Professionalism as a Social Construct: The Evolution of a Concept

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In this issue of the *Journal of Graduate Medical Education*, the article entitled "Creating a framework for medical professionalism: an initial consensus statement from an Arab nation"[1] by Abdel-Razig and colleagues provides another enlightening contribution to our understanding of professionalism in global terms and adds to the literature on professionalism in the Muslim world. Our comments will be directed to 2 areas of interest: (1) the evolution of our understanding of professionalism, and (2) a brief analysis of the consensus definition developed for the United Arab Emirates as compared to definitions in contemporary use within Western cultures.

The independent and self-regulating professions, as we in Western society understand them, have their origins in Hellenic Greece, are derived from the guilds and universities of medieval Europe and England, and emerged in approximately their present form in the middle of the 19th century.[2,3] Their moral foundations are deeply rooted in Judeo-Christian traditions of morality.[4]

The Anglo-American world has exerted significant influence on the concept of the medical professional, although the role of individual physicians and the medical profession is very similar throughout Western culture.[2,4] It is significant that if one consults dictionaries in non-English speaking countries, the references to professions and professionalism almost uniformly relate to differentiating amateurs from professionals. The autonomous and self-regulating professions are largely absent. Definitions of professionalism from dictionaries of the English language stress service and the fact that the professions are granted monopolies over the use of specialized knowledge, with the understanding that they will deliver certain services and behave in prescribed ways. We, and others, have termed this a *social contract*.[5]

There is little question that, until recently, there was an assumption within the English-speaking world that this concept of professionalism was truly universal and applicable to all nations and all cultures. Indeed, the intent of the committee that created the International Charter on Medical Professionalism, to which the authors refer in their article, was to provide a document that would be universally relevant.[6] We can attest to this, as we participated in the creation of the charter.

It is difficult to know when social scientists arrived at the conclusion that there were major differences in the interpretation of professionalism in different contexts. Most sociologists believe that society uses the professions as a means of organizing work—in the case of the professions, work of a specialized and essential nature. Thus it is logical to believe that even early sociologists would find it natural for different countries and cultures to choose different means of organizing this work. What is certain is that, for at least the last 2 decades, social scientists have recorded that each country expresses professionalism in a slightly different fashion. In 1993, contributors to a volume edited by Hafferty and McKinley[4] compared professionalism in 15 Western countries and China, and in 1996 Krause[2] studied 5 professions in 5 Western nations. Both seminal works noted, along with many commonalities, significant differences in the nature of professionalism across national boundaries. The contributors to this literature stressed the differences imposed in patterns of medical practice by different health care systems, but did not probe into the impact of culture. The consensus was that professionalism was used to organize the services of the healer, and that there were differences in national organizational approaches imposed by different health care systems.

Many assumptions long held by the medical profession in the Western world have been questioned in the course of an ongoing critical appraisal of professionalism in society that has taken place over the past half-century. These include the motivation of the medical profession to pursue its own self-interest,[3,4,7] the profession's failure to self-regulate with rigor,[7,8] its neglect of some issues of importance to society,[2,7,8] and, of course, the relevance of the concept of the professions to countries with their own histories, cultures, and concepts of morality.[8–11]

Ho and colleagues[10,12] systematically studied the differences between Western concepts of profession-

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alism and those rooted in Chinese culture. They compared the professionalism found in a North American medical school with students in Taiwan and, taking the study further, compared students in Taiwan and Beijing. They documented differences that appeared to arise out of both cultural traditions and different patterns of practice, while stressing the impact of Confucian thought on both.

The article that is the subject of this commentary is not the first to demonstrate that there is a concept of professionalism in the Arab world, and that it is deeply embedded in Muslim culture. Al-Eraky and colleagues,[13] again leaning heavily on the Delphi method, proposed the "Four-Gates Model" of professionalism with the following 4 levels: dealing with God, dealing with others, dealing with tasks, and dealing with self. Significantly, and not surprisingly, the physician's faith is seen to be essential to the conceptualization of professionalism. This is notably different from Western interpretations of professionalism that, although rooted in Judeo-Christian beliefs, now seem to be resolutely secular.

Monrouxe,[14] referring to her own work as well as that of others, has argued persuasively that national cultures, identified as norms, behaviors, beliefs, and customs, have a profound impact on the nature of the professional identity of each country's physicians. She points out the differences between Eastern and Western cultures, including individualism versus collectivism and major differences in hierarchies. It is difficult to escape the conclusion that differences in how professionalism is interpreted in different cultures are inevitable.

While there are major differences, it must also be noted that there are many more similarities found in the consensus statements developed within the Arab world than there are differences from the concept of professionalism extant in Western society. Thus, without making direct comparisons between the findings of Abdel-Razig and colleagues,[1] those of Al-Eraky et al,[13] and Western values as expressed in the Professionalism Charter,[6] it should be pointed out that there does appear to be truly universal aspects to a physician's identity. Thus the qualities of compassion, commitment to the patient, advocacy for the patient and the health care system, duty, integrity, commitment to social justice and responsibility, respect, commitment to the profession, commitment to teamwork in health care, commitment to continuous personal improvement, and protecting patient confidentiality are all fundamental to both Eastern and Western interpretations of professionalism.

Our feeling has long been that the physician's function can be interpreted as containing 2 separate roles—that of the *healer* and the *professional*.[3] While they clearly must be served simultaneously, they can be examined separately. The role of the healer is truly universal. Every human being needs the services of the healer when they are ill. We would suggest that the commonalities found refer to this traditional healer's role, and that the differences are in large part found in the professional role, derived from the fact that professionalism is used as a means of organizing the services of the healer. The differences based on culture and nationality are expressed in different national forms of professionalism.

It is important to understand these differences in a world in which movement of both patients and physicians across national and cultural boundaries is constant. Individuals from, for example, the Arab world who seek education and training in the Western world deserve respect, support, and understanding as they cope with the cultural differences and what it means to be a physician in their new setting. As they return to their native countries, it is equally important that they retain their national professional identities. Western physicians who function in non-Western cultures must adapt to the professional mores in which they find themselves, while attempting to retain their own professional identities. Hodges[15] has stated the consequences of this situation well: "Curricula will have to evolve to promote healthy suspicion about any truth or practice that is prescriptive, dogmatic, or posited as universal, emphasizing that laws, practices, and professional codes of conduct are constructed and reconstructed across history and geography."[15(p.285)]

In the first study of the sociology of medical education in 1957, Merton stated that the task of medical education is to "shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician."[16(p.5)] By now, based on the work of many perceptive individuals, including Abdel-Razig and colleagues, it should be clear to all that "thinking, acting, and feeling like a physician" varies between countries and cultures and that these differences demand to be respected.

References

1. Abdel-Razig S, Ibrahim H, Alameri H, Hamdy H, Haleeqa KA, Qayed KI, et al. Creating a framework for medical professionalism: an initial consensus statement from an Arab nation. *J Grad Med Educ*. 2016;8(2):165–172.
2. Krause E. *Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present*. New Haven, CT: Yale University Press; 1996.

3. Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. *Acad Med*. 1997;72(11):941–952.
4. Hafferty FW, McKinley JB. *The Changing Medical Profession: An International Perspective*. Oxford, UK: Oxford University Press; 1993.
5. Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. *Perspect Biol Med*. 2008;51(4):579–598.
6. Medical Professionalism Project. Medical professionalism in the new millennium: a physician's charter. *Lancet*. 2002;359(9305):520–522.
7. Freidson E. *Professionalism: The Third Logic*. Chicago, IL: University of Chicago Press; 2001.
8. Martimianakis MA, Maniate JM, Hodges BD. Sociological interpretations of professionalism. *Med Educ*. 2009;43(9):829–837.
9. Cruess SR, Cruess RL, Steinert Y. Teaching professionalism across cultural and national borders: lessons learned from an AMEE workshop. *Med Teach*. 2010;32(5):371–374.
10. Ho MJ, Yu KH, Hirsh D, Huang TS, Yang PC. Does one size fit all? Building a framework for medical professionalism. *Acad Med*. 2011;86(11):1407–1414.
11. Chandratilake M, McAleer S, Gibson J. Cultural similarities and differences in medical professionalism: a multi-region study. *Med Educ*. 2012;46(3):257–266.
12. Ho MJ, Yu KH, Pan H, Norris JL, Liang YS, Li JN, et al. A tale of two cities: understanding the differences in medical professionalism between two Chinese cultural contexts. *Acad Med*. 2014;89(6):944–950.
13. Al-Eraky MM, Donkers J, Wajid G, van Merrienboer JJ. A Delphi study of medical professionalism in Arabian countries: the Four-Gates model. *Med Teach*. 2014;36(suppl 1):8–16.
14. Monrouxe LV. Theoretical insights into the nature and nurture of professional identities. In: Cruess RL, Cruess SR, Steinert Y, eds. *Teaching Medical Professionalism in Support of Professional Identity Formation*. Cambridge, UK: Cambridge University Press; 2016:37–53.
15. Hodges BD. Professional identities of the future: invisible and unconscious or deliberate and reflexive. In: Cruess RL, Cruess SR, Steinert Y, eds. *Teaching Medical Professionalism in Support of Professional Identity Formation*. Cambridge, UK: Cambridge University Press; 2016:277–287.
16. Merton RK. Some preliminaries to a sociology of medical education. In: Merton RK, Reader LG, Kendall PL, eds. *The Student Physician: Introductory Studies in the Sociology of Medical Education*. Cambridge, MA: Harvard University Press; 1957:3–79.

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