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HISTORY AND HUMANITIES IN DERMATOLOGY

Ethics in Dermatology: Toward a New Paradigm[☆]

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Abstract Medical ethics have evolved over time, and ethical responsibilities have often been shared by priests, the governing classes, and physicians. The emergence of scientific medicine led to the separation of functions, yet physicians have nonetheless continued to enjoy an extraordinary degree of moral authority and great social privilege. From this starting point, professional medical ethics developed as a specific moral system based on special rights and duties (paternalism and medical confidentiality). Various historical events brought this long-standing situation to a point of crisis toward the middle of the 20th century, and for several decades since, medical ethics have been based on freedom of choice for the patient with regard to decisions about his or her own body and health. Recent developments have created a new, still poorly defined model that takes into consideration such matters as euthanasia, abortion, provision of information on the benefits and harm of treatments, the sharing of therapeutic decision-making with the patient and/or family members, the choice of public or private medical providers, therapeutic guidelines, and the extension of the scope of practice to include preventive measures and cosmetic procedures. What is needed now is a new ethical system for plural societies that harbor different religions, beliefs and lifestyles, but that is also rational, universal and subject to ongoing revision—a system always striving for scientific, technical and moral excellence. Such an ethical system would have to be taught in medical schools, as it would need to bear fruit beyond mere good intentions.

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Dermatología y ética: el nuevo paradigma

Resumen La ética de la profesión médica ha sufrido una evidente evolución histórica. Médicos, sacerdotes y gobernantes coincidían a menudo en la misma persona. Con la aparición de la medicina científica se discriminan las funciones pero siguen dominando una extraordinaria autoridad moral y un alto privilegio social. Desde estas premisas, se desarrollará la ética de la profesión médica sobre la base de una moralidad especial, que implica unos derechos y unos deberes especiales (paternalismo, secreto médico). Diferentes hechos históricos inciden

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en esta situación largamente mantenida llevando a una crisis de los paradigmas establecidos hacia mediados del siglo xx.

Desde hace unas décadas, la ética médica se apoya en la libertad para elegir qué quiere uno hacer con su cuerpo y su salud. La eutanasia, el aborto, la información de beneficios y perjuicios, las decisiones terapéuticas compartidas con el enfermo y/o con sus familiares, la diferente elección en la sanidad pública o privada, la guías terapéuticas, la ampliación del ejercicio más allá de la enfermedad, llegando a la prevención y a la búsqueda de la belleza mediante técnicas estéticas, junto al papel trascendente de los gestores en la asistencia médica (recursos), entre otras cuestiones, crean un nuevo modelo todavía mal definido.

Se hace necesaria una nueva ética plural que integre religiones, creencias y formas de vida diferentes, pero que a la vez sea racional, universal, sometida siempre a revisión, aspirante perpetua de la excelencia científico-técnica y moral. Esta ética debería además enseñarse en las facultades de Medicina, ya que debería ser mucho más que el fruto de unas buenas intenciones. © 2012 Elsevier España, S.L. y AEDV. Todos los derechos reservados.

Introduction

To talk about dermatology and ethics today is not an easy task. The consolidation of dermatology as an essential branch of modern medicine started in the latter half of the twentieth century. During precisely the same period medical ethics faced the crisis that challenged the classic paternalistic paradigm and led to the emergence of a new paradigm grounded in the rights of individuals to freely choose what they want to do with their bodies and their health. In this article, our aim is to substantiate this statement. On the subject of how this new paradigm affects dermatology, however, we know very little because the question has not been studied. In conclusion, we hope to demonstrate the need for such investigation.

The Classic Ethical Paradigm of the Medical Profession

It is generally accepted that Hammurabi (1728-1686 BC) was the first person in the history of humanity to lay down an objective moral code governing the act of healing, in which he established the legal responsibility of the healer toward the patient and enforced it by a system of rewards and punishments depending on the results achieved. In the famous code that bears his name, Hammurabi laid down 10 concise standards of medical practice and 282 rules governing both the healers' fees and the fines applicable when their actions had unforeseen results.¹ With this regulation of fees and fines, the social responsibility of the healer was clearly delineated by law for the first time.² We should clarify that these rules related to the work of healers and not to the practice of the medical profession, because what the Hammurabi Code regulates is not the medical profession, but rather the practice of a manual trade, undoubtedly more elevated than some, but a trade nonetheless. It is difficult to understand the historical development of the ethical paradigm of the medical profession without first clarifying a number of issues relating to the role of the physician in society in different cultures and at different times throughout history. The first and most fundamental issue concerns the difference between a trade and a profession; the professional status accorded to the practice of

medicine is what defines it, and everything else follows from this attribute.

Etymologically, the word *profession* is derived from the Latin word *profesio*, referring to the professional's public vow to fulfill a series of obligations and activities and the acceptance by society of that pledge. The term profession is used therefore to identify activities intended to benefit the community, and, as a result, the professions enjoy a position of social privilege not accorded to the trades. This special status is what essentially differentiates professions and trades. There have traditionally been very few professions, an indispensable precondition for the enjoyment of great social prestige. We might in fact say that there are really only 3: priesthood, government, and medicine. Until the advent of scientific medicine, religion and medicine were often combined and practiced by the same person, and in some archaic cultures, all 3 professions were integrated and practiced by the same person.

In 1949, in his book *Essays in Sociological Theory* (published in Spanish as *Ensayos de teoría social*, Paidós, Buenos Aires, 1967), Talcott Parsons clearly shows that there are very few professions and that these are limited to the 3 spheres mentioned above: religion (priests); law (kings, rulers, and judges); and medicine (physicians). In his study, Parsons focused mainly on medicine because, in his opinion, it was the only profession that had been able to assimilate the evolution of science, and he therefore saw it as the modern paradigm of a profession.³ The social prestige granted by the community to professionals empowers them to regulate the lives of others and to ordain what is right and wrong in terms of behavior. The role in society of the profession is defined by 5 characteristics: choice, segregation, privilege, impunity, and moral authority.³ The way these 5 aspects are expressed has evolved over time, but essentially they are still all present in some form or another. The following is a brief description:

1. *Choice*. In ancient cultures, it was believed that people destined to play a prominent role in society were chosen by the gods. As it was their destiny, they could and should occupy an elevated position within the community. They had been granted a special gift that set them apart from other members of their group. They used external signs to mark this difference, so that the community could

identify them as the elect few chosen to play a singular role.

2. *Segregation* follows automatically from the fact that professionals are the chosen ones and from the fact that they stand apart from the other members of their community. Physicians hold the life and death of others in their hands. This sets them apart. They are not normal people. They are respected and feared at the same time. Because they are not normal, they should not live as equals with the other members of the group and consequently society wants to keep healers at a certain distance.
3. *Privilege* is a consequence of both choice and segregation. Because physicians are the elect, society elevates them to a privileged position. And because they lay down the rules they are not subject to them. This means that they are permitted to hold attitudes and do things that are forbidden to others. This, in turn, creates a double privilege: they are the lawmakers but they are not bound by the law.
4. *Impunity*. An individual who wields such social power and enjoys such privileges can hardly be subject to the dictates of justice. Thus, to a greater or lesser extent professionals enjoyed legal impunity. While not enshrined in law, the legal impunity of physicians existed in practice down through the centuries. There is a great deal of evidence to that effect. Starting with the Hammurabi Code, we can trace the evidence, example by example, until the middle of the twentieth century. As we noted earlier, the Hammurabi Code established penalties for surgeons because surgery was considered to be a trade but not for physicians, as medicine was deemed to be a profession; this distinction existed until not too long ago.
5. *Moral authority*. Finally, we come to the subject of moral authority, which physicians enjoy because they have power over life and death—a situation of social privilege. Since they have the power to stipulate what must be done—what is good and what is bad—physicians lay down the law concerning our habits and fix our moral standards. This is demanded of them and they are empowered to do it. They themselves answer to a special morality that transcends common morality. This special morality stems from their status as leaders, as the mirror into which others look, as the example others follow. This special morality includes 2 duties: confidentiality and beneficence toward others even when they can expect no economic benefit in exchange for the service rendered.

Society expects moral excellence from the professional, and the other side of that coin is legal impunity. The important position of the healer within the group must be occupied by individuals with impeccable morals who, consequently, should not be subject to the laws binding ordinary people.³

But besides these singular attributes, which determine the status of physicians in the community, there are other features that characterize the medical profession, perhaps in a more specific way. In his book, Parsons defines 4 such values:

1. *Universalism*. The physician is expected to treat everyone equally, regardless of aspects such as social position, race, belief, and culture.
2. *Functional specificity*. Physicians occupy an exceptional position within the community, and this confers upon them great power that derives specifically from their profession.
3. *Affective neutrality*. Since physicians cannot use the dominance they exercise over their patients for their own benefit, they must exercise a high level of self-control.
4. *Collectivity orientation*. Physicians are expected to put the common good above individual interests and, consequently, to continue to fulfill their obligations even in adverse conditions, for example when they have no expectation of remuneration. This contrasts with what is expected of tradespeople.

These 4 values can be summarized in 2 concepts: physicians enjoy privileged social status and have a great deal of power and moral authority. This conclusion led Max Weber to describe the classic professions as “positively privileged” social institutions that operate as monopolies, in contrast to the trades, which are governed by free market principles and, as such, are “negatively privileged” social institutions.³

These characteristics and values have given physicians an ethical code to regulate their professional lives and their lives as citizens that has endured over the centuries. From these basic premises, the ethics of the medical profession developed a special morality for physicians, a code involving certain rights and duties that differs from common morality. Starting with priestly and magical medicine and reaching well into the twentieth century, a code of behavior was defined. First roughly outlined and later consolidated, this code of conduct is what we know as paternalistic medical ethics. It is this classic paradigm of medical ethics that we first find documented in magic medicine and which later found its maximum expression in the *Corpus Hippocraticum* in the technical medicine of the Greeks and became a universally accepted paradigm in the Hippocratic Oath. The basic premise underpinning this paradigm is that the power and authority to define what is good or bad for the patient lies solely in the hands of the physician, the person responsible for the primary goods—the life and death of his or her peers. The physician’s behavior toward the patient is comparable to that of a father who decides unilaterally what is good for his child without consulting her about how she would define the concept of “good”. He completely negates patients’ autonomy to decide what they want for themselves or what they think is good for their health. Inherent in this type of ethics is a basic and indisputable principle: that the physician and only the physician is in a position to decide what is best.

Another aspect that defines the classic paradigm is its conception of medical confidentiality. The first documentary evidence we have of this concept is the Hippocratic Oath. Confidentiality is the physician’s moral duty, and it is the physician alone who decides what information should be confidential. But this duty does not flow from the patient’s right to confidentiality; the concept is not that

the patient has a right to be respected or that what a physician knows about a patient should not be revealed. In the classic paradigm, confidentiality is a duty self-imposed by the physician, who is, as we have said, a person governed by a particular morality, one that is superior and different to the common morality. It is the physicians, by virtue of the oath they take, who oblige themselves to keep professional information confidential.³

Today, paternalistic medicine is much maligned, and we may sometimes even feel a tinge of shame when we look back at this way of conceiving of the professional practice of physicians, but we should not forget that for more than three and a half millennia (the period for which there is documentary evidence) and on the basis of these ethical principles, those who preceded us in the arts of healing wrote down and handed down the story of a desire, a challenge, and a passion: to help in birth, to cure the sick, to relieve pain, and to come to the aid of their fellows in their final hour. They were physicians. Respect for their memory honors us.

The Adaptation of Paradigms

Scientific advances, the vicissitudes of history, and changes in society continually modify the mutable character of the medical profession. Changes in the paradigm decisively reshape the ethical postulates, reducing the importance of the vocational aspect and increasingly giving the ethical principles the status of a code of conduct. In all human endeavors there is an established model that explains the activity and addresses the more or less complicated issues that arise. As medical practice evolves, the model is changed by the new issues and new problems that emerge, and there are 2 ways to integrate these new circumstances and address new challenges.

The first approach is to adapt the existing model or paradigm of the activity, transforming it so that it can incorporate the new phenomenon. This is what has been called peaceful evolution or “gradual and progressive change.” The second approach is used when it appears that the new data cannot be assimilated into the existing paradigm even if this is extended. In such cases, radical structural change of the paradigm is necessary; this is what we call the revolutionary approach or “drastic, radical, or structural change.” Peaceful evolution is normally the first choice unless the new data cannot be integrated, in which case we must resort to drastic change. In the case of science, what happens at this point is called a *scientific revolution*.³

The point of crisis faced by the classic paradigm of the professions was evidenced by 2 types of indicators which occurred at the same time: conceptual or theoretical symptoms and social or practical symptoms. Space constraints prevent us from including any analysis of these symptoms here, but we refer the reader to our previous analysis of the subject.¹ In short, these crises occur when the established model is challenged by new circumstances and possibilities that call its operability into question. In some cases, the solution is an amendment of the existing model, but in others the model is shown to be obsolete; these solutions reflect the 2 approaches described above.

Crisis and a New Ethical Paradigm for the Medical Profession

The publication at the beginning of the nineteenth century of a book by Thomas Percival, *Medical Ethics; or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons* (England, 1803), marked a turning point in medical ethics. However, it was not until the following century that medical ethics took a new and definitive course set in motion by scientific advances, the terrible events in Nazi Germany, the Nuremberg trials and their repercussions, the first atomic explosions, the crisis that affected the traditional paradigm of the professions in general, and the advent of bioethics and codes of conduct and practice. Many of these events were the result of rapid changes in a society undergoing the transformation of its mental, individual, and collective structure and, therefore, of its philosophical tenets, values, moral codes, and lifestyle. This transformation, in turn, led to changes in organizational structures, giving rise at all levels of society to a need for structural alignments to support new systems and new approaches, which in turn would influence the administration and organization of society. In our profession, the force of change came not from within but from external factors, primarily judicial decisions and pressure from civil society organizations. The first salvo of note came in 1914, when Justice Benjamin Cardozo found for the plaintiff in the case of *Schloendorff versus the Society of New York Hospital*. The importance of this case was not the judgment itself, but the arguments adduced to support it:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.”⁴

At this point, everything started to change, and the idea that those in professional practice had been elected because they had extraordinary qualities that set them apart from their fellows and allowed them to enjoy a position of privilege that included legal impunity and moral authority started to weaken; it finally began to disappear toward the middle of the twentieth century. Apparently, the society that emerged and developed after World War II in the world’s high-income countries was no longer prepared to tolerate legal impunity or accept a special morality applicable to some individuals and different from the common morality. It accepts the existence of a common morality, with nuances that depend on each individual’s activity or social role, and it requires a minimum code of practice—established by law—to prevent ignorance, incompetence, negligence, and imprudence in professional practice. The new standard was that everyone should strive for moral and professional excellence, irrespective of their occupation; and the more important the professional’s role, the more stringent the ethical and legal requirements.³

Traditional medical ethics was affected by these changes. From the mid-twentieth century onwards, as a result of rapid advances in scientific knowledge and the growing awareness within society of respect for individual autonomy and freedom of belief and choice, the classic paradigm of the

medical profession and the ethics supporting it entered into a period of crisis. The premises underpinning the classic ethical code on which traditional medical ethics were based had started to lose their validity.

Today, the defense of precepts such as sharing one's goods with the master, teaching the art of healing to the master's children, abstaining from surgery, or practicing on the basis of a priestly model (unpaid) no longer make much sense.

The once absolute prohibition of abortion has been significantly tempered by the decriminalization of therapeutic and prophylactic abortion and the termination of pregnancy in cases of rape. The attitude to euthanasia has likewise changed, with certain political and social movements questioning its prohibition and defending the freedom of the individual to choose the terms of his or her own death. The laws of some countries are changing in this respect.

The concept of professional confidentiality, as defined in the classic paradigm, has disappeared.⁵ The principles of beneficence and nonmaleficence, cornerstones of the classic ethical paradigm, are acquiring very different connotations. The principle of beneficence, on which the paternalist attitude was based, has taken a new turn. While physicians know what is beneficial for their patients, it is important for them to remember that patients have become aware that neither they nor their science are infallible and that the patient's own concept of what is beneficial must be taken into account. This is why patients request information about the beneficial and harmful aspects of recommended exploratory or therapeutic procedures before giving their consent; they seek a solution that is ideal from their perspective. In this new context, it has been advocated that treatment decisions should be shared and should involve patients and/or their relatives. It is the physicians' duty to put all their knowledge and professional skill at the service of the patient, but they should not feel that they are solely responsible for their patients' lives or the masters of their fate; they should always respect their patient's fundamental rights. The doctor-patient relationship shifts from a vertical model to a horizontal model, with the introduction of shared decision-making. With respect to the principle of nonmaleficence, the physician's duty to do no harm must be extended to include not only physical but also mental harm, which could be the result of a doctor's closed or negative attitude or inability to accept that the patient may have a different moral universe or hold a different worldview.⁵ However, some of the classic precepts remain in force. Such is the case of respect for one's teachers, for the patient, for oneself, and for the medical profession, general principles that derive from the oath. Another concept that continues to be implicit is that the physician must be a capable, cautious, and sensitive person.

Given the scope of the changes described in the preceding paragraphs, it would appear impossible to adapt the old paradigm to accommodate the new requirements. Thus, by acknowledging that the solution is not to adapt the classic paradigm to the new situation, we are admitting that a new professional paradigm is needed.

And what should these new rules be that will regulate the professions in general and the medical profession in particular? Let us define a few basic concepts.

Our moral lives and, by extension, our professional ethics have 2 different dimensions: the public dimension, which establishes a minimal ethical framework, and the private dimension, or each individual's maximal ethical code.³

Minimal ethics derive from the principles of nonmaleficence and justice, and are the prerogative of the state. They are universal and binding upon all members of society. In health care terms, minimal ethics can be equated with minimal health; that is, the level of health the state should guarantee equally to all members of society according to the principle of justice. This principle, which may seem a very natural one, is not applied in many countries, where the citizens do not have access to the most basic health care services. The law should, in any case, require medical professionals to be legally responsible for their professional actions and legally accountable to the courts for acts arising from ignorance, incompetence, imprudence, or negligence.⁶

Private or maximal ethics, deriving from the principles of autonomy and beneficence, lie within the sphere of personal aspiration in that the achievement of happiness is a personal project.⁴ Unlike minimal health, which we perceive to be the duty of the state, maximal health is an individual prerogative and only totalitarian states have attempted to intervene in this sphere; and they have failed in the attempt.⁶

Let us complete this very rough sketch of what might constitute the new professional paradigm. With respect to the model of medical ethics that first appeared during the twentieth century, we wish to refer briefly to the concept of patient confidentiality or professional secrecy and, comparing the past with the present, highlight some of the changes that have occurred. Earlier, we mentioned that the conception of confidentiality in the classic paradigm was flawed because the physician's duty did not derive from the rights of the patient but was rather conceived of as a self-imposed duty and professional privilege. This conception allowed the physician to qualify or decide on the degree of secrecy required. This is no longer the case. Today, the obligation to maintain professional confidentiality stems from the citizen's right to intimacy, privacy, and freedom of conscience. Moreover, it is these patient's rights that impose upon professionals the obligation to maintain the confidentiality of the intimate and private information to which they have access. The laws of free nations, including those of Spain, criminalize the violation of these rights and apply different levels of regulation to trades and professions. While they do not recognize any special moral for the professions, they do differentiate them from the trades and consider them separately insofar as their activity affects the most sensitive areas of human life.^{6,7}

Another aspect that must be considered is the role of religion. While secular, medical ethics has been influenced by moral principles and mandates that have their origin in religious beliefs. Today, people holding very different beliefs and moral codes—agnostics, atheists, and patients of many different religious faiths—are all treated in the same health care facilities. Such institutions have an obligation to respect each patient's freedom of conscience and should establish a minimum moral code that everyone must comply with and respect. This code cannot be based on the moral injunctions of a particular religion or religions,

but should be based on secular, civil, and rational criteria. Based on this principle, the medical profession must, if it wishes to recover its proper role in society, establish a new professional paradigm deeply rooted in the medical tradition and in a new ethical code based on civil and religious criteria rather than religious tenets which is pluralistic, participatory, deliberative, and underpinned by the concept of rational, universal, and autonomous responsibility. Modern ethics has to be pluralistic; that is, it must accept the diversity of approaches and positions that exist, seeking to bring them together and unify them in a higher consensus; moreover, this position should not be a constraint, but rather an aspiration in that it may lead to a truly human universal ethics. Interpretative and decisional individualism must be replaced by participation in an open discussion as part of the deliberative process of all the stakeholders affected by the norm or decision in question. Moral deliberation involves a joint and collective search for truth enriched by input from the different moral viewpoints of the participants. The end result will achieve a higher level than any of its component parts. This is the task of ethics committees in the health care setting.

Occupying the middle ground between strategic ethics (ethics benefiting only a select group) and the ethics of conviction (maximalist ethics), we find the ethics of responsibility, a concept that emerged in the twentieth century. This ethics of responsibility, developed and advocated by Max Weber, is based on the principle that all human beings are moral subjects worthy of consideration and respect, and that they should, therefore, all participate in the process of defining the rules and making the decisions that will affect them, each individual declaring and asserting their moral principles, beliefs, needs, and interests, and at the same time obliged to take those of others into account. An autonomous ethic considers that the criterion of morality is none other than the human being, and that human reason is what constitutes the standard of morality: it is the human conscience and the voice of that conscience that constitute the standard and the final court of appeal.

The idea that ethics should be rational does not imply that it should be rationalist in that complete and self-sufficient systems cannot be established because human reason is always open and has a principalist or a priori aspect as well as a consequentialist or a posteriori one. Ethical reasoning must, therefore, encompass both of these levels. Finally, a modern medical ethics should be universal and always open to a constant process of review; it should go beyond pure moral conventionalisms and seek to establish universal laws that apply to everyone, at all times, and in all circumstances and places.⁷

We want to make mention of the fact that the world of medicine today is no longer in the hands of physicians or of the beneficiaries of medical knowledge—the patients. The intervention of medical and health service administrators has introduced a distorting factor into the evolution of the profession, relegating those who should be the architects of the profession to a secondary plane. From the moment economic considerations take priority in medical management, everything changes. The ethical theories and principles that underpin our professional practice take into account the fact that resources are limited, but in no way consider the possibility of evaluating yield or performance

in medical practice in financial terms. Diagnostic and therapeutic methods are assessed by the physician in terms of the positive and/or undesirable effects they may have on the patient. Prescribing or treatment guidelines, whether drawn up by civil servants for public health authorities or by private health care providers, assess therapeutic strategies from the point of view of economic considerations. All professionals working with patients, whether in a doctor's office or a hospital ward, are under increasing pressure from this army of bureaucrats and the countless manuals and tools that guide prescribing. We need a very strong ethical and moral sense to withstand the pressures emanating from the centers of political and business power and to act freely according to our scientific knowledge and our conscience. And to all this we must add the burden of a heavy caseload, the anxiety of patients and their families, the constant and not always fair demands of patients, and an ever increasing and excessive list of other pressures. These are some of the consequences of our current system of socialized medicine and of the principle of autonomy that has shifted the authority to establish a need for care from the doctor to the patient. In this context, it would appear to be essential for medical students to receive a good grounding in ethics in addition to their scientific training. From the first day of their studies, they should be conscious that they have chosen a different path, a path that does not make them better or worse than their peers, but that does make them different from the other young people who are trying to find their way and define their futures in other classrooms, in other disciplines, and in other occupations. In medical school, these future doctors should gain a basic understanding of the key principles that govern life and death, pain, and human suffering. Their training should also include resources for alleviating the problems of their fellows, who will be the object and the motivation of their work as professionals, typically in an asymmetrical relationship in which the physician has the inescapable duty to comply with certain rules that ensure the good of the patient and are rooted in absolute respect for the patient's individual freedom. Moreover, students will learn certain methods based on paradigms that, over time, may prove to be ineffective or even wrong. They will learn that these healing methods will not always be able to halt the inexorable course of human disease and in some cases will not even address the patient's suffering. They will learn that they will not always be understood by their patients, patients' families, or their own colleagues. But they should also learn that when their methods are shown to be imperfect, inadequate, or useless, they can still count on their own value as people, their identification as fellow human beings, their respect for life and the freedom of others, and their love for the sufferer.

In conclusion, we should add that the new paradigm of the profession must be based on the pursuit of excellence, which, according to Diego Gracia,³ should be the watchword of the medical profession as opposed to the conformism of nonnegligence.

Thus, among the virtues and ideals to which the physician must aspire in his or her practice, we should not overlook the pursuit of moral excellence, in terms of attitude and commitment, taking the form of an aspiration to do the right thing, to go beyond the minimum moral obligations. Since Aristotle, thinkers have accepted that human virtues, in

terms of the disposition to act, feel, and judge in a particular way, arise from an innate discernment and are subsequently shaped by the process of learning and by the exercise of the quality. The character thus formed and its realization is his model of moral excellence.⁸ Exceptional people, such as heroes and saints, have taken moral excellence to almost superhuman levels; the examples in medical practice are legion. This is not the time or the place to discuss these examples from the history of medicine. But we do not have to look at such elevated examples. Even in medicine, the role of heroes and saints is to be put on altars for veneration. The mundane daily practice of medicine normally occupies a much lower echelon.

The pursuit of professional excellence should start from the premise that professional medical acts have to be based on 2 fundamental standards: correctness and goodness.

The first quality refers to the physician's technical preparation and the proper application of this training. Just as there are bad drivers or bad painters, there are bad doctors, who lack the training they need and do not properly apply the diagnostic and therapeutic methods made available by current scientific knowledge. The second quality refers to the physician's moral condition, to their human kindness and how they express their moral values in their actions.

"Expertise in the art of healing determines the technical correctness of medical practice and makes the person who has it a skilled doctor; human goodness, on the other hand, defines the physician's moral goodness, and makes him a good doctor."⁷

Both factors are essential, because the lack of one or the other is incompatible with the proper exercise of the medical profession. In the case of goodness, we must not forget that, no matter how hard the individual and the collective strive to regulate medical practice, something will always be missing: rules, ethical principles, codes, and laws, enriched by the currents of thought, extend their reach as far as they can. But there will always be some aspect that they cannot encompass, not even when they are interpreted according to the spirit rather than the letter of the law. Beyond ethics, deontology or professional standards, and the law, there is still a place that is home to the most intimate aspect of human beings, and this cannot always be encompassed by the codes that govern medical practice; we are talking about feelings.

It is impossible to legislate what the attitude of a physician at the bedside of a terminally ill patient with cancer should be when he or she is trying to alleviate the patient's pain and anxiety and the distress of the family present. Undoubtedly that attitude is to some extent shaped by training, by what the doctor has learned. But it is also the result of an unequivocal compassion, a desire to help those who suffer, the capacity to empathize with someone else's pain. The physician's feeling is also determined by his or her sensitivity, professional moral responsibility, commitment, good judgment, moral discernment, and strength of character; without these qualities, medical ethics would be a cold practice and would cease to be medical ethics.⁸

Medical practice is governed by both the science learned and also by ethical principles, codes of practice, and by the legal framework laid down by national legislative bodies.⁹ However, a love of the profession and of the sick, sensitive

emotional conduct, and a disposition to serve others are not encompassed by any ethical, professional, or legal code governing medical practice. In the Middle Ages, the great Arab medical schools coined a term to describe these moral issues in medicine that exist at the very edge of the rational and touch on the deepest human mysteries. They called it *niya*, and the term was used to refer to the most intimate convictions of the doctor's soul, which spring not only from education or experience gained dealing with the problems encountered in everyday practice, but also from the deepest recesses of the heart.¹⁰

In modern times, this quality has been called vocation, virtue, spirit of service, and other names. It is difficult to classify and impossible to quantify. It is the quality that differentiates us from other professions and above all from the trades. It does not make us better or worse. It makes us different. Because one thing goes beyond trends in ethical thought, ethical principles, codes of conduct, rules, and laws: the heart of the physician.

That said, let us now return to our first paragraph in which we talked about how the consolidation of dermatology as an essential specialty in modern medicine coincided with the crisis of the classic ethical paradigm of the medical profession and the emergence of a new paradigm.

Dermatology and the New Ethical Paradigm

In 1986 in the USA, Faden and Beauchamp published a study on the acceptance of informed consent and how physicians complied with this obligation.¹¹ They summarized the situation with the famous phrase "Everything has changed and nothing has changed" and, in an embarrassing account of medical practice in the USA, showed that while the social, cultural, political, legal, and professional structures had adapted to the new ethical paradigm of the medical profession, physicians themselves had done so only in form but not in fact. Several years later, Simón¹² published a work in which he dismantled the myths surrounding the same issue in Spain.

What is happening today in Spain in general and in Spanish dermatology in particular? Has Spanish dermatology adapted to the new ethical paradigm of the profession? Have Spanish dermatologists? The studies available, both publications and doctoral theses available from the TESEO database, are incomplete, and none, to our knowledge, deal with dermatology.

In Spain today, there are 3 types of professionals who are officially qualified to practice as specialist dermatologists. The oldest group studied their specialty in medical school, the following generation received specialist training but do not have an official qualification (MESTOS), and the youngest dermatologists have been trained in the medical resident intern (MIR) system. All of the first group and a large proportion of the second received no formal training in medical ethics during their studies. Most MIR graduates have had the opportunity to study ethics, either as an optional or a mandatory subject. There is, therefore, a marked difference in the basic training received. All 3 groups have had the same opportunity, at least in theory, to participate in postgraduate training. And the first question is a simple one: what knowledge do practicing dermatologists have of the

3 fundamental pillars that govern medical practice: ethics, deontological codes, and laws?

Physicians have many professional concerns, but for the sake of simplicity we can summarize them in 2 main categories: technical and ethical. Ethical concerns can, in turn, be classified into 3 categories: concerns that affect them personally, such as their educational level, their relationship with their peers, and their job security; those arising from the doctor-patient relationship; and those arising from their relationship with third parties (e.g., their employer and the pharmaceutical industry).

What is the attitude of Spanish dermatologists to the ethical dilemmas they encounter in their medical practice? This attitude will be shaped both by the training they have received and by external influences; it will indicate in what kind of ethical framework they are working, whether this has adapted to the new ethical principles based on respect for patient autonomy, and it will provide clues to how they will respond to the ethical problems they encounter every day in their practice.

And that is the crux of the matter if we are to find out where we stand and where we are going: the physicians' response to the ethical issues that arise every day in their offices, the operating room, and in the wards of our hospitals. This is what we call the *ethics of everyday practice* and it covers most of the ethical dilemmas in medicine. What is more, physicians are usually obliged to solve these dilemmas alone, on the fly, with no time or opportunity to consult their colleagues in the department, let alone the hospital's ethics committee. And, often, the response may not fit into the dermatologist's personal ethical framework. For example, a dermatologist who, being a Catholic, is against the use of contraceptives but who, in order to treat a patient of childbearing age, must prescribe isotretinoin. What will he/she do? And this is just one example among thousands. We could also talk about informed consent, the relationship between immigrant patients and their doctor from whom they are separated by barriers arising from differences in language and religion, as well as the relationship with local and state authorities which, as a result of the current climate of salary cuts, higher taxes, and longer working hours may have a negative impact on the physicians' professional spirit and even affect the quality of care. Other examples include the relationship with the pharmaceutical industry, the pressure on physicians to reduce spending, and a long list of other factors.

Studies are needed to investigate the situation. The ethical approach of the medical profession will determine whether it will continue to enjoy the level of respect and dignity it deserves. Just as we are obliged to honor those who came before us, we also have a moral duty to hand

down to those who will succeed us in the exercise of the most beautiful profession of all a legacy that will allow them to feel the rational and reasonable pride in their profession that we have today.

Ethical Disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this investigation.

Confidentiality of data. The authors declare that no private patient data disclosed in this article.

Right to privacy and informed consent. The authors declare that no private patient data are disclosed in this article.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. López S. *Ética y deontología médica*. 1st ed. Madrid: Editorial Marban; 2011.
2. Lain P. *Historia de la medicina*. 1st ed. Barcelona: Salvat Editores S A; 1982.
3. Gracia D. *Como arqueros al blanco. Estudios de bioética*. 1st ed. Madrid: Editorial Triacastela; 2004.
4. López S. *Ética y deontología médica*. Madrid: Marban; 2011. p. 320.
5. Ocampo J. La bioética y la crisis de la ética médica tradicional. *Anales Médicos de la Asociación de Médicos de Hospitales*. 2001;XLVI:92-6.
6. Gómez M. *Medicina paliativa. La respuesta a una necesidad*. 1st ed. Madrid: Aran; 1998.
7. Farreras P, Rozman C. *Medicina interna*. 15th ed. Vol. I. Madrid: Editorial Marin; 2004.
8. Beauchamps TL, Childress JF. *Principios de ética biomédica*. 1st ed. Barcelona: Masson; 2002.
9. Sierra X. *Ética e investigación médica en humanos: perspectiva histórica*. *Actas Dermosifiliogr*. 2011;102:395-480.
10. Schipperges H. *La ética médica en el Islam medieval*. *Asclepio*. 1965;XVII:107-16.
11. López M. *Aspectos éticos y legales del consentimiento informado en anestesiología. Estudio en el Complejo Hospitalario de Toledo [doctoral thesis]*. Salamanca: Universidad de Salamanca; 2011.
12. Simón P. Diez mitos en torno al consentimiento informado. *Anuario del Sistema Sanitario Navarro*. 2006;29: 29-40.