Ethics, advertising and the definition of a profession

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Author’s abstract
In the climate of concern about high medical costs, the relationship between the trade and professional aspects of medical practice is receiving close scrutiny. In the United Kingdom there is talk of increasing privatisation of health services, and in the United States the Federal Trade Commission (FTC) has attempted to define medicine as a trade for the purposes of commercial regulation. The Supreme Court recently upheld the FTC charge that the American Medical Association (AMA) has been in restraint of trade because of ethical strictures against advertising. The concept of profession, as it has been analyzed in sociological, legal, philosophical, and historical perspectives, reveals the importance of an ethic of service as well as technical expertise as defining characteristics of professions. It is suggested that the medical profession should pay more attention to its service ideal at this time when doctors are widely perceived to be technically preoccupied.

The status of medicine as a profession has long gone unchallenged. If anything was a profession, it was medicine. Medicine, along with law and the clergy, the so-called ‘learned professions’, were defined by the knowledge held by their members and by the application of that knowledge to the needs of fellow citizens. The relationship between the professional and those served was considered of special importance, and societies have traditionally placed sanctions on that relationship, such as the protection of confidentiality, notable in English common law dating back to medieval times. But the sanctity of relationships with professionals has always existed alongside an uneasiness about the mercantile aspects of professional practice. In the contemporary era, the criticisms of the medical profession have become so widespread that the idea of a profession being defined primarily by an ethic of service shared by its members is no longer entirely convincing. More prominent is the idea of a profession being defined by technical services traded in the market-place.

Key words
Ethics; medical ethics; advertising; profession; Federal Trade Commission; cost; monopoly.

This paper attempts to assess the meaning of contemporary challenges to the profession of medicine by looking at what it means for medicine to be considered a profession as distinct from a trade. Specifically it considers the role codes and traditions of ethics play in defining medicine as a profession.

The definition of a profession
Originally the word profession meant ‘to profess’ religious vows. Medicine was a profession along with the clergy because its members shared a common ‘calling,’ and law was considered professional through a similar educational background in the medieval university (1). University ‘professors’ (the masters at the University of Paris) were first allowed to incorporate in the thirteenth century (2), and the debate about whether guilds and guild-like groups exert true monopoly power over prices has yet to be settled (3).

What is considered professional might best be understood in contrast with what is not. In athletics as in sexual activity, the designation ‘professional’ merely implies getting paid for what others do for free (4). But the professional is also distinguished from the amateur by a greater level of proficiency which merits the monetary compensation. Thus some level of skill or expertise is generally held to be requisite for professional status. Reiser, Dyck and Curran extend this consideration in a particularly useful definition of profession. They suggest that ‘self-conscious reflection on standards of conduct is one of the defining characteristics of a profession’ (5).

The dual themes relating professions to knowledge on the one hand and its application to practice on the other place professions in an intermediate position between sciences and trades with features in common with both, but also distinct from both (6). The literature distinguishing professions from trades is abundant, (7), (8), (9) but in the twentieth century, as knowledge has come to mean scientific knowledge, the medical profession is increasingly identified with technical expertise. But technical expertise is not sufficient to characterise a profession, as sociologists of the professions have demonstrated. The ethical dimension is also required.
The sociology of professions

A popular generalisation of the sociological literature is that occupations are becoming ‘professionalised’. But specialisation, technical skills and expertise do not suffice to establish a work group as a profession. What does? According to Wilensky, any occupation wishing to exercise professional authority must find a technical basis for it, assert an exclusive jurisdiction, link both skill and jurisdiction to standards of training and convince the public that its services are uniquely trustworthy (10).

The theme of trustworthiness is the pivotal criterion of professional status. The understanding of someone as a ‘professional’ ultimately depends on the ability to trust that individual with personal matters. The various articulated codes of ethics of professional groups all stress the maintenance of the trustworthiness of members of the professional group through control of entry into and exit from the professional group and discipline of deviant members if necessary (for example censure or removal from membership of the group, or removal of licence). Table 1 (overleaf) illustrates the process of professionalisation of a number of professions and would-be professions in the United States. It demonstrates that the route to professional status includes the establishment of university training programmes, the formation of professional associations, and the presence of formal codes of ethics.

Profession and monopoly

One of the most noticeable features of professional organisations, viewed in sociological perspective, is their attempt to control markets and promote self-interest. The theory of professional monopoly was developed by Max Weber, who described the following steps by which the medical profession, as all commercial classes, achieves monopoly power: creation of commodities, separation of the performance of services from the satisfaction of the client’s interest (ie doctors get paid whether or not the therapies work), creation of scarcity, monopolisation of supply, restriction of group membership, elimination of external competition, price fixation above the theoretical competitive market value, unification of suppliers, elimination of internal competition, and development of group solidarity and co-operation (11). Such careful delineation of an economic component to human motivation was truly radical in its time, but today it has become commonplace to reduce all human motivation to economic considerations. The problem with this analysis of professional monopoly is that it is one-dimensional; it considers only economic motives and overlooks the benefit to the public which occurs from such things as the promotion of scientific medicine and efforts to maintain professional standards.

The basic issue is whether physicians can place concern for the public good ahead of their own self-interest. Trust or trustworthiness is the keystone of medical virtue in the traditional canons of medical ethics from the Hippocratic Oath to Percival’s code to the various versions of the AMA codes (see Table 2, page 77). Trust is the basis of what it means to be a professional, what it means to be ethical. From the antitrust point of view, any trust, even basic human trust is suspect as a form of monopoly.

Berlant, applying Weber’s theory of monopoly to the medical profession, states the case very cogently:

‘[The] trust-inducing devices of the Percivalian code can increase the market value of medical services and help convert them into commodities . . . It also creates a paternalistic relationship toward the patient, which may undermine consumer organization for mutual self-protection, thereby maintaining consumer atomization . . . Through atomization of the public into vulnerable patients, paternalism results in the profession’s dealing with fragmented individuals rather than bargaining groups. Moreover, by appealing to patient salvation fantasies, trust inducement can stimulate interpatient competition by increasing each patient’s desire to see that nothing stand between doctor and himself. Much of the emotional power of the sentiment of the doctor-patient relationship resides in this wish of the patient to save himself at any cost to himself or others’ (12).

Berlant offers a sharp attack on professional ethics from a particular ideological perspective. But basically this attack is not just on professional ethics, it is also an attack on a kind of community in which people may not be autonomous and independent, but in which people may be dependent and in need of help which they willingly seek. This argument introduces a note of almost cynical suspicion into a society whose members seem almost too willing to trust and to place themselves in the care of others. This is a crisis of confidence – both for medicine and for our civic life in general: to what extent is it possible and necessary to trust and rely on others and to what extent is it possible to remain isolated, self-reliant and autonomous human beings?

It is because of such challenges to the medical profession’s codes and traditions of ethics that a closer look at the form and substance of those codes is necessary.

The antitrust challenge to the professions

A profession’s service ideal has several manifestations: a formal code of ethics, more personal ethical outlooks, and certain activities, such as licensure, specialty certification and the accreditation of institutions and training programmes, undertaken by a professional association to maintain standards of the group. It can be argued that such professional gate-keeping is an essential aspect of professional responsibility, but there is a widespread perception that the restrictions that the learned professions have placed on themselves
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*Modified after Wilensky
under the aegis of professional ethics have been motivated not in fact by ‘ethics’ in the sense of a desire to achieve a higher plane of moral conduct, but rather to serve the self-interest of the existing members of the profession.

Perhaps because of the ambigious relationship of public interest and professional self-interest, the learned professions were considered exempt from the antitrust laws from the time of the passing of the Sherman Antitrust act in 1891 until the Supreme Court’s Goldfarb decision in 1975, in which Virginia lawyers were found liable to charges of price-fixing of the fees charged for title searches. The Goldfarb decision heralded a flurry of antitrust activity, most notably the suit by the Federal Trade Commission against the American Medical Association, the Connecticut State Medical Society, and the New Haven County Medical Association, charging that these professional organisations were in restraint of trade because their code of ethics prohibited advertising. After a seven-year legal battle, this case was settled on March 23, 1982, when the Supreme Court split 4-4 leaving in place the lower court ruling that barred the AMA from making any reference to advertising and the solicitation of patients, and further prohibiting the AMA from ‘formulating, adopting and disseminating’ any ethical guidelines without first obtaining ‘permission from and approval of the guidelines by the Federal Trade Commission’ (13). Though advertising is the focal issue in this particular case, the ethics of the profession both as explicitly formulated in the AMA’s Principles of Medical Ethics and as implicitly practised, as well as the right and propriety of a professional association to formulate its own code of ethics, are being called into question (14, 15).

The FTC suit hinged on the questions of cost, advertising, and the mercantile aspects of the medical profession. The position of the FTC is that the reason costs are high is because doctors have a monopoly on health care delivery and can thus maintain artificially high costs for their own profit. If doctors were not prohibited from advertising, it is argued, prices would come down because patients could shop for the best deals. FTC chairman, Michael B. Perschuk, stated the case as follows: ‘One possible way to control the seemingly uncontrollable health sector could be to treat it as a business and make it respond to the same market-place influences as other American business and industries’ (16). In other words, medicine could better be controlled if it were understood as a trade and not as a profession.

The categorisation of medicine as a trade is obviously an oversimplification. The profession is inescapably concerned with the public well-being. Medicine is both a trade and a profession. It is certainly appropriate for the commercial aspects of medical practice to be regulated (or de-regulated), but it would be a catastrophic mistake to assume that medicine is merely a trade and subject all aspects of professional regulation either to market influences or to the crude tools of antitrust litigation.

The courts have clearly recognised that professions have trade aspects. They have not eliminated the responsibility for professional self-regulation except in such instances in which such self-regulation may be in restraint of trade. For medicine the issue the Supreme Court decided in FTC v AMA is that the AMA’s code of ethics cannot prohibit advertising. It remains for conscientious physicians to decide what constitutes ethical advertising.

The ethics of advertising

Medical advertising is at the crossroads of two very different philosophies about what medicine should be and how professions should be regulated. The traditional view opposes advertising in order to protect the public from physicians who are too commercially oriented. The more prevalent contemporary view holds that medicine is indeed commercially oriented and thus cannot be trusted to regulate itself. In order to reconcile the best aspects of traditional professionalism with the need for greater public accountability, it is necessary to consider what might be ethical and unethical in advertising.

Would advertising of physicians’ fees and services be a desirable and ethical thing? If increased competition through advertising could reduce medical costs, then it would be socially desirable unless lowered costs were achieved through a lowering of the quality of service or unless increased advertising created a demand for more services further straining the economy beyond the approximately ten per cent of the US Gross National Product which currently goes to health care. The cost-quality equation is always a delicate balance, and although costs are easy to measure, the values by which we assess quality are impossible to quantify.

Advertising is a multi-faceted issue. It serves two very distinct objectives: 1) the dissemination of information and 2) product differentiation, which economists define as public perception of difference between two products, even though such differences may not in fact exist. The AMA has traditionally held that dissemination of information is acceptable, but that product differentiation or solicitation of patients is not (17). The physician was to be distinguished from the itinerant merchant of nostrums by de-emphasising the commercial aspects of practice and emphasizing professional ethics (actually standards which minimised the difference between physicians similarly credentialed and certified). Thus if someone were to develop appendicitis while travelling in an unfamiliar part of the country, it would not be necessary to shop for a physician who believed in the germ theory or hospital that maintained antiseptic standards. The physician would be taken care of by credentialing procedures. The physician would obtain patients, not by direct appeal to the public but by building a reputation in a community. Although the distinction
It is paradoxical that medical ethics should be at the centre of controversy about what is in the public interest. Ethical strictures against professional advertisement have a long and venerable tradition in the Western world, which stems from a view of professional life which cannot be easily reduced to economic analysis. The traditions represented by professional ethics stress the personal nature of professional practice. In the traditional model, trust is essential, for the patient/client must trust the professional in order to reveal such confidences as may be necessary to understand the problem. The professional is worthy of that trust according to (i) knowledge possessed and (ii) such 'professional' attributes as ability to keep confidences, to refrain from taking advantage of vulnerable patients, to put the patient's interests before his/her own, and to refrain from self-aggrandisement at the patient's expense. It is out of such a view of professionalism that strictures against advertising arose.

The question of whether physicians should advertise and how the profession should be regulated cannot be settled until the prior question of what it means to be a profession is addressed. The economic analysis of market forces addresses a different concern from the concerns of professional ethics. The question is not whether doctors should be allowed to advertise, but what are the trade-offs of a strictly economic analysis of professional activities.

From the economic standpoint the question is this: Are there any reasons not to allow market forces to solve pricing and other problems? In other words, government regulation or professional self-regulation would be warranted only if the market failed. This is not the only question of interest, however. The ethical concern must also be addressed, namely can quality care be maintained if the economically most efficient methods of health care delivery are adopted? From this point of view, the FTC strategy of reforming the medical profession by treating it as a business fails at the outset because it fails to consider the issues of quality care which are so much the concern of physicians and patients alike.

The message for the medical profession from the current round of antitrust litigation is clear: Unfair trade practices will not be tolerated. A more subtle message must also be recognised: The reputation of the profession and its ethics has become tarnished as the public has come to perceive professional ethics as a protective mantle under which professionals cloak self-interest. This does not mean that the old ethics should be abandoned, but rather that they should be taken more seriously.

The doctor-patient relationship, spoken of almost religiously as the keystone of medical practice, has traditionally been a dyad in which the doctor answered directly only to the patient and his own conscience:

\[
\text{DOCTOR} \quad \leftrightarrow \quad \text{PATIENT}
\]

In the modern era, financial considerations, even more than changes in technology, have transformed all
TABLE 2

THE CODES OF ETHICS ON ADVERTISING

The Hippocratic Oath: Nowhere in the surviving Hippocratic writings do we find anything about advertising or self-promotion, but we do find a clearly established concept of the profession as a fraternity in the following statement: 'I swear . . . to regard my teacher in this art as equal to my parents; to make him partner in my livelihood, and when he is in need of money to share mine with him; to consider his offspring equal to my brothers; to teach them this art, if they require to learn it, without fee or indenture; and to impart precept, oral instruction, and all the other learning, to my sons, to the sons of my teacher, and to pupils who have signed the indenture and sworn obedience to the physicians' Law, but to none other.'

Percival's Medical Ethics: Percival apparently had no occasion to refer explicitly to advertising on the part of English physicians, though his code is concerned throughout with maintaining the dignity, honour, and reputation of the profession.

American Medical Association, 1847 code: Duties of physicians for the support of professional character: 'It is derogatory to the dignity of the profession, to resort to public advertisements or private cards or handbills, inviting the attention of individuals affected with particular diseases — publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints or suffer such publications to be made; — to invite laymen to be present at operations, — to boast of cures and remedies — to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician.'

AMA, 1903 revision: In this first revision after the Sherman Act the caption 'Principles of Medical Ethics' is substituted for 'Code of Medical Ethics' leaving broader discretion to the State and territorial medical societies. The strictures against advertising specify methods to be avoided: 'It is incompatible with honorable standing in the profession to resort to public advertisement or private cards inviting the attention of persons affected with particular diseases; to promise radical cures; to publish cases or operations in the daily prints, or to suffer such publication to be made; to invite laymen (other than relatives he may desire to be at hand) to be present at operations; to boast of cures and remedies; to adduce certificates of skill and success, or to employ any of the other methods of charlatans.'

AMA, 1912 revision: 'Solicitation of patients by circulars or advertisements, or by personal communications or interviews, not warranted by personal relations, is unprofessional. It is equally unprofessional to procure patients by indirect means through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-adulations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, . . . is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct.'

AMA, 1957 revision: A physician 'shall not solicit patients.' (A physician shall not attempt to obtain patients by deception.)

AMA, 1980 revision: No comment on advertising in the Principles of Medical Ethics, as per FTC order. The Current Opinions of the Judicial Council (1982) offers the following comment: 'Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only unethical but is encouraged.'

British Medical Association, Handbook of Medical Ethics (1984): (Quoting the General Medical Council booklet Professional Conduct and Discipline: Fitness to Practise — 1983) 'The medical profession in this country has long accepted the tradition that doctors should refrain from self-advertisement. In the Council’s opinion advertising is not only incompatible with the principles which should govern relations between members but could be a source of danger to the public. A doctor successful at achieving publicity may not be the most appropriate doctor for a patient to consult. In extreme cases advertising may raise illusory hopes of a cure.'

L'Ordre des Medecins, Code de Deontologie Medicale (Belgium, 1975): Publicity, direct or indirect, is forbidden. The reputation of the physician is founded on his professional competence and on his integrity.

Canadian Medical Association, Code of Ethics: An ethical physician . . . will build a professional reputation based only on his ability and integrity, will avoid advertising in any form and make professional announcements according to local custom.

World Medical Association, International Code of Medical Ethics: Any self advertisement except such as is expressly authorised by the national code of medical ethics [is deemed unethical].
parties in this relationship and added new ones:

![Diagram: PROVIDERS ↔ CONSUMERS, THIRD PARTIES]

Patients have become ‘consumers’; doctors have become ‘providers’; health care has become a commodity; and ‘third parties’, including insurance companies, social service agencies, and allied health professionals, are very much part of the picture. The patient seldom appears privately (and confidentially) before the doctor for help. Likewise the physician does not answer only to the patient. The conscientious physician concerned about cost-containment may be put in the position of limiting the resources given to a demanding or anxious patient. Still, however, the appeal of a person in need of help and the response of a concerned physician remain the essence of medical practice. Though some would suggest that medicine should, in the interests of efficiency, be limited to treating just physical ailments, most responsible physicians still concern themselves with the impact of disease and illness on people’s lives and not just with the disease itself.

It is this broader concern of medical practice which professional ethics attempts to address, and which is generally not understood to be an essential feature of a trade. The attempt to regulate the medical profession as a trade comes at a time when the activities of physicians are largely perceived as commercial and impersonal. Physicians must bear the responsibility for maintaining a broader concern for the patient as a person as part of their professional identity. To the extent that medicine fails in maintaining its professional ethical standards of public service and personal care, it is vulnerable to the criticism of self-serving commercialism. To the extent that medicine relies merely on technique and not on an ethic of service, it becomes merely a trade and not a profession.

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References

(4) Moline J. On professionals and professions. See reference (1).