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ETHICS

Professionalism and Medicine

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> The practice of medicine is not a business and can never be one ... Our fellow creatures cannot be dealt with as a man deals in corn and coal; the human heart by which we live must control our professional relations.
>
> Sir William Osler, 1903 [1]

It is widely acknowledged that potent forces of a political, legal, and market-driven nature are producing great stress on the practice of medicine [2–5]. Recognizing that such influences potentially threaten the underpinnings that unite physicians, patients, and society, there is widespread concern both inside and outside the profession concerning the impact such forces impart on medical practice. As a consequence of these matters, the discourse pertaining to medical professionalism is of considerable interest to the practicing physician and their professional societies, the institutions where they work, and the myriad of bodies that oversee and regulate the practice of medicine. This interest has spawned a substantial literature examining the influences that bear on how medicine is practiced and broadly perceived. This paper is an attempt to distill the prodigious and sometimes contentious literature.

Background

Since the late 1960s, the ethics of patient care in the United States has developed primarily along two, relatively distinct pathways [6].[1] One pathway developed largely outside the domain of organized medicine, influenced not by physicians, but rather by participants whose expertise was grounded in other academic disciplines—philosophy, theology, and law. Stimulated and initially focused on the ethical dilemmas arising in human subject research, the field we now know as *bioethics* was thrust into public view by several historic court cases involving end of life decisions. With its focus on "rights" and "principles", and its problem (case)-based orientation, bioethics has influenced clinical practice through the application of bioethical theory to the often difficult and challenging ethical dilemmas arising in patient care. Institutional ethics committees, ethics consultation, and the ethics education in general find their origins in this domain of medical ethics.

There is however, a second pathway, more traditional in its foundations and more oriented toward the practicing physician. In contrast to rights and principles, the precepts that underlie this pathway—*professional ethics*—are centered on the integrity of the individual clinician [6]. Usually documented in the form of professional codes, the origins of this arm of medical ethics date back to antiquity with the Code of Hammurabi (2,000 B.C.), the first known code of medical ethics, and later, the Hippocratic Oath (5th century B.C.), which to this day is pledged (often in modified form) at medical school initiation and graduation ceremonies [6, 8, 9]. It remains the defining traditional statement concerning the conduct of the physician. However, it was not until the eighteenth century that the concept of medicine as a profession was in effect invented by two physician-ethicists, the Scott, John Gregory (1724–1773) and the Englishman, Thomas Percival (1740–1804) [10]. Before Gregory's time, physicians employed the term "profession" to distinguish themselves from surgeons, apothecaries, and other perceived competitors, all regarded by the university trained physicians as lower order practitioners of the day. Gregory, whose writings were based on Hume's principle of sympathy, introduced a vital shift in emphasis and orientation—that is away from the physician and toward the patient. Indeed, Gregory and Percival were the first physicians to employ the word "patient" rather than the term "the sick" [10]. In addition to this orientation, Gregory's principles (code) also emphasized scientific and clinical competence, cautioned against physician self-interest, and introduced the notion of medicine as a public trust (as opposed to a merchant guild, which is what it was in his time). Building on these views, Thomas Percival introduced the term "medical ethics" employing it

[1] In contemporary times, a third potentially dominant pathway of medical ethics known as *organizational ethics* has emerged to address ethical issues associated with the business and managerial aspects of healthcare organizations. This approach recognizes that the quality of care experienced by patients depends in part on the values of the healthcare organization with which they and their physicians and other heath care providers interact [7].

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in his examination of physician conduct in hospitals and charities and with respect to professional etiquette [10–12]. More recently and further underscoring the central role that codes have played in the professional discourse of medicine, it is noteworthy that a Code of Ethics was the first item on the agenda of the first meeting of the AMA (1847). Thus, as a consequence of this engrained tradition, codes of ethics in the profession of medicine are regarded as touchstone statements that direct the behavior and define the character of the ideal medical practitioner.

As argued by Spencer, how decisions in clinical care are conceptualized is fundamentally a function of which of these perspectives the decision-maker holds to be authoritative [6]. According to Spencer's view, contemporary *bioethics*, case-based with its emphasis on patient rights and autonomy, requires a sharing of decision-making authority, the final power residing with the patient not the doctor. In contrast, *professional ethics* centers on the clinician. Spencer presents these distinctions in the form of two contrasting questions. Within the domain of *bioethics*, where an ethical problem is examined as a case or clinical problem requiring a response, the bioethicists would ask ...

> What should I do and how should it be done?

In contrast, from the perspective of *professional ethics*, the question is posed differently and might take a form such as ...

> What kind of a person should I be in order to fulfill my professional obligations?

When seen through the lens of professionalism, an ethical problem is therefore viewed as a deviation from an accepted norm and it is the inattention to these norms that results in problems for the patient or the physician. Thus, depending on which of these orientations one adopts (bio vs professional ethics), these differing perspectives may result in tensions when attempting to decide what is right in an actual clinical situation.

Ethical and philosophical foundations

As an intellectual and academic pursuit, medical ethics has looked to the field of moral philosophy for its foundations [13, 14]. Indeed, virtually every school of moral thought has been employed. Among the most dominant and influential are those which are focused on netting the most overall good (utility-oriented); the deontological (pertaining to "duty") approaches, which are focused, not on the consequences of one's actions, but rather on the adherence to principle; law-based approaches, which reference "natural laws" (not the legal system) from which certain accepted rules of human conduct are derived; contract-grounded beliefs, which considers an idealized society and the idea of a hypothetical social contract; and more recently, feminist approaches, which attempt to reformulate those aspects of traditional western ethics that devalue women's moral experience. In addition to these and other philosophical frameworks, however, when considering the domain of medical professionalism, it is another approach to ethical analysis that has received the most attention.

Perhaps the oldest, most enduring system of ethical thought is the virtue-based ethics of the Greek philosopher Aristotle (384–322 B.C.) [14–16]. In this system, which centers on the moral agent (the physician), one considers the kind of person the physician should be, rather than the clinical problem he or she is confronting. Thus, with its focus on the physician, virtue-based ethics provide a natural orientation to the discourse concerning matters of professionalism as how professional obligations and standards are acted upon, are shaped directly by the character of the moral agents themselves [6, 15]. Given the influence that virtue-based approaches have had on this discussion, a brief word about the "virtues" would seem in order.

In the context of medical professionalism, virtues can be seen as character orientations or dispositions possessed by effective physicians that enable them to provide optimal medical care to their patients. Among the many virtues that could be considered necessary attributes of an effective physician, a number would appear central [13–15]:

> *Compassion*: focused on others (the patient), compassion couples the regard for the welfare of another with an expression of sympathy for their suffering; it presupposes that an effective physician feels something of the patient's predicament while maintaining sufficient emotional detachment to allow for effective medical decision-making.
> *Discernment*: involves the capacity to make judgments and effective decisions on behalf of the patient without being unduly influenced by extraneous influences, considerations, and the circumstances in which the patient's sickness has arisen.
> *Trustworthiness*: involves a confidence and a belief that the physician will make decisions and act with competence, guided by appropriate norms and standards, and in response to motivations determined by moral character.
> *Integrity*: a virtue particularly relevant to a discussion of professionalism, the notion of integrity speaks to a soundness and reliability of moral character and requires an integration of such aspects of self as emotions, knowledge, hopes, aspirations, and fidelity to one's moral values.
> *Conscientiousness*: refers to the motivation to do what is right.

Yet, despite its obvious intuitive appeal, there are problems with a virtue-based approach, not the least of which is the plethora of virtues from which to choose. As noted by Veatch, multiple virtues, arising from disparate traditions, have been championed throughout history [16]. Examples include the Cardinal virtues of the Greeks (wisdom, temperance, tolerance, and justice), the Christian virtues (faith, hope, and charity), and there is the

Hippocratic ethic (which emphasizes purity and holiness) [16]. An examination of Eastern thought expands this list even further and thus debate inevitably follows when contemplating which of the virtues should be regarded as dominant. Further, even with agreement concerning which of the virtues to honor, other questions arise [16]. Veatch argues that ethical theory makes the distinction between the ethics of character and the ethics of action (conduct) and points out that professional codes tend to focus on rules. Rules are then employed to guide conduct. However, does good character insure good behavior? If one had to choose, which would count most? Finally, can virtuous behavior be taught? Whereas these are only some of the problems arising from a virtue-based approach to medical professionalism, the notion of the virtuous physician, one who comports him/herself in concert with these concepts remains an enduring notion.

What is medical professionalism?

In recent decades, organized medicine's professional standing has been severely challenged by a myriad of social forces and phenomenon. As articulated by Hafferty, these include ever increasing health care costs, continued failure to establish a viable health insurance structure for the country, research demonstrating large variations in physician practice, the advent of evidence-based medicine and the quality and patient safety movements, the availability of clinical information systems supporting the efforts of the latter, and most recently, problems relating to conflict of interest [5, 17–23]. In the collective, the profession has been perceived as insufficiently engaged in the resolution of these problems, and as a consequence, various forces have challenged the traditional privilege afforded by society to the medical profession [2]. The response to this assessment from both inside and outside the profession has been great, indeed of a magnitude justifying its characterization as a "social movement" [24]. Nonetheless, despite the renewal of attention that professionalism has received from the medical societies and the enormous resultant literature, professionalism as it pertains to medicine remains difficult to define with precision. Before fully discussing medical professionalism per se, a word regarding the general concept of professions is appropriate.

Eliot Freidson, a noted authority, describes professionalism as a "set of institutions which permit the members of an occupation to make a living whereas controlling their own work" [25]. His definition acknowledges two elemental characteristics of a profession, the presence of a specialized body of knowledge and the ability to oversee and self-regulate practice. There is another characteristic, however, one particularly germane to medicine although less honored in modern times. Recognizing that physicians have responsibilities that go beyond that of the individual patient, the commitment to public service speaks to how the medical profession addresses a broader societal commitment. Driven by the extraordinary successes of the medical profession in the modern era, the practice of medicine has become increasingly identified with technical expertise and less a sense of public service. As will be discussed shortly, the result of this shift has been a renewed interest in medicine's societal role and responsibilities [2–6, 26].

For the purpose of this paper, the formulation of Arnold and Stern provides a useful approach to an examination of medical professionalism [28]. Whereas disagreement may exist concerning what constitutes ideal professional behavior, most would agree on the constituent elements presented. In this conceptualization of medical professionalism, certain foundational *elements*—those of clinical competence and fund of knowledge, well-developed communication skills, an understanding of the ethical underpinnings (autonomy, beneficence, nonmaleficence, and justice) and legal influences that bear on the practice of medicine, support four aspirational *principles* or value statements. Distilled from the American Board of Internal Medicine's Project Professionalism [28], these principles include *excellence*, *humanism*, *accountability*, and *altruism*. A brief expansion of these concepts follows.

Fundamental to the concept of *excellence* is a life-long commitment to the maintenance of competence in medical knowledge, cognitive and technical, not in the sense of a minimum standard but rather, to use the term of Arnold and Stern, of the "quintessence" of excellence [27]. Implied is a dedication to continuous quality improvement with the additional goal of avoiding overuse and underuse of health care resources. The second principle, *humanism*, denotes a concern for humanity and subsumes such concepts and behaviors as a respect for persons, their rights, and their choices with regard to their medical care; also implied is the ability to express empathy and convey compassion to the sick and their families, backbone elements of the doctor–patient relationship. The concept of *accountability* refers to taking of responsibility for one's actions, whether in decision-making in medical care, the adherence to ethical principle or to the acknowledgement of conflict of interest. Finally, *altruism* is a principle that connotes behavior designed to benefit others.

Thus far, this paper has considered the historical development of medical professionalism, its ethical underpinnings have been presented, and an attempt to explain what it is has been offered. Whether each of these considerations encompasses ones' own conception of professionalism is a matter that sparks considerable discussion and disagreement. Whereas this analysis may seem rudimentary to some, it should nonetheless convey something of the breadth of the current discourse pertaining to medical professionalism. The following section examines some of the recent dialogue as it pertains to the problems facing contemporary medicine.

Professionalism, clinical care, and the social contract

Of the many commentaries concerning professionalism in medicine, one of the most erudite discussions is that of Dr.

Jeremiah Barondess of the New York Academy of Medicine. In his paper entitled *Medicine and Professionalism*, two central perspectives are developed—that of professionalism in clinical care and the important, but perhaps less appreciated, societal responsibilities of the medical profession [2].

For the individual physician, professionalism is expressed primarily through the clinical interaction, a patient-centered encounter that relies on certain physician-based characteristics and behaviors, some of which recall the "virtues" just considered. These include: *competence*, a reference to well-developed clinical skills and a restrained deployment of the available technologies; *engagement* in the clinical transaction, one in which the primary determinant of care is the needs of the patient; *reliability*, a reference to timely access and help in navigating the health care system; *dignity* in the conduct of the patient–doctor relationship; *agency*, a reference to a commitment to the patient's health and priorities; the *dual focus on illness and disease*, considerations that imply an approach to care that recognizes both the human experience of illness and the biological processes that underlie it; and a *concern for quality*, a reference to the judicious use (both overuse and underuse) of diagnostic procedures and therapy. Whereas most would agree on the desirability of these aspirational concepts, Barondess and other authors argue that these are not enough. Indeed, the notion of medical professionalism needs to go beyond the doctor–patient relationship through an explicit recognition of the profession's responsibility to society at large.

As it is the contribution to a greater public which forms the basis upon which medicine is enfranchised by society, discussions pertaining to the ethical challenges facing medicine must also take into account the profession's social responsibility. Often referred to as medicine's *social contract*, this concept has become the focus of deep interest and commitment from those interested in matters of medical professionalism. Consider the recent *Charter on Medical Professionalism*, a collective work of the leadership of American and European medical organizations [3, 4]. In contrast to the covenantal Hippocratic Oath, the *Charter* is more contractual [26]. Premised on four categories or priorities (Table 1), the intent of the charter is to provide a framework from which the challenges facing the modern medicine can be addressed. Note how two of the four priorities—improving access and equality and addressing equity in resource distribution—are primarily societal mandates, not focused on the individual patient or the physician. The *Physician Charter* presents ten professional responsibilities or physician commitments, founded on three fundamental principles (Table 2). Taken in its entirety, the *Charter* acknowledges the physician's duty to serve the individual (patient) whereas discharging the profession's broader social responsibilities.

Table 1 Charter on Medical Professionalism: Ethical Priorities

Advancing the well-being and dignity of patients
Improving the accessibility and equality of institutional health services
Encouraging principled physician behavior
Moving society to equitable positions in distributing health resources

Table 2 The Physician Charter

Fundamental principles
Primacy of patient welfare
Patient autonomy
Social justice
Professional responsibilities and commitments
Professional competence
Honesty with patients
Patient confidentiality
Maintaining appropriate relations with patients
Improving quality of care
Improving access to care
Just distribution of finite resources
Scientific knowledge
Trust by managing conflicts of interest
Professional responsibilities

Discussions of the social contract in general, and efforts such the *Physician Charter* specifically, have entered the debate as a consequence of a number of potent forces impacting broadly upon the medical profession. These include technological change and innovation, market forces, bioterrorism, and globalization, to reference a few [3, 4]. The charter implores physicians to "reassert their authority and recapture the medical high ground" in their efforts to improve the welfare of patients. This process will require not only an open engagement with the health care players such as the government and managed care organizations, but also a broadening of interests to include an active role in addressing problems such as disparities in health care and life expectancy and the challenge of the uninsured, a problem that grows inexorably, year by year, now affecting upwards to 45 million Americans [27]. As argued by Barondess, the involvement of organized medicine into these arenas of health care policy is important as the process will require, by necessity, input which is medically informed. Furthermore, on moral grounds, it is simply right that such population-based initiatives should be driven by the profession. He emphasizes several problems concerning which there is a sense of urgency. These include an enhanced focus on quality, a commitment to cost containment, a renewed obligation to the health of the marginalized and disadvantaged, and an active role in resolving the problem of the uninsured.

Whereas the response to the *Physician Charter* has been generally favorable, it should be acknowledged that the effort does have its detractors. Reflecting origins in the bioethics movement, it has been criticized for its duty-based as opposed to virtue-based foundations and its emphasis on autonomy [26]. In addition, with its reliance on the language of contracts and its focus on physician competence, the *Charter* has also been criticized for its inattention to the "higher" values of medicine, those of beneficence, compassion, and altruism [26]. As stated in their thoughtful analysis, Swick et al. succinctly state—"Duty alone is not

enough" [26]. Furthermore, McCullough, another detractor, has criticized the *Charter's* authors for failing to present a clear ethical conception of professionalism, for having various historical inaccuracies, and for blaming external forces for the changes that threaten the system [10]. To acknowledge the critics, those who decry the current state of medical professionalism, the *Charter* may indeed be soft on physicians in the sense of not holding them sufficiently accountable for the role they have played in the current state of the profession. So is the problem the system or it's primary participants—the physicians? Asked another way—Are physicians the victims or simply disengaged participants? Neither is desirable.

Teaching professionalism

The assumption that the process of medical training naturally imparts those qualities that define a good physician does not seem viable, if it ever was, to modern medicine [28]. In earlier eras when this was the belief, discussions of medical professionalism centered primarily on matters of self-regulation, technical expertise, and knowledge [29]. As a consequence of this orientation, mechanisms such as Board Certification and Continuing Medical Education evolved to address these needs. Indeed, these approaches have been so successful at achieving their goal that medical education is no longer a primary consideration in discussions pertaining to professionalism in medicine. Rather, problems such as responding to the changing health care environment brought on by managed care (i.e. organizational ethics), and most recently, the difficult problem of conflict of interest have dominated the discussion [5, 18–23]. Nonetheless, spurred on by recent studies suggesting that unprofessional behavior and the resultant need for disciplinary action for practicing physicians may have its genesis much earlier, indeed, during medical school [30–32], interest in professionalism and how to teach it remains a topic of active consideration [33, 34].

Amongst the leaders in this field, Stern and Papadakis have made particularly important contributions [34]. In their conceptualization, the teaching of professionalism in medicine includes three primary actions: setting expec tations, providing experiences, and the evaluations of outcomes. With respect to the setting of expectations, events such as "white coat" ceremonies and the recitation of the Hippocratic Oath[2] are traditional and common methods employed by medical schools to impart expectations pertaining to humanistic behavior in the practice of medicine. Further, the recent inclusion of professionalism as one of the six core competencies for residents in training by the Accreditation Council for Graduate Medical Education (ACGME) is another important statement of support for these concepts [35]. The aforementioned Charter on Medical Professionalism [3, 4] and professional codes such as that of the AMA and those of subspecialty colleges and societies, extend these expectations beyond the years of formal medical training. The provision of experiences is a reference to such activities as the inclusion of ethics and professionalism in the medical curriculum; the development of problem-based learning, an approach that fosters teamwork and leadership (attributes relevant to professionalism); and community-based and international electives that cultivate a broader, societal consciousness. Finally, the evaluation of outcomes addresses the need to evaluate students to assess what lessons have been learned and to formally emphasize the importance of learning them. Conceptual frameworks and the development of objective methodologies for the measurement of professionalism are currently a matter of great interest and active investigation in the halls of academia [28, 35–37].

The impact of role models should not be forgotten in this discourse. In this regard, history has provided many examples of the ideal physician, the greatest of whom in modern times may have been the Canadian, Sir William Osler. Through his clinical research, his textbook and vast bibliography, and his reputation as the consummate clinician and compassionate physician, he remains to this day the embodiment of an ideal and the exemplar of what is meant by professionalism [38, 39]. Other iconic figures come to mind as well—Cushing of Baltimore, Peabody of Boston, and Penfield of Montreal—as do many, less heralded individuals, those who influenced each of us in some way in the course of our own professional development. Whereas these relationships remain important, role modeling is apparently not enough as research suggests that in order for role modeling to effectively impart the principles of professionalism, such interactions must be combined with subsequent reflection on the action [34].

Concluding remarks

In this paper, a general overview of the subject of medical professionalism is presented, beginning with its historical and ethical–philosophical foundations, followed by a discussion of its constituent elements and relevance to clinical care, closing with a brief discussion of the some of the current concepts relevant to the teaching of professionalism. To some, the issue of conflict of interest may be insufficiently represented given its preeminence in the current discourse of medical professionalism. Nonetheless, as a topic that stands alone, it has been comprehensively reviewed in a previous issue of the journal [18] and elsewhere [19–23]. Furthermore, an acknowledgement and deeper discussion concerning the frequently strident commentary concerning the state of medical professionalism, often written by nonphysicians, has been eluded to where appropriate but otherwise deliberately avoided [5, 10, 29]. This was done not because such opinion is unimportant or not instructive to the profession as indeed it is but rather because the "call to arms" nature of these writings seemed out of sync with the general intentions of this review. Nonetheless, suffice it to say, problems abound and criticisms that hold the medical profession and its membership accountable for the existing state of professionalism are

[2] Medicine is the only profession that still honors an oath [26].

highly relevant and place the responsibilities for finding solutions precisely where they belong.

> You are in this profession as a calling, not as a business, as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow-men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed [40].

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