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Professionalism in Medicine; the transition of a movable feast and its implications for clinical and educational practices

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Literarily, a profession means a type of job that requires special education, training, or skill; a professional is a member of such a profession; and professionalism is the demonstration of competence expected from a professional. Professionalism in medicine, however, has been defined with a different connotation¹; it is generally agreed that professionalism in medicine encompasses a set of attitudes, e.g. collegiality, respecting patients' autonomy, values, e.g. honesty, integrity, accountability and behaviours, e.g. teamwork, communication, reflective practice, which are associated with the practice of medicine². It is meant to be a profession that practices and displays high standards in these aspects by means of self-regulation¹.

Historically, however, the medical profession has been responsive to changing needs and expectations and adaptive to different contexts and cultures^{3,4}. Therefore, it has no concrete and universal definition and is characterised by dynamism in defining its standards⁵. For example, in the infancy of allopathic medicine, 'doctors' were no different from soothsayers as they lacked knowledge on the basic, applied and clinical sciences underpinning their decisions and practices. The Hippocratic Oath emphasised the nobility of medicine as a profession by advising the members of the profession on three important elements: to do no harm', to work for the betterment of the profession, and to engage in 'evidence-based practice'⁵. In the 18th and 19th centuries, the surge of technology and knowledge created by the industrial revolution led to considerable advances in medicine. Professional standards for doctors emerged in this period, especially in the western world. This facilitated the protection of medicine as a profession against the threat of it becoming an industry⁵. Professional codes emerging in many countries during the last three decades suggest that the main focus of medical professionalism is on protecting patients from the conflicts of autonomist, commercialist and consumerist interests within the profession^{6,7}. As a result, the practice of medicine initiated a transition from: detachment to empathy; paternalism to emotional engagement; restricted communication to open and patient-centred communication; and medical beneficence as the most expected ethical principles to patient autonomy⁸.

Throughout the history of medicine, professionalism has acted as a social contract between doctors and society to maintain public trust in the profession⁹. Therefore, in medicine, the validity of the notion that a person who enters into the profession

automatically becomes a professional, i.e. an individual attracts respect and reputation by entering a respectable and reputed profession, is negligible. Rather, professionalism of individuals, i.e. the respect and reputation earned by individuals, who enter into the profession, indorses the process of 'professionalization' of medicine. This is an affirmation of the quote "Professional is not a label you give yourself – it's a description you hope others will apply to you" by David Maister, who is a former Harvard Business School professor.

Self-definition and self-regulation of standards is becoming increasingly challenging with the expansion of the medical profession, the increasing diversity of personalities and expectations of people selecting medicine and changes in the socio-economic environment. The overemphasis of the vocational element of medicine but sub-optimal expression of self-regulation, both in practice and in education, has been recognised as an almost global phenomenon in the recent past¹⁰. As a result, medical professionals have faced uncomfortable but unavoidable questions about 'professionalism'. Therefore, the traditional definition of fitness to practice medicine, as the presence of necessary skills and the absence of physical or psychological impairments (i.e. the doctor as a competent person), has been transformed to encompass professionalism (i.e. the doctor as a professional person)¹⁰. Many regulatory and professional bodies¹¹⁻¹³ not only in the West but also in the eastern parts of the world¹⁴ have adopted and embraced this significant and important change in order to prepare the medical profession for the demands of the new millennium. They believe that, in the current context, professionalism is the habitual and judicious use of multiple skills namely, communication, cognition technical skills, clinical reasoning, emotional intelligence, the values of the professional concerned and the reflection in daily practice¹⁰. It is normatively defined by all stakeholders based on the benefits to the individual and the community being served¹⁰.

During the last two decades, the notion of 'defining professionalism by all stakeholders' was the focus of many researchers who worked on professionalism. Complying with this conceptualisation, in our own research, we explored the importance of different attributes of professionalism from the perspective of the public and also of medical professionals. Our study with the UK general public¹⁵, which is the only study in published literature which gathered the perceptions of a nationally representative sample, was participated by 958 members of the public. It demonstrated that the public identify three facets to professionalism. Certain essential attributes were related to the doctor-patient relationship (clinicianship), e.g. respecting a patient's autonomy, being empathetic when caring for patients, communicating in a clear and effective manner, treating patients fairly and without prejudice. Another group of essential attributes reflected the relationship between doctors and their co-workers (workmanship), e.g. working well as a member of a team, treating other healthcare professionals fairly and without prejudice, reflecting on one's actions with a view to improvement, being able to manage situations where there is a conflict of interest.

Finally, there were those attributes relating to doctors in society (citizenship), e.g. functioning according to the law of the country, expression of honesty and integrity, avoiding substance or alcohol misuse and being accountable for one's actions. It was

revealed in the follow up discussions with the public that, contrary to what really happens in our context, the public felt that if a doctor commits an offence, he/she should be punished more severely than a layman, as doctors always need to be exemplary in society. Furthermore, the findings of this study challenged the common belief that personal appearance, including dress code, flaunting one's wealth and conforming to social norms are important to become a 'doctor'. In a subsequent study¹⁶, we gathered the perceptions of 584 clinicians and medical educators from different parts of the world, e.g. the UK, Europe, North America and Asia. The participants of this study demonstrated the widest cultural and geographical diversity in a published study on professionalism. Several Asian participants were from Sri Lanka. In general, their overall conceptualisation of medical professionalism demonstrated an appreciable amount of overlap with the public model. The probable conclusion is that, as a profession, medicine is still conscious of public expectations and maintains its social contract with the public.

The responses of the medical practitioners from different geographical regions on the essentialness of individual attributes reflected important similarities and differences. The similarities depicted the core values of practicing allopathic medicine wherever in the world, e.g. moral behaviour, reflective practice, lifelong learning, empathic and caring attitude. These similarities may be simply due to a western influence on an eastern 'definition' of professionalism or vice versa. Whatever the reason, it was encouraging to observe that these universal attributes of professionalism were largely in concordance with the expectations of regulatory and professional bodies worldwide. The differences may be explainable by socio-economic and cultural variations between the geographical regions they represented. For example, to North American medical professionals, being altruistic was more essential than looking after their own health and wellbeing; to the UK medical professionals, their own health and well-being was more essential than altruistic attitudes. This may well be attributed to the fee structure of the two healthcare systems. In North America, patients personally pay for their healthcare, but in the UK patient care is funded by the state. It is plausible that the North American doctors feel they should at least demonstrate that they are altruistic. The necessity of 'acting with confidence when conducting one's duties' to Asian medical professionals, but not to others, may reflect socio-cultural differences. The notion that 'the doctor knows best' is still deeply rooted in Asian societies and demonstrating confidence may be a determinant of a 'good' doctor-patient relationship. However, in an environment where patient safety is at the heart of regulatory and legal frameworks¹², doctors in western countries may need to portray themselves as safe rather than confident practitioners. Regardless, certain responses were counter-cultural; medical practitioners attempted to break cultural barriers to provide better healthcare. For example, Asians, who are considered culturally to have less flexible attitudes¹⁷ indicated that adaptability to workplace changes should be an essential attribute of professionalism.

This study was a clear demonstration of the contextual and cultural sensitivity of professionalism and cast doubt on the success of implementing an 'imported framework of professionalism', e.g. using western concepts in the East. It was confirmed in a Delphi study which we conducted with a group of medical practitioners in the Gulf region to determine the applicability of the western concept of professionalism to the Arabian context¹⁸. Although certain aspects of the western concepts were acceptable, there were

important differences. The value of autonomy of practitioners, i.e. the authority of doctors to take decisions for patients, was important to medical practitioners in the Gulf region in contrast to patient autonomy, i.e. empowerment of patients in taking decisions, which is valued by their western counterparts. Therefore, adaption rather than adoption is a key message if a foreign framework of professionalism is to be implemented in a local context. Although these studies were extremely useful to understand the general scope of professionalism from the perspectives of practitioners as well as the public and its sensitivity to socio-cultural factors, the findings need to be supplemented with studies exploring the actual practice of professionalism at ground level. Accordingly, using a qualitative methodology, this study explored the help-seeking behaviour of doctors in making clinical decisions which is identified as a professional attribute of responding to one's own limitations¹⁹.

Our study included 51 Scottish and Irish surgical trainees from five surgical specialties and at different levels of training. The study revealed that seeking help from superiors for decision making was not simply a way of dealing with one's limitations but could also be a 'political exercise' to maintain rapport with supervisors. Therefore, the act of a trainee approaching a trainer to seek help may be merely a 'demonstration' of professional behavior rather than a true indication of his/her instinctive professional behaviour. Moreover, the translation of this attribute to practice would not be universal to every trainee and is related to the trainees' level of experience, competence and confidence; trainers' rapport with trainees, approachability and accessibility; workplace environment factors such as time of the day, complexity of the procedure; and patients' clinical condition and attitudes.

The propensity to seek help when faced with own limitations was high if trainees possess a clearer insight into their own abilities, the expectations of the consultants and the anticipated outcomes of a given patient. However, the working environment would also play a key role. Seeking help will be hindered by trainees' fear of showing weakness to their superiors or being reprimanded for seeking help, trainees' desire to develop their own decision making/technical skills and any negative experiences in seeking help. The common dilemmas of seeking help include difference of opinion between consultants and trainees' desire to develop their own skills versus seeking help from consultants. Therefore, the overall message revealed by this study is that professional behaviour in actual practice can be instinctive or demonstrative; the workplace environment and culture and intra-personal and interpersonal factors play a vital role in the development and fostering of professionalism and in translating it into practice.

The effect of a professional environment in the clinical setting may influence the development and practice of professional behaviour among medical students, which was the next focus of my research²⁰. I am involved in an international multi-centre programme of research exploring professionalism dilemmas faced by medical students. The participants are medical students from Sri Lanka, the UK, Australia and Taiwan. In the initial part of the study we analysed personal incident narratives of 64 Sri Lankan medical students and determined that there are a wide range of lapses in professionalism seen in the clinical environment. The lapses observed by students were

related to communication, respect towards patients, accountability, integrity and probity, inter-professional relationships, compassion and care, acting within limitations, commitment to their duty, managing conflicts of interests and ethical conduct among doctors in different grades. Although the broad areas were common to many countries, there were variations in the nature of such lapses. According to Sri Lankan medical students, the professionalism lapses they observed have seemingly caused a variety of adverse patient outcomes: psychological distress, suboptimal treatment and even suicidal thoughts and unwanted deaths. In almost all instances, incidents were not reported, discussed or reflected upon to prevent future occurrence. Medical students appeared to suffer from high levels of moral distress by observing professionalism lapses but tended not to express their concerns due to their lowly status within the hierarchy. Such situations may have an adverse impact on the development of professionalism in medical students.

There are several implications of understanding professionalism to clinical practice and medical education. The insights gained from similar studies to those described above have been translated into practice in many countries. As a result, the self-regulation of the medical profession has been exposed to regular public scrutiny to ensure public trust in the profession²¹. These insights should also be transferred to all levels of medical education (undergraduate, postgraduate and continuing medical education). A lecture delivered in a classroom setting may be useful to introduce the expectations of professionalism to undergraduates but they will not be fully grasped by students until they experience these attributes being practiced, encouraged and rewarded in the clinical environment.²² Therefore, every clinician who shares the working environment, with or without a specific educational role, knowingly or unknowingly contributes to fostering professionalism among their colleagues, trainees and students²². However, in our studies, it was evident that the current approach to professionalism and ethics education needs to be transformed across undergraduate, postgraduate and continuing medical education²⁰.

We explored the conventional education of ethics and professionalism in a medical school curriculum from the perspective of students²³. In this qualitative study, students expressed that the formal curriculum as a whole rewards academic abilities, primarily 'knowing' the knowledge and skills, but not the professional soundness or the behaviour of students. They were critical of the assessment-oriented professionalism curriculum and focusing more on what students 'know' than what they 'do'. Students see a discrepancy between the marks students scored in existing exams and actual professional behaviour in the ward, i.e. students who score high marks do not necessarily behave professionally. Although the professionalism curriculum provides them with sound theoretical knowledge on ethics and professionalism it is not appropriately supportive of dealing with professionalism dilemmas they face in clinical setting. With the current approach to ethics and professionalism education, despite what students learn, their moral principles appear to change over time to be compliant with the existing culture. Alternatively, students value learning professionalism from clinicians in clinical setting rather than being taught in classroom. In terms of assessment, students liked to be observed not only by their superiors but also by patients and peers for their professional behaviour. However, students have reservations about nurses

becoming their assessors of professionalism. As observed in one of our experimental studies on professionalism of foundation-year doctors in the UK in prescribing, a very small educational intervention with the participation and engagement of clinicians, e.g. a blog, yields significantly positive outcomes²⁴.

It is also important to assess professionalism explicitly based on the understanding gained, because it has been demonstrated that professional lapses during the undergraduate stage predict doctors who faced 'fitness-to-practice' issues later in their careers.²⁵ Professionalism can be assessed, for example, in OSCEs, but also needs to be observed or collated from multiple sources in the working environment to ensure its persistence.²⁶ Given the nature of the concept and the sensitivity of its consequences, it is more effective to adopt an inclusive, supportive and constructive approach to assessment of professionalism (i.e. assessment for learning) than an exclusive and punitive approach (i.e. assessment of learning).²⁷ However, as the primary role of a medical practitioner in today's context is dealing with uncertainty and making decisions,⁸ I propose that the assessment of professionalism should not be in isolation or in parallel to the education of basic, applied and clinical sciences. Rather the integrated goal of all assessments should be the progressive development of higher-order abilities, namely clinical or practical reasoning, moral reasoning, problem solving and reflective practice.

Finally, in my leading commentary to the journal, *Medical Education*,²⁸ I examined the current global trends of professional practice in the provision of healthcare and made a few assertions for the future. With increasing emphasis being placed on team-based healthcare delivery and the patient as the primary focus rather than the practitioner, professionalism will evolve from its current role of defining the boundaries of individual healthcare professions to breaking the boundaries between them. The point of dialogue will shift from professionalism in medicine to healthcare professionalism.

As I have discussed in my leading article in the *Ceylon Medical Journal*,²⁹ the emphasis on professionalism is a growing trend, not only in Sri Lanka but also in the eastern parts of the world in general. With the rapid expansion of an empowered and knowledgeable society and globalisation of the healthcare profession, the day that Sri Lankans embrace this trend cannot be too far away. It is important to adapt the concept of professionalism to suit the social, cultural and economic realities of the Sri Lankan context, whilst upholding its guiding principles, rather than adopting the western concept simply because it is western. This needs willingness and openness to self-reflection, creating dialogue and research. What the future holds for Sri Lankan doctors in terms of public expectations of professionalism should be seen as challenge rather than a threat. It will strengthen the profession if these expectations are satisfied willingly. Amidst the technological and scientific revolutions currently taking place in the field of medicine, professionalism, the social contract between doctors and society, has been and will be the indicator of a civilized and an exemplary medical profession. The responsibility of this contract lies with each and every member of the profession, to be handed over, further enhanced, to prospective future generations.

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