

Preserving Medical Ethics and Professionalism: Meeting the Challenges of Modern Practice

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Medical practitioners today are confronted with an unprecedented degree of complex challenges and expectations. At the same time, their conduct and services are placed under close scrutiny by an increasingly critical and demanding public. On one hand, they are expected to be empathic communicators armed with good bedside manners and sensitivity to the needs and rights of their patients.¹ In multi-ethnic Singapore, they also have to be cognizant of religious and cultural influence in patient's decision-making, and negotiate with great sensitivity. Yet on the other hand, they have to be effective stewards of healthcare resources, in particular those in public healthcare institutions, and be capable of articulating concepts of distributive justice to patients who may feel otherwise. An analysis of General Medical Council (GMC) documents regarding regulation and fitness to practice from 1963 to 2005 demonstrated a shift over the period of time from a doctor-centred regulatory discourse to a patient-centred health improvement agenda.² To add to these, the infiltration of commercial values and consumer-driven practices into the healthcare delivery system threaten to undermine patient trust and confidence. Yet, society expects doctors, especially those in private practice, to adopt a business mentality without losing their professional virtues. Besieged by these challenges, doctors begin to question the meaning and relevance of medical professionalism, and to wonder if values and aspirations articulated in their professional code are still pertinent in this rapidly changing world.

It is a common misconception for many, including doctors, to interpret professionalism narrowly in terms of technical competency alone, referring only diagnostic accuracy, therapeutic use of drugs or surgical skills. Few would disagree with the position that assurance of a benchmark in these so-called "hard skills" is fundamental to maintaining the trust of patients and society. But recognising that medical uncertainty, information asymmetry and patient vulnerability are still very much relevant factors even in this age of advanced medical and information technology, doctors need also be "competent" in a code of behaviour where they pledge to always use their technical abilities for the best interests of the patients, even if it means having the doctors' own interests sidelined. Indeed, if professionalism is about earning and enhancing patient and societal trust, then medical ethics can be seen as an accumulation of values and principles, including their reasoning and justification, which help distinguish conduct and practices that are trustworthy from those that erode both trust and professionalism.² This was emphasised in the 2005 report by the London Royal College of Physician's Working Party on Medical Professionalism which defined 'medical professionalism' as a set of values, behaviours, and relationships that underpins the trust the public has in doctors.³

Therefore, to maintain and nurture trustworthiness, doctors can no longer rely on therapeutic skills or technical competency alone. They require a new set of skills and attitudes, defined broadly as a familiarity with fundamental ethical principles and guidelines, and the ability to apply them practically in daily clinical and practice management decisions, especially in resolving challenging ethical dilemmas. Ethical competencies will enable doctors to give reasonable justifications for their decisions and actions, and guide them when encountering new situations in practice. Unfortunately, ethics and professionalism have only gradually become an integral part of medical education in the last decade or so, thus leaving many doctors "untrained" in medical ethics.

The ethics of professional medical practice (and the ensuing ethical codes and practice guidelines) have evolved from the Hippocrates tradition as recorded almost 2500 years ago in the *Corpus Hippocraticum*, and the Hippocratic Oath. This ethical framework remains today as one of the most important perspectives and source of guidance for doctors, expressed in the ethical codes, guidelines and advisories of medical councils and professional bodies. The ethical code represents the fundamental tenets of conduct and behaviour expected of doctors while the ethical guidelines elaborate on the application of the code and are intended as a guide to all practitioners as to the minimum standards required of them in the discharge of their professional duties and responsibilities.⁴ Most of the modern equivalents today, in particular the ethical guidelines, have been revised or rewritten to incorporate novel developments in medicine so as to keep the guidelines relevant and effective for self-regulation. Examples of such revisions include interaction of doctors with complementary therapies, telemedicine and end-of-life care, to list just a few. As an effort to reaffirm the principal importance of medical professionalism, many medical councils and medical schools now mandate the public recitation of their respective physician's oath or pledge by newly registered doctors and medical students, respectively, as a sign of public profession and affirmation of their ethical obligation towards the patients. Meanwhile, postgraduate courses and lectures on ethics and professionalism are gradually becoming a regular feature on the Continuing Medical Education calendar.

Although ignorance has frequently led to many doctors inadvertently committing unprofessional behaviour that has resulted in disciplinary proceedings, most will agree that familiarity or even an ability to recite the entire ethical code and ethical guidelines without missing a punctuation mark does not guarantee ethical conduct and professionalism. Internalisation of the profession's moral edict has to take place before it can manifest as attitudes and behaviour. Doctors need to adopt a "sense

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and sensibility” approach, where ethical sensitivity precedes the application of sensible principles to guide decisions and behaviour. For without a sense of what is right and wrong (*the ‘heart’*), one is unlikely to initiate an ethical analysis to arrive at a conclusion consistent with one’s professional ethos (the application of *‘head knowledge’*). Doctors will need both sets of skills in order to effectively detect and resolve ethical issues in their day-to-day practice. Therefore, in addition to proficiency in ethical principles and analytical skills, doctors will need to develop their moral alarm to ethical issues.

One of the more established (but often neglected) approaches to nurturing ethical sensitivity is to adopt a life-long regular practice of *reflective learning*. Reflection is the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self: and this can result in a consolidated or changed conceptual perspective, which then translates into a modification in insights, attitude and behaviour.⁵ Reflective learning accompanied by critical thinking can also result in development of new knowledge, intellectual skills, better self-awareness and creativity.^{6,7} Unfortunately, the practice of medicine has often been narrowly portrayed as an “action-oriented” profession with incentives and recognition leaning heavily towards visible and overt clinical activity. Even the highly regarded clinical quality improvement movement tends to comprise busy activities such as clinical audits and implementing action plans. (Although one may argue that reflection is inherent in the attempt to come up with improvement strategies, this is usually less overt and highly task-centric.) The consequential neglect or under-emphasis of introspective skills, especially at the individual level, has led to superficial, or worse, erroneous interpretation of the ethical tenets of professionalism with no substantial attitudinal and behavioural transformation. Many medical institutions are only now beginning to recognise this deficiency, hence are incorporating the teaching of reflective skills into medical training and education.

A significant number of doctors practice today in healthcare organisations (HCOs) or institutions which have their own set of organisation ethics, expressed in vision and mission statements and in core policies and values. As a member of the organisation where they are employed, doctors are contractually bound to embrace and comply with the organisation’s vision, mission, policies and culture. Nevertheless, their commitment to the principles and practice of medical ethics and professionalism, which is primarily a fiduciary and patient-centred framework, is *not* a negotiable obligation. This interface of professional medical ethics and organisation ethics often leads to challenging conflicts for the practitioner. Alignment between professional ethics and organisation ethics is needed to avoid such inconsistency, and to ensure the integration of professional medical ethics into organisational ethics without a loss of integrity.

Spencer and colleagues⁸ highlighted in their book titled *Organisation Ethics in Healthcare* that there are several issues inherent in this interface. Firstly, clinical ethics problems have organisational implications. Resolution and prevention of recurrence of similar issues may require changes in organisational structure and policies. Secondly, many problems in clinical and professional ethics have organisational causes. Analyses of ethical cases have often identified contributions from existing

organisational structure and policies, either due to the neglect of clinical ethics when implementation of organisational policies or a lack of discussion or negotiation when shifting organisational values or priorities. Thirdly, paradigmatic issues in clinical ethics such as confidentiality, truth-telling, conflicts of interests and informed consent, have organisational analogues. Spencer and colleagues⁸ rightly pointed out that HCOs are very much a part of the social contract between the healthcare profession and society for delivery of healthcare services. The practice of clinical and professional ethics is thus an organisational obligation of HCOs and they are therefore similarly subject to many of the ethical expectations the society has of individual medical practitioners.

In a HCO which incorporates clinical and professional ethics as an integral function of the organisation, doctors no longer need to be “moral heroes” in order to do the right thing for patients. It also injects a more balanced perspective on their role as patient advocates, taking into account valid organisational and population considerations. The Integrated Ethics programme implemented in the US Veteran Affairs healthcare system views a strong ethics programme as a form of preventive framework⁹ that can reap many concrete benefits for a HCO, from increasing patient satisfaction, to improving employee morale, to reducing risk of ethics violation and medical litigation, to conserving resources and saving costs.¹⁰

However, it is imperative that the discussion of organisational ethics described above is not limited to doctors working in HCOs, overlooking those in private sole proprietorship or small group medical practices. On the contrary, the smaller the number of physicians in a practice, the more perilous, potentially at least, the position of clinical ethics. This can be due to a lack of a good governance structure that allows objective and rational management of various conflicts of interests. In an “organisation” where one or few doctors take on multiple roles, effectively taking on an all-in-one role as the Board Chairman, Chief Executive Officer, Risk Manager, Director in the Office for Conflicts of Interest, Purchasing Officer, Chairman of Drugs and Therapeutics Committee and the Professional Practice and Ethics Committee. In the absence of an objective, external monitor, doctors in such a form of practice will need an even greater ethical sensitivity and sensibility, and must create their own healthy practice environment and structure to avoid the many conflicts and moral hazards that threaten to erode their professionalism. There are several steps that can be taken to manage these potential practice pitfalls. Firstly, there needs to be a strong personal commitment to professionalism, and to the personal growth of ethical competencies, in terms of knowledge, analytical skills, moral sensitivity and an ability to convert ethical insights into actionable decisions. Secondly, when they encounter difficulties in matters related to ethics and professionalism, they should readily seek advice and guidance from fellow practitioners and professional bodies. Thirdly, as in many HCOs, the doctor (or doctors) can draw up objective patient-centred policies and boundaries governing their practice to which they must do their best to adhere, and they must be committed to a regular process of self-audit for deviations. Fourthly, they need to provide channels for feedback and communication from patients and be responsive to valid points raised by their patients.

Healthcare’s organisational ethics, in the simplest and most distilled sense, can be viewed as how the organisation’s healthcare

delivery system reflects its professional, business and management values and principles. As the organisation plays a central role in patient care, physicians playing a leadership role are in a unique position to shape significantly the ethical values, environment and culture of HCOs, so that physicians are able to preserve and grow their fiduciary professionalism within the organisation.^{11,12} This has highlighted the importance and existing lack of attention to medical leadership, which until recently, has been largely under-recognised relative to excellence in clinical care and research. Wass¹³ described leadership in medicine as “multiple commitments to the patient, fellow professionals, the institution or system within which healthcare is provided, and at a national level”. Doctors in HCOs have corporate responsibilities shared with managers, though this has been a neglected aspect of modern healthcare organisations. Doctors and managers in HCOs have been known in general to have poor working relationships and communication,¹⁴ and this impairs physician-leaders’ effectiveness in conveying professional concerns and making clinical ethics and professional obligations a key agenda of many HCOs. The advocacy of medical professionalism therefore needs stronger leadership to have the desired impact on organisational policy and practices. And medical leadership includes also leaders in medical education, whose responsibilities should include advocating an organisational structure that facilitates positive role-modelling, and avoids injecting scepticism in students as they learn one thing from their ethics and professionalism module and observe inconsistencies in their clinical clerkship.

In summary, to preserve patient and public trust, medical professionals must actively equip themselves with competencies and learning habits that promote continuous internal transformation of ethical knowledge to professional conduct and medical virtues. The rapidly evolving healthcare environment, blurring of lines of authority, change in traditional roles and the increasing impact of organisational issues on patient care⁸ mean that doctors must also be supported by healthcare organisations that make medical ethics an integral part of their organisational ethics, thereby creating an environment and culture that is conducive to the promotion of medical professionalism. The key to this advocacy and negotiation process are leaderships (and not mere leaders)³ in medicine, who are respected role-models and professional advocates capable of convincing non-clinical stakeholders in their respective healthcare organisations to grant medical professionalism its due importance in shaping management policies and service strategies, ultimately making it easier for doctors to do the trustworthy thing for their patients.

These, then, are some of the challenges that confront modern medical practice, and it is essential that the profession faces up to them and seeks a defence of its values, which can withstand the pressures to subordinate the welfare of patients to commercial or institutional ends. In the set of papers published in this issue, some of this essential reflection and self criticism will be found. Ranging from the radical reformation in the teaching of medical ethics to a series of moral dilemmas in several different areas of clinical

practice, these papers show a way to take the debate forward that is both relevant to the current experience of practitioners and open to criticism from society at large. Gone are the days when the medical profession saw itself as a self-protecting guild, keeping its problems and dilemmas behind closed doors. Instead, as these papers illustrate, the profession seeks dialogue within its own ranks and in the society at large. The medical ethics of our time must be interdisciplinary, interprofessional and answerable to society. We trust that these articles will stimulate widespread reflection and debate; and while we make no claim to have covered all, or even most of the field of medical ethics, we believe a standard has been set for the kind of dialogue and debate that truly fosters the spirit of professionalism reaching back to Hippocrates.

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