Human Resources for Health

Professionalism in Medicine

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"...nothing is more estimable than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution, and pays equal attention to the rich and the poor." – Voltaire

Introduction – What is Professionalism?

Professionalism has been described by the American Board of Internal Medicine as "constituting those attitudes and behaviors that serve to maintain patient interest above physician self-interest."[1] The word profession is derived from *profess* which means 'to proclaim something publicly'. The act of 'profession' of commitment to an ideal to which the professional should conform is the essence of a profession. Physicians profess two things: to be competent to help the patients and to have the patient's best interests in mind. Such commitment invites trust from their patients.

Physicians profess in two ways: the first is the public act of 'oath taking' during medical graduation ceremonies. This is truly the moment of transition – from being a student to becoming a professional. The oath, not the medical degree, professes the way the newly-acquired competencies are to be employed. Without the oath, the doctor is just a skilled worker. The second way of professing is implicit in the doctor-patient encounters: Whenever a physician asks the patient, "What can I do for you?" they commit themselves to having adequate technical expertise and to using that in the best interests of the patients. Such tacit commitment occurs every day between a physician and a patient. Otherwise, the patient would never willingly consult the physician.[2]

Profession and Vocation

To differentiate between a vocation and a profession, recent sociological literature has proposed a 'checklist' method. An occupation is considered to be a profession if:

- Practising it requires formal education;
- Its members enjoy control over their own training standards;
- Its members have their own disciplinary mechanisms;
- There is a scholarly journal devoted to its standards;
- Its practitioners enjoy relatively high social status, and
- Its practitioners have secured protection from state regulation as well as from market pressures.

The checklist method permits us to debate whether or not certain occupations, like librarian, social work and journalism are professions. Traditionally, a small number of professions, by virtue of their educational breadth and their importance in satisfying some fundamental human need, have been called "learned professions." Medicine, law, ministry and other academic occupations have enjoyed this special status.[3]

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History of Professionalism

"Three kinds of medical practitioners are found in this world; firstly, the impostor in physician's robes; secondly, the vainglorious pretenders and thirdly, those endowed with the true virtue of the healer" -
Charaka (120–162 AD)

The noteworthy physicians in the history of medicine – physicians of the ancient Hindu, Confucian, or Hippocratic schools, Thomas Percival, Francis Peabody and William Osler, etc.- practised virtue-based ethics. However, for several centuries 'the mercenary doctor' has been a problem. "A doctor who can help a poor man and will not do so without a fee, has less sense of humanity than a poor ruffian who robs a rich man to supply his necessities. It is something monstrous to consider a man of liberal education tearing the bowels of a poor family by taking for a visit – as fee – what would keep them for a week," lamented Richard Steele (1672–1729). In Sanskrit, there is an ancient couplet, which says, "A physician is the elder brother of Yama, the Lord of Death, because Yama takes away only your life but the physician takes away your life and all your money!"[4]

Plato had described two types of doctor-patient relationships. The first – 'slave medicine' in his parlance – is described thus: "The physician never listens from the slave any account of his complaints, nor asks for any; he gives some empiric treatment with an air of knowledge in the brusque fashion of a dictator, and then is off in haste to the next ailing slave." Plato contrasted this with the physician-patient relationship for 'free citizens' thus: "The physician treats their disease in a scientific way and takes the patient and his family into confidence. He never gives prescriptions until he has won the patient's trust, and when he has done so, he aims to produce complete restoration to health by persuading the patient to comply with the therapy. "

In the early 20th century, professionalism included issues like maintaining technical expertise and self-regulation of medical practice. Formulated by Talcott Parsons in the 1920s, these tenets formed the foundation of professionalism. In the developed world, technical expertise improved with the Flexner's report of 1910 on Medical Education but quality of education is still a matter of concern in developing countries. Self-regulation by the profession has always been its Achilles' heel: Most professional bodies do not effectively discipline their members; most do not publish records of their disciplinary actions, if any. Such shortcomings make it clear that effective self-regulation is non-existent and needs to be created.[5]

The de-mystification of the medical profession in the 1970s and 1980s resulted in two great upheavals. First, medicine changed from an autonomous, publicly respected profession to one vilified in the public press. Doctors, once the 'perfect angels,' had fallen from the pedestal of public adulation. Second, health managers appeared to be potent rivals for the authority that physicians thought they owned. Sociologist Paul Starr commenting on the growing privatization and monetarization of medicine, described medicine as a "sovereign profession", that once had reigned supreme, but was now threatened by the "coming of the corporation."[5]

Today, medical professionalism is in peril as several factors have weakened it. Increasingly, physicians encounter perverse financial incentives as well as restrictions, fierce market competition, and the resultant erosion of patients' trust. Professionalism has virtually vanished in the battle between market competition of the "health care industry" and ineffective government regulation of health care services.[5]

Perspectives of Professionalism

Professionalism in medicine can be viewed from the perspective of professional virtues or that of professional obligations. Professional virtues are the desirable qualities and traits a physician ought to possess and professional obligations are what a responsible physician needs to understand and do.

Professional Virtues

"*Virtue engenders excellence; therefore virtue ought to be fostered more than life.*" – Tiruvalluvar – Tamil Saint-Poet

Medicine has always been considered a "noble profession." The image of a doctor has always suggested integrity, loyalty and compassion – key aspects of a physician's professional identity. The world over, communities have always acknowledged medicine's vital role in healing the sick and permitted unique powers and privileges to those who practiced it. In turn, the societies expected medical professionals to altruistically serve the sick and suffering.

Some of the virtues a physician needs to commit to possess are:

- Fidelity to trust – essential for establishing rapport and for healing to occur;
- Benevolence – action taken for patient's welfare, and avoiding all avoidable harm;
- Intellectual honesty to accept when one does not know, having the humility to admit it and obtain assistance and specialist help;
- Courage to face the dangers of contagion, to possibilities of physical harm, and political retribution, and deceptions of various kinds; courage to be the patient's advocate in a commercialized health care setting;
- Compassion – empathize and feel something of the patient's plight in order to make scientific judgements that are morally defensible and suited to the life-world of a particular patient, and
- Truthfulness – enables the patient to make informed choices, on treatment modalities.

These are virtues obligated by the dyadic nature of the medical encounter between a physician and an individual patient.[2]

Professional Obligations

Professions have a duty to protect vulnerable persons and vulnerable social values. Many values are vulnerable: individuals and societies may abandon the sick and the elderly, and permit unequal treatment based on gender, etc. Though humanism, trustworthiness and the preservation of important values are important for all members of any civilized society, the professionals are obligated to practice these values. When professionalism in core social activities such as medicine and law becomes unsteady, it marks the emergence of societal problems. Thus, professional obligations constitute an important stabilizing and morally protective force in a society.[3]

Professionalism obligates doctors to be competent and updated in their expertise and proficiency. It obligates doctors to suppress self-interest in their service for the well-being of their patients. It obligates doctors to cultivate a fiduciary relationship with their patients and be trustworthy. It obligates medical institutions to promote society's trust and not undermine it.

If medicine is a profession, then the medical team – physicians, nurses, physician assistants, social workers, nutritionists, physiotherapists and other care givers – is a

group of professionals obligated to share a core of common professional duties. All members have the ethical responsibility to know and respond to their colleagues' professional duties and to be caring and respectful in their professional interactions with each other. The professional actions, values and commitments of the medical team must be transparent to patients and the community.[3]

Professional Authority

The flip side of professional obligation is professional authority, which is derived from technical expertise. To the three types of legitimate authority that Weber described, viz., legal, traditional and charismatic authority, Parsons added a fourth type: expert authority, which is most applicable for professionals. People obey orders from physicians because they believe that physicians possess the expert knowledge that they do not have.[3]

In the 1970s, the concept of "expert professional authority" was criticized as being mostly a sham. Much of the clinical practice was shown to be merely empirical, not based on scientific evidence, not as uniform as any scientific practice ought to be and to be heavily influenced by economic and marketing forces. Such harsh criticism has ushered in the current push for practice of evidence-based medicine and clinical outcomes research. [3]

Unprofessional Relationship

"*When a doctor does go wrong he is the first of the criminals. He has nerve and he has knowledge*." – Sir Arthur Conan Doyle in "The Speckled Band"

A fiduciary relationship is one in which a person, usually with special expertise, agrees to act in the best interests of the other, e.g. a patient, generally in exchange for monetary reward. Besides the doctor-patient relationship, doctors are also involved in a range of other fiduciary relationships, as medical teachers, supervisors, senior colleagues or team leaders.

Inappropriate sexual behavior in fiduciary relationships is considered sexual harassment, even if there is no apparent resistance from the patient or client. In anonymous surveys, 3%–10% of doctors admit to a sexual relationship with a patient. In an Australian survey, it was found that 7.6% of psychiatrists, almost all male, reported erotic contact with patients during or after termination of treatment; about 4% of male psychiatrists in New South Wales have been reported for sexual abuse of patients.[6]

Charter on Medical Professionalism[1]

A charter was released by the Medical Professionalism Project, a joint effort of the American Board of Internal Medicine (ABIM) Foundation, the American College of Physicians-American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine, in 2002. This charter has recently been revised.

The three guiding principles of the charter are:

- Primacy of patient welfare;
- Patient autonomy, and
- Social justice.

The 10 professional responsibilities included in the charter are:

Commitment to:

- 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;
- Maintaining trust by managing conflicts of interest, and
- Professional responsibilities.

A charter on medical/dental professionalism of the University of Western Ontario derives from the ABIM charter with minor differences. In lieu of "improving quality and access to care," which are system issues beyond the control of an individual professional, the following principles have been added.[7]

- Commitment to cooperation and collegiality;
- Commitment to open and honest relationships with colleagues and third parties, and
- Commitment to improving the health of the community.

Charters are useful signposts that point out the correct path that health care professionals ought to take. However, critics say that charters and professional resolutions might influence individual behaviour in some instances, and are doubtful if these would have substantial collective impact on health care delivery in the current era of managed care.

Threats to Professionalism

There is a profound unease with the seeming primacy of economic factors currently affecting medical practice in most of the developed world. A special challenge arises in medicine because health care is often expensive and a third party generally reimburses these costs. Other professional relationships are different: a lawyer or an engineer charges clients directly for services rendered, and the clients can consider costs when they decide what kind of services they want. However, in medicine, the decisions are now heavily constrained by the payers' decisions about whether a proposed treatment is "medically necessary" and appropriately cost-effective. This intrusion of third party payers into the health care decision-making process has significantly curtailed physicians' accustomed professional independence.[8]

While physicians and their professional associations are preoccupied with struggles on issues of payment and political power, professionalism is seriously threatened. The New England Journal of Medicine has warned, on behalf of patients, against the "new medical-industrial complex" as inimical to the free exercise of professional responsibilities.

Another major threat to professionalism arises from the undue influence of the pharmaceutical industry over continuing professional education and research. Unlike issues related to managed care, the excessive dependence on drug industry is under the control of physicians and their professional associations.[8] These issues may well subvert the effort to make professionalism relevant to contemporary medicine.

Challenges to Professionalism in the Third World

"*The medical profession is under siege. The public increasingly distrusts us because we are too condescending to listen, too mediocre to keep up, and too greedy to truly care about their welfare*." – S.Y. Tan, MD

In India and other developing countries, a doctor is greatly trusted, but more and more people are questioning the practice. However, "my-doctor-knows-what's-best" type of blind trust is giving way, especially among the educated, to the realization that decision-making is the right of the patient.

There are numerous instances of unethical advertising by doctors. The regulatory councils look into such matters but no tangible action is taken and the doctor often goes scot-free. Of late, advertisements by hospitals and diagnostic centers vie with those put up by alternative systems of medicine, often proclaiming their superiority over others.

Hi-tech equipments are imported at great expense. Most of these equipments are in excess of the needs and paying capacity of patients. Health care centres use fee-splitting and other incentives to lure referrals from physicians. Is it ethical for the physicians to order expensive investigations without explaining to the patient how much it would cost to undergo the full treatment? It is estimated that about two thirds of rural families are in debt because of health care expenditure.[9]

Another major problem in most developing countries concerning equipment imported from abroad has been the poor quality of service and maintenance. Is it ethical to procure costly equipment, which is not likely to function for long? Is it ethical for vendors to supply these items without effective after-sales service? Thairu has suggested that manufacturers, vendors and users regarding the sale and maintenance of equipments should agree upon a professional code.[10]

Another unprofessional facet of health care in developing countries is the doctors' tendency to prescribe fashionable and expensive drugs or irrational drugs with limited therapeutic value. The drug vendors and producers 'push' doctors into using their products by all means – fair or foul. This is responsible for distortions in drug production and consumption. [11]

Article 25 of the Universal Declaration of Human Rights states, that everyone has the right to a standard of living adequate to the health and well-being of himself and his family. This includes food, clothing, housing and medical care and necessary social services. These rights raise the ethical issue of distributive justice in developing countries where resource crunch is a major problem. How to provide acceptable and affordable care to all is a challenge. Is it ethically permissible for the society to compel physicians to provide service in under-served areas and remote villages? Do the professional bodies not have the responsibility to influence the health policy and promote distributive justice? Sadly, they have, with a few exceptions, been passive spectators in the fight against discrimination in health care. [12]

It is perhaps peculiar to India that modern science is employed for female feticide. Even after it has been made illegal, some doctors in India perform fetal-sex determination tests. Such abortion clinics thrive in the country in spite of the law against it. Gender discrimination, loaded against the girl child, is however quite prevalent in developing countries.[12]

Recent media reports spoke of 'exploitative research' in the developing countries. An important safeguard is needed to avoid the exploitation of potentially vulnerable populations in these countries. Clinical trials should be limited to those that are responsive to the host country's health needs.[13]

Teaching Professionalism

"*The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head*." – Sir William Osler

There is widespread concern today among conscientious physicians, medical educators and the general public that medicine is becoming 'unprofessional' and that the profession is losing its commitment to protect the welfare of patients. How should medical schools respond to this challenge?

Importance of Role Models

Source credibility is an important principle of adult learning. Role models are therefore necessary to impart effective training and inculcate professionalism among learners.

How can medical schools find physicians who can, without hypocrisy, teach these courses? They have to start with a faculty development programme on professionalism and create a critical mass of role models among the educators. Then they have to develop a programme on how best to transmit those values to the learners. Mentoring is clearly the most effective means of transmitting values. Another effective way is to create an environment for professionalism, not by telling students what to do, but by raising their awareness by asking questions. Feedback to tell the learners how they have evolved and rewarding them for their progress is very important as well.[14]

Relevant Issues for Future Professionals

Today's students need skills that will serve them well in future. Some of the important issues for future professionals' are[15]:

- How forces such as managed care and drug industry threaten professionalism;
- How the field of medicine must adapt to the current reality and yet remain ethical;
- How to practice humanistic and compassionate medicine within the 10 minutes spent in seeing a patient;
- How to truly care for our patients if third party payers (insurance industry) decide which tests and which medicines are permitted, and dictate the time allocated to each case;
- The knowledge and the skills needed to adhere to the principles of professionalism even as health care reform continues, and
- Empowerment of the learners so that they – the future doctors – can lead the reform.

A Successful Model

The University of Chicago, USA emphasizes six principles (the "Six Cs") in teaching clinical medical ethics.[16] The "Six Cs" principles for teaching clinical ethics are:

- Clinically based – for relevance;
- Cases (real) – narratives for fidelity and effectiveness;
- Continuous – reinforcement of learning outcome;
- Coordinated – integrated approach of all issues pertaining to the case;
- Clean (i.e. simple case) – for clearer take-home messages and better impact, and
- Clinicians as instructors – for source credibility and all-round case discussion.

Informal Curriculum

The social milieu or "informal" curriculum of a medical school has great influence on values and professional identities acquired by its students. The Indiana University School of Medicine, USA runs a programme to foster a social environment that embodies and reinforces the values of competency-based curriculum. The school uses an appreciative narrative-based approach to encourage its students and faculty to be more mindful of relationship dynamics. They discover how much relational capacity already exists and how widespread is the desire for a more collaborative environment. Their perceptions of the school seem to shift, evoking behaviour change and hopeful expectations for the future.[17]

There are further questions that need to be addressed by every medical school. Some of them are:

- How to overcome the resistance to teaching professionalism;
- How to know that the professionalism curricula are working;
- How to develop a reliable and valid set of professionalism assessments tools, and
- Does educating professional behaviour ensure professionalism.

Evaluation

Periodic assessment of professional behaviour of the residents and other learners is needed. Giving them feedback in a non-judgemental way helps in further shaping their behaviour. In the Department of Internal Medicine, we use faculty staff as mentors of postgraduate residents. The residents are assessed using the checklist (*vide infra*) every six months, leading to five assessments during the three-year period. Their progress – or lack of adequate progress – is commented upon in a non-judgemental way.[18]

Resident Evaluation Checklist on Professionalism

Marking: 0 1 2 3 4 *Unsatisfactory* 5 6 7 8 *Satisfactory* 9 10 *Exemplary*

(1) Empathy in patient care.
(2) Appropriate fund of knowledge.
(3) Soundness of clinical judgment.
(4) Technical expertise with diagnostic and therapeutic procedures.
(5) Communication with patients, families and staff.
(6) Sensitivity and responsiveness to individual patient differences in economic status, ethnicity, age, gender and disabilities.
(7) Honesty in dealings with patients and colleagues.
(8) Accountability for actions.
(9) Conflict-resolution skills.
(10) Adherence to regulatory, institutional and departmental norms.

(*Modified from - Catherine A. Marco. Medical Professionalism In Emergency Medicine Graduate Medical Education.*)

Looking to the Future

Fostering Professionalism – The Milieu

We ought to create the kind of health care environment which is conducive for physicians to be truly professional, regardless of who controls it – the manager or the physician. Some of the major issues in health care organization and delivery are[19]:

- The ability to treat patients, using high standards of care, without undue concern about cost and insurance issues;
- Satisfaction in providing continuity of care to patients with chronic illnesses;
- Building and maintaining trusting relationships with patients and with the general public;
- Opportunities to participate creatively as 'patient advocates' to improve the health care system;

- Good information systems and audit for more effective patient care and continuous improvement in quality;
- The ability to exercise professional curiosity through meaningful clinical research and outcome assessment;
- Open and fair communications with other members of the health care team, including managers, and
- Reasonable working conditions and income levels.

Fostering Professionalism – The Strategies

Ethical principles are difficult to implement in a corrupting environment. Therefore, a major commitment by all stakeholders to establish and maintain ethical standards in all aspects of health care delivery is of paramount importance.

There are several options but most of them require a change in the mind-set and major departure from current procedures.

(1) Professional and certifying bodies could regulate rather than merely recommend standards of behaviour and service;

(2) A requirement to render a minimal quantum of free care might convey commitment to medical professionalism and improve the health of the poor;

(3) Professional associations could form issue-based alliances with consumer groups to accomplish goals that neither can realize separately;

(4) The medical curriculum should be revised to inculcate the skills necessary to promote professionalism and advocacy skills;

(5) Professional bodies could encourage and protect whistle-blowers, so that the profession is not dependent on 'outsiders' to identify and publicize problems;

(6) Professional associations could be expanded the agenda for their lobbying and advocacy. The society will positively respond to advocacy that is driven not by narrow self-interest but by a broader professional vision of patients' welfare;

(7) Professional societies, medical schools, and teaching hospitals could be proactive and minimize the influence of pharmaceutical companies and their represent-atives, and

(8) The agencies and individuals who have done worthwhile acts to promote professionalism could be appreciated and rewarded like, the awards given by the foundation of The American Board of Internal Medicine.[20]

The responsibilities of fostering professionalism are indeed awesome. The obvious question is, "*Are the key players and professional organizations competent and willing to move ahead?*"

To sum up, how can one prove one's love to others? It can only be proven by consistently demonstrating love. Similarly, to prove their professionalism, the physicians can only act as true professionals, striving always to deserve the trust and admiration they hope to inspire.[3]

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Further Reading

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