Professionalism: the historical contract

Death and taxes may be life's only guarantees, but suffering is also a safe bet. Who hasn't fallen ill or ached from injury or endured pain of some sort? It should come as no surprise, then, that people who relieve others' misery have held high standing in their communities throughout history.

The role of the healer — tasked with setting broken bones, stitching open wounds and administering medicine — is valued by every society on earth. In general, those who take on this role receive trust, respect, autonomy, social status and financial reward. But these good things come at a cost.

Society has always expected much of those put in charge of citizens' health. Healers are to be altruistic, moral, objective, competent, accountable and accessible. This social contract — what patients expect from doctors and vice versa — changes over time but has always been central to the medical profession.

"The essence of professionalism is a bargain between society and medicine," says Dr. Richard Cruess, a professor of surgery at McGill University's Centre for Medical Education in Montréal, Quebec.

In the Western world, the roots of the the healer date to Hellenic Greece and the Hippocratic Oath. For centuries after, there was no medical profession to speak of, but rather individuals who independently tended to the sick. "The role of the healer has remained fairly constant, but the concept of professionalism has changed in response to societal and professional needs," Cruess and colleagues have suggested (*Lancet* 2000;356:156-9).

As medicine became more complex and demands from society more intense, there grew a need for structure and organization. This was accomplished by delivering health services according to the concept of a profession. The idea of establishing professions to deliver complex services dates to medieval Europe. By the mid-nineteenth century, the concept had morphed well beyond the medieval notion of a guild. "The modern professions were established in the mid-nineteenth century, when laws governing licensure granted a monopoly over practice, with a clear understanding that professions would be altruistic and moral and would address society's concerns," Cruess and colleagues have noted (*J Bone Joint Surg* 2000;82:1189-94).

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The notion that doctors are primarily good Samaritans motivated by altruism is viewed by some with increasing skepticism.

There are several widely accepted tenets of a profession. One is that members require specialized knowledge that takes long periods of intense study to acquire. As such, a profession is granted monopoly over how that knowledge is used and taught. Because the knowledge is largely inaccessible to laymen, a profession is also granted autonomy to set standards, self-regulate and discipline unprofessional behaviour. The condition for these privileges: professions must serve the public in an altruistic manner.

Sociologists have been studying various professions for more than a century. Interest in the medical profession, specifically, increased in the 1930s. Though it was recognized that, like all humans, doctors aren't above selfishness, academics found that the profession was held in high regard. "The early literature was largely favourable," wrote Cruess and his colleagues. "There was faith in the virtue, morality, and service commitment of professionals, although the tension between self-interest and altruism was identified."

By the 1960s, however, attitudes about doctors had begun to sour. Medicine was becoming increasingly complex. There were new specialties and technologies and financial models. The public found the field too confusing. Tension had also arisen over the rising cost of health care, the decrease in interest among doctors about their patients' emotional lives and the preoccupation of physicians to spend time in laboratories rather than with patients, anthropologist and sociologist Murray Wax suggested (*J Health Hum Behav* 1962;3:152-6).

Within a decade, society entered a period of deconstruction. People were more cynical and questioned authority and expertise. Respect for all professions took a dive. The notion that doctors were altruistic was viewed with increased skepticism, and their professionalism was no longer assumed.

Still, despite growing discontent, the general attitude within medicine was that professionalism came automatically — a mere byproduct of medical education. "The degree (M.D.) defined and established everything. In turn, carrying out one's clinical work in a 'conscientious

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manner' established that one was practicing medicine in a professional manner. … physicians began to treat professionalism as something they were owed by a 'grateful' public," Frederic Hafferty, professor of medical education and associate director of the program in professionalism and ethics at the Mayo Clinic in Rochester, Minnesota, and colleagues wrote in "Two Cultures: Two Ships: The Rise of a Professionalism Movement Within Modern Medicine and Medical Sociology's Disappearance from the Professionalism Debate," chapter 11 of the *Handbook of the Sociology of Health, Illness, and Healing* (www.springerlink.com/content/q831w4579306163j).

But that attitude changed in the early 1980s, which marked the beginning of a bull market that stretched for nearly two decades. Suddenly, billions of dollars were being poured into pharmaceutical companies, medical device manufacturers and other areas of health care, transforming it into big business and a major part of the economy.

"When I started out, there were no for-profit hospitals. There was no private, for-profit health insurance. Nobody referred to medicine as an industry," says Dr. Arnold Relman, professor emeritus of medicine and social medicine at Harvard Medical School in Boston, Massachusetts, and former editor in chief of the *New England Journal of Medicine*, who graduated from medical school in 1946.

In the United States, medicine entered a corporate era. Doctors were making more money. Some became entrepreneurs, raising concerns that profits were trumping professionalism. Others worried that professionalism's greatest threat was managed-care operators robbing their autonomy. "Managed care presented issues for doctors in so far as they found that managed-care operations were micromanaging them," says Michael Yeo, a philosophy professor at Laurentian University in Sudbury, Ontario. "Their relationships with patients became filled with this third party looking over the doctors' shoulders."

A new professionalism movement arose to counter the influence of managed-care organizations. By stressing they were professionals, not mere employees, physicians could create rules about what they could and could not be forced to do. "If you can say it's against my professional ethics, that is a stronger case than saying it's against my morals," says Yeo. "There is a difference between being an employee and being a member of a profession. You are less malleable."

This rekindled passion for professionalism, now two decades old and still going strong, has led to many changes in medicine. Medical schools now teach professionalism to students. Academic physicians write paper after paper on the topic. Health care organizations have attempted to formalize in words the social contract between medicine and society that for centuries had been acknowledged but unwritten. Much of this effort was fueled by a longing to return to what many doctors viewed as the golden age of medicine, before corporations and governments took over.

"The nostalgia part was fuelled by how medicine chose to define the problem," says Hafferty. "How do we solve the problem? By recommitting ourselves to those traditional values. Medicine came up with a variety of ways of institutionalizing this. They created codes and charters and competencies and curriculum — all these 'c' words."

Where will discussions of medical professionalism go from here? Of late, there has been much interest in the professional behaviour of physicians on social media. Will that still be a topic of interest in the future? No one knows that, of course. Until doctors start trading in their stethoscopes for crystal balls, there will be no consensus on future trends in professionalism.

"What's it going to be in five years?" says Hafferty. "The point is, whatever it is — whether it's duty hours or Facebook or something else — it's going to be an opportunity to engage in the critical question: What does it mean to be a good doctor?" — Roger Collier, *CMAJ*

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Professionalism: Can it be taught?

There's a saying in basketball: You can't teach height. Of course, there are many things that would provide advantages in life that can't be taught — competitiveness, intelligence, curiosity, creativity, stick-to-it-iveness. And we've all heard the one about old dogs and new tricks. Should medical professionalism be added to the list of unteachable subjects?

The medical profession, evidently, doesn't think so. Almost every medical professional body in North America considers professionalism an essential topic and has mandated that it be taught in faculties of medicine. The Accreditation Council for Graduate Medical Education, responsible for accrediting residency and internship programs in the United States, considers it a core competency. Questions on professionalism appear on the Medical Council of Canada's licensing exam, completed by all Canadian undergraduate medical students.

Some doctors, however, wonder if professionalism can really be learned in the classroom. Many of the qualities required to meet the professional ideals of medicine go far beyond biological know-how. Selflessness, empathy, benevolence — these aren't exactly things one gleans from books. Medical professors can preach altruism, but no sermon can transform a student's personality. The challenge of teaching a medical student to be a "good" doctor is, in some ways, akin to that of teaching an individual to be a "good" person. It is, in short, challenging indeed.

Still, professionalism in medicine is too important not to include in medical curricula, especially considering the prevailing opinion that doctors are less altruistic and more financially driven now than they once were, says Dr. Richard Cruess, a professor of surgery at McGill University's Centre for Medical Education in Montréal, Quebec.

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Professionalism cannot be assumed. "It has to be taught," says Cruess.

With his wife, Dr. Sylvia Cruess, he has long extolled the importance of teaching professionalism. Nearly two decades ago, they suggested that relevant topics include ethical codes governing physician conduct, the concept that being a professional is "not a right but a privilege," and relevant material on professionalism from the fields of sociology, philosophy, economics, political science and medical ethics (*BMJ* 1997;315:1674-7).

"The profession is now diverse, as in almost every country doctors come from various cultural, ethnic, and economic backgrounds," they wrote. "Though this represents an advance in terms of equity and fairness, it makes the transmission of common values more difficult and, in our opinion, requires explicit teaching of the role of both the healer and of the professional."

Many others obviously agreed, and education on medical professionalism has flourished. But what are the teachings based on? And are they making a difference? Those questions remain difficult to answer.

"How do you measure degrees of benevolence and compassion? If it is so obvious to our profession what professionalism is, then why is it so difficult to teach it to medical students and residents?" Dr. Sze Wan Sit of Toronto, Ontario, wrote in a letter to *Canadian Family Physician* (www.cfp.ca/content/55/12/1183.short). "As a clinical teacher, I can testify that professionalism is no doubt one of the hardest points to evaluate and to remediate in our trainees."

Indeed, when it comes to quality evidence supporting how best to teach and evaluate professionalism, there appears to be a rather short supply, according to Dr. Pier Bryden, a psychiatrist and the faculty lead in ethics and professionalism for undergraduate medical education at the University of Toronto in Ontario. "Currently, professionalism continues to receive some attention in training programs, primarily through faculty example and mentoring, yet there is no clear consensus or evidence base to inform best practice, teaching, and evaluation in this area," Bryden and colleagues have suggested, noting that faculty involved in medical education claimed their "own lapses in professionalism and their failure to address these with one another posed the greatest barrier to teaching professionalism to trainees, given a perceived dominance of role modeling as its most influential teaching tool" (*Acad Med* 2010;85:1025-34).

But that doesn't mean there is no value in at least introducing medical students to concepts of professionalism "rather than just throwing them out there and saying this is the reality of medicine," says Bryden. Though mentoring may be more important, the classroom is an appropriate setting for exploring certain topics and for discussing how ethical principles should be applied in particular clinical scenarios. There may also be benefits to such activities as reflective writing and small-group discussion of clinical experiences. "You get the students to take a step back from the biomedical context and ask them to pause and reflect in a broader context about what they are doing," says Bryden. "Do they experience more empathy? Does that change the way they interact with patients? That's hard to measure, but it's not a reason not to explore these topics."

Another subject worthy of exploration, though largely ignored today, is medical history, says Bryden. "The history of medicine is part of our professionalism. It's our elders' legacy to us, their mistakes and their successes."

The introduction of courses in humanities into medical curricula has also been driven by the professionalism movement. The theory is that evaluating literature or art will develop critical thinking skills and enable young doctors to better consider multiple perspectives on a topic — a patient's perspective on a treatment, for instance. Though considered of dubious merit by some, the humanities are thought of by others as a good vehicle for making physicians more contemplative.

"Studying the humanities necessarily involves reflection. Individuals exposed to the humanities become more self-aware, more other-aware. They have better-honed critical analysis capacities. They can appreciate multiple coexisting and conflicting perspectives," says Johanna Shapiro, director of the program in medical humanities and arts for the school of medicine at the University of California, Irvine. "Physicians are often more complex than we allow them to be. If you scratch the surface, you find they are curious and intrigued about other ways of understanding their patients."

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Many of the qualities required to uphold the professional ideals of medical practice — such as selflessness, empathy and benevolence — aren't exactly things a physician can glean from a text book.

One aspect of professionalism that has become of particular relevance to today's medical students is appropriate use of social media. Though tech-savvy, medical students need to learn what is and isn't appropriate to do on the Internet, even if their peers in other fields of study haven't yet grown tired of uploading photos of eye-glazing, face-reddening, vodka-induced debauchery. "They need to be cognizant of online professionalism right from the beginning of their medical training," says Dr. Kevin Pho, who practises internal medicine in Nashua, New Hampshire, and writes about social media on his website (kevinMD.com).

Some medical students haven't learned that lesson. In one survey, 60% of 78 US medical schools reported unprofessional online behaviour by students (*JAMA* 2009;302:1309-15). The incidents included violations of patient confidentiality (13%), profanity (52%), discriminatory language (48%), depictions of intoxication (39%) and sexually suggestive material (38%). About two-thirds of schools reporting incidents issued warnings and three dismissed students for their transgressions.

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"The formal professionalism curriculum should include a digital media component, which could include instruction on managing the 'digital footprint,' such as electing privacy settings on social networking sites and performing periodic Web searches of oneself," states the study, led by Dr. Katherine Chretien, chief of the hospitalist section at the Washington DC VA [Veterans Affairs] Medical Center and an associate professor of medicine at George Washington University in Washington, DC.

A survey of medical students' thoughts about online professionalism, also led by Chretien, revealed conflicting views (*Acad Med* 2010;85:S68-71). Though many were concerned about the risks and consequences of online behaviour, others resented the very idea of their schools attempting to control their lives. "Some said that, from 8 a.m. to 5 p.m., you can tell me what to do, but after that you can't tell me what I can do, online or not," says Chretien. "But some said they would never want someone to even see a picture of them holding a glass of wine."

No matter how medical schools attempt to install professional values in future doctors — whether through encouraging exposure to art or discouraging overexposure on Facebook — it is important they make the attempt, says Michael Yeo, a philosophy professor at Laurentian University in Sudbury, Ontario. If nothing else, it's good for public relations. Medical educators can truthfully profess to be concerned about turning out well-rounded doctors rather than those only comfortable nose-deep in medical textbooks. "It's an assurance to the world: Don't worry. We've got things in hand," says Yeo. "We are teaching them not to just be competent, but also to be professionals." — Roger Collier, *CMAJ*

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More news online

Plan proposed to make organ donation less "ad hoc" in Canada: It appears that a national agency or mechanism for allocating donated organs for transplantation isn't in the cards. But after four years of wrangling with provincial governments and transplant programs, Canadian Blood Services (CBS) has proposed a strategic plan for an "integrated interprovincial organ donation and transplantation system" to help reduce current inequities in access to organs and vastly improve Canada's current "mediocre" performance with respect to organ transplantation rates.

Although the proposal does not feature any manner of mandatory organ sharing between jurisdictions or pan-Canadian organ allocation, CBS Chief Executive Officer Dr. Graham Sher told a press conference there's enough "good will" within the transplant community to implement at least a measure of agreed-upon reforms to improve the system's overall performance.

And if governments cough up $800 million over 10 years, it would result in about 7000 additional organ transplants in Canada, Sher said (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4239). — Wayne Kondro, *CMAJ*

Vaccinating children against anthrax: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4238) — Cal Woodward, Washington, DC

UK unveils patient-centred electronic health strategy: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4233). — Paul Christopher Webster, Toronto, Ont.

"This ain't my daddy's AMA": (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4234). — Wayne Kondro, *CMAJ*

Private practice on life support in America: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4235). — Wayne Kondro, *CMAJ*

The heartburn of meaningful use: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4236). — Wayne Kondro, *CMAJ*

Medicare woes prompt AMA brouhaha: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4237). — Wayne Kondro, *CMAJ*

Flush and run: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4196). — Michael Monette, *CMAJ*

Farmyard drug use a US battlefield and a Canadian wasteland: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4231). — Paul Christopher Webster, Toronto, Ont.

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Uncertainties shroud medical isotope supply: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4217). — Tim Lougheed, Ottawa, Ont.

Nodding disease confounds clinicians: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4210). — Jocelyn Edwards, Kampala, Uganda

High court sanctions law edging US toward universal health coverage: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4251). — Cal Woodward, Washington, DC

Professionalism: social media outreach: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4207). — Roger Collier, *CMAJ*

Health assessments urged for federal laws and regulations: (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4241). — Laura Eggertson, Ottawa, Ont.

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