Introduction

Concerns have been raised, both within and outside medicine, that physicians and the medical education system have lost their commitment to medical professionalism. One senses that in the perennial struggle between self-interest and altruism self-interest may be winning out. The realities of today's medicine, including commercialism, conflicts of interest, decreased autonomy, and increased oversight, have led to the erosion of the idealistic values expected of physicians since the conception of the Hippocratic Oath. This attrition of professionalism has, in turn, led to renewed calls to refine how professionalism is taught in medical schools. Many organizations, including the Association of American Medical College, the Accreditation Council for Graduate Medical Education, and the American College of Physicians have advocated initiatives to emphasize professionalism in medicine and medical education.

Despite the calls for change, challenges remain about how an ethos of professionalism should be inculcated in doctors-in-training. Professionalism is taught in the explicit and the implicit curriculum in most medical schools. Early in their education, students are first taught professionalism through the explicit curriculum. This occurs mainly during lectures, small group discussion and isolated events, including the ''white coat ceremony.'' The challenge with learning professionalism in these settings is manifold. The explicit curriculum (1) may not be consistently and readily integrated with the four-year curriculum; (2) may be overly simplistic; (3) tends to focus more on the negative aspects of professionalism (such as using lists of rules and behaviors and describing the negative consequences of bad actions); and (4) lacks a single resource or text used for teaching students about medical professionalism. Perhaps the greatest challenge of learning professionalism is that the behavior stressed in the classroom setting is only partially corroborated by the students' experience in the clinical setting. As students advance in their training, learning professionalism skills increasingly occurs through the implicit, or

hidden, curriculum. Values that were learned in lecture, small groups, and ceremonies become less memorable as students are more influenced by what they observe first-hand. Unfortunately, many of these first-hand observations are not ideal. Students often complain that a significant number of their educators display unprofessional conduct. The adage ''do as I say, not what I do'' well describes the conflict students have as they consider both their lessons learned in the classroom and in real-world settings. The cognitive dissonance generated through exposure to unprofessional behaviors in the hospital and outpatient setting frustrates and confuses students, and the behaviors observed trump those of the explicit curriculum every time!

Another challenge to teaching about this subject is gaining a common understanding of what the term *professionalism* means. Many physicians claim to ''know it when they see it,'' yet when pressed have difficulty defining it. Each profession – the clergy, law, engineering, architecture, and the multiple professions of medicine – has at its foundation a social contract between that profession and society. From this perspective, professionalism may be defined as the means by which members of that group fulfill the obligations of that profession's social contract. In the case of medicine, several benefits may follow from the contract. One benefit is that the profession is permitted to autonomously set expectations and guidelines for the field, while it regulates and disciplines physicians when deviation from standard practices occur. The returned benefit for society from the social contract is that it can then trust that physicians will be capable, moral, accountable, and will act in the best interest of those whom they are serving.

Our primary goal in the creation of *Professionalism in Medicine: A Case-Based Guide for Medical Students* is to give medical educators and medical students a resource that can be useful throughout the four years of the medical school experience. We aim to facilitate discussion and further understanding of a wide range of topics within the domain of medical professionalism. Following a review in **Part I** on how professionalism has been defined, the book is organized around a collection of cases, commentaries, and literature reviews. The seventy-two cases portray real life medical challenges that are relevant to the experiences of medical students. Many of the cases focus on ethical dilemmas where there is no clear resolution. Some are dilemmas encountered where solutions may be easier, but other issues arise that demand deliberation. And still other cases broach topics where students and physicians struggle with the friction between the patient's welfare and the practitioner's own self-interest. Through applying clinical judgment and fundamental ethical and professionalism principles, the commentators explore reasoning behind and potential approaches to the case dilemmas.

The organization of this book is based on a view of professionalism described in the publication *Medical Professionalism in the New Millennium: A Physician Charter* (Ann Intern Med 2002:136:243–246). Developed by the American Board of Internal Medicine, the American College of Physicians, and the European Federation of Internal Medicine, the Charter has been endorsed by specialties throughout the world and in all fields of medicine. The Charter recognizes a set of three principles and ten professional responsibilities that must be practiced by the medical profession and understood by society (see Table). Such an expansive set of ideals, avowed by each physician, allows the public to place their trust in an ideal or virtuous physician.

The Physician Charter

Fundamental Principles
Principle of primacy of patient welfare
Principle of patient autonomy
Principle of social justice

Set of Professional Responsibilities
Commitment to professional competence
Commitment to honesty with patients
Commitment to patient confidentiality
Commitment to maintaining appropriate relations
Commitment to improving quality of care
Commitment to improving access to care
Commitment to a just distribution of finite resources
Commitment to scientific knowledge
Commitment to maintaining trust by managing conflicts of interest
Commitment to professional responsibilities

Very early in their medical education – with the start of anatomy dissection or with the first patient interview in front of the class – students realize that even this stage in their education presents encounters with ethical meaning. In **Part II** of the book, medical students are the central characters in cases. Each of the thirteen areas of the Physician Charter is explored by two cases, one in which the student is at an earlier stage in his or her medical education, and one later. Following each case, two commentaries are written, one authored by a faculty member and another by a medical student. Many of the cases raise issues asking students to balance their own health and welfare, their own expectations, or their own educational needs with the needs of their patients and with their vulnerable status in the academic educational hierarchy.

Students aspire to learn from situations in which doctors have the leading role. The cases in **Part III**, the main section of this text, shift to vignettes based on situations that physicians across medical specialties encounter. This section comprises forty-two cases, each followed by two commentaries that explore eight of the thirteen areas of professionalism in the Physician Charter: the three principles (patient welfare, patient autonomy, and social justice) and five of the professional responsibilities (honesty with patients, patient confidentiality, improving quality of care, managing conflicts of interest, and professional responsibilities). Following each case, two commentaries are authored. The first, a physician commentary, is written by specialists from family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, surgery, neurology, and emergency medicine. The physician-commentator briefly describes the clinical issues that are relevant to render a judgment, explains the salient professional issues to be considered, and offers an opinion about how they would proceed with resolving the dilemma.

A second commentary is included because it is important to understand that perspectives and approaches to the cases will differ. The authors of these commentaries represent a wide variety of voices, each with a stake in health care decisions. These authors include ethicists, lawyers, psychologists, nurses, social workers, pharmacists, health administrators, health service researchers, patient advocates, and other medical educators. Family members of patients also comment on several of the cases. A unique format for learning about medical professionalism has been created with the video production of eight of the cases. These cases are brought to life by specially trained standardized patients from the Rector Clinical Skills and Simulation Center at Jefferson Medical College of Thomas Jefferson University. For access to the videos and more information on medical professionalism, see http://professionalism.jefferson.edu/.

Professionalism requires not only allegiance to the qualities discussed in the Physician Charter, but also an understanding of the medical literature and an awareness of where opinions originate. With this in mind, each of the eight areas of medical professionalism in **Part III** includes a comprehensive literature-based review of that topic. The authors also reflect on the commentaries and connect these writings with current literature.

Learning medical professionalism is a challenging, evolving, lifelong endeavor. *Professionalism in Medicine: A Case-Based Guide for Medical Students* will help this process by engaging students and their teachers in reflection on and discussion of cases that will resonate with life experiences. If this text, reinforced by appropriate clinical role models, fortifies the aspirations of future physicians to practice medicine guided by the precepts of professionalism, we will have achieved our purpose.

PART ONE

Defining Medical Professionalism

1 Defining, Teaching, and Learning Professionalism

Professionalism is frequently described as the fundamental core of medicine. This chapter discusses the importance of professionalism, its historical contexts, the current challenges, and the Physician Charter[1] as a worldwide medical response to these challenges. The chapter also examines and elaborates on other definitions of professionalism, explores how professionalism is acquired and strengthened, and summarizes current medical education approaches to promoting professionalism.

PROFESSIONALISM TODAY

Why Is Professionalism Important?

The Physician Charter avers in its preamble that ''professionalism is the basis of medicine's contract with society.''[1] This pact or agreement denotes a reciprocal, though tacit, relationship between the public and the medical profession. The public gives physicians rights and privileges in return for their adherence to values that enable them to protect the public health, which is vital to the very existence of society itself. That is, in exchange for authority to control key aspects of their working conditions, the public expects physicians to maintain high standards of competence and moral responsibility. According to the Charter, trust is essential to this contract.[1] Public trust depends on whether the actions of physicians and their leaders demonstrate the values of medical professionalism.

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Why Is Professionalism Increasingly Important?

Healers across time and cultures have embraced the values of professionalism. Derived from the need to care for the sick, professionalism in Western societies expanded in Hellenic Greece to include service and in medieval England to include obligations to society and individual patients. In the early 1900s William Osler reminded physicians in North America and Britain that medicine is a calling, not a business. He also stressed the role of empathy in doctoring. Later, leading the charge to reform medical education in the United States, Abraham Flexner added excellence and self-regulation to the notion of medical professionalism. As medicine increasingly relied upon science, expertise became an ever greater part of professionalism. In the last two decades of the twentieth century, the American Board of Internal Medicine (ABIM) reintroduced the notions of service and caring, and triggered a growing movement to reaffirm the importance of professionalism in medicine in both the United States and abroad.[2]

Why has this groundswell for professionalism emerged among physicians and the public alike? Authors of the Physician Charter note that physicians everywhere face unprecedented challenges that endanger the existence of medical practice as a profession.[1] These challenges involve the changing nature not only of medicine, but also of health care systems, resources for health care, physicians, and even patients.

Advances in medical technology and our increased reliance on it in patient care, for example, have diminished physicians' expression of humanism.[1,3] With the enormous advances in medical science have come significant progress in helping the sick, as well as heightened anxiety about the efficacy and safety of procedures and powerful drugs.[4] Technology has outpaced our ability to use it wisely.

Importantly, health care has become a business where commercial values clash with those of the profession.[1,5–9] Health is a commodity to be bought and sold to customers where market forces dictate health care delivery. Consumer and physician media marketing have influenced and perhaps corrupted medical decision making. Other highly skilled health care professionals compete with physicians for the health care dollar. Bureaucracy, at times, trumps patient care. Limited resources fail to meet patient needs, and result in unequal access to and coverage for health care.[1,6] These colliding forces have led to rising health care costs with an added pressure to contain costs.[1,7]

The intentional and unintentional acts of physicians themselves have markedly contributed to the interest in medical professionalism among physicians and the public.[7,10,11] Faced with the above changes in medicine,

health care delivery, and resources, physicians have found it increasingly difficult to meet their responsibilities to patients and society.[1] They did not anticipate and adapt to the changing context of medical practice.[6] They were reluctant to become socially engaged[12] and address the injustices in health care,[13] and they placed undue emphasis on income and power to the detriment of patient welfare and the primacy of the patient's interest.[1,13] They failed to regulate themselves and allowed incompetent and unethical physicians to continue to practice medicine.[10,12–14] In addition, a younger generation of physicians favors a more balanced lifestyle.[4] In these ways, physicians themselves have contributed to the rising interest in professionalism within and without the profession.

For their part, patients have heightened expectations for the efficacy of medicine, while disparities among the legitimate needs of patients grow.[1] With greater access to medical information[4,8] and the rise of patient choice and empowerment,[7,8] patients have become dissatisfied with physicians and medical care. Moreover, there is a generalized mistrust in society today. This mistrust not only transcends the profession of medicine, but targets it as well.[6]

As a consequence of all these factors, external oversight and other outside influences have become more dominant in health care. This, in turn, has made it more difficult, yet more important, to maintain a commitment to medical professionalism.[12,15]

What Is the Physician Charter?

In response to the challenges facing the medical profession, authors from the United States, Canada, and Europe developed and propagated the Physician Charter, which enunciates three principles of medical professionalism and specifies ten professional responsibilities.[1]

The *primacy of patient welfare, patient autonomy, and social justice* constitute the Charter's principles. The principle of patient primacy contributes to patient and societal trust by ensuring that ''the interest of the patient'' will not be compromised by ''market forces, societal pressures, and administrative exigencies . . .''[1] The principle of patient autonomy requires physicians to be honest with their patients and to empower them so they can make informed and appropriate decisions about their own care. The principle of social justice demands that the profession promotes the fair distribution of health care resources and works to eliminate discrimination in health care.

Among physicians' professional responsibilities are those that focus directly on their *commitments to patients: to be honest with them, safeguard*

patient confidentiality, and maintain appropriate relations with patients. Honesty requires that patients understand their condition and treatment. It involves telling patients about medical mistakes, should they occur, and reporting and analyzing mistakes to prevent them in the future. Patient confidentiality extends to persons acting on a patient's behalf when the patient cannot give consent. Commitment to confidentiality is more important than ever because of electronic information systems. However, physicians must recognize that considerations in the public interest must occasionally override confidentiality.

Several other principles in the Physician Charter refer to broad social issues such as *commitment to improved access to care and just distribution of finite resources*. Physicians must strive to eliminate barriers to health care, so that uniform and adequate care is available. Commitment to equity in care entails promotion of public health, preventive medicine, and public advocacy without concern for self-interest of the physician or the profession. A just distribution of finite resources requires physicians to develop guidelines for cost-effective care and scrupulous avoidance of unnecessary tests and procedures.

The remaining principles relate to the collective responsibilities of the profession. These include the *commitment to professional competence, improvement of the quality of care, and scientific knowledge*. They also include *commitment to the management of conflicts of interest and discharge of professional responsibilities to the profession and its members*. Regarding professional competence, physicians themselves must engage in lifelong learning; the profession as a whole must ensure that the means exist for all of its members to achieve professional competence. In addition, physicians must be dedicated to improving quality of care by working with other professionals to increase patient safety and optimize outcomes of care, by developing and using better measures of quality, and by creating better mechanisms to encourage continuous quality improvement of care. The commitment to scientific knowledge entails the duty to uphold scientific standards, promote research, create new knowledge, ensure its appropriate use, and guard the integrity of medical knowledge. To maintain public trust, physicians and their organizations must recognize, disclose, and deal with conflicts of interest that arise in the course of their multiple activities. Professional responsibilities include collaboration to maximize patient care and respect for one another. Other responsibilities address standard setting for current and future members of the professions and self-regulation, including remediation and discipline of members who have failed to meet professional standards. A final aspect of professional

responsibility is the acceptance of internal assessment and external scrutiny of all aspects of professional performance.

How Have Others Explained Medical Professionalism?

Teachers, clinicians, and learners have struggled with the meaning of professionalism because it is a complex multidimensional concept.[16] Frequently they say they cannot define it but know it when they see it. However, scholarship in the social sciences and medicine has produced more systematic explanations of medical professionalism that can enable medical faculty, practitioners, and physicians-in-training to better understand its meaning.

In the social sciences, early theoretical analyses of occupations distinguished the professions from other types of work and identified medicine as the prototype profession. The features of a profession were: a specialized body of knowledge, the altruistic service to patients and society, the right to establish practice standards for its members who maintain them through self regulation, and the responsibility to guard the integrity of the profession's knowledge and its use.[16] The nature of the relationship between client and professional was key. In the specific case of medicine, the placement of the welfare of the patient above self-interest was a central and positive feature of the profession.[11,17]

In medicine, the American Board of Internal Medicine (ABIM) contributed to delineating professionalism through its project on humanism.[18,19] The Board identified three humanistic qualities that a physician should bring to the profession of medicine: integrity, respect, and compassion.[18,19] In the mid-1990s, it defined professionalism per se in terms of aspiration to altruism, accountability, excellence, duty, service, honor, integrity, and respect for others.[20] It noted that altruism – serving the best interests of patients, not self-interest – is the essence of professionalism. It also listed challenges to professionalism such as greed, arrogance, and impairment.

By the end of the 1990s, the Accreditation Council on Graduate Medical Education (ACGME) designated professionalism as one of six core competencies for resident physicians to demonstrate. It specified professionalism as ''a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.''[21] About the same time, the Association of American Medical Colleges (AAMC) published a normative definition of professionalism to assist medical schools with understanding and assessing professionalism.[22,23] It listed nine behaviors necessary for physicians to exhibit in order to meet their obligations to patients, communities, and their profession.