Introduction

A profession sets standards of competence and behaviour and is self-regulating. The administration of the Hippocratic Oath is the student’s introduction to the ethics and behaviour expected of a physician. The public believes that the profession has the Oath as the ultimate guide for physicians. Such codes of behaviour are characteristic of professions and over the centuries, the Oath has been modified to reflect the changing mores of society.

At the same time, the business of medicine has produced guidelines of behaviour between physicians and their patients that indicate how to practice medicine and these are used to govern medical practice. These guidelines have often been made into standards and regulations. The public has trusted that the profession applies these standards and ensures the proper practice of medicine.

Legislation governing medical practice is nothing new. The first example is seen in Mesopotamia, Babylon, whereby the ruler Hammurabi 1728–1686 B.C. had a code that applied to many legal matters including land-owning, divorce, boat building while a few deal with medical practice. For instance, regulations set the fees for treatment as well as the penalties for failure depending on the rank of the patient. This code is in the Louvre, Paris.

“If a physician has performed a major operation on a lord with a bronze lancet and has saved the lord’s life . . . he shall receive ten shekels of silver; but if he caused the death of such a notable, his hand would be chopped off. A doctor causing the death of a slave would have to replace him.”

The modern code of ethics emerged in the 18th century with John Gregory (1724–1773) a Scot who became Professor of Physic at Edinburgh. He would lend his students his lecture notes and one of them arranged their publication in 1770. “Offices on the Duties and Offices of a Physician, and on the Method of Prosecuting Enquiries in Philosophy.”

In this, he advised on the moral qualities of a physician. The chief is humanity—“that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites us in the most powerful manner to relieve them.”

He drew attention to sympathy, gentleness of manners and compassion. He advised that the physician develop a composure and firmness of mind so as not to be enervated. This was what was to be known as Osler’s Aequanamitas.¹

The Profession of Medicine

Medicine is the branch of health science and the sector of public life concerned with maintaining or restoring human health through the study, diagnosis, treatment and possible prevention of disease and injury. It is both an area of knowledge—a science of body systems, their diseases and treatment — and the applied practice of that knowledge.

The practice of medicine combines both sciences as the evidence base and art in the application of this medical knowledge in combination with intuition and clinical judgement to determine the treatment plan for each patient.

Central to medicine is the doctor-patient relationship established when a person with a health concern seeks a physician’s help; the ‘medical encounter’. Other health professionals similarly establish a relationship with a patient and may

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perform various interventions, e.g. nurses, radiographers and therapists.²

Values in a Doctor

High standard of ethics
From the time of Hippocratic oath, medical practice has always had a very strong ethical foundation, and rightly so, as it is one of the key features of a profession. More than ever, the ethical principals associated with clinical practice need to be debated and clarified. New procedures and ethical dilemmas arise constantly. Greater public awareness of the issues means that the debates are no longer confined to professional audiences and it is appropriate that the wider public is included. There is greater scrutiny of professional practice, and standards are now openly discussed in the media and public fora. The profession has nothing to fear from such debates as long as it is not defensive or secretive.

Continuing professional development is an issue, which is broader than continuing education. It is concerned with personal growth and satisfaction with professional work. It is an issue, which has been neglected, in recent years but, with the changing role of the consultant, it is one, which will need to be looked at afresh in the near future.

Ability to work in a team
As medicine and health care increases in complexity so it becomes even more necessary to be sure that all the skills of professions other than medicine are utilized to the full. This means working and learning in teams, but it does not mean relinquishing the key patient-doctor relationship, which is so central to the therapeutic process.

Concern with health as well as illness is a key issue. Are doctors to be concerned only with those who are ill or do they have a wider role in the community?

Patient and public focused
The purpose of medicine is precisely to do with serving the patient and the public. Perhaps we should be more willing to say this explicitly rather than implicitly. There is great energy and power in this process if it can be harnessed effectively.

Concern with clinical standards, outcomes, effectiveness and audit
More and more of the care given to patients and the treatment offered will be based on proper outcome based evidence. This is not to deny innovation or to stifle research and development. Rather the opposite. Standards record where we are now; research and innovation should take us to new levels of quality and care. It is clear from many studies that there are variations in treatment and outcomes across Britain. Some of these are understandable and explainable. Others are not. It is this aspect which from a public point of view requires resolution. Audit is a tool, which has value in measuring that quality of care provided. It is only one tool but an important one to assure quality. As part of professional practice, all doctors should be involved in auditing clinical work.

Ability to define outcomes
Outcomes in some instances are not easy to define but are an important professional challenge. The use of guidelines, which can be seen as no more than the formalization and clarification of good clinical practice, is part of the process of care and is not an end in itself. Guidelines need to be feasible, to encourage local involvement, and not to inhibit new methods of management. Rather, they should be a base from which to build. They should help us to understand and explain variations in care.

Interest in change and improvement, research and development
Medicine cannot and should not stand still. It is continually evolving and improving. All doctors need to be involved in changing and improving clinical practice. Indeed, they have an obligation to be so, though this does not mean that all need to be involved in “research.” This key value, however, emphasizes the importance of academic input and of teaching.

Ability to communicate
Of all complaints against doctors, problems of communication must be one of the greatest. Yet, it is perhaps the key part of the function of the doctor if you accept that making a diagnosis, assessing prognosis, and defining treatment are central roles for the doctors. Arrogance and discourtesy
reflect badly on a profession whose primary purpose is to care for the patients. The importance of communication (a two-way process) is increasingly being recognized in medical schools, and role models (Consultants and General Practitioners) must also recognize the effect of the “hidden agenda” (their attitudes and behaviour) on medical students and post-graduates.

Definitions

**Professionalism**

“The term professionalism is used to describe those skills, attitudes and behaviours which we have come to expect from individuals during the practice of their profession and includes concepts such as maintenance of competence, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice, respect for others, self-regulation, etc.”

“In Canada and the United States the social basis of the extraordinary grant of occupational authority and independence to professionalized occupations such as medicine and law has been a social contract between the profession and the public. Professionalism is the moral understanding among professionals that gives concrete reality to this social contract. It is based on mutual trust. In exchange for a grant of authority to control key aspects of their market and working conditions through licensing and credentialing, professionals are expected to maintain high standards of competence and moral responsibility.”

“We think of professionalism as an activity that involves both the distribution of a commodity and the fair allocation of a social good but that is uniquely defined according to moral relationships. . . . Three core elements of professionalism, each different in nature, are necessary for it to work properly. First, professionalism requires a moral commitment to the ethic of medical service, which we will call devotion to medical service and its values. This devotion leads naturally to a public, normative act: public profession of this ethic. Public profession of the ethic serves both to maintain professionals’ devotion to medical service and to assert its values in societal discussion. These discussions lead naturally to engagement in a political process of negotiation, in which professionals advocate for health care values in the context of other important, perhaps competing, societal values.”

It is clear in these statements that professionalism is above all an ethical concept. Its distinguishing features are those of a profession: a strong commitment to the well being of others, high moral standards, mastery of a body of knowledge and skills and a high degree of autonomy. These features clearly apply to the individual members of a profession. Their application to the group as a whole, including professional associations, is less evident.

**Ethics**

Put simply, ethics is the study of morality — careful and systematic reflection on and analysis of moral decisions and behaviour, whether past, present or future. Morality is the value dimension of human decision-making and behaviour. The language of morality includes nouns such as ‘rights’, ‘responsibilities’ and ‘virtues’ and adjectives such as ‘good’ and ‘bad’ (or ‘evil’), ‘right’ and ‘wrong’, ‘just’ and ‘unjust’. According to these definitions, ethics is primarily a matter of knowing whereas morality is a matter of doing. Their close relationship consists in the concern of ethics to provide rational criteria for people to decide or behave in some ways rather than others.

Since ethics deals with all aspects of human behaviour and decision-making, it is a very large and complex field of study with many branches or sub-divisions. Medical ethics is a branch of ethics that deals with moral issues in medical practice. Medical ethics is closely related, but not identical to, bioethics (biomedical ethics). Whereas medical ethics focuses primarily on issues arising out of the practice of medicine, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally.

**Ethics and Professionalism in Medicine**

Medical professionalism affects just about everybody — physicians, patients, other health providers, health care administrators, governments and the general public (as taxpayers, potential patients, relatives of patients, etc.). Some of its features may be good for some of these groups but not for others. For professionalism to be preserved and enhanced, it will likely have to be seen as serving the overall good of society, not just one or two groups.
Ethic of service

“Professionalism in medicine requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others.”

This fundamental characteristic of professionalism is clearly in the interests of patients, who are its primary beneficiaries. Society also benefits, by having those who control the knowledge and skills for providing such an essential service as medical care do so not primarily for their own gain but for the good of others. The benefit of the ethic of service to physicians is less direct but still of considerable importance. It entitles them to the trust, respect and gratitude of their patients and of society (even if these are not actually bestowed). For the profession as a whole, the ethic of service contributes to the credibility of its advocacy work.

Clinical autonomy

“Professional autonomy has been the highest ethic of the medical profession for much of the twentieth century.”

This viewpoint is reflected in the World Medical Association Declaration on Physician Independence and Professional Freedom. Although the power of physicians to control their own work and to direct others involved in the care of their patients has diminished in recent times, it still exceeds that of many, if not most, other occupations. This is clearly a desirable feature of professionalism for physicians, in that it allows them to act as medical expert and healer on behalf of their patients.

This benefit is always obvious to others. Many patients want their physician to do what they think best, not necessarily what the physician recommends. However, patients need their physicians to exercise clinical autonomy in making recommendations about what is best for them, whether or not they accept the recommendations. Hospital administrators and third-party payers may consider physician autonomy to be incompatible with prudent management of health care costs. However, the restraints that administrators and third-party payers attempt to place on clinical autonomy may not be in the best interests of the patients. Furthermore, restraints on the ability of physicians to refuse demands by patients or their families for inappropriate medical services are arguably not in the best interests of either patients or society.

Self-regulation

If there must be restrictions on their autonomy, physicians prefer that they be imposed by their peers rather than by non-physicians. They have traditionally been granted this privilege by society on the grounds that only physicians know medicine well enough to determine appropriate standards for its practice; they can be trusted to set and enforce appropriate standards of physician behaviour; and this is the most effective way for society to achieve the good it desires from medicine. In this regard, it is important to note that society has benefited from physician self-regulation too, not least because relatively few resources have to be devoted to the surveillance of physicians.

However, there have been many accusations that the profession has abused the privilege of self-regulation by failing to deal fairly with complaints against physicians. If self-regulation is to be seen as serving the overall good of society, not just that of physicians, the profession has to accept its burdens as well as its benefits, i.e., physicians have to undertake the tasks required by self-regulation, including meting out penalties to their errant colleagues, and must also be seen to do so.

William Sullivan, a prominent medical sociologist: “Neither economic incentives nor technology nor administrative control has proved an effective surrogate for the commitment to integrity evoked in the ideal of professionalism.” Without question, the medical profession itself wishes to function within a system dominated by a healthy and flourishing professionalism. As Sullivan and Friedson points out, there should also be substantial advantages to society in preserving professionalism as an effective value-based system. The original reason for the use of the profession as a means of organizing healthcare was because of the complexity of the knowledge base, the difficulty in regulating it, and the presumption that the profession would be altruistic and devoted to the public good. We believe that nothing in the past 150 years has altered that fact. Thus, both society and the profession should wish for the same type of physician — competent, moral, idealistic and altruistic. This is best guaranteed by
a healer functioning as a respected professional.\(^6\)

The practice of medicine has a special characteristic not found in so pronounced a manner in other occupations. Doctors deal directly, and at the time when a person is most vulnerable, with the immediate issues of life and death, health and illness. The patient is heavily dependent upon the technical knowledge and integrity of the doctor. The doctor thus has a unique involvement with the patient, but this relationship between doctor and patient is not balanced. The patient’s attitude is a complex of trust (which comes from perceived competence and integrity of doctor) and paradoxically also that of distrust which comes from the state of uncertainty and vulnerability.

This ambivalence in doctor-patient relationship is addressed by medical ethics, which tries to guarantee the patient that the doctor will not abuse his dominance in the relationship. Thus, medical ethics is essentially a regulatory mechanism that makes the doctor commit publicly that though medical practice is the source of his living, he will strive to the utmost for the benefit of the patient and not be driven by just for mere personal aggrandisment.

It is normally accepted as a rule that ethics is something more than law. The formulation of various aspects of ethical code is based on ethical principles, which are in many ways different from legal principles. Ethics govern conduct. Principles based on it thus delve into fine aspects of the conduct of doctors. Ethics and its principles also come into play to resolve recurrent ethical dilemmas in medical practice. As the occurrence of a particular dilemma increases and as its resolution in a certain manner gains general acceptance within the profession, it gets integrated into the code itself. This creates a dynamic mode which makes the ethical code progressively more elaborate. Laws are circumscribed. Their elaboration by the judiciary is also greatly limited. Since the profession acts as lawmaker as well as its implementing agency, its elaboration is wider.\(^7\)

**Teaching Ethics and Professionalism**

Medical schools, teaching hospitals and those responsible for continuing medical education should teach professionalism as a subject formally identified in the curriculum. The material to be taught will change in different cultures and certainly with time. The teaching of professionalism should include several components.

1. Identifiable educational content in the undergraduate medical school curriculum devoted to professionalism, which should be reinforced in postgraduate programmes and in continuing medical education. The subject should be part of the evaluation of all students.
2. The concept that to be a professional is not a right but a privilege with a long history and tradition of healing and service.
3. The separate but linked concepts of the physician as healer, and the physician as professional, and the fact that society uses professional status as a means of organizing the delivery of services.
4. A clear definition of professionalism and its characteristics.
5. Professionalism as an ideal to be pursued, emphasizing its inherent moral value. The concept of altruism and “calling” must be highlighted as essential to professionalism.
6. An understanding that proper professional behaviour is essential for the healer to function fully and to maintain the trust of patients and society.
7. Knowledge of codes of ethics governing the conduct of both the healer and the professional, as well as the philosophical and historical derivations of these codes.
8. The essential nature of the autonomy of the individual doctor, along with the legitimate limitations that have always existed. The degree of autonomy will vary in different societies, but a minimum is required for a doctor to exercise the necessary independent judgement to best serve the patient.
9. The nature of collective autonomy of the profession, along with its legitimate and inherent limitations.
10. Relevant material drawn from sociology, philosophy, economics, political science and medical ethics as related to professionalism, including interpretations of both the historical course of events and of doctors’ behaviour that are critical of the medical profession. The profession must not be allowed to build and maintain its own myths while avoiding ideas challenging them.
11. The link between professional status and the obligations to society that must be fulfilled to maintain public trust. These obligations should be explicitly outlined and included in
the teaching. They include obligations to know and be guided by the applicable codes of ethics and national and regional laws; to participate in more effective and transparent self-regulation; to address health issues of concern to society; to maintain competence throughout one's medical career, to be prepared to be fully accountable for all decisions taken; to expand and ensure the integrity of medicine's knowledge base by supporting science in its broadest sense; to insist on the maintenance of sufficient individual and professional autonomy to enable the doctor to act in the best interests of the patient; and to be governed by professional standards of conduct no matter what role is being filled — private practitioner, employee of the state or corporation, manager, administrator, or a mixture of roles. Finally, of course, the obligation to put the welfare of the patient and of society above one's own is paramount. 8

Ethics and Professionalism in a Changing World

Our professionalism is shaped by the context in which we work. First and foremost, medical knowledge and skill have expanded at an unprecedented rate. This, together with the revolution in information technology, has huge implications for the profession.

People know more about health matters because they have independent access to clinical information and because their interest has been stimulated by media attention. More patients want an open relationship with their doctors; they want to be well informed and involved in decisions about their care. Doctors are no longer alone in the clinical management of patients. Multi-professional teamwork, the philosophy behind modern shared care, has to be reconciled with the personal nature of doctor-patient relationship.

Doctors' attitudes are also changing. For example, more doctors attach as much importance to the quality of their lives outside medicine as to their medical work. Part-time practice has become more common for both men and women. Such developments have major implications for continuity of care and the organization of medical work. 9

Doctors today are experiencing frustration as changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism. At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. 10

References

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