Professionalism and Virtues

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Professionalism is one of the six core competencies of both the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). It is being taught and discussed at the medical school level as well as throughout residency and continues during the lifetime of an orthopaedic surgeon. This paper will review its definition as well as the virtues that are necessary to sustain medical professionalism.

In 1996 I titled my Presidential Address to the American Orthopaedic Association (AOA) “Professionalism—where are all the heroes?” I hadn’t really given professionalism much thought until I became a Director of the American Board of Orthopaedic Surgery (ABOS) and was assigned to the ABOS Credentials Committee. This committee is responsible for reviewing the candidate applications and peer review information for certification and recertification. The Applicant Evaluation Form, used to collect peer references, uses a 4-point Likert Scale to rate, among other traits, the ethics and professionalism of individuals applying for certification or recertification. There were many occasions when candidates received a low rating for this category, which prompted me to consider the attributes—or lack thereof—of competent and conscientious orthopaedic surgeons.

The doctors Cruess of Canada, both of whom are physicians (and one an orthopaedic surgeon) have rededicated their lives to the study of professionalism and medicine’s social contract. They have been instrumental in designing this social contract and sat on the committee to assist in constructing the Physician Charter, which was a project developed by the American Board of Internal Medicine (ABIM) Foundation, the American College of Physicians, the American Society of Internal Medicine, and the European Federation of Internal Medicine and published in 2002.

This new assignment has provided me an opportunity to review the literature since I made my address to the American Orthopaedic Association (AOA) and I find it to be extremely voluminous. I will try to crystallize my ideas and definition of professionalism and some of the virtues that I find most appropriate to the medical profession and link the moral virtues to the type of person a physician should be.

Professionalism and Virtues

Professionalism, the process of professionalization, and the teaching of professional behavior have become major concerns of medical educators, practicing physicians, and many professional associations. I draw heavily from Pellegriño and Thomasma’s works on ethics and virtues of medical practice, and MacIntyre’s “After Virtue: A Study in Moral Theory.”

The word profession is defined in Webster’s Third New International Dictionary as: (a) (1) the act of taking the vows of a religious community; (2) an act of openly declaring or publicly proclaiming a belief, faith or opinion; (3) avowed religious faith; (4) a calling requiring specialized knowledge and often long and intensive academic preparation; (b) a principal calling, vocation or employment; and (c) the whole body of persons engaged in a calling. In common usage profession has often been defined in the following terms: (1) possession of a body of specialized knowledge, (2) practice within some ethical framework, (3) fulfillment of some broad societal need, and (4) a social mandate that permits substantial latitude in setting standards for education and performance of its members.

John Racy, in an essay on professionalism, suggested an alternative definition: “...[a] profession is a socially sanctioned activity whose primary object is the well being of others above the professional’s personal gain.” Traditionally, a small number of professions by virtue of their educational breadth and their importance in satisfying some fundamental human need have been called the
learned professions. Medicine, law, ministry, and academic occupations have enjoyed this special status and satisfy the criteria for sociologically defined profession, but they also occupy a special niche among the vast number of occupations now claiming to be professions.

The art of professionalism is the practice of doing the right thing, not because of how one feels, but regardless of how one feels. To paraphrase Sir Thomas Brown from his Religio Medici, “I desire rather to cure his infirmities than my own necessities.” The distinguishing feature setting medicine, ministry, law, and teaching apart from other professions is the degree of altruism or suppression of self-interest when the welfare of those they serve demands it. A profession in the best sense of the term is a moral undertaking. There are those unusual individuals who give of their skills and energy without any apparent reward. They are cherished, revered, and often times sacrificed. They are the saints and martyrs among us and there are too few of them. The learned professions are, in a sense, professed, ie, publicly committed to the welfare of those who seek their help. Thereby they become ethical enterprises, and it is this dimension of the medical profession that demands our attention.

Profession, in its etymological root, means to declare aloud, to proclaim something publicly. Thereby professionals make a profession of the specific kind of activity and conduct to which they commit themselves and to which they can be expected to conform. The essence of a profession then is this act of profession—of promise, commitment, and dedication to an ideal. Clearly, a profession is much more than a job, it is an identity. Individuals give much of themselves to their professions, but also receive much in return. The giving, however, precedes and supersedes the receiving. In other words, to be a professional is to assume and maintain a lifelong role of dedication to the welfare of others—a role which confers dignity, status, and power. Inherent in professionalism is a commitment to excellence. Inevitable to professionalism is expectation of personal gain and neglect of the self-discipline and learning required to sustain professionalism.

The act of profession occurs in two ways in the field of medicine. One is the public profession, or the solemn proclamation upon graduation from school when the Oath of Hippocrates is spoken, a ceremony separate and distinct from the conferring of degrees which is simply evidence of completion of the academic requirements for a Doctorate of Medicine. This degree says nothing about how the knowledge and skills acquired during education will be committed to use. Those who do not take the oath are simply skilled technicians or laborers whose knowledge is fitting for an occupation, but not a profession. Upon professing the Hippocratic Oath, if it is taken seriously as a binding commitment to use one’s special knowledge, skills, and services in treating the sick, the graduate has then made his profession of faith. He or she enters into the company of others with a similar commitment to respond to and advance the welfare of their patients—those who are ill or in need of help, healing, or relief of suffering from pain or disability.

As physicians, when we ask our patients, “How can I help you?” or “What is wrong?” or “What is the problem?” we are also declaring our profession. This is a commitment inviting trust from the patient. The doctor voluntarily promises trust and incurs a moral obligation to uphold that promise.

According to Pellegrino, the first written use of the word profession in relation to medicine was in 47 AD. In a book of prescriptions written by Scribonius, who was physician to the court of the Roman Emperor Claudius, he defined the word profession as a commitment to compassion or clemency in the relief of suffering. He did so in the context of one of the first references to the Hippocratic Oath in literature arguing the proper use of drugs was consistent with the Hippocratic injunction to help and heal patients. Scribonius also spoke about the Hippocratic profession and the bans on abortion and euthanasia and the requirement to always act to help the sick by whatever means are available. Scribonius presented a humanistic interpretation of the profession of medicine and linked it to humanism and the humanistic virtues of benevolence, compassion, mercy, and competence in the use of medications. Thus, we can learn from Scribonius the history of the word profession has been linked to these virtues from its very first usage. Indeed, the ethics of the profession was, until very recently, a virtue-based ethic that associated the good physician with certain character traits.

What is a virtue? Aristotle’s definition of virtue seems most appropriate for the profession of medicine because it links moral excellence (the moral virtues) with the kind of person the physician should be. As stated earlier, a physician professes in two ways—publicly by taking the Hippocratic Oath and privately by inferring his or her competence to practice medicine and his or her commitment to always keep a patient’s best interest first and foremost. This philosophy invites trust between the physician and the patient. These character traits most effectively achieve, and indeed are indispensable for, the good outcomes of any intervention. Some of the virtues entailed by professional commitment and the outcomes which actualize that commitment are: (1) fidelity to trust; (2) benevolence; (3) intellectual honesty; (4) courage; (5) compassion; and (6) truthfulness.

First, a physician has invited trust. If a patient accepts a physician then the patient cannot avoid trusting the physician and it is essential if helping and healing are to occur. Second, the prime concept of medical ethics since the time...
of Hippocrates has been acting for the good of the patient and, of course, primum non nocere, first do no harm: benevolence. Third, medicine is a powerful instrument of both good and harm, depending upon how medical knowledge and skill are used. Knowing when one does not know and having the humility and ability to admit it and to obtain assistance are virtues critical to avoiding harm and demand intellectual honesty. Fourth, a physician may expose himself or herself to possible physical harm in emergency situations. It takes courage to be a patient advocate in our commercialized and industrialized system of care. Fifth, for any situation or clinical decision a physician must assume the predicament of the patient in order to feel something of the patient’s plight (compassion) if his scientific judgments are to be morally defensible and suited to the life of that patient. Finally, a patient is owed the knowledge necessary for making informed choices. A patient must be able to assess a doctor’s competence and truthfulness to undertake the proposed course of action.

These are but a few of the virtues necessary for the profession of medicine—a silent commitment made in every doctor-patient clinical interaction. These are essential if the outcome of medicine, which is the healing of the patient or the betterment of the diseased state, is to be obtained with some degree of assurance and excellence.

What are some of the practical implications of these observed virtues? For example, it is difficult to imagine a doctor committed to the virtues outlined above would ever consider the relationship with their patient as primarily a commodity transaction, a contract for service, or a mere application of scientific knowledge. The virtue-inspired physician recognizes pro bono work is crucial to the stewardship of medical knowledge. Neither would such a physician see him or herself as an entrepreneur, investor, or owner of a healthcare facility, such as a for-profit hospital. Also, such a physician would not claim proprietary rights over his or her knowledge. The relationship with a patient is a covenant of trust, a special kind of promise to serve those who require a physician’s expertise. Suppression of self interest to some degree would be a natural corollary of a virtue-oriented physician. A prudent physician would recognize the limits of legitimate self interests and when those interests should be set aside to care for his or her patients or family.

This leads us to the central virtue of medicine, that of practical wisdom. Aristotle described phronesis, the virtue of practical wisdom, as the capacity of deliberation and judgment and discernment in difficult moral situations. Practical wisdom unites the moral and intellectual virtues and helps the individual resolve conflicts among virtues. It helps put them in a proper order of priority and helps them make the right and good decision in the most difficult situations. Practical wisdom is the most valuable virtue for the physician when he acts as a physician. It is the habitual disposition to make right choices in complex clinical situations. The practically wise physician is not one who acts cautiously and in his or her own self interest to protect him or herself. Practical wisdom assists the physician in making choices and is the virtue of wise clinical judgment. The virtue-based physician would never see his or her patient as a customer or consumer, insured life, or any other commercialized, industrialized transformation of the ancient and respectable word patient. Nor would he or she compromise his or her personal or professional integrity for political, economic, or social advancement. Nor would a virtuous physician become a member of a union, go on strike, or engage in blatant self-promotion in advertising even though it is sanctioned by the law. This would suit the ethics of professionalization, but not of a true profession. The virtuous physician would recognize being a member of a moral community united by those physicians who have made the same act of professional commitment to the welfare of the sick, and would seek professional organizations and associations as an extension of the ethical and moral commitments shared with fellow physicians. The contemporary model of so many professional associations as corporate, money-making, lobbying, advertising enterprises is inconsistent with what the profession of medicine is all about. The virtue-based physician sees the importance of working in professional associations to change their character and to urge upon them the primacy of a patient’s welfare and advocacy for justice in healthcare. He or she would understand withdrawal from professional organizations is to abdicate the responsibility to transform them for the better. Indeed, if professional organizations are to regain their honor and celebrity, they will need doctors who are committed to an ethic of virtue. On the other hand, a virtuous physician cannot fully realize his personal virtues unless a community of virtues exists to sustain and reinforce his commitment to his virtues. In other words, no man is an island. MacIntyre made much of this point in his seminal study of the virtues of contemporary life. As medicine today confronts the current crisis in professionalization, the mutual moral interdependence of the individual physician and the professional society must be confronted. One cannot be reformed without the other if anything resembling the pristine notion of a profession is to be recovered.

We as medical educators, practitioners, and leaders of professional organizations all share in the accountability for our present state of deprofessionalization. We also share in the success or failure in recovering some remnant of moral credibility. We must promote character formation and virtue in our schools, our residencies, and in the conduct of affairs of medical organizations. It is a sad state of
affairs that some medical professions and associations have compromised or lost their moral credibility.

Can Character Be Formed?

There is mounting evidence that students go through the 4 years of medical school and become much more cynical and less idealistic. How can we reverse this process? How can we form their character and teach them virtues? The ability to teach virtue has been a question since the time of Plato. Socrates was once asked, "Can you tell me whether virtue is acquired by teaching or practice?" Socrates, as usual, illuminated the question but did not answer it definitely. Aristotle, on the other hand, definitely did so. He said we learn by practice and the best practice is to follow a model of the virtuous person. In medicine, this means we need virtuous individuals to teach. We need role models and we need mentors. The term mentor comes from Homer's Odyssey wherein Odysseus' trusted friend Mentor nurtured and protected and educated his son Telemachus in his absence. Mentor introduced Telemachus to leaders and guided him in the assumption of his rightful place in society and politics. Mentor's instruction went far beyond the teaching of special skills, also encompassing personal, professional, and civic development, that is, the development of the whole person to full capacity and the integration of the person into the existing community. The characteristics of a modern day mentor are derived from the relationship between Mentor and Telemachus. A mentor should help his or her protégé define goals, develop the talents to enable him or her to reach maximum potential, teach the skills and knowledge of the discipline being pursued, help cultivate social and professional values and behaviors, and protect the protégé until he or she can sustain autonomous work. Other traits of a mentor include experience and empathy, particularly the introspective understanding gained through successes and failures, breeds wisdom enabling the mentor to help the protégé sift through difficult professional and personal issues and declare a final life direction. Empathy, on the other hand, reminds the mentor of the need for support during the educational process. Mentoring takes time and energy and should be rewarded. Once a student has chosen a field of specialization, consciously or subconsciously, he or she shapes the self-image of that physician. The student, in fact, begins to practice the virtues and/or vices of the role model. The more morally mature the student, the more he or she will distinguish the virtues from the vices. The less mature individual will confuse the two because of a lack of the practical wisdom to discern the differences. Clinical educators bear heavy responsibility for the character traits they model for their students and residents.

If there is one essential element in the effort of a medical school to shape the professionalization of its students, it is the dominant concept of the professional defining its faculty, especially its clinical faculty. Character formation cannot be evaded by medical educators. Students enter medical school with their characters partly formed, yet they are still malleable as they assume roles and models on the way to their formation as doctors. While role models or mentors are the most powerful force in professional character formation, certain ancillary educational effort can also shape the developing physician more than modeling. Courses in ethics, humanities, human values, etc. can sensitize, raise awareness, and force critical reflection about the virtues of the good physician. Courses introduce students to a body of literature that gives evidence of the importance, depth, and complexity of the moral issues commonplace in medical practice today. They challenge the reflective student to at least examine, verify, assimilate, or reject what he or she is being taught or what is seen in clinical faculty behavior.

Medical history and literature also add to the process of character formation. They do this by offering students an acquaintance with historical figures as role models. One needs only to ask today's students if they have ever heard of Osler, Halsted, or Harvey to appreciate how neglected this form of character formation has become. They are more likely to be exposed to corporate entrepreneurs, power players in the healthcare industry, athletes, and entertainment celebrities. In any event, if our profession is to regain its prominence and be considered as a moral enterprise and not just a branch of high-tech industry, medical schools need to give substantial attention to inculcating virtues and to evaluating their students, faculty, and institutional behaviors by these standards as well. In medicine there is no greater role model than Sir William Osler, perhaps the greatest physician of all time. He was a Canadian by birth and became chief of medicine at McGill University at the age of 25. He subsequently moved to the University of Pennsylvania to succeed Dr. Pepper as chief of medicine and 10 years later moved to Hopkins, where he lived and worked for physicians like Halsted. His final move was to Oxford, England where he was a Regius professor of medicine. We could do much to emulate the qualities of Osler. He lived by three personal ideals: (1) to do each day's work well and not to be bothered about tomorrow—a phrase he frequently quoted was "Our main business in life is not to see what lies dimly at a distance, but to do what lies clearly at hand"; (2) to live by the Golden Rule; and (3) to develop and cultivate equanimity. Osler was not a dreamer, but a practical man and a doer. He credited his success to what was once referred to as the Master Word in Medicine—the open sesame to every door, a word capable of making the stupid man bright and the bright man brilliant—work. If Osler were alive today I am certain he would reject the current approach to medi-
cine as simply another business selling a somewhat different commodity. Today Osler would surely be a vigorous spokesperson against the external constraints interfering with patient care. At the same time, he would also be critical of the profession for any self-serving or financially motivated initiatives. Osler believed as physicians “...we are here to add what we can to, not to get what we can from, life.” We need to remember happiness in our profession comes primarily from service to others.

To Osler, the medical profession is honored above all others because it calls on the highest powers of the mind and brings the physician into warm and personal contact with his or her fellow human beings. Osler thought the practical outcome of the long years of medical education was the glorious opportunity to spend one’s career in “...befriending the sick and suffering and helping those who cannot help themselves and in lessening the sad sum of human misery and pain.” Likewise, professional societies, if they are to be true to their claims to represent the profession, should recapture the notion of profession and deemphasize the guild-like connotations of professionalism. There is a need for physicians with a virtue of courage sufficient to enable them to stand clearly and visibly for what makes medicine a profession. This will mean leadership of a kind that denounces self-interest and truly advances the welfare of patients as medicine’s raison d’etre (reason for existence). Unfortunately today many professional associations are preoccupied with financial survival, corporate growth, investment strategies, benefits for members, etc. There is little energy left for promoting the ethical purposes of the profession as a profession. In this respect, the professional medical associations seem to justify the opinions of the Federal Trade Commission (FTC), which classifies medicine primarily as a business and not as an ethical entity. If societies were to take their moral purposes to heart they would be concerned about the character formation and ethical socialization of their members. Admittedly, this would be difficult in a morally pluralistic society where the personal moral beliefs of the members of the professional associations can be expected to vary widely. But this is less the case when it comes to the virtues associated with medicine as a profession—fidelity to trust, intellectual honesty, courage, benevolence, etc. If medicine as a profession is to have any unity of purpose, these essential virtues ought to be honored. The alternative is unthinkable. This same concern for ethical socialization and professionalization in the best sense of those terms applies to medical education. The primary task of medical schools is to prepare physicians with the skill and knowledge to make them safe and competent practitioners following graduation. This implies some conscious shaping of the character of medical students so they will exhibit then as students, and later as practitioners, those virtues entailed by the idea of a profession. This leads to another essential component of a profession, the element of self-regulation and autonomy. The medical profession has been perceived by the lay public as not having lived up to its contract by not disciplining those practitioners who have fallen below the standard of adequate care. Just as medical students know which of their classmates they would not trust to treat members of their own families, so do the practitioners in the community know which of their colleagues are unfit for the practice of medicine. We must have the courage and conviction for self-discipline. The difficulties are not trivial, but nonetheless there is an obligation to protect society from unsafe and untrustworthy practitioners. In essence, graduation from American medical colleges is tantamount to licensure. Society permits a large degree of discretionary attitude to medical educators and their evaluation of students. When this discretionary latitude becomes an obligation to protect future patients from blatantly dishonest or ethically marginal future physicians, it becomes a dangerous territory in which there is a genuine possibility for the abuses of power. The difficulties, however, do not constitute reasons for avoiding the issue. At the very least, some effort must be expended to detect the more flagrant disordered character or personality. With the growing sophistication of the public in matters of medicine and the pervasive variable state of trust as a whole, schools of medicine must confront this obligation or face a narrowing of freedom as educational institutions, just as the profession may face a narrowing of their freedom if they do not discipline in their own ranks. The same applies to residencies. Do not finish a suspect resident. Once the problem resident finalizes, he or she becomes everyone’s problem. The department chief has an obligation to protect society by not allowing the resident to sit the certifying examination.

We can learn much from the lives of men such as William Osler. The formula for a professional life is simple in concept, but difficult in practice. We must first master our field and then maintain our proficiency through life-long learning and study. We must care for each other and each of our patients as unique human beings. We must go beyond what is simply our duty and we must always put the welfare of our patients above our own. Although few of our patients in orthopaedics face life-threatening illnesses, they still desperately need the emotional support of a caring, competent, and dedicated surgeon. If we can meet their needs, we have succeeded not only as doctors, but as human beings.

DISCUSSION

In this brief essay I have tried to define the concept of a profession as well as professionalism. I believe the pro-
fession in the best sense of the term is a moral undertaking. In addition, a profession is "professed," i.e., is publicly committed to the welfare of those who seek a professional’s help. I stress that some of the virtues entailed by professional commitment are (1) fidelity to trust; (2) benevolence; (3) intellectual honesty; (4) courage; (5) compassion; and (6) truthfulness. These virtues are necessary for the profession of medicine. These combined virtues lead us to the central virtue of medicine which is that of practical wisdom which unites the moral and intellectual virtues and helps an individual physician resolve conflict among virtues.

I believe that character can be formed in medical school. I also believe that we must promote character formation and virtues in our medical schools, residency programs and in the conduct of the affairs of medical organizations. Certainly, medical students are being taught by the "hidden curriculum," but this must stop. Medical schools must provide professional role models and mentors as they are the most powerful force in the development of professional character.

References