7%	24%	69%

What the respondents usually charge : medical students & hospital associates

	No charge	Discount	Full fee
Medical students	87%	8%	5%
Their families	63%	13%	24%
Hospital administrators	51%	16%	33%
Laboratory technicians	27%	38%	35%
Physical therapists	21%	34%	45%
Other hospital personnel	14%	36%	50%

What the respondents usually charge : allied professions

	No charge	Discount	Full fee
Optometrists	17%	19%	64%
Their families	12%	18%	70%
Osteopaths	26%	9%	65%
Their families	21%	10%	69%
Veterinarians	20%	25%	55%
Their families	17%	22%	61%

What the respondents usually charge : employees

	No charge	Discount	Full fee
Office workers	95%	4%	1%
Their families	65%	20%	15%
Domestic workers	66%	17%	17%
Their families	43%	22%	35%

What the respondents usually charge : clergymen

	No charge	Discount	Full fee
Own faith	78%	16%	6%
Their families	71%	19%	10%
Other clergy	58%	30%	12%
Their families	51%	32%	17%

What the respondents usually charge : friends & relatives

	No charge	Discount	Full fee
Close friends	30%	14%	56%
Immediate relatives	90%	4%	6%
More distant relatives	56%	18%	26%
In-laws	86%	5%	9%

Source : Sherwood, Hugh C. How Much Professional Courtesy for Non-M.D.s? Medical Economics. April 14, 1958:74-82.

PROFESSIONAL COURTESY SURVEY : 1962

How many physicians give courtesy reductions to :

Other physicians	.....	93%
Own employees	.....	99%
Nurses	.....	77%
Pharmacists	.....	47%
Hospital Employees	.....	41%
Dentists	.....	63%
Clergymen	.....	76%
Close relatives	.....	94%
Distant relatives	.....	74%

How much M.D.s usually charge when they give professional courtesy to :

Other physicians	.....	No fee
Own employees	.....	No fee
Nurses	.....	2/3 fee
Pharmacists	.....	3/4 fee
Hospital Employees	.....	3/4 fee
Dentists	.....	1/2 fee
Clergymen	.....	No fee
Close relatives	.....	No fee
Distant relatives	.....	No fee

Source : Gifford, James P. Professional Courtesy : Who gives how much to whom. Medical Economics. May 21, 1962:81-87.

PROFESSIONAL COURTESY SURVEY : 1966

Table 3. Frequency of Charges for Services Rendered to Physicians or Dependents Service Not Covered by Insurance

	Never	Rarely	Usually	N/A
General Practice	95.0	3.2	1.1	0.7
General Surgery	96.7	2.3	0.5	0.5
Internal Medicine	92.0	7.1	0.7	0.2
Obstetrics-Gynecology	95.6	3.4	0.7	0.3
Anesthesiology	94.8	3.0	1.5	0.7
Orthopedic Surgery	94.7	4.4	0.9	0
Otolaryngology	90.8	7.6	0.8	0.8
Pediatrics	94.7	2.9	0.5	1.9
Ophthalmology	89.8	8.0	2.2	0
Psychiatry	20.5	15.9	58.3	5.3
Radiology	90.6	6.8	2.6	0
Dermatology	86.8	8.8	1.5	2.9
Urology	96.5	3.5	0	0
Allergy	100.0	0	0	0
Pathology	95.2	4.8	0	0
Other	89.1	5.7	2.3	2.9
Median	91.2	4.7	3.2	0.9

Table 4. Frequency of Charges for Services Rendered to Physicians or Dependents Service Wholly Covered by Insurance

	Never	Rarely	Usually	N/A
General Practice	36.4	12.9	47.8	2.9
General Surgery	28.6	10.1	59.2	2.1
Internal Medicine	30.0	17.1	51.8	1.1
Obstetrics-Gynecology	42.1	8.8	47.8	1.3
Anesthesiology	19.3	11.1	68.9	0.7
Orthopedic Surgery	14.0	14.9	71.1	0
Otolaryngology	35.3	11.8	49.5	3.4
Pediatrics	38.9	16.8	41.4	2.9
Ophthalmology	27.7	10.9	59.2	2.2
Psychiatry	27.8	4.0	60.9	7.3
Radiology	16.2	16.2	67.6	0
Dermatology	35.3	20.6	38.2	5.9
Urology	45.3	7.0	45.3	2.4
Allergy	52.2	13.1	30.4	4.3
Pathology	38.1	14.2	45.3	2.4
Other	27.8	11.2	60.4	0.6
Median	32.6	12.7	52.4	2.3

Table 5. Frequency of Charges for Services Rendered to Physicians or Dependents Service Partially Covered by Insurance

	Never	Rarely	Usually	N/A
General Practice	95.8	0.9	0.3	3.0
General Surgery	97.3	0.2	0.	2.5
Internal Medicine	94.2	1.7	0.4	3.7
Obstetrics-Gynecology	96.6	0.3	0	3.1
Anesthesiology	97.0	1.5	0	1.5
Orthopedic Surgery	96.5	0.9	0	2.6
Otolaryngology	98.4	0.8	0	0.8
Pediatrics	94.7	0.5	0.5	4.3
Ophthalmology	97.1	0	0.7	2.2
Psychiatry	40.3	13.9	35.8	9.9
Radiology	94.8	2.6	0	2.6
Dermatology	91.1	1.5	3.0	4.4
Urology	98.8	0	0	1.2
Allergy	87.0	0	0	13.0
Pathology	90.5	2.4	0	7.1
Other	94.7	2.4	0.5	2.4
Median	93.6	1.5	1.7	3.2

Source : Judicial Council of the American Medical Association. Professional Courtesy Survey. JAMA. 1966;195(4):159-161.

PROFESSIONAL COURTESY SURVEY : 1974

Policies of physicians who extend professional courtesy

Patient : Physician

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	72%	28%	0%	97%
Internist	60%	40%	0%	99%
General Surgeon	42%	58%	0%	98%
OB/GYN	57%	43%	0%	98%
Psychiatrist	37%	31%	32%	69%
All fields	56%	42%	2%	96%

Patient : Physician's Spouse

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	69%	31%	0%	95%
Internist	58%	42%	0%	98%
General Surgeon	37%	63%	0%	98%
OB/GYN	53%	47%	0%	99%
Psychiatrist	34%	33%	33%	68%
All fields	52%	46%	2%	96%

Patient : Physician's Child

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	67%	32%	1%	94%
Internist	57%	42%	1%	94%
General Surgeon	36%	64%	0%	98%
OB/GYN	49%	48%	3%	93%
Pediatricians	72%	25%	3%	97%
Psychiatrist	34%	32%	34%	65%
All fields	52%	45%	3%	94%

Patient : Relative

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	68%	29%	3%	84%
Internist	60%	36%	4%	84%
General Surgeon	58%	39%	3%	78%
OB/GYN	40%	59%	1%	84%
Pediatricians	77%	18%	5%	86%
Psychiatrist	69%	23%	8%	43%
All fields	60%	37%	3%	82%

Patient : Employee

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	66%	32%	2%	95%
Internist	66%	32%	2%	95%
General Surgeon	36%	63%	1%	94%
OB/GYN	56%	41%	3%	94%
Pediatrician	76%	21%	3%	95%
Psychiatrist	57%	31%	12%	39%
All fields	59%	39%	2%	92%

Patient : Nurse

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	17%	46%	37%	67%
Internist	6%	32%	62%	68%
General Surgeon	6%	73%	21%	79%
OB/GYN	3%	31%	66%	79%
Pediatrician	4%	14%	82%	55%
Psychiatrist	17%	25%	58%	38%
All fields	8%	43%	49%	68%

Patient : Pharmacist

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	21%	44%	35%	49%
Internist	5%	32%	63%	33%
General Surgeon	5%	66%	29%	43%
OB/GYN	1%	27%	72%	34%
Pediatrician	4%	13%	83%	31%
Psychiatrist	13%	27%	60%	17%
All fields	10%	40%	50%	37%

Patient : Dentist

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	35%	39%	26%	62%
Internist	15%	29%	56%	49%
General Surgeon	10%	66%	24%	56%
OB/GYN	8%	32%	60%	48%
Pediatrician	7%	10%	83%	48%
Psychiatrist	18%	29%	53%	23%
All fields	18%	38%	44%	51%

Patient : Clergyman

	No Fee	Insurance Only	Reduced Fee	% Offering Courtesy
GP	38%	40%	22%	68%
Internist	30%	42%	28%	65%
General Surgeon	15%	71%	14%	73%
OB/GYN	24%	42%	34%	60%
Pediatrician	28%	16%	56%	59%
Psychiatrist	24%	29%	47%	30%
All fields	27%	45%	28%	63%

Source : Owens, Arthur. See how professional courtesy is changing. Medical Economics. February 4, 1974:79-84.

PROFESSIONAL COURTESY SURVEY : 1990

Patient : Physician

	No Charge	Insurance Only	Reduced Fee	Situational	Full Fee
Family Practitioners	38%	39%	1%	23%	2%
General Practitioners	40	32	3	26	3
Internists	27	52	2	21	2
General Surgeons	25	62	1	17	1
Obstetrics/Gynecology	31	58	3	16	1
Pediatricians	36	36	3	21	11
Psychiatrists	19	25	17	22	21
Orthopedic Surgeons	22	70	2	11	0
Anesthesiologists	10	78	0	11	1
Radiologists	20	63	0	19	0
Cardiologists	21	65	2	17	0
Dermatologists	28	59	2	17	2
Gastroenterologists	21	61	1	19	1
Neurologists	25	54	3	20	1
Plastic Surgeons	21	74	10	9	1
Neurosurgeons	19	73	1	10	1
Thoracic Surgeons	19	63	0	21	1
Cardiovasc. Surgeons	14	66	2	21	0
All Surgical	26	62	3	15	1
All Non-Surgical	25	50	4	19	7
All Physicians	29	50	3	19	3

When the patient is a :

Recipient	No Charge	Insurance Only	Reduced Fee	Situational	Full Fee
Employee	31%	42%	3%	21%	6%
Nurse	3%	29%	24%	23%	25%
Relative	32%	35%	2%	24%	9%
Dentist	4%	17%	11%	23%	46%
Cleric	6%	26%	9%	24%	37%
Pharmacist	2%	14%	10%	20%	55%

Source : Norman, James. Are You Giving Away Too Much Care? Medical Economics. January 22, 1990:142-158.

PROFESSIONAL COURTESY SURVEY : 1993

Table 1. Demographics and Professional Courtesy

CHARACTERISTIC	NUMBER RESPONDENTS	% OFFERING COURTESY
Sex		
Male	1888	96
Female	329	92
Age		
30-39	598	94
40-49	708	96
50-59	457	97
60-69	309	97
>69	76	99
Race/Ethic		
Black	46	85
Asian	203	98
White	1754	95
Hispanic	52	96
MD-patients/mo.		
0	232	83
1-4	1465	96
5-9	330	98
>9	153	97
Practice type		
Private solo	1023	98
Private group	802	98
University	152	93
Community	91	85
HMO/Prepaid	84	62
Income type		
FFS	1728	98
Salary	360	81
Capitation	27	85
Income		
<$50,000	81	93
$50-$100,000	505	91
$101-150,000	625	95
$151-200,000	383	96
>$200,000	497	99
Total	2224	96

Table 2. Specialty Group and Professional Courtesy

SPECIALTY	NUMBER RESPONDENTS	% OFFERING COURTESY
Primary Care		
General Medicine	146	91
Pediatrics	196	94
Family	172	95
Obstetrics-Gyn	182	99
Total	696	95
Non-Primary Care		
Neurology	187	97
Dermatology	236	98
Ophthalmology	223	99
General Surgery	180	98
Surgical Sub.	196	99
Invasive Medicine	149	98
Noninvasive Med.	196	96
Total	1367	98
Psychiatry	161	80

Table 3. Form of Professional Courtesy

Form	Never	On Occasion	Often	Always	No Answer
Insurance only	2%	14%	39%	36%	10%
No Charge	4%	33%	30%	19%	15%
Discount	19%	21%	18%	5%	37%

Source : Levy, Mark A. et al. Professional Courtesy--Current Practices and Attitudes. New England Journal of Medicine. 1993;329(22):1627-1631.

APPENDIX III

Table 1. Services Provided to Family Members

SERVICE	NUMBER	PERCENT
Prescribed Medication	386	83
Diagnosed Illness - Tx	372	80
Performed Physical Exam	334	72
Provided Samples	334	72
Diagnosed Illness - No Tx	311	67
Provided Immunization	146	31
Primary Attending	68	15
Elective Surgery	44	9
Consulting Physician	32	7
Heimlich maneuver	18	4
Emergency Surgery	17	4
Administered CPR	3	1
None	16	3

Table 4. Reasons for Refusal of Requests by Family Members

REASON	% REFUSAL
Outside field of expertise	34
Lack of examination	18
Relationship too close	17
Medically not indicated	9
Patient needs own doctor	7
Prefer not to be involved	7
Unethical	4
Legal concerns	3
Family conflict	1

Source : La Puma, J and Priest, EF. Is there a doctor in the house? Analysis of the practice of physicians' treating their own families. JAMA. 1992;267:1810-1812.

APPENDIX IV

Opinion 8.19
Self-treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as primary or regular care providers for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

Source : Council on Ethical and Judicial Affairs. Code of Medical Ethics: Current Opinions with Annotations. American Medical Association, June 1993.

APPENDIX V : PRINCIPLES OF MEDICAL ETHICS 1957

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7
In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8
A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical services may be enhanced thereby.

SECTION 9
A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10
The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

APPENDIX VI : PRINCIPLES OF MEDICAL ETHICS 1980

PREAMBLE : The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. 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.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patients.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

APPENDIX VII

A guide to gift-giving for professional courtesy
By Lucia Fischer-Pap, MD

Do spend at least 25 per cent of what the fee would have been--and perhaps more than that if the "no charge" slip covers merely a $15 physical.

Do sound out the doctor's spouse and/or assistant before buying anything. Even if they don't come up with bright ideas, they'll help you avoid giving duplicates.

Don't give food unless you know the family's size and eating habits. The doctor with a violent allergy to lobster may have trouble trying to foist your gift off on a neighbor.

Do remember that not all gifts must come in boxes. One courtesy patient I know expressed his gratitude this way: He phoned his colleague's secretary for the names of all the doctor's courtesy patients, then sent them a letter asking for contributions to a stock-purchase gift certificate, with checks to be payable to Merrill Lynch. At Christmas the doctor received a gift certificate--with all contributors' names listed--allowing him to purchase $280 worth of any stock he chose.

If you don't want to go to that much trouble, you can send the doctor an invitation to take his wife--and kids, too, if he wants--to dinner at any nearby restaurant that will charge it to you.

Do make sure, when you send a gift certificate, that the store is in the doctor's community. Distance can discourage attempts to redeem it, making your gift just another piece of paper.

Do give returnable gifts, if at all possible. Find out if the store will be willing to exchange the item or refund the purchase price without fuss.

Don't give gifts requiring special care and feeding. We once received a rare tropical plant, a Central American bromeliad with an exotic phallic-symbol flower. It needed a very exacting combination of temperature, humidity, and sunlight to bloom. At our house, sad to say, it never bloomed again.

Do consider giving at a less-hectic season than Christmas. There's no need to wait until the Big Rush, and besides, you'll have a lot more time to talk to spouses and secretaries and shop around. If you like to send gifts at a time of a general celebration, how about Valentine's Day, Hanukkah, Easter, or Thanksgiving?

HARVEY CUSHING / JOHN HAY WHITNEY
MEDICAL LIBRARY

MANUSCRIPT THESES

Unpublished theses submitted for the Master's and Doctor's degrees and deposited in the Medical Library are to be used only with due regard to the rights of the authors. Bibliographical references may be noted, but passages must not be copied without permission of the authors, and without proper credit being given in subsequent written or published work.

This thesis by has been used by the following persons, whose signatures attest their acceptance of the above restrictions.

NAME AND ADDRESS DATE