The Philosophy of Professionalism and Professional Ethics

By Prof Alastair Vincent Campbell and A/Prof Anita Ho

PROFESSIONALISM HAS become something of a buzzword in medical circles, appearing constantly in guidelines for medical training at both basic and specialist levels. But how do we teach, assess or practise "professionalism"? Is there a consistent understanding of what the word means and what it requires of those practising medicine?

One way of finding a consistent usage is to look at the root meaning of the term *profession*. To "profess" is to make a public declaration or commitment according to which one's actions can be judged. In the case of medicine, the commitment is clearly spelled out in all the medical codes: To put the welfare of patients above personal advantage. Thus a medical professional is someone who can always be trusted to honour this commitment. This fundamental requirement stems from the vulnerability created by illness, injury or disability, which prevents people from safeguarding their own interests during their interactions with doctors.

Every aspect of professionalism flows from this commitment, since it requires adequate and up-to-date knowledge, appropriate and effective skills, and a consistently caring and respectful attitude towards all patients without fear or favour. However, while such a definition of professionalism in medicine may be clear and (possibly) incontestable, the problem lies in its detailed specification and its implementation in medical training and in the assessment of professional or unprofessional attitudes and behaviour. In Singapore, there is widespread debate and uncertainty about what should be taught and whether professionalism can be assessed in a fair way. Moreover, radical social changes have made this task even more difficult.

Evolution of the healthcare landscape

Firstly, there is an ever–increasing commodification of healthcare. Patients have become "consumers" and healthcare professionals "providers" in imitation of the market in which the principle, caveat emptor, is thought to ensure protection. Related to this is an increasing tendency for medical graduates, heavily in debt from the high cost of their education, to look for the best ways of increasing

their income while running the risk of putting "profit before patients". In addition, the advent of the internet has resulted in patients feeling much more informed about what used to be "medical mysteries", and thus likely to be less convinced of the adequacy of the treatment or medical advice they receive. As medical technologies progress, patients and families may demand more treatments, sometimes raising cost-benefit concerns and imposing additional challenges of balancing various professional duties.

There are clear moral gains from some of these changes, particularly in the demise of old-style paternalism, in which patients were expected to submit passively to the unquestioned authority of doctors, who always knew what was best for them. In the era of patient-centred care and shared decision-making, patients (and their families) are increasingly partnering with their physicians in making medical decisions. However, the obverse of this moral gain in the context of commercialisation is a potential erosion of professionalism in medicine. Patients who can afford private healthcare become vigilant purchasers – ready to complain if their demands are not fully met. Responding to this opportunistic environment, some doctors who started off as idealistic medical students become high-earning technicians, who cater to patient demand at whatever rates the market can sustain. Others who remain service-oriented and work in the public system, face the challenge of respecting patients' and families' wishes while balancing their professional obligation to be responsible clinicians and good stewards for healthcare resources.

Nonetheless, few, if any, medical encounters genuinely fit this market model. A Google search is no substitute for years of medical education; and patients (in most situations) are bound to be anxious, vulnerable and dependent, instead of impartial assessors of the "best buy". Thus, the notion that healthcare provision is a straightforward market, whether coming from physicians or patients, is a dangerous fiction.

Tackling these issues

So how can these new challenges best be met? Clearly, simplistic formulations of ethical principles (such as the much quoted four principles of Beauchamp and Childress) are not up to the task, especially when medical students and junior physicians witness the "hidden curriculum" on the ground, where norms and values transmitted to trainees often undermine the formal messages of the declared curriculum. The problem is not a lack of knowledge of what constitutes professional behaviour, although clearly practitioners do still need to study ethics, develop skills in ethical reasoning and gain knowledge of the legal requirements of their practice. Similarly, professional codes of practice, though essential to establish clear and adequate sanctions to discipline errant practitioners, do not in themselves create trustworthy professionals. Instead a two-pronged approach seems required.

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Firstly, we need to reform the environment in which healthcare is delivered to ensure that there are no perverse incentives or external pressure to foster unethical behaviour. For example, if the only way a practitioner can make an adequate income is by overprescribing or recommending unnecessary treatments or tests, then it is hardly reasonable to expect self-sacrificial professional behaviour. Secondly, as all the literature consistently demonstrates, professionalism (or the lack of it) is learned by example – through role modelling. Theoretical knowledge of what professionalism means will not promote good behaviour, especially if trainees consistently observe unprofessional behaviours in their senior mentors.

In philosophical terminology, professionalism relates to virtue ethics, the character of moral agents; and this is not intellectual cleverness but "habits of the heart", engrained ways of acting that ensure a sustained commitment to patients. In the last analysis, then, the survival and full flourishing of professionalism will depend both on the political commitment of doctors to an equitable system of healthcare and on the profession's ability to supply teachers at all levels of training, who inspire their students to emulate them and to be resistant to countering forces.

There is no primrose path to professionalism; it can come only from the constant self-reflection and self-renewal of the profession itself. ■

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