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*Knowledge, Wisdom, and Service:
The Meaning and Teaching of
Professionalism in Medicine*

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Center for the Study of Ethics in Society

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Knowledge, Wisdom, and Service: The Meaning and Teaching of Professionalism in Medicine

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Emperor of his nation, in fact – when, tragically for them both, their relationship fell apart. She became so disenchanted with him that she called Dr. G for help. Now, you might be wondering why she would need a doctor to help with her marital woes. This was about 2,000 years ago, so she didn't ask him for Valium or Prozac. She didn't need him to testify as to her husband's abusive nature at their divorce hearing. No, she called her doctor because he had scientific expertise in using herbs and chemicals. She needed his help to poison her husband, who was the Emperor Claudius (Tacitus, *The Annals* Book XIV, 1-16). And, apparently like many a good doctor of the time, he obliged his client.

Margaret Mead, the anthropologist, observed that the followers of Hippocrates seem to have been the first to separate the roles of healer and sorcerer (Bulger and Barbato, 2000). Most Greek physicians didn't follow the Hippocratic dicta, either before or for many years after Hippocrates' time. Agrippina tried to murder Claudius with her doctor's assistance 400 years after Hippocrates probably lived, and many Greek doctors assisted in suicides and acted in other ways contrary to the proposed standards of the Hippocratics, who were a distinct minority sect. As the medical historian Albert Jonsen has put it: In Ancient Greece, "there does not seem to have been anything like a medical profession" (Jonsen, 2000, p9).

Even the Hippocratics themselves seem to have recognized their minority status. They did not aim to establish shared standards of practice for all physicians. Their Oath is focused on individual, not collective, promises, starting with the phrase, “I swear by the Gods, that I will...” The Oath might even be seen as a marketing tactic, a set of public promises made to bring more patients into the unique Hippocratic franchise. And, as the story of Aggripina shows, the Hippocratics did not succeed in professionalizing Greek medicine. Yet, what they undeniably did was lay the *foundation* for the eventual development of medical professionalism, by combining the scientific and moral aspects of medical practice and making them explicit. In fact, specific details of their beliefs about medical knowledge, wisdom, and service were all addressed in the Hippocratic texts.

For example, in addition to specific teachings about how to treat a condition, they also urged humility in practice and the importance of learning from mistakes. The famous Hippocratic aphorism, “life is short, the art long, opportunity fleeting, experiment treacherous, judgement difficult,” demonstrates their recognition of the high-risk nature of medical practice (Hippocrates, *Aphorismi*, part 1). In fact, the Greek word “experimentum,” generally translated as “experiment,” actually referred to *any* treatment regimen given to a patient, further

suggesting their recognition of the inherent dangers of medical practice. They also write that “describing a mistake with all its consequences makes it avoidable” (Michler, 1977), presaging modern-day concerns for patient safety and quality improvement.

In the moral realm, they promised not to intentionally harm patients, to protect patients’ privacy, and to share what they learned with each other, thus laying the groundwork for a collegial community with shared standards for moral behavior.

They also seem to have recognized the interplay between the scientific and moral bases of their work. Patients won’t share information if they fear breaches of privacy. Medical practice will improve if practitioners share what they learn with each other, rather than holding new methods secret.

But it would take 2000 years for the full meaning and promise of this necessary interplay between science, ethics, and the service-oriented goals of medicine to come to fruition as medical professionalism. Throughout the Middle Ages, for example, little new learning took place in medicine. Religion then taught that illness was a punishment from God, over which men had little control, and the medical culture was oriented around a reverence for the ancients, such as Galen and his teachings about “humours” (Geraghty and Wynia, 2000). The aim of medical training in this time was simply to memorize what the ancients had to pass down. Even basic investigations to better

understand human anatomy, for example, were vigorously discouraged. There is some irony in the fact that the Hippocratic texts, which were revered, urged humble scientific investigation and learning while religious beliefs, combined with an outsized reverence for ancient learning, prevented physicians from heeding this advice for more than 1,000 years. It wasn't until the Renaissance and Enlightenment eras that medicine would re-emerge as a scientific and ethical, rather than ideological and religious, enterprise (Geraghty and Wynia, 2000a).

England's John Gregory, who was heavily influenced by Scottish enlightenment thinkers and the methods of Baconian science, proposed a uniform ethic to govern medical practice in the mid-1700s. While he saw humility, which he called "diffidence," as a core personal virtue – it was a key part of his "ethics of character" – he also began to see what he called "our art" as entailing shared service to humanity (Gregory, 1772). This shared service included moral duties that applied to all physicians – and resembled those of the Hippocratics, such as the obligation to acknowledge errors, learn, and share new information with other practitioners.

This notion that all physicians have a moral obligation to conduct scientific inquiries, to learn and improve, took root among many leading physicians of the 1700s, though it was usually framed as a matter of individual virtue rather than as part

of an explicit social contract. American physicians like Thomas Bard told students their whole lives would be “one continued series of applications and improvements,” and they would be responsible even for their “errors of ignorance,” unless they had “embraced every opportunity for obtaining knowledge” (Bard, 1769).

Benjamin Rush, was a leading physician at the time of the American revolution, who signed the Declaration of Independence, and who formed the first incorporated hospital in the United States with Benjamin Franklin, urged his students to “open all the dead bodies you can [and] record the epidemics of every season...Record the name, age, and occupation of your patient; describe his disease accurately, and the changes produced in it by your remedies; mention the doses of every medicine you administer to him...” (Rush, 1815). He thought great progress in human happiness would arise if physicians were to collect these data and share their knowledge with each other to improve medical practice. As a side note, George Carlin once said, “Isn’t it unnerving that doctors call what they do, ‘practice’?” Which is funny, but the word ‘practice’ is, in fact, appropriate. It reflects this ancient notion that we are always learning – always practicing and always aiming to improve.

Another English physician, Thomas Percival, first coined the terms “medical ethics” and “professional ethics” in the late

1700s (Percival, 1803). He even went on to articulate a *practical* rationale for shared ethical responsibilities for all doctors. His work was grounded in the fact that hospitals demanded teamwork in a way that independent practice had not. His own hospital, the Manchester Infirmary, had been riven by feuds, some leading to duels, between competing doctors. As a result, he argued for a professional collegial culture of respect and sharing, including with non-physician members of the team. He urged the keeping of a clinical register with data on every patient admitted to the Infirmary, and for team rounds during which “the junior physician present should deliver his opinion first, and the others in the progressive order of their seniority” (Percival, 1803, pp19-21), a model of shared care, information transfer, and teaching that persists to this day on hospital rounds.

But Percival was stymied when he tried to take this model nationwide in England. The British medical establishment saw a shared code of ethics as unnecessary, because English doctors were gentlemen and already knew how to behave. Acknowledging the need for a code would be an affront to their presumed dignity and virtue. In fact, some saw a code as frankly undesirable, because – as the historian of medical ethics Bob Baker has put it – they thought a written code would be “useful only to persons who, lacking decent character, wish to pretend that they had one” (Baker et al, 1999).

American medicine, however, was ripe for development and adoption of an explicit, shared code of medical ethics. Like England, the United States was suffering from similar medical chaos at the time, with multiple competing ideologies of medical practice – Thomsonians, Eclectics, Homeopaths – no standardized medical training curriculum, and widely disparate values among practitioners, many of whom were blatantly commercial in their medical work. American medicine also suffered from internecine warfare among competing practitioners, including pamphlet wars and even duels.

But unlike in England, American physicians were not fully steeped in the presumptions of class-based virtue, honor and privilege. They were more attuned to ideals of social mobility, free contracts between equals, and to the French enlightenment idea of social contracts as governing relations within communities. After some state and local efforts, especially in Baltimore and New York, an explicit social contract for the United States medical profession was first published as the American Medical Association Code of Medical Ethics, at the founding of the AMA in 1847.

It is worth reflecting on this for a moment. Codes of ethics have since become common; every profession or wanna-be profession has one now. But the AMA's Code was the first code of ethics adopted nationally by any profession, anywhere. It was

widely hailed as revolutionary then, only a little over 150 years ago. Commentators at the time thought it “the most important public document since the Declaration of Independence” (Baker et al, 1999)

It was revolutionary because it made an explicit, combined and integrated set of promises from doctors to their patients, their colleagues and their communities with regard to their scientific, ethical and service orientation. It promised that *all* physicians were to undergo training in “scientific medicine,” to promote “scientific logical medicine,” and be “conservators of the public health” (Baker et al, 1999). They would also *all* promise to protect patient confidences, seek to use the best and most effective treatments, maintain a sense of humility in practice, share information with each other, continue providing care during epidemics, and so on.

Philosophically, the Code was based in easily understood moral notions of *reciprocity*, with society, physicians and individual patients all receiving explicit benefits and having explicit reciprocal obligations. The Code thus followed in the great tradition of Bard, Percival, Gregory, and the Hippocratics, but it made these promises *clear*, and it made them *as a collective* – *as a profession*. In sum, the Code *created* the formal profession of medicine and, equally important, it made an implicit argument

for professionalism as a way to organize and deliver medical care.

Definitions

Before moving on, I should be clear about my use of these terms – and especially what “professionalism” means.

Professionalism is derived, at its root, from the word “profess,” which means to speak out or declare, with obvious connotations of making a public promise. At a wedding, the bride and groom profess their love and commitment, and a professor is someone who ‘speaks out’ on a subject.

A “profession,” then, is a group of people who speak out and publicly declare, together, something about the shared values and standards that govern their work. Note that while a professor is a single person, a profession is always a group – because it implies a group professing something, together, about the aims, methods, competencies, and so on entailed in doing their work. So a professor works as a member of the teaching profession, a lawyer as a member of the legal profession, and so on. Note also that professions must be further specified by reference to the work under discussion – the legal profession, the engineering profession, or the medical profession.

A “professional,” then, is an individual member of the profession. But “professional” can also be used as an adjective –

an action can be professional or unprofessional, for example – and in that case, a professional action is one that is in accordance with the professed standards and values of the group. Unprofessional actions are those that contradict the shared standards or values of the group.

So what is professionalism? Professionalism, like other-isms, is an ideology about how best to structure and deliver particular social goods. Communism, capitalism, libertarianism, consumerism, Protestantism, Catholicism – all of these are ideologies about some important aspect of social functions and relations. The ideology of professionalism is that developing and maintaining a profession is the best way to deliver and protect a specific social good. That is, those who promote professionalism argue for the value of creating a group of people, professed experts in some field of work, who are willing and able to come together to determine and declare the standards and values that they promise will govern their work, and then entrusting that group – the profession – with a specific scope of work that is important to society. Professionalism, as an ideology, promotes a desired social role for the professions, as groups that establish, promote, and enforce shared standards for work that is important in society.

Like the professions, professionalism must be specified to a type of work – medical professionalism is not the same as legal

professionalism, for instance, because the groups do different work, operate in different social structures, and have made different sets of social promises. As a result, there can be a better or worse case for some types of professionalism compared with others, because some socially important work almost requires the development of a profession, while other work does not.

In medicine, we have more or less successfully made the argument that medical care is best delivered by entrusting it to medical professionals, members of social groups who have made shared promises about their competence, ethics, and a particular service orientation. The arguments for professionalism in medicine often focus on the inherent challenges facing patients, who may be ill, fearful, or even unconscious.

I'm not going to put forward a complete argument for professionalism at the moment; instead, let me just say that there are alternatives to professionalism as ways of organizing and delivering medical care. The sociologist Eliot Friedson called professionalism "The Third Logic" because it contrasted with two other major methods of organizing and delivering social goods. One is the marketplace, in which various vendors with varying quality goods and services compete with each other; trade secrets are the norm; and *caveat emptor* (buyer beware) is the motto (Friedson, 2001). This method is promoted by the ideologies of libertarianism and consumerism, both of which are

antithetical to professionalism because they eschew the restrictions on individual liberty that are inherent in making group promises. I'll come back to this in a moment.

The second major method is to use an external bureaucratic mechanism, usually the state, to organize and deliver medical care. In this model, standards of practice are established by civil servants, presumably acting on behalf of society and individual consumers, and these practice standards are then enforced by those outside the group of practitioners. Note that this model arises from a distrust of both the market and of practitioners. It is most popular where individual consumers cannot look out for their own interests (in areas like environmental standards, national defense, or other shared social good like roads and bridges, where *caveat emptor* just doesn't make sense) and where practitioners cannot be trusted to act in the public's good and therefore need close monitoring.

Medical professionalism posits that individual patients cannot always act to protect their best interests – so *caveat emptor* won't work as a ruling principle for health care – but also that medical care is impossibly complex and difficult to regulate for state bureaucrats. Therefore, advocates of medical professionalism argue, it is best to empower professionals to act together to protect the best interests of patients and the public. That is, rather than leaving health care to the vagaries of the

market, or the strictures of government regulation, health care should be entrusted to health care professionals.

This assertion can be challenged, of course. In closing, I'm going to address briefly two core challenges to professionalism. First, can we really trust health professionals to keep their promises? Second, if we can trust the profession, then what are the core promises we expect medical professionals to uphold?

Can We Trust Doctors?

There is no easy answer to the first question, about trust. After all, there are a lot of health professionals out there, so no system of organizing and delivering medical care will be perfectly trustworthy 100% of the time. But even to approach an answer I think we need to be much more explicit about what we mean, within and outside the profession, when we talk about trusting doctors by empowering them with "professional autonomy."

There are two very different understandings of professional autonomy in circulation today, and they reflect a debate within the profession that has been going on since at least 1847, but that is rarely made explicit. I'd like to make this debate explicit because it is critical to understanding the job of health professional education. Namely, does "professional autonomy"

mean the right of *each individual* medical practitioner to choose their own modes of practice, methods of treatment, and so on? Or does it mean the right of the *professional group* to establish – and to enforce – its shared standards for group members? And note that these are opposing ideas, so it cannot mean both at the same time.

The first version of professional autonomy really equates it with personal liberty: the right of individual doctors to practice as they wish. But that is the very opposite of what I have asserted that professionalism really promotes, which is the activity of a group coming together to establish and enforce its practice standards.

To put this very bluntly, the core question is: To what extent did I give up my own personal liberty when I became a physician and, implicitly or explicitly, agreed to live up to the shared promises of my chosen profession? When I put on a white coat, draped a stethoscope around my neck, and put an MD after my name, what was I conveying to my patients and the public about the standards and values that would govern my interactions with them? When I completed medical school, was I ready to live up to those shared promises, even if they might sometimes conflict with my personal preferences?

These are important questions, in part because our profession, as a group, has accomplished a number of important

tasks, many of which benefit individual practitioners and, we hope, patients too. Licensure requirements effectively preclude non-professionals from providing certain dangerous medical services. We have attained important social privileges, like the right to help our patients get out of work, or get a refund on an airline ticket. But these prerogatives of being a doctor were only accomplished because our profession made a set of promises both to society at large and to our individual patients. Are medical school graduates today ready, willing, and able to live up to those promises? Do they even know what our shared promises are?

Before speaking to what these promises are, let me say that these questions are at the heart of health professional training. Medical students need to understand how these promises come about, what organizations are involved, and how they work. They need to understand the *degree* to which different standards are binding or are mere recommendations, and they need to accept their professional responsibility to be involved in ongoing deliberations about the standards and values that govern medical practice. If they disagree with a standard, or think our shared professional values are off-track, it is not enough simply to ignore the standard or subvert the value with which they disagree. We work as a profession, together, or the profession doesn't work at all.

The second core question, then, is what are the standards that we all should aspire to uphold? I have argued that being a health professional means making a set of shared promises, and now I'd like to specify that at the heart of medical professionalism is a set of promises about three basic things: medical knowledge, wisdom, and purpose.

First, medical professionals promise to acquire, maintain, and advance the scientific and technical skills necessary for competent medical practice. This promise with regard to medical knowledge is obvious and requires little defense (unless one is unfamiliar with professional practice standards or not in agreement with them, at which point questions and disagreements about professional enforcement of practice standards arise).

Second, as regards wisdom, we promise to acquire, maintain and improve the interpersonal skills necessary to work with patients to elicit goals and values that can help direct the use of our medical knowledge and skills. This is sometimes referred to as the "art" of medicine, and it is what promotes the wise use of our scientific and technical skills. For example, a technically correct solution to a medical problem, but one that won't be accepted by the patient, is the wrong answer. To pursue it might not reflect a deficiency of medical knowledge, but it would be ineffective and hence unwise.

Some might argue that this promise about the wise use of our technical skills and knowledge, guided by our patients' values, preferences, and goals, is a new professional promise, since physicians sometimes have developed a reputation for being poor communicators, ignoring patient input, being brusque, and so on. But in fact, this is an ancient obligation that was, I believe, temporarily set aside as the era of scientific medicine arose. For almost a century, some in medicine have acted as though because we could cure patients, we didn't need to be attentive to their values and goals. With great medical success came increasing paternalism and the waning (if not the obliteration) of the humility in practice that Hippocrates, Percival, and others had long promoted. But that doesn't mean this promise isn't critical and doesn't need to be revived, especially in an era of increasing chronic disease and the need for patients to manage their own care over long periods of time at home.

Even in the time of Plato, it was recognized that a good physician communicates well with patients and enlists them in making treatment decisions. In Plato's Laws, Book 4, he writes:

[The Athenian asks]...did you ever observe that there are two classes of patients in states, slaves and freemen; and the slave doctors run about and cure the slaves, or wait for them in the clinic. They never talk to their patients individually, nor do they allow them to talk about their own individual complaints. The slave doctor diagnoses

and prescribes a remedy on an empirical basis, [but does so] as if he had exact knowledge; He gives his orders [to the patient], like a tyrant, and then rushes off, to see some other slave who is ill, all the while projecting an air of confidence and assurance.

But the other doctor . . . attends and practices upon freemen; and he carries his enquiries [with his patient] far back, and goes into the nature of the disorder in a scientific way; he enters into discourse with the patient and with his family, and is at once getting useful information from the sick person, and also instructing him as far as he is able. [The physician] will not prescribe for the patient until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure.

Now which is the better way of proceeding in a physician and in a trainer? Is he the better who accomplishes his ends in a double way, or he who works in one way, and that the ruder and inferior?

Finally, our third set of promises, which is equally important, encompasses the larger purposes, or service, to which we put our knowledge and our wisdom. Namely, we promise to acquire, maintain and advance our *professional values*, which hold above all that medical professionals will use their medical knowledge and skills always in the service of patients and the public's health.

One might call this the "triple promise" of professionalism – because these three core professional promises about our technical knowledge and skills, our interpersonal

knowledge and skills, and the values that will govern how we use these skills, all tie together to ensure the trustworthiness of the medical profession.

The Role of Organizations in Supporting Professionalism

Finally, with more time, we might delve into more details on each of these three promises and what it might take to ensure that all health professionals understand and live up to them, but I'd like to close instead with a brief comment on how professionalism and health care delivery organizations interact to facilitate, or to hinder, the ability of health professionals to live up to these promises.

The systemic and organizational milieus in which health professionals work can make it much easier, or much harder, to do the right thing. My belief is that we, as a profession, have a responsibility to help develop systems and organizations that support professional actions. As the AMA has framed this, we need to work together to make it easier for doctors to “promote the art and science of medicine and the betterment of public health.” While it is fair to measure whether physicians are providing high quality care – and the AMA is playing a central role in this process by developing clinical performance measure through the PCPI, the Physicians’ Consortium for Performance Improvement (www.ama-assn.org/go/pcpi) – the AMA has also

argued that it is fair to ask, and to measure, whether the organizations and systems in which physicians work are providing an environment that makes it easy to do the right thing (www.ethicalforce.org).

For example, we know that effective communication is necessary for informed consent and patient engagement in their care – and research shows that ineffective communication disproportionately affects racial and ethnic minorities, the poor, those with lower literacy, and those who don't speak English well (Ethical Force Program, 2006). In other words, ineffective communication is widely recognized as a key driver of health and health care disparities. Racial and ethnic inequities in care have been recognized, by the AMA and others, as a moral blight on our profession, and we know that improved communication might help.

One response to this problem is to improve how we train physicians. Clear communication skills are teachable; specific methods like "teach-back" are effective at ensuring patients understand, and they have even been correlated with improved clinical outcomes (Weiss, 2007). But what do we do about systemic and organizational barriers to effective communication? A well-trained clinician in an organization that doesn't have effective interpreter services is hamstrung. Mistrust in health care organizations is more common among minorities, and is

associated with reduced adherence and increased disparities, but individual clinicians are limited in their ability to engage local communities to improve trust in the medical profession.

Organizational leaders are responsible for creating a practice climate that supports effective communication and care for diverse patients. Organizational culture affects job performance, but individual clinicians working alone can't change an organization's culture.

Our recent work has been to develop a method for organizations to measure their communication climate – using a set of tools we call the C-CAT, or Communication Climate Assessment Toolkit (www.ama-assn.org/go/ccat). We've shown that organizations' scores on the C-CAT are correlated with patients' perceptions of the quality of care they are getting, and with patients' trust in health care (Wynia et al, 2010).

Given the increasing complexity of the care we deliver, and the importance of addressing quality improvement in systemic ways, I hope that the future will bring even more tools to measure whether organizations are making it easier, or harder, for doctors to do the right thing. By creating tools to measure and improve the ethical climate of health care organizations, we hope to build the promises of professionalism into the very fabric of health care delivery organizations.

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No. 1, October 1989

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No. 4, April 1990

Harriet Baber

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Emily Hauptmann

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Ethics in Academia, 2000

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A Paper by Michael Davis

Response by Joseph Ellin

Professor Davis' Reply

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