Medical professionalism: is it really under threat?

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ABSTRACT

- Recent publications on medical professionalism have created an impression of a medical profession under siege in several countries.
- These publications recommend a new approach to medical professionalism to assist the profession to respond to new challenges.
- I suggest that the issue is not one of failed professionalism, but a shift in the balance of the ethical responsibilities brought about by major changes in health care systems. This shift has not yet been accepted or responded to by the medical profession.
- Medical professionalism is not under threat in Australia.
- Stronger leadership is required to address this altered ethical balance in the responsibilities of doctors.

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Three sentinel publications on "medical professionalism" have expressed concerns about the professional status of medical practitioners in some health care systems.[1-3] Each recommends a new approach to medical professionalism and links this to the "social contract" the medical profession must have with the community it serves.

I explore the possible origins of these concerns and conclude that medical professionalism is not under threat, and certainly not in Australia. Instead I suggest that profound changes to health care and its delivery have altered the balance of application of the ethical principles which underpin medical practice and that the medical profession has failed to clearly identify and adjust to this new balance. I note that expression of concerns about medical professionalism seems to be cyclical rather than a new phenomenon, as articles published in 1987[4] and 1980[5] and a book published in 1975[6] addressed similar themes.

Why is "medical professionalism" an issue now? Is the sky falling in?

A common perspective of the three recent publications appears to be that the medical profession in many countries is under siege. Wynia et al, writing from the United States, make the following opening statement in their 1999 article *Medical professionalism in society*:

> Today, at the dawn of a new century, genuine medical professionalism is in peril. Increasingly, physicians encounter perverse financial incentives, fierce market competition, and the erosion of patients' trust, yet most physicians are ill equipped to deal with these threats.[1]

In their opening sentence, the authors of *Medical professionalism in the new millennium: a physicians' charter* declare:

> Physicians today are experiencing frustration as changes in the health care delivery systems in virtually all industrialised countries threaten the very nature and values of medical professionalism.

They go on to state:

> At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalisation. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society.[2]

The summary of the more recent United Kingdom Royal College of Physicians document, *Doctors in society: medical professionalism in a changing world*, states that "the exercise of medical professionalism is hampered by the political and cultural environment of health, which many doctors consider disabling" and adds at the end of the summary: "our collective and abiding wish is to put medical professionalism back onto the political map of health in the UK".[3] The latter two publications also suggest that renewed medical professionalism will be one of the means of restoring the trust that the public used to have in the profession.

There have been enormous changes in the way medicine is practised and health care is delivered in industrialised countries from that which applied even a generation ago. In brief, these include:

- the gradual change from a medical care system based around individual doctors, both generalists and specialists, working in small medical practices — a "cottage industry" — to more corporate-style practices;
- advances in science and technology, which have allowed for the better diagnosis and treatment of a wider range of conditions and spectrum of ages, leading to rising health care costs;
- the consequent pressure on governments to find ways to fund, fully or in part, health care delivery or to more efficiently deliver health care, using approaches that include managed care, rationing or deliberate under-funding, and delegation of tasks to differently qualified personnel; and
- increased scrutiny of health care outcomes, influenced by increased community knowledge, better access to information, rising expectations of what doctors and the health care system should provide (including ready and affordable access to care, partnership in decision making, and avoidance of adverse events and/or adequate compensation for adverse events) and greater use of litigation.

I sense that these changes to the way in which health care is now delivered and funded have altered the balance of the ethical issues facing individual doctors. This is similar to the way that, three or more decades ago, the shift from a primary focus on the ethical principle of beneficence to a greater recognition of, and respect for, the autonomy of patients changed the way doctors approached their work. I believe that the medical profession (and especially its leaders) needs to examine and accept this altered balance and assist medical practitioners to work within this new balance. This is not to deny the importance of trying to define medical professionalism, debating its core principles and inculcating those principles into medical and postgraduate training.

In a forthcoming Australian Medical Council publication (*Handbook of clinical assessment*, in press), I state that:

> Professional skills or "professionalism" covers a wide range of elements, including communication skills, knowledge of medi-

cal ethics, personal and professional development, awareness of relevant laws pertaining to medical practice and cultural awareness in our multicultural society. Above all, "professionalism" includes an assumption that a person wishing to practise medicine effectively will bring to the task positive attitudes to all the roles involved in being a doctor.

Medical professionalism (also referred to as "professional and personal development" and covering such matters as communication skills, ethics and law) has become central to medical student curricula in Australia as one of the important outcomes of the reforms triggered by the Doherty inquiry into medical education of 1988.[7] Recognised then by another name, it was also central to a "professional practice program" piloted for postgraduate medical trainees in Victoria in the early 1990s.[8] Medical professionalism is now gradually finding its way into Australian postgraduate medical training programs.

This long history, together with a strong health consumer movement, community involvement in medical regulation, and a health care system which in most states and territories has been free of major scandals, may explain why medical professionalism is not under threat in Australia and why as an issue it has not gained attention. In addition, the Australian health care system, which combines genuine universal access with a strong private sector, probably insulates Australian doctors from the influences at work in some other developed countries.

The changing balance in application of ethical principles

I return now to my suggestion that changes to the way in which health care is provided, funded and organised have altered the balance in application of agreed ethical principles, and that the tension created by this changing balance is the source of the perceived threat to medical professionalism.

When I entered medicine, the central ethical principle that seemed to be lived out by my mentors was beneficence. In the space of one generation this was gradually overshadowed by the principle of respect for patient autonomy. Now I think we are moving into an era where the ethical principle of justice will become a more dominant influence, because of the evident need to use finite resources wisely. Putting this principle into practice is not a simple matter for individual clinicians, as the need to use resources justly is often in conflict with the need to act in what seem to be the best interests of the immediate patient (who, relying on the principle of autonomy, might be insisting on receiving treatment). Neither is it a simple matter for segments of the profession, where different groups fight for their own interests, sometimes disguised as the best interests of their patients. This ethical dilemma is not being widely acknowledged and discussed by the medical profession.

Ethical principles are a platform or structure upon which to base good clinical practice. While we in the developed world have grown accustomed to the four "pillars" of beneficence, autonomy, non-maleficence and justice, there are other ethical qualities — some call them virtues — that a competent practitioner should display, including compassion, fidelity and integrity. Tensions between principles applicable in any specific clinical situation have long been identified, as is implied by the balance between striving to help without causing harm, so it should come as no surprise that these tensions might change as circumstances change. Undoubtedly, circumstances have changed, as the complexity and costs of tests and treatments have increased and as the possibility of prolonging life (sometimes at unacceptable costs, whether measured in terms of intrusiveness and human distress, or in terms of financial costs) has also increased. In some clinical areas, such as neonatal and adult intensive care, clinicians are daily confronted with such ethical dilemmas.

Justice as an ethical principle when applied to health care means distributive justice or fairness in allocating health resources.[9,10] This ethical principle comes into play at what have been termed "macro", "meso" and "micro" levels in the health care system.[11] At the macro level, the principle applies to decisions taken by governments and health departments as to how budgets are allocated. At the institutional or meso level (hospitals, health care networks, etc) administrators must take account of this principle in determining resource allocations. Less evident (or even denied by some doctors) is how this principle applies at a micro level in each patient–doctor interaction in daily practice. In simple terms, where health care budgets are finite, money spent on one patient means less money available to another patient. To date, the medical profession in Australia has been able to avoid engaging in a meaningful debate of these issues at the micro level and instead has emphasised the role of the doctor as the patient advocate, "fighting" for access to health care for "their" patients, using the notion of patients' "rights to health care".

If justice is becoming a more influential ethical principle, who should take responsibility to show leadership in helping the profession to adjust to this change? In my view, those appointed or elected to leadership positions in the profession must take this responsibility. The adjustment will not be easy, as most doctors are sincere in their role as patient advocates and have no access to information that meaningfully demonstrates the effects of their decisions about investigations and treatment of one patient on the entire health care system. Such leadership will take considerable moral courage, but to be responsible for a changed attitude that eventually makes it comfortable for any doctor to discuss resource issues in addition to rights and needs with their patients, as well as

The World Medical Association Declaration of Geneva, adopted in May 2006

At the time of being admitted as a member of the medical profession:

I solemnly pledge to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude that is their due;

I will practise my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets confided in me, even after the patient has died;

I will maintain, by all means in my power, the honour and noble traditions of the medical profession;

My colleagues will be my sisters and brothers;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I will maintain the utmost respect for human life;

I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

I make these promises solemnly, freely and upon my honour. ◆

to be responsible for renewed community respect and confidence in the medical profession, will be the reward. Doctors who appreciate these ethical issues are also likely to be more confident and better equipped to participate effectively in working in teams and working with managers of health care institutions.

At the international level, an opportunity for such leadership has recently been missed. The World Medical Association released its Declaration of Geneva (Box) in May 2006 as a modern version of the Hippocratic Oath. Imagine how much more powerful the Declaration would have been if it had included the words:

> Despite my patient being my first consideration, I will also seek to use resources wisely and to play a constructive part in the health care system my country chooses to establish.

Competing interests

None identified.

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