

PROFESSIONALISM: WHAT'S TRUST GOT TO DO WITH IT?

For many, the word “*profession*” is part of our everyday language. We use it most frequently to refer to an individual’s job (e.g. salesman) or his/her business (e.g. insurance). Its general connotation notwithstanding, professions have often been defined by several general characteristics: the possession of some general body of special knowledge, a practice within some “ethical” framework (i.e. codes of practice or behavior), its field of knowledge fills some broad societal need, a social mandate that permits significant discretionary latitude in setting standards for education (e.g. certification, accreditation) and performance (i.e. self-regulating, self-policing). An individual becomes a “*professional*” when he or she fulfills the educational standards and formally acknowledges a dedication to the stated ethical framework or code of conduct. The latter is generally accomplished through a professional organization which exemplifies and fosters the profession’s standards.

Although many occupations may lay claim to the title of a profession, society has traditionally recognized a smaller number by virtue of their importance in serving some fundamental societal or human need. Hence fields such as Medicine, Law, Ministry and perhaps Academia (i.e. teaching) have been viewed as “*learned professions*”. They occupy a special niche in the realm of professionhood in large part due to their dedication to other than self-interest. This “otherness” requires the “*learned professional*” to suppress his/her self-interest when the welfare of those whom they serve requires it (i.e. altruism).

Within the learned realm the word “*profession*” takes on a different and perhaps etymologically purer connotation based on its root word “*profess*” meaning “to speak out” or “to speak for”. In contrast to its general connotation (i.e. business, job), within the learned professions a better synonym would be “*advocacy*”. Thus one enters a *profession* through a formal, structured educational process, becomes a *professional* by demonstrating a basic level of expertise and by committing him/herself to the requisite standards of the profession and, finally, practices *professionalism* when he/she dedicates his/her actions to this altruistic otherness. Within the medical profession that dedication and commitment occurs in a formal profession process by reciting an oath (e.g. Hippocratic Oath).

What does all of this have to do with healthcare and our current debate over healthcare reform? It is a fair question that is worthy of exploration.

The opening words of Charles Dicken’s classic *A Tale of Two Cities* could well describe our current healthcare dilemma:

“It was the best of times, it was the worst of times...”

Recent advances in science and technology have provided physicians and their patients with a rich array of diagnostic and therapeutic options. Recurrent epidemic diseases such as smallpox, polio, diphtheria, yellow fever and a host of other infectious disorders are either preventable with vaccines or treatable with broad-spectrum antibiotics. Many forms of cancer can now be detected in their earliest stages with sophisticated imaging techniques and treated with targeted chemotherapeutic agents. Childhood leukemia, once a uniformly fatal diagnosis, is now considered curable for many patients. Mortality rates for even the smallest

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premature infants have reached a seemingly irreducible minimum while life expectancy rates now stretch into the seventh decade.

Yet our ability to deliver these benefits in a just and efficient manner is painfully inadequate. A growing number of patients lack sufficient financial resources to access optimal medical care. And those who can, too frequently receive inadequate care for their illnesses. Yet the costs of healthcare are increasing at a seemingly uncontrollable rate. Many middle-class wage earners are forced to make critical healthcare decisions based solely on affordability and not on their best interests. On a relative scale, Americans receive far less value for their health care dollar than do those in other developed countries. Nor are physicians immune from the inefficiency of our current healthcare system. Today, the average physician spends nearly three months (142 hours) per year dealing with administrative activities dictated by regulatory entities originally designed to address healthcare inefficiencies. Perhaps most importantly for an aging population, social programs designed to care our most vulnerable citizens (i.e. Medicare, Medicaid) rapidly approaching insolvency. In a world of medical riches, there remains too much poverty and too little social justice.

There is now a near universal feeling that our healthcare system is broken and something needs to be done. As we speak today, our country teeters on the brink of an as yet uncertain healthcare reform. What will it look like? Will it expand access to those most in need? Will it make healthcare more affordable, both now and in the future? How much will it cost and who will pay for it? All important questions but are they the right questions? Are we dealing with the root cause of our dilemma or merely providing palliative responses to its symptoms? Physicians and patients alike ponder an uncertain future.

Medicine's most important and distinctive element – the physician-patient relationship – sits at the heart of both the dilemma and its solution. Traditionally this relationship has been characterized in a relatively simplistic parental paradigm; the dyad of an ill patient (the child) seeking soothing comfort and relief from a skilled and learned physician (the parent). Based on the Hippocratic teachings of nearly 3 millennia ago (500 BC – 200 AD), it is based on what modern principalists would label as **beneficence** and **nonmaleficence**. Among the extant Hippocratic texts, *Epidemics I* instructs the physician “...as to diseases make a habit of two things, to help or at least do no harm”. And from the brief 400-word *Oath* the physician professes “...into whatever houses I enter, I will enter to help the sick, and I will abstain from all intentional injustice and harm...”.

It was however a distinctly physician-driven, patient-passive (paternalistic) encounter. Again from the physician's profession in *Oath*, “*I will use treatment to help the sick according to my ability and judgment and never bring them harm or injustice.*” Treatment decisions are clearly vested in the physician's judgment with no reference to the patient's desires. And from *Epidemics I*, “*The art has three factors, the disease, the patient and the physician. The physician is the servant of the art. The patient must co-operate with the physician in combating the disease.*”.

Plato (427-347 BC) in his treatise *Laws* describes the basic social nature of the physician-patient relationship.

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The physician treats their (the patient's) disease by going into things thoroughly from the beginning in a scientific way and takes the patient and his family into confidence. Thus, he learns something from the patient. He never gives prescriptions until he has won the patient's trust and when he has done so, he aims to produce complete restoration to health by persuading the patient to comply."

Although the ethical principals in Hippocratic lore still resonate in modern medicine, the social relationship has undergone significant changes. As medicine has become more scientific and modern life more transient, Plato's social relationship may be obsolete. In an era of highly specialized, technology driven medicine no one doctor ministers to a whole family let alone a whole person. Doctors and patients now meet as strangers. Seemingly there is no single source to address a patient's uncertainty. Often conflicting opinions turn uncertainty into fear. Unqualified trust is replaced by frank skepticism and feelings of abandonment. As patients struggle with their uncertainty, they turn to alternative sources for medical information (e.g. internet, public media). Near daily reports of "break throughs" in medical science fosters a sense of expectation among patients which, when not met, leads to a sense of betrayal, further undermines their trust and leads patients to file malpractice claims while physicians order more tests to defend against such claims (i.e. defensive medicine). Some feel that medicine has lost its soul and that its commercialization has robbed it of its basic individualistic and humanistic qualities. Doctors have been replaced by healthcare providers and patients have simply become covered lives. Devoted cynics would say patients are nothing more than commodities to be channeled through a seemingly indifferent healthcare system by brute market forces.

With some slight editing, Scott Buchanan in *Doctrine of Signatures, A Defense of Theory in Medicine (1938)* succinctly describes our current predicament.

"Medicine stands at the head of the natural sciences, and does not know which way to go. It has a record maximum of knowledge and a minimum of understanding. It has science and wonders if it has art. It is suffering from an intellectual imbalance of virtues."

Have we really lost our soul or have just misplaced our moral compass as Buchanan seems to suggest? And what about this virtue stuff? So, where does one reasonably look for solutions? Well, perhaps it no so much inventing some new system as it is returning to what has worked in the past and modifying it to our current circumstances. Modern professionalism encompasses the medical ethics of the Hippocratic physician and adds patient autonomy and Aristotolean virtue to agenda.

We need to re-create and nurture that healing dyad relationship that we have already mentioned. Every patient needs A doctor, someone to drive the train and keep it from jumping the tracks, someone to coordinate patient care across specialty lines if necessary, someone to talk to patients, someone who embodies the ideals of **professionalism** and can regain the trust of patients. What are those ideals? They are the basic virtues of a good physician; altruism, beneficence, nonmaleficence, truthfulness, empathy, compassion, fidelity.

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Second, we need to accord greater respect for patient autonomy. We need to insure that the physician-patient relationship reflects the important values and desires our patients harbor yet guides them through the alternatives in a deliberative and respectful manner.

How could we do achieve these goals? Doctors Ezekiel and Linda Emanuel had described four models for the physician-patient relationship which look at alternative solutions to issues surrounding patient autonomy and health (JAMA 267:2221-2226).

The first model is the **parental or paternalistic model**. Here the physician acts as the patient's guardian. It is the physician who selects what is best for the patient but under the assumption that the patient's best interest are paramount and that a reasonable discussion has informed the physician of what the patient's interests and values are. Patient autonomy is reflected by his/her assent.

The second model is the **informative model**. In this model the patient resemble a consumer. The physician present the options for intervention and all the relevant facts, the patient makes his/her selection and the physicians executes selected procedures. The physician's obligations are ones of truthfulness and competency. Patient autonomy is manifest in his/her control over decision making.

The third model is the **interpretive model**. Here the physician acts as the patient's counselor. The physician help elucidate the patient's values and then assists in selecting the most appropriate intervention available. Although the physician may determine which tests or treatments best realize the patient's expressed values, he/she does not dictate the choice. The concept of autonomy is self-understanding.

The fourth and final model is the **deliberative model**. Physician-patient interaction centers around determining the best health-related values. The physician presents a full and truthful delineation of the patient's condition and helps elucidate what health-values are available and which are most worthy. The patient is empowered to select those intervention or treatments which he/she deems of greatest value.

Clearly under varying circumstances different models might be applicable. Each has its critics and supporters. The ideal, however, exists when the caring physician who integrates medical information and relevant patient values through discussion and the attempts to persuade the patient to accept this recommendation as the intervention that best promotes his/her overall health and well being. The caring physician persuades but does not impose.

Finally, we must develop a healthcare system that properly incentivizes physicians and patients to make the most appropriate healthcare choices. Patients and physicians are responsive to market forces and move where financial incentives drive them. At present those incentive seem badly misdirected. Hospital care is favored over outpatient/office care, subspecialists over primary and preventive care, complex treatment over early prevention. There are no financial incentives to keep patients out of the hospital. Diagnostic technology

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is rewarded while a thorough history and detailed exam are not. We need a financial system that emphasizes prevention fosters ethical and professional health care. There is no doubt that the best clinical medicine is practiced when the scientific and technical aspects of care are placed in the context of a personal professional relationship in which the physician strives to win the patient's support and trust. Evidence-based guidelines and best practices can guide in the decision process but are not sufficient to dictate individual treatments. Ultimately, the physician's core ethical and professional values are the foundation of good clinical care.