Medicina Academica Mostariensia, 2013; Vol. 1, No. 1, pp 6-17 *Review*

PROFESSIONALISM IN CONTEMPORARY MEDICINE: IF IT IS AN IMPORTANT ACADEMIC ISSUE, THEN SURELY IT IS A "HOT" ISSUE AS WELL

Miro Jakovljević & Ljerka Ostojić

School of Medicine, University of Mostar, 88000 Mostar, Bosnia and Herzegovina

SUMMARY

Professionalism has been a hot topic in medical education and in medicine in general. Professionalism in medicine embodies the relationship between medicine and society as it forms the basis of patient-physician relationships and the mutual expectations patients and physicians have of each other. Education on professionalism in medicine and professionalism in medical education are two important liasions. Increasing efforts have focused on fostering professionalism in medical education. Medical faculties have long taught the theoretical and technical aspects of medicine, but teaching professionalism in medicine and healing qualities has been a recent trend. The concept of professionalism has evolved over time by a process of exploration and reflection. It seems that medical professionalism has been changing from paternalism to partnership with patients and mutuality, from tribalism to collegiality, and from self-sacrifice to shared responsibility. There is still no consensus on how professionalism in medicine should be defined as and about the best methods for teaching medical professionalism. The aim of this "landscape" review is to promote the complete integration of a culture of professionalism into the educational and research body, including staff, faculty, residents and students.

Key words: *professionalism – medicine - education*

* * * * *

INTRODUCTION

The question of the identity and future of the medical profession is strongly associated with professionalism - the ways in which we define and practice fundamental principles, professional responsibilities, and competences in medicine. Medicine is generally defined as a profession in which a medical doctor's (MD's) knowledge, clinical skills and judgement is devoted to protecting and restoring human health defined as physical, psychological, social and spiritual well being. However, medicine should be more than simply a profession, rather a kind of calling and vocation. In the early 1900s William Osler claimed that „medicine should be a calling, not a bussines, a calling in which your heart will be exercised equally with your head" (see Arnold & Thompson 2012). According to the Royal College of Physicians and surgeons of Canada (2005) „physicians as professionals are commited to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior". However, the realities of contemporary medicine are awash in an ocean of complexities: global economic crisis; multiple specialties of medicine; increased demand for health services with limited resources; advantages and disadvantages of on-line technologies; concerns of cost-effectiveness; commercialism and evidence associated with the marketing based clinical trials; multiple roles of MDs which have led to neglecting vocational values and ideals established by the Hippocratic Oath (Cruess et al. 2002, ABIM et al. 2002, Spandorfer et al. 2012, Faman et al. 2013). Many MDs today experience profound obstacles to fulfilling the rules of medical professionalism and concerns, both within and outside of medicine, have been issued claiming that the medical education system may have lost its commitment to medical professionalism (Spandorfer et al. 2010). Commercialism and market mentality have expanded their influence to universities and medical professions. Health has become a comodity to be bought and sold to patients and their families where the market's offer and search as well as a bureaucracy influence health care delivery, not always for the benefit of the patient. Medicine has lost control over the health marketplace, no longer deciding its structure, methods of payment, or levels of remuneration (Cruess et al. 2002). The fundamental threats to the professional status of medicine come from public mistrust of the profession as the whole (Cruess et al. 2002). This increasing mistrust is related to the public perception that medicine has failed to self-regulate in a manner that can guarantee competence and responsibility, and that it places other interests before the interests of patients and the public. Medicine's reputation for altruism and humanism has also been undermined. Humanism has become just an addle concept for many people. On the other side, humanism and medical professionalism have been and are the heart and soul of medicine. Professionalism is what we do and how we do it when other people are looking at us; humanism is who we are when no one is looking. Professionalism without humanism in medicine is pure commercialism, amounting to nothing more than a bussines.

According to the Royal College of Physicians medical professionalism is more important now than ever before, partly because of recent high profile cases that have indicated poor professionalism (Engel et al. 2009). Surprisingly enough, the most complaints directed to the General Medical Council in the UK did not concern an MD's lack of knowledge, but rather their behavior (Engel et al. 2009). Similar situations in many countries and the time challenges stress the importance of redefining and developing professionalism in medical students and residents. Unfortunately, there are no widely accepted guidelines on the most effective ways to teach medical students/residents develop high standards of medical professionalism. An understanding of what medical professionalism is, its features, responsibilities, obligetions and competences, is very important if we are to face the challenges of our ever more interdependent, informed and complex world. This understanding should both involve and go beyond regulation by professional bodies, state institutions and governments. Both society and the medical profession should want compentent, responsible, moral, idealistic, altruistic, and humanistic MDs. For the ideals of professionalism to survive, medical students and physicians must understand it and its role in the social status and reputation of medicine. The aim of this viewpoint article is to summarise some issues of great importance for medical professionalism understanding and its promotion.

THE PHYSICIAN CHARTER–DEFINING PROFESSIONALISM IN MEDICINE SINCE 2002

Defining the essence of professionalism has been a hot topic in medicine during the last two decades (Gabbard et al. 2012). The major pillars of medicine as a profession are: 1. a specialized body of knowledge; 2. the altruistic service to patients and society; 3. the right to establish practice standards for MDs who maintain them through self regulation; and 4. the responsibility to guard the integrity of the profession's knowledge and its use (Spandorfer et al. 2010). Professionalism has traditionally been defined as a quality in an MD that embraces the morals, values, knowledge, judgement, and skills necessary for the provision of health services, as well as a degree of self-regulation, integrity, and autonomy (see McQueen et al. 2009). Current definitions of medical professionalism are evolving from autonomy to accountability, from expert opinion to evidence-based medicine, and from self-interest to teamwork and shared responsibility. Medical professsionalism involves both the relationship between MD and patient and the relationship between an entire profession and an entire society. It is apparent that all defenitions of medical professionalism represent some form of relationship between medicine and society (Table 1), where a set of values, knowledge, skills, and behaviors underpins the trust the public has in MDs.

Table 1. Professionalism as a contract between medicine and society

Society's Expectations of Medicine:
1. services of the healer,
2. assured competence,
3. altruistic service,
4. morality and integrity,
5. accountability,
6. transparency,
7. source of objective advice,
8. promotion of the public good.
Medicine's Expectations of Society:
1. trust,
2. autonomy,
3. self-regulation,
4. health-care system value driven and adequately funded,
5. participation in public policy,
6. shared (patients and society) responsibility for health,
7. monopoly,
8. status and reward, financial and non-financial, respect and status

The practice of medicine should be based on a love of humanity, guided by high ethical values, and administered by sound management and business methods. According to The Physician Charter developed by the American Board of Internal Medicine, the American College of Physicians, and the European Federation of Internal Medicine, the cornerstone of professionalism in medicine (see table 2) is related to the three fundamental principles and ten professional responsibilities (see Sox 2002, Spandorfer et al. 2010). The Charter has been endorsed by over 120 medical instititions all over the world in all fields of medicine, translated into more than 10 languages, and should be recognized as a universal document by society in the form of a contract between medicine and society.

Although the principles of the charter are a natural and obvious outgrowth of the basic principles of Western bioethics, the charter has been challenged by some critiques (Jotkowitz & Glick 2005). According to some opinions, no matter how noble the intentions of the charter are, MDs today have no power to carry out its mandates because the real power belongs to corporate health institutions, insurers, managed care organisations and politicians (Reisser & Banner 2003). Furthermore, the charter is contradictory in itself because it calls for the primacy of patient welfare (individual rights) and the pursuit of social justice (group rights), which are considered by some to be mutually exclusive (see Arnett 2003). As the MD-patient relationship should mandate obligations on both sides, a lack of emphasis on the side of patient responsibility may be the cause of problems in real life circumstances (Wartman 2003, see Jotkowitz & Glick 2005).

Table 2. The Physician Charter – A Declaration on Medical Professionalism Requirements for the New Millenium (Sox 2002, Jotkowitz & Glick 2005, Spandorfer et al. 2010)

Fundamental principles

1. Principle of primacy of patient welfare dates from ancient times and is intuitive and acceptable to most physicians. Altruism contributes to the trust that is crucial to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
2. Principle of patient autonomy is a product of the past century post-modern Western ethics. Physicians must be honest with their patients and empower them to make informed decisions about the way how they will be treated, cured or healed. („No decision about me, without me").
3. Principle of social justice is at first glance the most contradictory principle, but achievable and very important one. Physicians should promote justice in the health care system and work actively to eliminate discrimination based on race, gender, socioeconomic status,ethnicity, religion, or any other social category.

Professional responsibilities

1. Commitment to professional competence: Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care.
2. Commitment to honesty with patients: Physicians must ensure that patients are completely and honestly informed before they have consented to treatment. If patients are injured as a consequence of medical care they should be informed promptly because failure to do so seriously compromises patient and societal trust.
3. Commitment to patient confidentiality: Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information.
4. Commitment to maintaining appropriate relations with patients: Given the inherent vulnerability and dependency of patients, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.
5. Commitment to improving quality of care: This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimise overuse of health care resources, and optimize the outcomes of care
6. Commitment to improving acces to care: Physicians must individually and collectively strive to reduce barriers to equitable health care as well as to a uniform and adequate standard of care.
7. Commitment to a just distribution of finite resources: While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources.
8. Commitment to scientific knowledge: Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use.
9. Commitment to maintaining trust by managing conflicts of interest: Physicians have an obligation to recognize, publicly disclose, and deal with conflicts of interests that arise in the course of their professional duties and activities (conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals, etc).
10. Commitment to professional responsibilities: Physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the process of self-regulation, including remediation and discipline of members who have failed to meet professional standards

Addendum. Contribution of psychiatry to professionalism in medicine (Jakovljevic 2012)

1. Transdiciplinary principles of the learning organization: systemic thinking, shared vision, dialogue (thinking together),mental model, personal mastery, (Senge 2006, Jakovljević 2012)
2. Commitment to person-centered medicine with a holistic approach to physical, psychological, social and spiritual needs. Establishing rapport with patients and a relationship of mutual trust, respect and responsibility, is very important for treatment success.
3. Commitment to medicine as a calling, vocation, and mission, not simply as a duty, because a mission provides a sense of purpose that propels us into the future.
4. Commitment to post-conventional moral development and internalization of the values of virtuous MDs whose selflessness and humanism strives for the development of professionalism. Professionalism should be learned as a vision to be pursued in the context of learning organization, rather than a teaching organization with a set of rules and obligations.

Table 3. The challenges of time and the changes in medicine (Rosen & Dewar 2004, Beauchamp 2004, Cruess & Cruess 2012)

We are living in an exciting time of ever rapid change and increasing complexity associated with an explosion of new knowledge and fascinating developments in informatics and technology. However, we must be very careful to retain some of the traditional values of the medical profession and not become cyber-professional or rational technicians.
Since the second part of the last century all forms of authority were questioned and undermined, including the professions. It seems that the golden age of deference has gone, but let's hope not definitely.
Medical knowledge has been transformed from something possessed by MDs to something that can be accessed by anyone. In general, medical knowledge is not only something a MD posesses, but also something a MD permanently accesses.
According to the postmodernism movement, what we use to call 'truth', 'evidence' or 'knowledge' are in a great deal, just like 'good grammar', constructs of the operation of power and authority in medicine, typically at the level of social and medical institutions.
The tasks of healing have simply passed the capacity of any single MD, no matter how skilled or altruistic or self-surveillant. The craft of care has transformed into the machinery of care.
An increasing emphasis on evidence as opposed to clinical experience tends to undermine the equation between age and ability. Where evidence changes fast a reverse equation may be established, and the preference is for a MD who is experienced enough to be competent, but not so experienced as to be out of date.
A growing emphasis is being placed on the patient's commitment and role as an active partner in the treatment. MDs are expected to be interpreters helping patients to understand the mass of available information on internet.
A fundamentally moral rejection of paternalism ('MD knows best', 'MD has power') which implies some kind of parent-child relationship ('daddy/mammy knows the best), in line with principle „No decision about me without me". MDs are expected to transfer the knowledge and power to the patient. It is easier to reject paternalism than to offer a model to assume its place.
It is evident that our society is more consumerist, and less paternalist, than it was several decades ago. Paternalism represents a concern for what experts believe is good for people, irrespective of what those people want or think, while modern consumerism represents a concern for what people want, irrespective of whether or not it is good for them.
Increasing specialisation within medicine and the huge proliferation of tretment methods and possibilities has resulted in a narrower and narrower focus on conditions or parts of bodies, as opposed to the whole patient, their experiences, and the sense they make of them (person-centered medicine). Thus, a false opposition between curing and healing has been dominant.
A greater awarenes that MDs in general are not perfect and that individual MDs may be very bad has lead to a lower trust patients place in their MDs. Patients are more likely to challenge MDs and seek second opinions.
A conflict between the duty of care and the duty of the public purse guardians is very unpleasant. The question of how to handle the conflict between responsibilities to the individual patient and responsibilities to the wider community is emerging as one of the critical challenges for modern medical professionalism

Medical professionalism is associated with a long process of education and professionalisati with developping professional identity (Hilton & Slotnick 2005) and can be divided in the four contexts: 1. professionalism with patients, 2. professionalism in clinical/health-care teams, 3. professionalism across care pathways, and 4. professionalism in healthcare organisation (Christmas & Millward 2011).Within the medical profession itself there is enormous variety related to high technology application, hospital-based specialities and community-oriented branches. MDs carry out an increasingvariety of roles as clinicians, medical experts, managers, academics, communicators, collaborators, advisers, health advocates, and strategists. It is vital that they are clear about their specific areas of responsibility, professional boundaries, understand their own place in the team and understand the value and principle they follow.

THE CHALLENGES OF THE TIME AND MEDICINE: OPERATIONALIZING CONCEPTS FOR TEACHING

Health care has become a major industry in which physicians have a central role, and commercial interests, private or public, may pressure them to compromise their traditional responsibilities to their patients, study subjects and society. The increasing number of professional roles, commercialism and market mentality have made physicians and medical associations more vulnerable to situations that present conflicts of interest. Therefore, teaching professionalism may significantly contribute to building a framework for harmonius and effective delivery of health care services and improve patient satisfaction, treatment adherence, alliance and partnership, clinical outcome and spending. We fully

agree with Thomas S. Inui (2003) that „the present intensity of our discourse about professionalism in medicine represents both a flight from commercialism on the one hand, and a corresponding need to reaffirm our deeper values and reclaim our authenticity as trusted healers". Reaffirming our deeper values is closely associated with our theory of mind (mentalisation), emotional, social and spiritual intelligence. Components of mentalisation and emotional intelligence at work are self-awareness, self-regulation, motivation, empathy and communication skills. According to Goleman (1998) emotional intelligence is the capacity for recognizing our own emotions and feelings and those of others, for managing emotions in ourselves and in our relationships, and for motivating ourselves and others. Although science recognizes how essential nourishing communications and relationships are, human connections today seem to suffer from social corrosion. Emotional and social intelligence are mutually related but whilst emotional intelligence refers to self-awarenes and self-management, social intelligence refers to social awareness: primal empathy, empathic acccuracy , listening, social cognition, as well as to relationship management: synchronicity, self-presentation, influence, concern (Goleman 2006). Spiritual intelligence, which includes the ability to transcend the physical and material, to experience heightened states of consciousness, to derive deep meaning from experiences, to create and master a life purpose, to utilize spiritual resources to solve problems, and to be virtous, is of great importance for synchronizing emotional and social intelligence and reaffirming deeper values in medical professionalism.

In teaching fundamental principles and professional responsibilities, many challenges arise associated with changes in medicine (see table 3).

The rise of postmodernism in our thought and knowledge has provoked a serious discussion of the new challenges in contemporary medicine, science and education (see Jakovljevic 2007). Surprisingly, the postmodern approach asks for a new interpretation of altruism, humanism and personal sacrifice. Traditionally, most MDs have paid little attention to their own health, self-care and personal needs because medicine has been considered a calling (Beauchamp 2004). Today, a more even balance between professional responsibilities and private life is recommended. For MDs, being in a state of good health is crucial to a better practice of medicine. Medicine has increasingly become scientific, rational and technocratic with little space to accomodate the humanities. However, on the other hand, there is a growing recognition of the importance of the subjectivism, values, meanings, ethics, pluralism, and a comprehensive and holistic understanding. In undergraduate and postgraduate education there is a disbalance between modern, postmodern and hypermodern approachs to science as well as between medicine based on science and medicine as an art or ars medica (see table 4).

Table 4. Emphasized and underemphasized areas in undergraduate and postgraduate education (Hilton & Slotnick 2005)

Underemphasized	Emphasized
Art	Science
Professionalism	Expertise
Reflective practitionar	Technical rationality
Mindfulness	Mindlessness
Humanism	Bioscience
Subjective	Objective
Empathy	Detachment
Relationship-centered	Evidence-based
Generalism	Specialism
Collegiality	Hierarchy
Inter-professionalism	Intraprofessionalism

Hilton and Slotnick (2005) propose a more evident balance to foster professionalisation from the earliest opportunities. Narrative-based and value-based medicine and discursive based practice are essential issues of clinical practice. A narrative approach means setting aside the view that there is a single truth, no matter whose, the MD's or the patient's, because the truth is based on the participants' overt and hidden values. It seems that there should be substantial advantages to society in promoting professionalism as an effective value-based system, because according to Sullivan (1995) „neither economic incentives nor technology nor administrative control has provedan effective surrogate for the commitment to integrity evoked in the ideal of professionalism" (see Cruess et al. 2002). Professionalism in medicine includes not only knowledge,evidence, expertise and specialism, skills of brain and hand, but also communication skills of the mind and the virtues of trustworthines, respectiveness, altruism and humanism, attributes of the soul and heart. With brain, mind, soul, heart and hand of MDs working in concert at benefitience of individuals and society, specialised medical knowledge and expertise promote what has always been recognised as the hallmark of medical profession: integrity, honesty, beneficience and public good

WAYS AND INSTRUMENTS FOR TEACHING AND ASSESSING MEDICAL PROFESSIONALISM

The importance of teaching and assessing medical professionalism has been recognized in many countries worldwide and literature on professionalism has grown exponentially over the past decade (Passi et al. 2010, Cruess & Cruess 2012). Notwithstanding the lack of a generally accepted definition of medical professionalism and guidelines concerned with how professiona-

lism in medicine should be tought and assessed, signifycant progress in the area of medical professionalism has been achieved. There are a wide range of approaches and instruments available for teaching and assessing medical professionalism, so each medical institution can make a choice appropriate to its specific environment. Simply presenting medical students with list of what professionalism is about in a parrot teaching fashion is usually disappointing. It is more productive to outline the positive and negative models and examples from real life through an open and interactive discussion. Professionalism issues are often a part of a „hidden curriculum", which is another challenge mentioned in medical education literature (Kirk 2007). This means that its components do not operate within the formal curriculum, but in more subtle educational topics and less recognized educational activities. The formal curriculum is related to what educators teach, whilst the „hidden" curriculum represents what they do. The hidden curriculum operates at the level of organizational structure and culture. Harmonizing „hidden", formal and informal curriculums can significanty contribute to the elimination of so called „double-bind", dissonant or contradictory messages.

Students' professional behavior is positively associated with their personal characteristics, but may be even more dependent on the context of their learning and practice. The educational and work context underpin the acquisition and maintenance of medical professionalism in positive (attainment) and negative (attrition) ways (Hilton & Slotnick 2005). Attrition results from the adverse effects of the environment such as negative role models, unsupportive learning or working conditions, and pressure from being overwork. This can transform the naive idealist into a cynic (Hilton & Slotnick 2005); and sarcastic cynics are often previously disappointed idealists.

Table 5. Teaching and learning methods (Passi et al. 2010)

Experiential; Reflective practice
Clinical contact including tutor feedback
Undergraduate ethichs teaching
Problem based learning
Role play exercises
Bedside teaching
Educational portfolios
Videotaped consultation analysis
Significant event analysis
Workshops, Interactive lectures
Humanities writing: reading poetry/prose related to patients and doctors
Monitoring programmes

There is currently no commonly accepted theoretical model being used for the integration of professionalism into the undergraduate or posgraduate curriculum. As the teaching and acquiring professionalism is highly context dependent and long term evolutionary process, medical educators may choose the methods the most appropriate for their circumstances (Passi et al. 2010) (Table 5).

It is a well known fact that teachers, being role models, consciously or/and unconsciously influence students through an identification or imitation processes. It is not uncommon for students to occasionally observe lapses in professionalism commited by their teachers that they have been taught to avoid (Hays et al. 2013). It has been generally emphasized that profesional values are caught and not taught to the majority of students (Galle-Grant et al. 2013). Hence, medical institutions are recommended to promote the professionalism of staff who act as positive role models (Passi et al. 2010).

Notwitstanding a large number of different instruments developed, there is no single instrument for measuring all aspects of medical professionalism (Passi et al. 2010). A multidimensional approach with instruments for both formative and summative assessment is recommended.The academic literature on the assessment of professionalism has changed the focus from development and attainment of professional identity to the attainment of a set of identifiable positive attributes and behaviors (Goldi 2013). Quite a number ways have been proposed how to more accurate assess professionnalism like the use of objective structured clinical exams (OSCEs) and simulated patient based assessment, student peer review, the so-called 360-degree evaluation from multiple sources, qualitative measures utilising humanism „connoisseurs" for expertise in the interpersonal components of the medical art, „virtual practicum" with a simulation that mirrors realism and complexity in practice with difficult ethical situations and communication dillemas (see Shrank et al. 2004). It is interesting that some schools have been developing policies and mechanisms for formally identifying and working with students who display unprofessional behavior (Shrank et al. 2004). The American Academy of Pediatrics has proposed a very useful and practical evaluation list represented on the table 6 (Klein et al 2003).

This evaluation views a professionalism as a set of virtues toward which MDs continually strive. Professionalism as a set of virtues involves the wise application of the principles of excellence, humanism, accountability, and altruism that rest upon a foundation of clinical competence, communication skills, and ethical and legal understanding (see Arnold & Thompson 2010).

Table 6. Evaluation of professionalismin residents (developed by the American Academy of Pediatrics, see Klein et al. 2003)

Components of Professionalism	Meets Expectations	Needs Improvement	Cannot Assess
1. Honesty/integrity Is truthful with patients, peers, and in professional work (e.g., documentation, communication, research).			
2. Reliability/responsibility Is accountable to patients and colleagues. Can be counted on the complete assigned duties and tasks. Accepts responsibility for errors.			
3. Respectful of others Talks about and treats all persons with respect and regard for their individual worth and dignity; is fair and non-discriminatory. Routinely inquires about or expresses awareness of the emotional, personal, family, and cultural influences on patient well-being and their rights and choices of medical care; is respectful of other members of the health care team. Maintains confidentiality.			
4. Compassion/empathy Listens attentively and responds humanely to patient's and family members' concerns; provides appropriate relief of pain, discomfort, anxiety.			
5. Self-improvement Regularly contributes to patient care or educational conferences with information from current professional literature; seeks to learn from errors; aspires to excellence through self-evaluation and acceptance of the critiques of others			
6. Self-awareness/knowledge of limits Recognizes need for guidance and supervision when faced with new or complex responsibility; is insightful of the impact of one's behavior on others and cognizant of appropriate professional boundaries			
7. Communication/collaboration Works cooperatively and communicates effectively to achieve common patient care and educational goals of all involved health care providers.			
8. Altruism/advocacy Adheres to best interest of the patient; puts best interest of the patient above self-interest and the interest of other parties.			

Table 7. The struggle to stay centered on values in the profession of medicine (Inui 2003)

Ideal	Foundational value	Reality
Evidence-based	Truth/Science	Uncertainty
COI (confluence)	Therapeutic Aliance	COI conflict
Caring, healing	Curing	Risk-harming
Open heart/mind	Accepting, Emphatic	Arrogant/unmoved
Error-free	Right action	Mistake-prone
Analytic	Reflective	Hassled, knee-jerk
Self-sacrificing	Altruistic	Avaricous

COI : conflict-of- interest

MOVING FROM PROCLAMATIONS TO BEHAVIORS IN PRACTICE

Acknowledging that the educational process in medicine changes, in some substantive sense, who we are as well as how we relate to others, may be the key to understanding why we need to be mindful, articulate, and reflective about the process (Inui 2003). It is truism that students and residents need to understand medical profession's ideals and values in practice (Table 7).

We value scientific truth and depict medicine as evidence-based practice, but we sometimes encounter the limits of evidence in specific clinical cases in the form of evidence-biased practice. It is not always easy to make the distinction between real evidence-based medicine and eminence-based, fashion-based or marketing-based medicine. Guidelines in the form of „cook-book" medicine offer a false certainty and may be very limitating and even dangerous (see Jakovljevic 2007b). Our first professional duty is to cure patients,

yet we always risk harm. It is interesting that the Old Greek word „pharmakon" means both remedy and poison, and is closely related to „pharmakeus" - magician or sorcerer and „pharmakos" – scapegoat. The fact that one and the same substance may be a remedy and poison stresses the double-sided aspect of pharmacotherapy (see Jakovljevic 2009). Scientific, rational and creative pharmacotherapy is a matter of estimating risk-benefit ratios. Though all MDs value right action in the right time and tend to minimize risks and errors, like all people, MDs are not error-free in practice. Furthermore, MDs tend to be analytic and reflective, but in every day practice may be hassled and engaged in emotional decision making and impulsive reactions. We tend to build therapeutic alliances and partnership with our patients through establishing a confluence of interests, but at the same time we encounter many conflicts of interest which we must resolved. „When exercising openhearted empathy, we are vulnerable and sometimes injured by those we are seeking to help. Learning from this hard experience, we attempt to establish a 'therapeutic distance' at the risk of appearing unmoved and arrogant" (Inui 2003). The power games (psychological roles which convert to each other: victim, persecutor and rescuer) happen sometimes between MDs and patients and always have adverse effect on the professional relationship and treatment outcome. We all proclaim humanism, altruism and self-sacrifice as admirable, but sometimes we appear to be selfish and our interests are income oriented. As early as 1930s Talcot Parsons pointed to an ostensible conflict between the profession's altruism and self-interests (see Hilton & Slotnick 2005). Considering all of the above, it is evident that our ideals have been clearly identified, but it remains a challenge to put theory into practice (Inui 2003).

The adage „do as I say, not what I do" illustrates the cognitive dissonance related to the conflict between lessons in the classroom and real-world settings (Spandorfer et al. 2010). In medical education, clinical teachers consciously or unconsciously represent role models for students, and that's why it is of great importance that medical institutions practice methods to develop the professionalism of staff who act as positive role models (Passi et al. 2010). If we really want to achieve a high level of professional behavior in practice on the part of students and faculty as well as residents and physicians, we need to provide education as a learning organization which designates and develops professionalism as a part of life philosophy, discovering life mission, personal identity, professional and social roles and life goals. Most people lack a sense of mission, and some people don't even think about it. Rather, they have a job, duty or career. Goals without a mission lack passion and deep meaning. Goals inside a mission energize everything we do with meaning, enthusiasm, and fun. A mission is something we discover within us. By discovering our mission, we can be sure the goals we pursue are ours, we love what we do, and we can make sure that our journey through life unfolds with a passion that energizes every fiber of our being (Andreas & Foulkner 1996).

The human rights of patients to interpret their experiences in their own way, and to receive help accordingly, have become a fundamental and confusing challenge to the old order of beneficient paternalism that has characterised professional work in health care. The typical paternalism of the medical profession, characterized by a MD's benevolence and beneficience for patients without their autonomy, may be sometimes defined as a human rights violation associated with a rough form of expertocratic thinking based on the idea that „doctors know best" (Lolas 2010). Human rights are not a matter of declarations, but a matter of life philosophy and axiology. Greater access to health and treatment information via the Internet, and the rise of human rights movements and empowerment of organizations of the users of medical services, may in some situations contribute to a dissatisfaction with medical services and health care in addition to mistrust in the pharmaceutical industry, politicians and society in general.

Table 8. Public expectations from MDs

MDs are wanted to:

- be good at 'curing' as well as in 'healing';
- treat people when they get ill and keep them healthy in the first place;
- balance the needs of the individual patients with the needs of the whole community (social justice);
- adopt different kinds of role in response to different kinds of patient;
- influence quality of care while maintaining personal standards of excellence;
- take responsibility for the quality of the work of the team and of the wider service in which it functions;
- to recognize own strenghts and weakness and take responsibility for decreassing weakness and increasing strengths:
- clarify what they do, how and why they do it.

For MDs 'patient centredness" might mean one of the four things: that they work in patients' interests; that they practice in accordance with patients' preferences or wishes; that they are in partnership with patients; or that they take a person-centered approach. The days of 'MD knows best' and 'your job is to do what I say and get better' have passed, and if not yet lost from the mind of

every MD and patient, then are numbered. Professional boundaries create a frame in which the MD-patient relationship can thrive and in which medical problems can be identified and solved, or in other words, the real meaning of patient-centredness. They designate an optimal context for the MD to act in a professional role that is designed to diagnose and treat the patient's health problems. Boundary violations may cause irreparable damage to the therapeutic process and to the patient because they commonly occur in „a descent down a slippery slope of ever-increasing transgressions" (Gabbard et al. 2012).

Public and personal trust in the profession of medicine is a necessary precondition for caring and healing, and restoring this trust will require all of us (Inui 2003). Public trust is a strongly associated with public expectations from MDs (see table 8).

Table 9. Seven professional sins or non-virtues

„All professions are conspiracy against the laity"
George Bernard Shaw: The Doctor's Dilemma

1. Greed (pursuit of money, power or fame);
2. Abuse of power (patients and their families, collegues or position);
3. Arrogance (towards patients and colleagues);
4. Misrepresentation (lying or fraud);
5. Lack of conscientiousness (lack of commitment, doing only the minimum, Iresponsibility, iatrogenesis and „doctor-made" sickness and injury);
6. Impairment (drugs, alcohol, severe smoking, illness, fatigue);
7. Conflict of interest (financial, pharmaceutical Industry).

Trust is always built over time, and earnerd through repeated successfull encounters between MDs and patients, and government and medical leaders.)

However, public trust is a very fragile commodity and can easily turn into mistrust. Public mistrust is often incurred through the commision of the seven professional sins in medicine (Table 9) which manifest as unprofessional behaviors (Table 10).

In addition to the positive components of professionnalism, it is of great importance that students/residents recognize unprofessional behaviors and features which can be threats to professionalism . Clear communication what is to be expected of MDs and what the professional standards for medical practice are may help to increase public trust (Rosen & Dewar 2004). These activities can beundertaken at a local or national level, between individual MDs and their patients, as well as between medical institutions and the wider public and government.

Table 10. Unprofessional behavior (the American Bord of Internal Medicine - ABIM 2001)

- Abuse of power: abuse while interacting with patients and collegues, bias and sexual harassment;
- Arrogance: offensive display of superiority and self-importance;
- Greed: when money become driving force;
- Misrepresentation: lying, which is conscious failing to tell the truth, and fraud which is a conscious misrepresentation of material fact with the intent to mislead;
- Impairment: any disability that may prevent
- the MD from discharging his/her duties;
- Lack of conscientiousness: failure to fulfil responsibilities;
- Conflicts of interest: self-promotiom and advertising and unethical collaboration with industry, acceptance of gifts;
- Misuse of services: overcharging, inappropriate treatment or prolonging contact with patients.

MEDICAL PROFESSIONALISM AND DIVERSITY AT THE SCHOOL OF MEDICINE, UNIVERSITY OF MOSTAR

Professionalism in medicine is a complex, multi-dimensional concept that varies across history and socio-cultural contexts (Goldie 2013). It has been rooted in a long tradition of altruistic service in health care and high ethical standards, and shaped by public expectations and legislative regulations. The role of MDs has always responded to changes in demands associated with changes in society, public expectations, the structure of health care services, and the development of medicine itself. It is a mistake to believe that there is one fixed version of medical professionnalism with its own autonomous existence. Claims that the pre-war years in Bosnia and Herzegovina saw the last days of a dark or golden age of paternalistic medical professionalism stability are at best a simplification, at worst false, depending on one's ideologic perspective. The story of a stable, monolitic socialistic or old medical professionalism is just a myth. The challenges to medical professionalism in post-war Bosnia and Herzegovina have different aspects. The profile of personal values and motivations that MDs bring to their health care practice is not the same as it was before the war. There are many reasons for this which in addition to postwar political and socioeconomical changes, include generational change, an increasing number of women in medicine, social mobility, cultural and political diversity, etc. The growth of evidence-based

medicine and the availabilty of information technology have radically changed medical knowledge from something exclusively possed by MDs to something that can be available to anyone. MDs need new skills and capabilities to deal with the changing demands from patients and their families. A number of MDs feel more or less deprofessionalised from many reasons. The word professionalism means different things to different people. Professionalism has traditionally been defined as a quality in an individual MD, combining values, knowledge, skill, integrity and clinical judgment. There have been a lot of problems with the mutual practice and application of professionalism in medical teams, not only with the individual MD.

The spirit of the time and shifts in public attitude have diminished the autonomy of the medical profession, have given patients more active and demanding roles, and have enhanced the potential for both conflict and collaboration. As the age of deference has passed, MDs are exposed to requests that demand clarification of what they do, how they do it, and why they do it. The practice of medical professionalism is hampered by the political, economic, and cultural factors and environment of health care, which many MDs recognize as disabling. The conditions of current medical practice do not satisfy the conditions that are expected and wanted. A crisis in professionalism has inspired leaders and schools of medicine to find agreement on what professionalism in medicine really is and call for a renewal in current circumstances. Adjusting course curicula and increasing the awareness of professionalism represents only the beginning. The great challenge is how to reconcile the gap between our aspirations and our current diverse reality.

Diversity in Bosnia and Herzegovina is multifaceted and remarkable in terms of ethnic and cultural origin as well as in political and economical terms. This diversity is mainly rooted in the history, the recent war, and geography. Research has shown that patients have a better treatment outcome when they are treated by physicians who can appreciate and relate to their background and experiences and that provide culturally safe and competent health care. The School of Medicine at the University of Mostar recognizes, supports and promotes diversity among students, stuff and faculty, encompassing diversity in ethnicity, culture, religion, gender, sexuality, physical ability, geography and socioeconomic status.

The goal of The Mostar School of Medicine is to promote the complete integration of a culture of professionalism in educational and research activities among its staff, faculty, residents and students. The study of professionalism has yet to be formally and distinctly recognized in the official curriculum, but is covered in subtler educational activities, through Medical Ethics, and spread through various other courses, recognized in the so-called „hidden curriculum". Through the „hidden curriculum" some practical and useful suggestions in promoting medical professionalism can be identified (see table 11)"

Table 11. Some practical suggestions for medical students

- Strive topractice the highest standards of honor and ethical behavior.
- Strive to develop medical knowledge and skills with love to the best of your ability.
- Strive for excellence, and practice humility. Recognize the limits of your competence. Ask for help whenever you really need it.
- Be observent and reflective, honest and trustworthy. Listen carefully to people/patients and respect their view.
- Show in your behavior and speech respect for all people and communicate with them in a courteous and considerate manner. Strive to create rapport.
- Be punctual, reliable, conscientious and truthful in fulfilling clinical responsibilities.
- Tell the truth in a careful and the most appropriate way. Give patients information in a way they can understand.
- Under no circumstances record false information or statistics, never purposely falsify information or misrepresent a situation.
- Ask for, be open to, and be grateful for feedback about professional performance.
- Say you are sorry when you heart someone or make a mistake. Learn from your mistakes lest you repeat them.
- Develop healthy self-care behaviors and coping skills. Work on your good sense of humor.
- Remeber that the best physicians are those who communicate well with their patients and their families and thus get their confidence and trust.
- Maintain a professional appearance, hygiene and demeanor with attire that is appropriate to the medical setting.
- Clear identify your role as a medical student, future MD or resident to each patient and do not undertake any clinical procedure unless you have been judged competent or are supervised by a qualified tutor.
- Remember Osler's paraphrased words that a good MD will treat the disease, while the great MD will treat the person with disease.
- Attainment of medical professionalism is a long term process of learning, experience and personal maturation for which a good start at the undergraduate period with explicit rather than implicit attention is very important.

Having finished the school of medicine, young MDs receive an official ceremony and solemnly swear to abide the Hippocratic oath which contains the basic principles and values of medical professionalism. The Oath represents a public statement about professional medical duties and responsibilities which includes a dedication to life under all circumstances, a commitment to service for the best interests of patients, altruism, avoiding all forms of discrimination, confidentiality, collegiality, life-long learning and promoting the MD-patient relationship at the highest level. We are fully aware that the learning environment should be transformed so that students and residents see, hear and experience the ideals of medical professionalism in day-to-day practice and can better understand the demands of public expectations and medicine in general.

CONCLUSIONS

We are constantly going through social changes as well as through scientific and technology changes, redefining the core and boundaries of medical professionalism. Pateints and their families have increased expectations for the effectiveness and efficiency of treatment. Modern medical care is delivered by teams, not by individuals, so the model of the heroic doctor single-handedly treating patients has little relevance compared to the collaborative nature of modern health care. Hence, MDs ability to interact with others, both with patients and their families and with colleagues is very important. Cooperation shifts the focus from control and compliance towards influence and alliance. Professionalism is a challenge and a mandate in medical education which serves an important societal purpose. It should be an essential component of the formal medical curriculum at the undergraduate and postgraduate training levels. Professionalism without humanism can be difficult to maintain, so the active engagement in activities that foster humanistic and altruistic behavior is very important. The values and competences of medical professionalism are both taught and modeled. In medical education, clinical teachers consciously or unconsciously act as role models for students . It is fundamental that medical institutions develop supportive learning environments and promote the professionalism of staff who act as role models. Learning medical professionalism is a challenging, evolving, and lifelong endeavor. Professionalism is not only about fulfiling a pre-defined role, it is also about recognising which role any given situation calls for. Last but not least, it is also very important that medical teachers worldwide exchange ideas and experiences regarding the promotion of medical professionalism.

Acknowledgements: None.

Conflict of interest : None to declare.

References

1. *ABIM (American Bord of Internal Medicine): Project Professionalism. 2001. http:/www.abim.org/resources/ publications/professionalism.pdf.*
2. *Andreas S, Faulkner & the NLP comprehensive training team: C: NLP: The New Technology of Achievement. Nicholas Breavely Publishing, London, 1996.*
3. *Arnett JC: Letter to editor (untitled). Ann Intern Med 2003; 138:853.*
4. *Arnold L &Thompson G:Defining, teaching and learning professionalism. In Spandorfer J, Pohl CA, Rattner SL & Nasca TJ (eds): Professionalism in Medicine – A Case-Based Guide for Medical Students, 7-21. Cambridge University Press, 2010.*
5. *Beauchamp G: The challenge of teaching professionalism. Ann Acad Med Singapore 2004; 33:697-705.*
6. *Christmas S & Millward L: New Medical Professionalism. A scoping report for the Health Foundation. The Health Foundation Inspiring Improvement, London, 2011.*
7. *Cruess SR, Johnston S & Cruess RL: Professionalism for medicine: opportunities and obligations. MJA 2002; 177:208-211.*
8. *Engel N, Dmetrichuk J & Shanks AM: Medical professionalism: can it and should it be measured? BMJ Careers 2009. Careers.bmj.com/careers/advice/view-article.html?id=20000522*
9. *Faman JM, Sulmasy LS, Worster BK, Chaudhry HJ, Rhyne JA, Arora VM, for the American College of Physician Ethics, professionalism and Human Rights Committee; the American College of Physicians Council of Associates; and the Federation of State Medical Boards Special Committee on Ethics and Professionalism. Annals of Internal Medicine 2013; https://annals.org/on 04/11/2013.*
10. *Gabbard G, Roberts LW, Crisp-Hahn H, Ball V, Hobday G & Rachal F: Profesionalism in Psychiatry. American Psychiatric Publishing, Washington, DC, 2012.*
11. *Galle-Grant O, Gatter M & Abel P: Developing ideas of professionalism. The Clinical Teacher 2013; 10:165-169.*
12. *Goldie J: Assessment of professionalism: A consolidation of current thinking. Medical teacher 2013; 35:e952-e956. DOI: 10.3109/0142159X.2012.714888*
13. *Goleman D: Working with Emotional Intelligence. Arrow Books, 1998*
14. *Goleman D: Social Intelligence: The New Science of Human Relationships. Arrow Books, 2006.*
15. *Hays R, Hamlin G & Worthington R: Developing professionalism in health professional learners. The Clinical Teacher 2013; 10:64-66*
16. *Hilton SR & Slotnick HB: Proto-professionalism: how professionalisation occurs across the continuum of medical education. Medical Education 2005; 39:58-65.*
17. *Inui TS: A Flag in the Wind: Educating for Professionalism in Medicine. Association of American Medical Colleges, 2003.*

18. *Jakovljevic M: Professionalism in psychiatry and medicine: A hot topic. Psychiatria Danubina 2012; 24:342-345.*
19. *Jakovljevic M: The side-effects of psychopharmaco-therapy: Conceptual, explanatory, ethical, and moral issues – Creative psychopharmacotherapy instead of toxic psychiatry. Psychiatria Danubina 2009; 21:86-90.*
20. *Jakovljevic M: The brave new psychiatry: Beyond modernism, antimodernism and postmodernism in psychiatry. Psychiatria Danibina 2007; 19:122-129.*
21. *Jakovljevic M: Myths and facts in contemporary psychopharmacotherapy: Evidence-based vs. evidence-biased treatment algorithms practice. Psychiatria Danubina 2007; 19:342-349.b*
22. *Jotkowitz AB & Glick S: The physician charter to medical professionalism: a Jewish ethical perspective. J Med Ethics 2005; 31:404-405*
23. *Kirk LM: Professionalism in medicine: definitions and considerations for teaching. Proc (Bayl Univ Med Cent) 2007; 20:13-16.*
24. *Klein EJ, Jackson JC, Kratz L, Marcuse EK, McPhilips HA, Shugerman RP, Watkins S & Stapleton FB: Teaching professionalism to residents. Acad. Med. 2003; 78:26-34.*
25. *Lolas F: Psychiatry: a specialized profession or a medical specialty. World Psychiatry 2010; 9:34-35.*
26. *McQueen D, Smith PSJ, Kemp G, Munk-Jorgensen P & Michael A: Psychiatric professionalism, multidisciplinary teams and clinical practice. European Psychiatric Review 2009; 2:50-56.*
27. *Passi V, Doug M, Peile E, Thistlethwaite J & Johnson N: Developing medical professionalism in future doctors: a systematic review. International Journal of Medical Education 2010; 1:19-29.*
28. *Reiser SJ & Banner RS:The Charter on Medical Professionalism and the limits of medical power (editorial). Ann Intern Med 2003; 138:844-846,*
29. *Rosen R& Dewar S: On Being a Doctor – Redefining Medical Professionalism for Beter Patient Care. King+s Fund, London, 2004.*
30. *Senge P: The Fifth Discipline – The Art & Practice of The Learning Organization. Random House Bussines Books, 2006.*
31. *Shrank WH, Reed VA & Jernstedt GC: Fostering professionalism in medical education: A call for improved assessment and meaningful incentives. J Gen Intern Med 2004; 19:887-892.*
32. *Sox H (ed) on behalf of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine: Medical professionalism in the new millenium: A physicvian charter. Annals of Internal Medicine 2002; 136:243-246.*
33. *Spandorfer J, Pohl CA, Rattner SL & Nasca TJ. Introduction. Professionalism in Medicine. A Case-Based Guide for Medical Students, 1-4. Cambridge University Press, 2010.*
34. *Sullivan W: Work and Integrity: The Crisis and Promise of Professionalism in North America. Harper Colins, New York, 1995.*
35. *Wartmann SA: Letter to editor (untitled). Ann Intern Med 2003; 138:854-855.*

Correspondence:

Prof. dr. Miro Jakovljević, MD, PhD
School of Medicine, University of Mostar
88000 Mostar, Bosnia and Herzegovina
E-mail: predstojnik_psi@kbc-zagreb.hr