Viewpoint

Professionalism: an ideal to be sustained

Richard L Cruess, Sylvia R Cruess, Sharon E Johnston

Introduction

A gulf has developed between the medical profession and the society it serves. As one observer noted, "A better informed community is asking for accountability, transparency, and sound professional standards", whereas medicine feels that "the professional's autonomy is severely restricted by budgets, bureaucracy, guidelines, and peer review".[1] The concept of professionalism bridges the interests of physicians and society[2–4] as society's need for the healer and its belief in the inherent virtue and morality of professionalism have served as the basis of modern medicine.[5,6] They are the source of the rights and privileges granted to the medical profession and of the values that physicians feel contribute to what is noble and good in their calling. Recently, a series of highly publicised events has encouraged the view that the medical profession fails to meet many of the obligations required to sustain its professionalism. In all countries, irrespective of the structure of the health-care system, threats to the values of professionalism are seen.[1] As physicians and society try to bridge the gap widened by the perceived lapses in professional standards, a redefinition of expectations and roles is taking place. To prevent medicine from becoming a commodity in a market-oriented world, physicians must participate in shaping the profession's future and understand the principles and obligations associated with being a member of a profession.

Role of professionalism

Society has used the concept of the profession to organise and deliver many of the complex services it requires, with the rationale that the expertise necessary to the practice of certain vocations is not easily comprehensible to the average citizen.[2,3,5,6]

Traditional professionalism came to apply to knowledge-based activities requiring long periods of education and training and entailing service for the common good. In medicine, it was the services of the healer, whose roots can be traced to Hellenic Greece and the Hippocratic Oath,[7] which were organised around the ideal of the professional.[5,6] The role of the healer has remained fairly constant, but the concept of professionalism has changed[4] in response to societal and professional needs. As this occurred, medicine's status and autonomy were challenged and its performance questioned. The major areas of concern relate to professionalism and its associated obligations. These challenges are not isolated events but are part of a continuing process, altering and expanding what is expected of the professional and the role of medicine in society.

There is a social contract between society and medicine that hinges on professionalism.[8] This contract has been and remains largely unwritten, leading physicians to treat it as an implicit rather than an explicit concept. As societal expectations have changed and new demands made upon the medical profession, the social contract has changed and the profession must adapt. A definition that is agreed on and explicit must serve as the basis for the expectations of both society and medicine.

Nature of professionalism

The core elements of a profession are possession of a specialised body of knowledge and commitment to service.[9] The *Oxford English Dictionary* defines a "profession" as, "The occupation which one professes to be skilled in and to follow. a) a vocation in which professed knowledge of some department of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it, b) in a wider sense any calling or occupation by which a person habitually earns his living."[10]

The word "professes" represents a public commitment to a set of values—ie, the Hippocratic Oath or its modern equivalent. The importance of the acquisition of knowledge and skills that are used to serve others is emphasised, and tacit knowledge is recognised as science and art are included. Because knowledge is used in serving others, professions are identified as being altruistic and value laden.

For a century the social science and ethics literature have gone beyond the definition and have agreed on the characteristics of a modern profession.[5,6,11] First, as professions hold specialised knowledge not easily understood by the average citizen, they are given a monopoly over its use and are responsible for its teaching. Second, this knowledge is used in the service of individual patients and society in an altruistic fashion. Third, the inaccessible nature of the knowledge and the commitment to altruism are the justification for the profession's autonomy to establish and maintain standards of practice and self-regulation to assure quality. Fourth, professionals are responsible for the integrity of their knowledge base, its expansion through research, and for ensuring the highest standards for its use.

Licensing bodies and professional associations have responsibility for many professional activities, and use collegiality to establish common goals and encourage commitment to them.[12] They have the obligation to discipline unprofessional and incompetent behaviour. These institutions serve an essential function, and professionalism can only survive if they function properly, which requires the support and participation of individual physicians.

Lancet 2000; **356:** 156–59

Centre for Medical Education, McGill University, 1110 Pine Avenue West, Montreal, Quebec, Canada H3A 1A3 (R L Cruess MD, S R Cruess MD, S E Johnston LLM)

Correspondence to: Dr Richard L Cruess (e-mail: rcruess@med.mcgill.ca)

For personal use only. Not to be reproduced without permission of The Lancet.

The literature recognises that morality and virtue are required[13] and that professionalism remains an ideal to be constantly pursued.[4] Society believes that the professions will place the welfare of society above that of the profession, and its trust is linked to its perception of how medicine meets its obligations.[14] If the public perceives that medicine is failing in its duties, professional status may be withdrawn or modified.

Evolution of professionalism

The fundamental principles of professionalism have not been analysed extensively by the medical community. Most contributions have come from the social sciences and bioethics.

The early literature was largely favourable. There was faith in the virtue, morality, and service commitment of professionals,[15–18] although the tension between self-interest and altruism was identified. The collegial nature of the profession was believed to encourage and foster altruistic behaviour.[8,9,17,18] This belief did not survive the period of deconstruction that started to take place in the 1960s and 1970s, when all forms of authority and expertise were questioned. The assumption that professions would be altruistic was greeted with scepticism.[3,19–22] The entry of the state and the corporate sector into health care caused medicine to adopt a defensive role and to be perceived as pursuing its own self-interest, rather than the good of society. Affluence, modern science, and technology greatly increased physicians' incomes, and some saw that medicine was just a business, with profit as its motivating force.

The monopoly enjoyed by all professions and the self-serving use of the power it bestowed was scrutinised.[3,20,22] The closed nature of professions and their inaccessibility to many segments of society was noted.[20] Decades before today's controversies, the literature noted that collegiality had led to a spectacular failure to self-regulate.[3] Medicine was analysed in economic terms, stating that as it controlled its own market it was able to create a demand for its services, which it then exploited. Issues of concern to society, such as accessibility, quality, and cost, were felt to be ignored by medicine. Finally, since medicine strongly influenced public policy, the public concluded that defects in the health-care system were mainly the responsibility of the profession.[2,3,23]

Much of this literature seems to have been bypassed by events, but it had a significant and lasting impact on public opinion and policy. The conflict between the profession's ability to promote its own interests and its obligation to serve society was believed to be a fatal flaw in the social contract.

Since the early 1980s there has been a shift, and a period of reconstruction seems to be underway. This occurred as medicine lost control over its marketplace to the state and corporate sector, which occurred at different times in different countries.[2,24,25] The sociology literature, after examining the difficulty of maintaining the values of altruism and service in alternative systems, returned to professionalism as the preferred way of organising the delivery of health care.[4,8,11,24] Titles such as "Professionalism reborn"[11] or "The new professionalism"[26] appeared. The literature became less critical of the profession, shifting its attention to the state and the corporate sector.

Despite renewed faith in professionalism by sociologists, today it is society that seems to have lost faith in medicine's ability to uphold its part of the contract. Thus, professionalism now faces its greatest challenge from the public. To bring society and the medical profession together there must be a renewed commitment by medicine to answer current societal concerns and to meet traditional and newly acquired obligations. The level of trust must be rebuilt, both to support healing and for medicine to serve as an expert advisor on issues relating to health.[6]

Taking professionalism into the future

As the contract between society and the professions is being redefined, both the public and the profession may, at times, be dissatisfied or disillusioned. Concerns expressed by the public as recorded in the lay press and social science literature relate to the integrity of medicine's knowledge base, imperfect self-regulation with unsatisfactory assurance of quality, less than altruistic behaviour on the part of some physicians and professional associations, and dissatisfaction with the relationship between physician and patient.

The medical profession also has concerns. They include, "frustrations in their attempts to deliver ideal care, restrictions in their personal time, financial incentives that strain their personal principles, and loss of control over their clinical decisions".[27] Probably the most demoralising is the belief that the evolution of health care is undermining the values that give meaning and pride to professionals. Much of medicine's dissatisfaction arises from the new levels of accountability demanded by an aroused public[28] and by the application of "accounting logic" (the evaluation of outcomes primarily in financial terms)[29] to the practice of medicine.

One of medicine's traditional obligations is self-regulation to ensure the quality of its services. However, "self-regulation is a vehicle, not the goal or the core of professionalism".[28] In the Anglo-American world, state authority and power is delegated to the professions for this purpose.[30] Many aspects of self-regulation have been carried out in an exemplary fashion and have often represented pioneering efforts in society. However, it is important to state that compliance with and participation in these activities are not options but obligations acquired by physicians on their voluntary entry into the profession. In addition, self-regulation was allocated to professionals because the nature of their activities is such that they were thought to be the most competent to evaluate them and this belief persists. To maintain self-regulation professionals must carry out these duties in a rigorous, effective, and transparent fashion, or responsibility for regulation and discipline will be transferred to others.

Recent intrusions into medicine's autonomy have not occurred spontaneously, but have resulted from dissatisfaction with medicine's performance and because of the cost and complexity of modern medicine, which has lead to new forms of accountability.[28] The Bristol cardiac surgery cases (with subsequent changes in legislation), instances of financial conflict of interest, sexual impropriety, and a failure to identify and deal with impaired physicians lead to the belief that collegiality, a valuable part of professionalism, has been used to protect professional colleagues.

Scientific fraud and unexplained variations in the rate and type of medical interventions for similar diseases have cast doubt on the integrity of medicine's

For personal use only. Not to be reproduced without permission of The Lancet.

knowledge base and has led to demands for evidence-based medicine and guidelines. These factors and the failure to identify incompetent behaviour are the cause of demands for recertification and revalidation. Finally, the failure of educational institutions to be sensitive to the needs of the communities they serve has cast doubt on medicine's ability to set and maintain standards. For the most part these are failures of the professional to meet societal obligations and not those of the healer caring for patients.

Medicine needs to develop a coherent and integrated approach to meet new societal demands. In the UK, action has been suggested by the General Medical Council.[26] In North America, guidelines for the behaviour of professionals[31] and their associations[32] have appeared. As part of these initiatives, efforts must be made to incorporate the ideal of professionalism, with its underlying foundation of altruism, morality, and virtue into the regulatory procedures that will reassure society. Physicians who regard bureaucracy, guidelines, and peer review[1] with suspicion must come to believe in both their appropriateness and validity.

New responsibilities have been acquired by the medical profession under the heading of accountability.[28] Traditionally, physicians have been accountable to their patients and to their colleagues. They are now responsible to individuals, the state, and corporate sector, who pay for services, and to society for the impact of their decisions on resources and on the community. These levels of accountability are now part of professional life and have had a wide impact on the practice of medicine. The application of accounting logic[29] to physicians' activities has affected their decision making and has often limited the amount of time allocated to treat patients. Finally, the additional responsibility for the health of populations often conflicts with the physician's primary responsibility to the individual patient, creating tensions that have yet to be resolved.[33]

The social contract must be renegotiated carefully and with the participation of the medical profession. More rigorous self-regulation must occur, formal recertification or revalidation should continue to be implemented, further guidelines developed and used wisely, the new levels of accountability accepted, and the relationship between physician and patient should continue to come under scrutiny. These are now part of medicine's professional obligations.

However, as changes are instituted, society should be mindful of the worries and concerns of the profession, as a demoralised and underperforming medical profession is incompatible with an effective health-care system.[11] First, most physicians believe with passion and some justification that there is a moral base to what they do and that they have genuinely served their patients to the best of their abilities. They believe that they are deserving of respect, despite real failings in performance by some individuals and the profession. For this reason, changes that society demands should be instituted with sensitivity and understanding. Second, the pressures of accounting logic[29] must be tempered so that physicians have the time and the needed autonomy to serve the patient.[1,26,27] Third, guidelines are only uniformly applicable in situations of absolute certainty,[26,34] something that rarely exists in medicine. Thus the use of guidelines and evidence-based medicine must take into account real variations in the needs of the patient. Fourth, the increasing transparency of regulations and discipline must be used judiciously, not to protect physicians, but to avoid inappropriately jeopardising public trust in the healer. Finally, medicine should expect and demand that major changes in the processes used to assure accountability are validated before they are implemented. Evidence is required as a basis for medicine and must apply equally to regulatory procedures for them to function as an extension of professionalism's core elements.

Conclusions

The ideal of the professional spans three centuries, originating in the 19th century. During the 20th century, some of the values and obligations of the profession were neglected and serious questions were posed as to whether professionalism constituted a proper basis for the organisation of the delivery of health care. As we enter the 21st century, the concept seems not only to have survived but also to be once more endorsed, albeit in renewed form. This renewal should build on the morality and altruism of the original concept, and these qualities should be transferred to the new processes through which the profession is held accountable to society. As medicine negotiates a new understanding with society, the preservation of the ideals of professionalism, which serve as the basis of trust, is of great importance. Professionals should show that professionalism is a benefit to society. For this to occur they should meet their obligations. The stakes are high, as adequate health care for the public is inconceivable without a committed medical profession, and physicians cannot function effectively as healers without the trust of the patient and society.

References

1 Dunning AJ. Status of the doctor—present and future. *Lancet* 1999; **354** (suppl IV): SIV18.
2 Starr P. The social transformation of American medicine. New York: Basic Books, 1984.
3 Freidson E. Professional dominance: the social structure of medical care. Chicago: Aldine, 1970.
4 Kultgen J. Ethics and professionalism. Philadelphia: University of Pennsylvania Press, 1988.
5 Cruess R, Cruess S. Teaching medicine as a profession in the service of healing. *Acad Med* 1997; **72:** 941–52.
6 Cruess R, Cruess S, Johnston S. Renewing professionalism: an opportunity for medicine. *Acad Med* 1999; **74:** 878–84.
7 Sohl P, Bessford R. Codes of medical ethics: traditional foundations and contemporary practice. *Soc Sci Med* 1980; **22:** 1175–79.
8 Sullivan W. Work and integrity: the crisis and promise of professionalism in North America. New York: Harper Collins, 1995.
9 Goode W Jr. The theoretical limits of professionalism. In: Etzioni A, ed. The semiprofessions and their organization. New York: Free Press, 1969: 266–313.
10 Oxford English Dictionary, 2nd edn. Oxford: Clarendon Press, 1989.
11 Freidson E. Professionalism reborn. Chicago: University of Chicago Press, 1994.
12 Ihara CK. Collegiality as a professional virtue. In: Flores A, ed. Professional ideals. Belmont, CA: Wadsworth, 1988: 56–65.
13 Perkin H. The third revolution: professional elite in the modern world. London: Routledge, 1996.
14 Mechanic D. Changing medical organization and the erosion of trust. *Milbank Q* 1996; **74:** 171–89.
15 Webb S, Webb B. Professional associations. *New Statesman* 1917; **9** (special suppl): 7–19.
16 Flexner A. Is social work a profession? *School Soc* 1915; **26:** 901–11.
17 Carr-Saunders AM, Wilson PA. The professions. Oxford: Clarendon Press, 1933.

For personal use only. Not to be reproduced without permission of The Lancet.

18 Parsons T. The professions and social structure. *Soc Forces* 1939; **17:** 457–67.

19 McKinlay J. Toward proletarianization of physicians. In: Derber E, ed. Professionals as workers: mental labor in advanced capitalism. Boston: GK Hall, 1982: 37–62.

20 Larson M. The rise of professionalism: a sociological analysis. Berkeley: University of California Press, 1977.

21 Haug M. Deprofessionalization: an alternate hypothesis for the future. *Soc Rev Monogr* 1973; **20:** 195–211.

22 Johnson T. Professions and power. London: Macmillan Press, 1972.

23 Moran M, Wood B. States, regulation and the medical profession. Buckingham: Open University Press, 1993.

24 Krause E. Death of the guilds: professions, states and the advance of capitalism, 1930 to the present. New Haven: Yale University Press, 1996.

25 Klein R. The new politics of the National Health Service, 3rd edn. London: Longman, 1995.

26 Irvine D. The performance of doctors: the new professionalism. *Lancet* 1999; **353:** 1174–77.

27 Kassirer J. Doctor discontent. *N Engl J Med* 1998; **339:** 1543–44.

28 Emmanuel EJ, Emmanuel LL. What is accountability in health care. *Ann Intern Med* 1996; **124:** 229–39.

29 Broadbent J, Laughlin R. “Accounting logic” and controlling professionals. In: Broadbent J, Dietrich M, Roberts J, eds. The end of professions? The reconstructing of professional work. London: Routledge, 1997: 34–49.

30 Stacey M. The case for and against medical self-regulation. *Fed Bull* 1997; **84:** 17–25.

31 Wynia M, Latham S, Kao A, Berg J, Emmanuel L. Medical professionalism in society. *N Engl J Med* 1999; **341:** 1612–15.

32 Pellegrino E, Relman A. Professional medical associations: ethical and practical guidelines. *JAMA* 1999; **282:** 954–86.

33 Smith R, Hiatt H, Berwick D. A shared statement of ethical principles for those who shape and give health care. A working draft paper from the Tavistock group. *Am J Intern Med* 1999; **130:** 143–47.

34 Tanenbaum SJ. Evidence and expertise: the challenge of the outcomes movement to medical professionalism. *Acad Med* 1999; **74:** 757–63.

For personal use only. Not to be reproduced without permission of The Lancet.