The Dedicated Enough Doctor: The Limits of Medical Altruism in the 21st Century

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ABSTRACT: The unique characteristics of the next generation of medical professionals in Israel and the current model of physician employment in the country may pose a real threat to the high quality of both public clinical care and medical education in the near future, and to the continued flourishing of clinical research. According to the Israel Medical Association's general obligations for Israeli physicians, the doctor should place the patient's interests foremost in his or her mind, before any other issue. This has led many to believe that selflessness or altruism should be among a physician's core values. Is the application and realization of these obligations compatible with the realities of 21st century medicine? Is altruism still a legitimate part of the modern medical world? The Y generation, those born in the 1980s and 1990s, now comprise the majority of the population of residents and young specialists. They have been characterized as ambitious, self-focused, entrepreneurial, lacking loyalty to their employer, and seeking immediate gratification. Under these circumstances, is it possible to encourage or even teach altruism in medical school? Demands on physicians' time are increasing. The shortage of doctors, the growth of the population, the way in which health care is consumed, and the increasing administrative burden have all gnawed away at the time available for individual patient care. This time needs to be protected. The altruism of physicians could become the guarantee of first-rate care in the public sector. The continued existence of clinical research and high level clinical teaching also depends on the allocation of protected time. In light of the emerging generation gap and the expected dominance of Y generation physicians in the medical workforce in the near future, for whom altruism may not be such an obvious value, solutions to these predicaments are discussed.

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The unique characteristics of the next generation of medical professionals in Israel combined with the current model of physician employment may pose a real threat to the high quality of public clinical care and medical education in the near future, and to the continued flourishing of clinical research. In this article we outline the obstacles as we see them and offer suggestions and recommendations to overcome them.

THE CHANGING MEDICAL WORKFORCE

The Lord turned to him and said, "Go in the strength you have and save Israel out of Midian's hand. Am I not sending you?"

Judges 6:14

"Go in the strength you have and save Israel" was the unit commander's concluding blessing to graduates of the recent soldier-teacher course in the Israeli Defense Forces educational corps. My daughter (P.G.) was among this fine group of young people whose altruistic idealism and commitment would make any parent proud. In contrast, an interview with a representative of the new Israeli Resident Physicians Union, formed to protect the workplace interests of this important and hard-working group of doctors, was recently broadcast. The burden of his message was that altruism or Zionism cannot and should not be a substitute for appropriate pay and conditions.

A Guide to Medical Ethics published by the Ethics Board of the Israel Medical Association details the general obligations of Israeli physicians [1]. It states:

> The doctor should place the patient's interests foremost in his mind, before any other issue. The doctor should practice justly and fairly at all times and ensure equality for all patients and not discriminate for any reason. The doctor should practice transparently, using independent professional judgment and avoid personal conflicts of interest, financial or otherwise. The physician should act to the best of her or his ability to promote equal access to medical treatment and just distribution of medical resources.

These obligations reflect the special nature of the medical profession, which has remained unchanged for centuries. A careful examination of doctors' oaths from the time of Hippocrates [2], through Maimonides [3] to modern times [4], reveals the essence and core of the doctor-patient relationship. In spite of scientific and technological breakthroughs of almost inconceivable magnitude, the doctor's general obligations have

remained unchanged. Are these philosophical beacon lights applicable today?

At the Bar-Ilan University Medical School in Safed we have set a goal of educating graduates committed to the health of both individuals and society in general. As written in the Doctor's Prayer attributed to Maimonides: "Put in my heart love for my art and for your creation and may neither the love of profit nor the desire for glory and honor engage my mind." Does the love of creation still prevail over self-interest? Is altruism still alive? It has been argued that a deepening generation gap is creating a new and disturbing reality.

The Y generation, those born in the 1980s and 1990s, now comprise the majority of residents and young specialists. They have been characterized as ambitious, self-focused, entrepreneurial, lacking loyalty to their employer and seeking immediate gratification [5]. Another source describes them as despising hierarchy and authority and being closed to criticism [6]. This is not the generation that formulated the above-mentioned codes, which they may see as inapplicable. These are not apparently the type of professionals for whom the current health system was designed. Moreover, the Y generation affects the preceding one. Our generation is subject to environmental influences and the *zeitgeist*. Some regard the younger generation with a mixture of contempt and jealousy.

How dare they not agree to work under the impossible conditions in which we worked? How did we not have the strength and the sense to resist those conditions and stand up for our rights? As part of the 2011 Labor Agreement in Israel, a requirement for doctors to clock in and out of work was introduced, partly because of illicit absences from the workplace by older-generation doctors. This unprecedented measure resulted in an unexpected, although predictable, contrary effect on younger doctors. Physicians' commitment to their jobs and to their patients became time limited and doctors were transformed into clock-punching laborers on the factory floor of the health services. No more a free profession with exceptional norms of endless commitment, but an "8 to 4" job like any other. The message was clearly understood: commitment finishes at 4 o'clock in the afternoon and at 10 o'clock in the morning after duty-call, on pain of penalty. The doctor-patient relationship is now defined only in legal, contractual terms. Will this benefit young doctors? Dissatisfaction among residents after the strike led them to form their own professional organization ("Mirsham") independent of the Israel Medical Association, thus institutionalizing the generation gap. This rift led to an unprecedented mass protest and near-resignation of a thousand residents after the signing of the collective agreement, and then to the state negotiating separately with residents and reaching an additional agreement awarding extra "benefits." These seismic events have now led to demands by residents to completely revamp their work conditions in a major campaign called "26 hours – Dying of Fatigue" [7]. Although the detailed examination of the various proposed work models (see examples from other countries in the next paragraph) is outside the scope of this article, they have in common a clear refusal of the new generation to accept conditions that were formerly deemed acceptable. One may ascribe this to the fact that previous generations were altruistic, or just too apathetic and complacent to protest. Whatever one's view, one could not describe the new doctors as complacent, and perhaps not altruistic in this sense.

REGULATIONS ELSEWHERE IN THE WORLD

Israeli residents are now engaged in an effort to achieve work-place reforms; however, experience from abroad has suggested that straight-jacketing doctors with bureaucratic restrictions may in fact be counterproductive. The European Union Working Time Directive (EWTD, 2009) mandated the reduction of physicians' working hours to a maximum of 48 hours/week [8] as well as setting out compulsory rest periods. The goal was to improve patient safety by decreasing doctor fatigue [9], a major claim of Israeli residents. Perhaps unsurprisingly, the new regulations have met with significant criticism from employers and regulatory bodies but more unexpectedly from junior doctors themselves. In a recent UK doctors' survey about the EWTD, only 31% agreed that its implementation has benefited them [9]. Many foundation doctors commented on the detrimental impact of the EWTD on their morale, with anger, disappointment and disillusionment being common. Specific complaints included: mismatch between contracted hours and those actually worked, not being paid for "overtime," being encouraged/forced to misrepresent hours worked, and loss of the traditional 'firm' structure causing juniors to feel isolated and unsupported [10]. This year has witnessed a series of bitter strikes by junior doctors in the UK.

In New York after the tragic death of a young woman, resident duty hour restrictions were introduced [11]. In July 2003, the Accreditation Council for Graduate Medical Education (ACGME) mandated an 80 hour weekly duty limit for residents and in 2011 a 16 hour duty period for first year residents [12]. Even before the 2011 changes, damage to patient care and resident education was clearly evident [13]. In a later study comparing a 2003 compliant model with two 2011 duty-hour regulation-compliant models, deteriorations in educational opportunities, continuity of patient care and perceived quality of care were confirmed despite increased on-call sleep duration [14]. The literature is not large and some is contradictory [15]. A recent *New England Journal of Medicine* report has highlighted the difficulty of evaluating the consequences of various supposedly resident and patient-friendly reforms, and calls for more implementation flexibility in order to permit data collection and objective evaluation [16]. If there is one point of agreement it is that there is a lack of data. Demands to limit working hours, while derived from the perceived importance of

adequate life-work balance, may have unexpected boomerang effects; any future changes will need to be incremental, flexible, reversible and fully evaluated.

THE ROLE OF MEDICAL SCHOOLS

In this atmosphere, is it desirable or possible to encourage or teach altruism in medical school? Until recently, accountability to patients, the public, and the profession were generally held to be the private and moral concern of individual physicians, rather than the collective responsibility of institutions or the profession as a whole [17]. Lately however, this formulation has been challenged. Much has been said and written in recent years about the social accountability of medical schools [18]. Social accountability in medical education can be approached in two major ways. The first is educating students to become capable and competent in tackling health inequalities; the second is through direct engagement with local communities [18]. Various approaches for achieving these aims have been proposed. These include enhanced institutional and student integration within the community, formal training in advocacy, and nurturing core values of care and altruism among students [19].

In recent years many medical schools throughout the world have added social medicine-related content to the curriculum. A recent study among Israeli pre-Y generation medical graduates of all ages compared their perceptions of the dominant orientation of their faculty's curriculum (research versus social medicine), the proportion of graduates working in the geographic periphery and the proportion involved in social activities [20]. The researchers concluded that a socially orientated curriculum reinforces humane values in the doctor-patient relationship and positive attitudes towards a role in society. Would Y generation graduates give similar answers? The effect of social orientation of medical schools on Y generation graduates is presently unclear.

A further study suggests that medical students just embarking on clinical studies have values at variance with those commonly ascribed to the Y generation. A survey of 146 preclinical students at the Bar-Ilan Faculty of Medicine in the Galilee [21] asked if an important part of the doctor's role is to advocate for population health needs within society. Eighty-four percent of students agreed enthusiastically, 69% believed that doctors should advocate beyond individual care, 86% believed they should volunteer skill and expertise for the welfare of the community, and 84% believed that doctors are accountable for the society in which they live; 88% also believed in advocacy for best-possible care regardless of patients' ability to pay. These responses are encouraging, reflecting a high level of altruism at least among preclinical students. However, it should be borne in mind that responses might have been biased by perceived social desirability, and that there is a well-described decline of empathy during the clinical years [22-24] after exposure to the medical system and "real life."

Indeed, what kind of reality do our graduates see in the field? Does the current system of health care delivery encourage desirable professional behavior in the next generation of doctors? Means of countering possible negative experiences, such as student mentorship programs, should be expanded [25]. Early patient contact through community clinical immersion and preceptorships has also been advocated [26].

Doctors' attitudes may also be determined by who they are even before they begin medical studies. Perhaps admission policies need to be reexamined, and there is some evidence for this. In Australia and New Zealand, a focus on recruiting medical students from rural backgrounds has clearly demonstrated an increased likelihood of opting for rural and general practice after graduation [27].

THE FUTURE OF CLINICAL RESEARCH

Demands on physicians' time are increasing and their time is decreasing. Physician shortages, population growth, increasingly complex health care, and increasing administrative and bureaucratic burdens, have all gnawed away at the time available for individual patient care. There is a need for more protection of this time. The altruism of physicians may be the guarantee of high quality clinical care in the public sector, but what about other aspects of doctors' work? Physicians are expected to perform many non-clinical roles in public health systems for which no time is allocated or protected. They are expected to be physician-researchers [28]. They are expected to create and disseminate new knowledge. The doctor must research and publish in order to advance academically. In many countries apart from Israel, part of the physician's contracted time is protected for research. Indeed, in Israel, residents are allocated 6 months protected research time, but for some reason it is assumed that the specialist doctor can and will conduct research in her or his spare, or stolen, time. No public contracts in Israel's medical system allocate protected academic time and this issue has not even been discussed nationally. Increasing regulatory complexity has also made clinical research more time consuming and difficult. We will undoubtedly see a gradual decline in the quantity and quality of research if these issues are not addressed. Unlike the doctors of our generation, Y generation doctors may not spend their nights and weekends writing research papers at the expense of their families. Perhaps they are right.

TIME FOR TEACHING

There are also teaching responsibilities [29]. In 2004 Irby et al. [30] noted that education is typically seen as secondary in research-devoted departments. Many good educators, they state, are simply unable to spend time away from research or patient care to teach or direct medical student courses. Our health service provides no protected time for student or physician teaching. True scholarly teaching is a scientific, evidence-based undertaking. It has been wrongly assumed that if doctors are

good practitioners they are also good teachers. Unfortunately, deficiencies in clinical teaching are common and have been widely recognized [31]. Teaching requires protected time for adequate preparation and execution. The document "Educating Physicians" (The Carnegie Foundation for the Advancement of Teaching, 2010) states that currently in the United States, clinical education is supervised by senior clinical faculty who have ever less time to teach and who have ceded much of their teaching responsibilities to residents. The authors hold that achieving the innovation and reform that U.S. medical education needs is not possible without faculty members who are invested in, prepared and honored for their role as teachers [32].

Data in Israel are lacking, but there is every reason to suppose that the situation in Israel is the same or worse. In the USA many faculties have "teaching tracks" up to full professor grade; in Israel these do not exist. Medical educators need to be up to date and prepared; yet with growing demands on physicians' time, the first thing to be sacrificed is often teaching. This could have profound implications for the quality of tomorrow's doctors.

CONCLUSIONS AND RECOMMENDATIONS

New developments in physicians' work conditions are posing threats to undergraduate and postgraduate medical education and clinical research in Israel. Altruism and self-sacrifice are no longer assumed by the new generation. They must have allocation of protected time. Teaching, learning and research can no longer be done on time stolen from unrelenting and ever-growing clinical duties.

So how can we change the present reality? Our strategy should be based on the understanding that Medicine is a special profession and we are still entitled to demand that our graduates favor the interests of patients over their own good. We may do so, but not in the same outdated way. Today, we can demand circumstantial or conditional altruism, altruism within the framework of defined working hours and conditions, but no more than that. Let's aim to produce the "*dedicated-enough*" doctor. Let's not aim for more than we can possibly hope to achieve.

HERE ARE SOME SUGGESTED PRACTICAL STEPS:

- Medical schools should strive to be socially accountable
- Medical schools should aim to conduct an admissions process focusing on humanistic as well as academic criteria
- Students should be exposed early on in their training to positive clinical role models
- Protected time for research and teaching must be allocated. This will require the addition of extra staff and a significant conceptual change in the current professional and employment paradigm
- Education should be recognized for academic promotion purposes and consideration given to fully accredited teaching tracks.

The changing world of health care and the growing generation gap will ensure that what was once possible will shortly become impossible. More of the same is just not an option.

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References

1. Reches A, ed. Medical Ethics – Rules and Position Papers. Israel Medical Association Ethics Board. April 2014.
2. Heubel F. The "Soul of Professionalism" in the Hippocratic Oath and today. *Med Health Care Philos* 2015; 18 (2): 185-94.
3. Simon SR. Moses Maimonides: medieval physician and scholar. *Arch Intern Med* 1999; 159 (16): 1841-5.
4. Antiel RM, Curlin FA, Hook CC, Tilburt JC. The impact of medical school oaths and other professional codes of ethics: results of a national physician survey. *Arch Intern Med* 2011; 171 (5): 469-71.
5. Almog O, Almog T. Y-generation research: graduates and lies. *Hed HaChinuch* 2013; 87 (4): 60-3 (Hebrew).
6. White G, Kiegaldie D. Gen Y learners: just how concerned should we be? *Clin Teach* 2011; 8 (4): 263-6.
7. http://www.mirsham.org.il/models (Accessed 18.07.16)
8. http://ec.europa.eu/social/main.jsp?catId=706&langId=en&intPageId=205 (Accessed 18.07.16)
9. Maisonneuve JJ, Lambert TW, Goldacre MJ. UK doctors' views on the implementation of the European Working Time Directive as applied to medical practice: a quantitative analysis. *BMJ Open* 2014; 4 (2).
10. Clarke RT, Pitcher A, Lambert TW, Goldacre MJ. UK doctors' views on the implementation of the European Working Time Directive as applied to medical practice: a qualitative analysis. *BMJ Open* 2014; 4 (2).
11. Asch DA, Parker RM. The Libby Zion Case. *N Engl J Med* 1988; 318: 771-5.
12. https://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx (Accessed 18.07.16)
13. Gilsdorf JR. The disappearing doctors. *Health Affairs* 2008; 27: 850-4.
14. Desai SV, Feldman L, Brown L, et al. Effect of the 2011 vs 2003 duty hour regulation-compliant models on sleep duration, trainee education, and continuity of patient care among internal medicine house staff: a randomized trial. *JAMA Intern Med* 2013; 173 (8): 649-55.
15. Ahmed N, Devitt KS, Keshet I, et al. A systematic review of the effects of resident duty hour restrictions in surgery: impact on resident wellness, training, and patient outcomes. *Ann Surg* 2014; 259 (6): 1041-53.
16. Rosenbaum L, Lamas D. Residents' duty hours – toward an empirical narrative. The *N Engl J Med* 2012; 367 (21): 2044-9.
17. Ritz SA, Beatty K, Ellaway RH. Accounting for social accountability: developing critiques of social accountability within medical education. *Educ Health* (Abingdon) 2014; 27 (2): 152-7.
18. Rudolf MC, Reis S, Gibbs TJ, et al. How can medical schools contribute to bringing about health equity? *Isr J Health Policy Res* 2014; 3: 17.
19. McCrea ML, Murdoch-Eaton D. How do undergraduate medical students perceive social accountability? *Med Teach* 2014; 36: 867-5.
20. Dopelt K, Yahav Z, Urkin J, Bachner Y, Davidovitch N. The social role of the faculties of medicine: physicians' perception of the dominant orientation of their medical studies and social involvement. *Harefuah* 2014; 153 (2): 87-91, 126 (Hebrew).
21. Spitzer-Shohat S, Reis S, Gilbey P, Weingarten M, Rudolf MCJ. Are we producing socially accountable graduates? Developing a new evaluation framework. Israel Society for Medical Education: "Healer" Conference. Sackler Faculty of Medicine, Tel Aviv University, September 2014.

22. Hojat M, Mangione S, Nasca TJ, et al. An empirical study of decline in empathy in medical school. *Med Educ* 2004; 38 (9): 934-41.

23. Hojat M, Vergare MJ, Maxwell K, et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Acad Med* 2009; 84 (9): 1182-91.

24. Chen D, Lew R, Hershman W, Orlander J. A cross-sectional measurement of medical student empathy. *J Gen Intern Med* 2007; 22 (10): 1434-8.

25. Bakshi S, James A, Hennelly MO, et al. The Human Rights and Social Justice Scholars Program: A Collaborative Model for Preclinical Training in Social Medicine. *Ann Glob Health* 2015; 81 (2): 290-7.

26. Wenrich MD, Jackson MB, Wolfhagen I, Ramsey PG, Scherpbier AJ. What are the benefits of early patient contact? A comparison of three preclinical patient contact settings. *BMC Med Educ* 2013; 13: 80.

27. Puddey IB, Mercer A, Playford DE, Pougnault S, Riley GJ. Medical student selection criteria as predictors of intended rural practice following graduation. *BMC Med Educ* 2014; 14: 218.

28. Freud-Silverberg M, Ben David L, Rabin S, Wainstein J. The dual role of the physician: medicine and research. *Harefuah* 2014; 153 (2): 101-3, 126, 125 (Hebrew).

29. Gilbey P. Reflections of a "legal alien": the importance of protected time for teaching. *Harefuah* 2014: 153 (10): 6101-2 (Hebrew).

30. Irby DM, Cooke M, Lowenstein D, Richards B. The Academy Movement: a structural approach to reinvigorating the educational mission. *Acad Med* 2004; 79: 729-36.

31. Harden RM, Laidlaw JM. Essential Skills for a Medical Teacher: An Introduction to Teaching and Learning in Medicine. Edinburgh: Churchill Livingstone Elsevier, 2012.

32. Cooke M, Irby DM, O'Brien BC. Educating Physicians: A Call for Reform of Medical School and Residency. San Francisco: Jossey-Bass, 2010.