

# Professionalism, Profession and the Virtues of the Good Physician

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## Abstract

The putative loss of "professionalism" in medicine has of late become of serious concern to practitioners, educators, ethicists and the public. Impassioned pleas for its restitution abound. Serious ethical obligations are linked to the idea of a profession. Yet, most of the definitions have been socio-historical, political or legal. Important as these aspects may be, there is need for a firmly grounded ethical derivation of the moral dimensions of professionalism. This essay undertakes to provide a philosophical grounding for ethically responsible professionalism in the phenomena of clinical medicine, in the character of the professional, and in virtue theory.

**Key Words:** Professionalism, profession, virtue, virtue ethics, medical education.

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PROFESSIONALISM, the process of professionalization, and teaching of professional behavior have become dominant concerns of medical educators, practicing physicians, and professional associations. Others have already sketched in the historical and sociological determinants of professionalization, and its codification in the Oath of the Hippocratic School. Against this background I will examine the place of the virtues of professionalism in medicine and to delineate the ethical foundations of medical professionalism.

I will divide my discussion into four brief parts: (a) a brief note on definitions and connotations of the terms profession and professionalism; (b) a short outline of the concept of virtue ethics; (c) the place of virtue ethics in the medical profession; and (d) teaching the medical virtues.

## Professionalism and "Profession"

"Professionalism" has come to be accepted as a watchword for those qualities and modes of

conduct proper to professions. In common usage, professions have often been defined in the following terms: possession of a body of special knowledge, practice within some ethical framework, fulfillment of some broad societal need, and a social mandate which permits a significant discretionary latitude in setting standards for education and performance of its members (1). On this view many occupations in modern society lay claim to the sobriquet of "profession."

Traditionally, a much smaller number of professions, by virtue of their educational breadth and their importance in satisfying some fundamental human need, have been called "learned professions." Medicine, law, ministry, and sometimes the military and the academic occupations have enjoyed this special status. They meet the criteria for a sociologically defined profession but they also occupy a special niche among the vast number of occupations that now lay claim to professionhood.

That special claim lies less in their expertise than in their dedication to something other than self-interest while providing their services. That something else is a certain degree of altruism, or suppression of self-interest when the welfare of those they serve requires it. This is the distinguishing feature of medicine, ministry, law, and teaching that sets them apart. They are in this sense "professed," i.e., publicly commit-

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ted to the welfare of those who seek their help. They thereby become ethical enterprises and it is this dimension of the profession of medicine that I shall focus upon in this essay.

“Profession” means, in its etymological roots, to declare aloud, to proclaim something publicly. On this view professionals make a “profession” of a specific kind of activity and conduct to which they commit themselves and to which they can be expected to conform. The essence of a profession then is this act of “profession” — of promise, commitment and dedication to an ideal.

In medicine this act of profession occurs in two ways. One is the public profession — the solemn proclamation on graduation from medical school when the “Oath” is taken. This is the moment when the newly graduated physician enters the profession, not when she receives her degree. The degree is simply evidence of completion of the academic requirements for the degree “doctor of medicine.” It says nothing of the commitment to the way the acquired knowledge and skill are to be used. Without the Oath the doctor is a skilled technician or laborer whose knowledge fits him for an occupation but not a profession.

When the Oath is proclaimed, if it is taken seriously as a binding commitment to place one’s special knowledge and skill at the service of the sick, the graduate has then made his “profession.” He or she enters the company of others with similar commitments. At this moment, one enters a moral community whose defining purpose is to respond to and to advance the welfare of patients — those who are ill, who are in need of help, healing, or relief of suffering, pain or disability.

The second way the profession is “declared” is in the daily encounter with patients. Every time a physician sees a patient and asks “What can I do for you, what is wrong, what is the problem?” he or she is professing (committing oneself) to two things: one is competence (i.e., having the knowledge and skill to help) and the other is to use that competence in the best interests of the patient. This “profession” or commitment, by its very declaration, invites trust. The doctor voluntarily promises that he can be trusted and incurs the moral obligations of that promise.

Implicitly, this same silent commitment obtains in every visit between physician and patient. If it were not understood as such, the patient would never consult the physician. This implicit profession persists even if the relation-

ship is not ideal and even if there is some mistrust or hostility. Whatever uncertainties there may be in the relationship, to be effective in helping the patient it must have a residuum of trust and the physician must be faithful to that trust.

Professionalism on the other hand is a somewhat different concept. Unquestionably it has been equated by many educators and professional groups with some of the characteristics of a profession that I have outlined. These groups are concerned about “deprofessionalization,” i.e., the defection from the moral demands of a profession. However, professionalism itself can also connote certain features which are less commendable ethically.

I refer here to such characteristics of “professionalism” as unquestioned loyalty to other members of the same profession, a certain exclusivity and elitism based on credentials, and a concern for titles or self-interests common to the group. In its more distorted forms professionalism can become an ideology, or a symbol of a guild; it can generate a union mentality focused on defending the group’s own interests. It is all too often expressed in the self-protective, retaliative and bureaucratic behavior of professional organizations.

These aberrant connotations are of course not what many well-intentioned educators mean but it is important to make it clear that the word “profession” essentially has a moral center that is not fully captured by professionalism and may even be antithetical to it. In any case, when discussing the virtues, I shall concentrate on the pristine notion of profession, in the sense that it first appeared in relation to the practice of medicine.

The first written use of the word “profession” in relation to medicine was in 47 A.D. in a book of prescriptions written by Scribonius, physician or pharmacist in the court of the Roman Emperor Claudius. In a few short pages having to do with the reluctance of his contemporaries to use medications, Scribonius referred to the “profession” of medicine. This he defined as a commitment to compassion or clemency in the relief of suffering. He did this in the context of one of the first references to the Hippocratic Oath in ancient literature, arguing that the proper use of drugs was consistent with the Hippocratic injunction to help and heal the patient (2–5).

Scribonius also outlines other moral precepts that he relates to the Hippocratic “profession” — the bans on abortion and euthanasia,

and the requirement to always act to help the sick by whatever means are available. Scribonius presents a humanistic interpretation of the profession and links that humanism to certain virtues like benevolence, compassion, mercy and competence in the use of medication.

Extending this discussion into the full history of the word “profession” is beyond the scope of this article. Suffice it to say that the word “profession” has been linked with the virtues from its first usage. Indeed, the ethics of the profession was, until very recently, a virtue-based ethic which associated the good physician with certain character traits. The personal ethics of some of the most worthy physicians in the history of medicine was a virtue ethic — e.g., physicians of the Confucian, Hindu, or Hippocratic schools. In modern times the ethics of Thomas Percival, Francis Peabody, William Osler and Florence Nightingale were essentially virtue based.

Before linking specific virtues to the profession of medicine it is useful to review concisely the notion of virtue as a basis for ethics.

### **Virtue Ethics in General**

Virtue-based ethics is the oldest and most durable system of ethics in both Western and Eastern cultures. It is a system that concentrates on the moral agent and the kind of person he or she ought to be, rather than on the acts themselves, the circumstances, or the consequences they produce. Until the Enlightenment, it was the dominant theory of ethics. In modern times it has persisted but has been superseded by other theories like deontology, utilitarianism, emotivism, etc. But all of these theories gave some account of virtue. In more recent times virtue ethics suffered erosion by the positivist and analytic approaches to moral philosophy. In the last several decades virtue-based ethics has enjoyed a renaissance, however, its ultimate place in moral philosophy is yet to be established firmly.

Currently there are three approaches to virtue theories of ethics: One is the so-called “thick” version, which reduces all of ethics to virtues. A second is the so-called “thin” version, which makes virtue one among many theories, but with no special claim. The third approach, which I shall follow here, is the complimentary version. On this view, virtue ethics is an essential element in any complete theory of the moral life. It cannot stand on its own, but it is also a necessary compliment to any other theory.

The reason for the indispensability of virtue ethics is the ineradicability of the moral agent in the moral life. All principles, duties and rules of ethics must ultimately be expressed in the moral life of the living human agent. How duties, rules, obligations, sentiments, etc., are acted upon, interpreted, given weight, put into priority and with what intention or motives, are all shaped by the character of the moral agent. The agent, therefore, cannot be left out of the judgment of the moral status of any particular human act.

As with so many other concepts fundamental to Western culture, Plato and Aristotle most aptly expressed the idea of a virtue. Plato associated it with the idea of excellence (*arete*) in knowledge of good. Aristotle, like Plato, equated the virtues with excellence (6): “The excellence of man also will be the state which makes a man good and makes him do his own work well.”

Elsewhere, Thomasma and I traced the concept of virtue from its origins to its revival in general ethics (7). Its revival in medicine has several origins. One is the growing reaction to the dominance of principle-based ethics which some consider too abstract or limited in its interpretation of the professional life. Another is the ineradicability of the moral agent and the place of the virtues in educating physicians. On the other hand, critics of the revival of virtue point to the absence of specific moral content and action guides or rules. They criticize the circular reasoning which defines “good” as what the virtuous person does and the virtuous person as the one who does “good.”

Virtues are compatible with principles, as Beauchamp and Childress have emphasized in later editions of their influential work (8). Virtue ethics, however, can also be related to other theories of ethics via links to duties, obligations, rules, etc. The conceptual connections are not always easy to make and this is a task for virtue theorists in the years ahead. In the remainder of this article I will concentrate on the virtues specific to the profession of medicine in the pristine sense of the word “profession.”

### **Virtue in the Ethics of the Medical Profession**

Aristotle’s definition of virtue seems most apposite for the profession of medicine since it links moral excellence (the moral virtues) with the kind of person the physician should be and with the excellence of the work he does specific

to his profession. Let us examine the act of profession in relationship to the ends of medicine to see what character traits the physician must possess to achieve the ends of medicine with excellence (9).

Publicly in his oath and privately in his encounter with the patient, the physician professes two things — to be competent to help and to help with the patient's best interests in mind. This commitment invites trust which ultimately the patient must place, to some degree at least, in his physician. The purpose of the physician-patient relationship is healing, i.e., curing when possible, caring always, relieving suffering, and cultivating health. This is what is promised implicitly by the profession that the doctor makes whenever he enters the clinical encounter.

It is these ends which give content to virtue ethics in medicine (9). The good physician will be one who exhibits those character traits which most effectively achieve and indeed are indispensable for attainment of the ends of medicine. Some of the virtues entailed by the profession or commitment of the physician and the ends which actualize that commitment are:

- *Fidelity to trust* — because the physician has invited trust, the patient cannot avoid it, and it is essential if healing and helping are to occur.
- *Benevolence* — because the prime precept of medical ethics since the Hippocratic era has always been acting for the good of the patient, and of course, avoiding all harm.
- *Intellectual honesty* — because medicine is a powerful instrument for good and harm depending on how medical knowledge and skill are used. Knowing when one does not know and having the humility to admit it and to obtain assistance are virtues crucial to avoiding harm.
- *Courage* — because the physician must expose herself to the dangers of contagion, to possibilities of physical harm in emergency situations, and to political retribution in regimes that enlist physicians in torture, interrogation of prisoners, and deceptions of various kinds. It also takes courage to be the patient's advocate in a commercialized, industrialized system of care.
- *Compassion* — because in any chronic or complicated illness or clinical decision, the physician must enter the predicament of the patient, to feel something of the patient's plight if his scientific judgments are to be morally defensible and suited to the life of a particular patient.
- *Truthfulness* — because the patient is owed the knowledge necessary for making informed choices, so he can make plans for his own life when disease disrupts those plans, and so he can assess his doctor's competence to undertake what he proposes.

These are a few of the specific virtues entailed by the profession, the silent commitment made in every physician-patient clinical encounter. There are other virtues, of course, but these few seem essential if the end of medicine — the healing of this patient — is to be attained with some degree of excellence.

These are virtues generated by the nature of the medical encounter with individual patients. They are also essential for the practice of preventive medicine. They are crucial as well to the fulfillment of the responsibilities of physicians to society, in public health and organized medicine. Time and space allow only for mention of these extensions of the way virtues undergird the profession, individual physicians, and the organized profession as they meet the obligations incurred by their public declaration of expertise in the service of the sick.

### Practical Implications

Critics of virtue-based ethics often accuse it of being without content, action guides, rules or duties. This is in part true, but it ignores the significant effect of a commitment to virtue on the conduct of the physician. It is difficult, for example, to imagine that a physician committed to the virtues I have just outlined would ever consider her relationship with the patient as primarily a commodity transaction, a contract for service, or the mere application of scientific knowledge to a sick organism. A virtue-inspired physician would recognize *pro bono* work as crucial to her stewardship of medical knowledge. Neither could such a physician see herself as an entrepreneur, an investor or as owner of a health care facility like a hospital operated for profit. She would not claim proprietary rights over her knowledge.

For the virtue-based physician, the relationship with the patient could not be a contract or a commodity transaction. It is a covenant of trust, a special kind of promise to serve those who require her expertise. Suppression of self-interest to some degree would be a natural corollary of a virtue-oriented physician. None of this is to deny that the virtue-based physician is also compelled on the basis of virtues of parent and husband to be faithful to his commitments to his family, friends and society. He would, however, recognize what the limits of legitimate self-interest are and when that set of interests should be set aside in the interests of his patient or vice versa.

This is where the central virtue of practical wisdom comes in. Aristotle described *phronesis*, the virtue of practical wisdom, as the capacity for deliberation, judgment and discernment in difficult moral situations. It is practical wisdom that unites the moral and intellectual virtues and helps the moral agent to resolve conflicts among virtues, to put them in the proper order of priority, and to make the right and good decision in the most difficult situations.

Practical wisdom is also the most valuable virtue for the physician as a physician. It is the habitual disposition to make right choices in complex clinical circumstances. The practically wise physician is not one who acts cautiously and self-interestedly to protect himself. That is the contemporary debasement of the word. Practical wisdom assists the physician in his choices and is the virtue of wise clinical judgment.

The virtue-based physician could never see his patient as a "customer," consumer, insured life or any other commercialized, industrialized transformations of the ancient and respectable word "patient." Nor could he compromise his personal or professional integrity for political, economic, or social advancement. Nor could the virtuous physician become a union member, go on strike, or engage in blatant self-promotion and advertising even though it is sanctioned by law. This would suit the ethics of professionalization but not of a true profession.

The virtuous physician would recognize that he is a member of a moral community united to those other physicians who have made the same act of profession or commitment to the welfare of the sick. She would see professional organizations and associations as extensions of the ethical and moral commitments that are shared with fellow physicians. The contemporary model of so many professional associations

as corporate, money-making, lobbying, advertising enterprises is inconsistent with what the profession of medicine is about.

The virtue-based physician would see the importance of working within professional associations to change their character, to urge upon them the primacy of the patients' welfare and their advocacy for justice in health care. He would understand that withdrawal from professional associations is to abdicate the responsibility to transform them for the better. Indeed, if professional associations are to be rescued they will need physicians who are committed to an ethic of virtue.

Conversely, the virtuous physician cannot fully actualize his personal virtues unless there is a community of virtues to sustain and reinforce his commitments to the virtues. Alisdair McIntyre makes much of this point in his seminal study of the virtues in contemporary life (10).

It is in the conjunction of the moral community and the moral individual that Aristotle's conjunction of "The Politics" and "The Ethics" become a model for professionals and professional associations today. The aim of Aristotle's "Nichomachean Ethics" was (as it was for the entire classical medieval ethical synthesis) the formation of virtuous (i.e., good) persons. In his writing on ethics Aristotle defined the virtues of a good member of a society, and in his "Politics" he defined the good society and the virtues that such a society should exhibit.

On this view, ethics and politics (in the etymological sense of politics and not its modern connotations) are reciprocal elements of a moral whole. Good citizens make for a good society; a good society makes for good citizens. As medicine confronts the current crisis of professionalization and deprofessionalization the mutual moral interdependence of the individual physician and the professional society must be confronted. One cannot be reformed without the other, if anything resembling the pristine notion of profession is to be recovered.

Medical educators, medical practitioners and the leaders of professional organizations all share in accountability for our present state of deprofessionalization and for our success or failure in recovering some remnant of moral credibility. This, I believe, translates into character formation and virtue promotion in medical schools and in the conduct of the affairs of professional organizations. Neither entity is engaged in this recovery. Indeed, most indications are that medical education and medical

professional associations have compromised or lost their moral credibility (11).

### Can Virtue Be Taught? How?

This brings me to the last of my topics — if character is to be formed, virtues must be taught. But there are serious doubts about whether virtue can be taught or even if they could be taught, whether they could survive in our present society where self-interest, not altruism, is the rule of success (12).

The teachability of virtue has been a question since Plato's time. In his dialogue with Meno, Socrates was asked bluntly — at the very outset — “Can you tell me, Socrates, whether virtue is acquired by teaching or practice. . . ?” (13).

Socrates as usual illuminated the question but did not answer definitively. Aristotle, on the other hand, did so definitively. He said we learn by practice and that the best practice is to follow a model of the virtuous person. In medicine this means we need virtuous physicians as teachers. Basic scientists often provide such models for medical students, but more often it is respected clinical teachers who provide the example in their conduct of the physician-patient relationship.

Once a medical student or resident has chosen a field for concentration or specialization, consciously or not she shapes her self-image as a physician. She begins, in fact, to practice the virtues (or vices) of that model. The more morally mature the student is, the more she will distinguish the virtues from the vices. But the less mature will conflate the two, since they lack the practical wisdom to discern the difference. Clinical teachers thus bear a heavy responsibility for the character traits that they model for their students and residents.

If there is one essential element in the effort of a medical school to shape the professionalization of its students, it is the dominant concept of profession that defines its faculty, especially its clinical faculty. Character formation cannot be evaded by medical educators. Students enter medical school with their characters partly formed. Yet, they are still malleable as they assume roles and models on the way to their formation as physicians.

While role models are the most powerful force in professional character formation, certain ancillary educational efforts can also shape the developing physician more than modeling. Courses in medical ethics, the humanities,

human values, etc., can sensitize, raise awareness and force critical reflection about the virtues of the good physician. Courses introduce students to a body of literature which gives evidence of the importance, depth and complexity of the moral issues commonplace in medical practice. They challenge the reflective student to at least examine, verify, assimilate or reject what he is being taught or what he sees in faculty behavior.

Medical history and literature also add to this process of character formation by offering students an acquaintance with historical figures as models. One has only to ask today's students if they have ever heard of William Osler, Francis Peabody or William Harvey to appreciate how neglected this form of character formation has become. The figures they are more likely to be exposed to are corporate entrepreneurs, power players in the health care industry, athletes and entertainment celebrities.

In any case, if the profession is to be resuscitated as a moral enterprise and not a branch of high-tech industry, medical schools will need to give significant attention to inculcating the virtues and to evaluating their students and faculty, and their institutional behavior by these standards as well.

Professional societies, if they are to be true to their claim to represent the profession, should recapture the notion of profession and de-emphasize the guild-like connotations of professionalism. Here too there is a need for physicians with the virtue of courage sufficient to enable them to stand clearly and visibly for what makes medicine a profession. This will mean leadership of a kind that eschews self-interest and truly advances the welfare of patients as medicine's *raison d'être*.

Unfortunately, today many professional associations are preoccupied with financial survival, corporate growth, investment strategies, benefits for members, fees for testimonials, etc. There is little energy left for promulgation of the ethical purposes of the profession as a profession. In these respects professional medical associations seem to justify the opinions of the Federal Trade Commission, which classifies medicine primarily as a business and not as an ethical entity.

If professional societies were to take their moral purposes to heart they would be concerned about the character formation and ethical socialization of their members. Admittedly this would be difficult in a morally pluralistic society where the personal moral beliefs of the

members of professional associations can be expected to vary widely. But this is less the case when it comes to the virtues associated with medicine as a profession — fidelity to trust, intellectual honesty, courage, benevolence, etc. These are implied by the ends of medicine. If medicine as a profession is to have any unity of purpose these essential virtues ought to be honored. The alternative is to reshape the ends of medicine to suit a variety of purposes other than healing, helping, caring, and sustaining the sick. What those other ends might be is problematic at best and raises questions as to whether medicine would lose its essential character.

The same concern for ethical socialization and professionalization, in the best sense of those terms, applies to medical education. The prime task of medical schools is to prepare new physicians with the skills and knowledge that would make them safe and competent practitioners after graduation. This in a significant degree implies some conscious shaping of the character of medical students so that they will exhibit, then as students, and later as practitioners, those virtues entailed by the idea of a profession.

Medical students usually agree that they know which of their classmates they would not trust to treat members of their families. They are aware that the faculty is often uninformed or indulgent about serious character flaws in some of their students. Students are also aware that faculty may treat problems in character lightly or shy away from dealing with the issue for fear of lawsuits or unpleasant encounters with other students or faculty.

These difficulties are not trivial but there is, nonetheless, an obligation to protect society from unsafe or untrustworthy practitioners. Graduation from an American medical school is tantamount to licensure. Society permits a large degree of discretionary latitude to medical educators in their evaluation of students. With this discretionary latitude comes an obligation to protect future patients from patently dishonest or ethically marginal future physicians (14).

This is dangerous territory indeed in which the possibility of abuses of power and injustice are genuine. The difficulties however do not constitute reasons for avoiding the issue. At the very least some effort must be expended to detect the more flagrant disorders of character or personality. Given the growing sophistication of the public in medical matters and the variable state of trust in the profession as a whole, medical schools must confront this obligation

or face a narrowing of their freedom as educational institutions.

### Summary

There is widespread concern today among conscientious physicians, educators and the general public that medicine is becoming “de-professionalized,” that the profession is losing its commitment to the kind of character traits requisite for protection of the welfare and interests of patients. In the analysis of this concern I distinguished between the idea of profession and professionalization and defined the character traits implied by a genuine act of profession. These important concepts have practical implications for individual physicians, professional societies and medical schools.

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