Medical Professionalism Crossing a Generational Divide

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Abstract A comprehensive discussion of professionalism in medicine must include its impact on successive generations of physicians. Fifty years ago, doctors acting professionally emphasized medicine as a calling and an ability to act as the authority for patients in crisis at home and in hospitals. Therapeutic options were limited relative to the modern era, and the laying on of hands was practiced as science and art. Today, doctors balance increasing demands on time and efficiency with the sense of primacy of patient care. Technological innovation and patients’ increasing access to medical knowledge through varying media of inconsistent quality challenge physicians in novel ways. Fifty years in the future, doctors will have access to vast amounts of information through a multitude of noninvasive diagnostics. Progressively more personalized medicine should inspire doctors to become even more adept at communicating effectively with patients. Professionalism in medicine throughout these generations embodies similar fundamental behaviors, such as demonstrating compassion, respect, and humility; adhering to high ethical and moral standards; subordinating personal interest to that of others; and reflecting on actions and decisions. Despite the dynamic nature of the profession itself, the omnipresent need for such traits will define medical professionalism for decades to come.

Understanding professionalism in modern medicine occupies a great deal of attention in medical education, research, and practice. A universally recognized definition eludes the profession, but professionalism itself may be considered in the context of the era in which it applies. This exploration of pro-
Medical Professionalism

Table 1  Physician Behaviors Defining Medical Professionalism

| Subordinating personal interests to the interests of others |
| Adhering to high ethical and moral standards |
| Responding to societal needs and reflecting a social contract with communities served |
| Evincing core humanistic values: honesty and integrity |
| caring and compassion |
| altruism and empathy |
| respect for others |
| trustworthiness |
| Exercising accountability for oneself and for colleagues |
| Demonstrating a continuing commitment to excellence |
| Exhibiting a commitment to scholarship and advancing the field |
| Dealing with high levels of complexity and uncertainty |
| Reflecting upon actions and decisions |


Professionalism across the generations of medical care utilizes three vignettes, each followed by brief discussion. The fictitious accounts chronicle doctors of three eras across 100 years of American medicine. The final vignette, which takes place five decades from today, encourages more vivid speculation on what it means to be a doctor in the 21st century.

While a comprehensive definition of medical professionalism might be better served by an exposition wholly devoted to devising its meaning, a brief consideration of the term may enhance the utility of both the physician vignettes and their corresponding discussions. The issue has been approached from various perspectives, including that of sociologists analyzing the interplay of professional autonomy in exchange for social value, and that of physicians formulating the fundamental principles and professional responsibilities required to maintain “medicine’s contract with society” (ABIM 2002; Freidson 1988, 2001; Swick 2000). One attempt at a normative definition of professionalism in medicine focuses instead on core physician behaviors (see Table 1). This definition emphasizes that “the concept of medical professionalism . . . must be grounded in what physicians actually do and how they act, individually and collectively” (Swick 2000, p. 614).

1950s

Dr. John Chapman crushes the remains of his cigarette in the ashtray and adjusts his tie in the rearview mirror. He has arrived for an after-dinner call at the Reeves home. At his office and in their home over the last 20 years, the Reeves...
family has received the bulk of its care from Dr. Chapman, even during occasional trips to the local hospital. Tonight the family patriarch, Henry, has taken a turn in his battle with cancer, as Mrs. Reeves informed Dr. Chapman over the phone earlier in the day.

Dr. Chapman quickly checks the contents of his bag, although he doubts he’ll use many supplies tonight. His stethoscope, morphine, digitalis, ampoules of 50% glucose, aspirin, codeine capsules, atropine, epinephrine, and others are included in his armamentarium.

After brief greetings, the doctor is ushered upstairs to Henry’s bedroom, where he performs a methodical physical exam while speaking reassuringly to his longtime patient. Mr. Reeves continues to suffer abdominal pain with intermittent fevers, and his reduced appetite has resulted in significant weight loss in the past few months. Dr. Chapman focuses on analgesia and comfort for Mr. Reeves, and he spends the next two hours at his patient’s bedside. Eventually, Mr. Reeves is comfortable enough to sleep, and Dr. Chapman leaves the room quietly to converse with the family.

He is encouraging regarding Mr. Reeves’s comfort and the level of care he is receiving at home. But he is also realistic about what can be done at this point. He reassures the family that he is always available to them. Mrs. Reeves asks few questions and is calm despite her grief; she has always appreciated and respected Dr. Chapman’s knowledge and steady demeanor. The doctor excuses himself and returns home to his family by 11 pm.

In the 1950s, the concept of professionalism suffused the work of doctors but was rarely discussed or addressed. While even today many “attempts to define professionalism as a set of virtues, obligations, and behaviors fall short of capturing its essence,” no one was trying to define it 50 years ago; issues of lifestyle, litigation, and quality assurance were simply not part of public discourse (Smith 2005). The lifestyle was doctoring itself. A solo practitioner hanging out his shingle was a commonplace sequela of completing training, and those practitioners were overwhelmingly white and male—even by 1970, only 9.2% of United States medical graduates were female (Silberger et al. 1987).

Although some timeworn therapies have persisted for decades, medical knowledge has advanced markedly in the last 50 years. In the past, both available therapies and understanding of disease processes were more limited. Patients like Mr. Reeves were told “No more can be done” more frequently and earlier in the course of disease. The doctor’s role in crisis was support at the bedside, either in hospitals or in patients’ homes.

Doctors in the community were often general practitioners; three-fourths of the population received care from family doctors who worked, in some cases, seven days per week, not including essentially nightly at-home call (Luce 1950). The pace was slower with long hours. Doctors’ lives lacked balance, and focus remained squarely on the patient; this was the norm. As Francis D. Moore (1959) said in the preface to his textbook: “The fundamental act of medical care is assumption of responsibility . . . complete responsibility for the welfare of the pa-
Physicians of every specialization practiced the laying on of hands as a true craft, an art form. With limited imaging and laboratory-based options, these doctors had no choice but to hone their abilities in the history and physical exam. Sequential physical exams, rather than technology, allowed physicians to follow their patients’ progress. These years solidified the concept of medicine as a calling, and a noble one at that.

The patriarchal nature of health-care delivery produced the sense of “doctor knows best”—doctor as the authority. The doctor-patient relationship demonstrated notable formality; one would not hear patients calling physicians by first names other than “Doctor.” Physicians and surgeons extended “professional courtesy” often at no charge when treating doctors or their family members—whether or not any prior personal connection existed. While these aspects of doctor-patient interactions may no longer be as common, physicians like Dr. Chapman exemplified those core behaviors that rest at the heart of medical professionalism, such as subordinating one’s own interests to those of others, demonstrating high moral standards, and contending with matters of great uncertainty.

Health care 50 years ago was even more focused on “sick care” than it is now. Topics of diversity, the underserved and underrepresented, and direct-to-consumer marketing (though it occurred through radio and print) were less germane for physicians of the day. Polio held the attention of the Western world. The dawning of “the DNA era” occurred with the discoveries of James Watson, Francis Crick, and Rosalind Franklin. Prescription and nonprescription drugs were differentiated for the first time, and by 1956 the NIH had achieved a budget of $100 million (Shannon 1987). The Medicare and Medicaid Program would not be signed into law until 15 years later, on July 30, 1965; the landscape did not yet reflect the immense financial, procedural, and cultural influence of this initiative (CMMS 2008). The emphasis on research and discovery would evolve, but over the next 50 years, doctors would begin to question what it meant to practice medicine in the midst of technological advances and what it meant to be professional at the turn of the 21st century.

2000s

Dr. Luisa Martinez takes advantage of the 30 minutes before her first scheduled appointment to check her voicemail and e-mail. A general pediatrician, she still focuses more heavily on diabetes mellitus than others in her group.

She hears a mix of Spanish and English coming from Exam Room 1 and recognizes the voice of Lucy Pasley, a seven-year-old girl with type 1 diabetes. Lucy giggles in response to her mother, Maria, tickling her as she has her temperature checked with an aural thermometer. Lucy has appeared for a well-child check, and Dr. Martinez spends the next few minutes asking how Lucy has been doing at home and in school while conducting a physical exam that Lucy thinks is just play.

Maria always arrives with a list of questions jotted for the doctor on note-
paper and a separate list of “Lucy’s sugars” for the past few months. Today, she is most interested in asking Dr. Martinez about an article she read online from the *Chicago Tribune* describing the use of a sulfonylurea to treat another young girl with formerly insulin-dependent diabetes. The doctor discusses the implications of that article with Maria and emphasizes the rarity of the genetic mutation involved that permits the therapy to work. She’s happy spending a few extra minutes with the Pasleys, but she is not surprised to notice that the remaining exam rooms are already full.

Dr. Martinez closes the visit after 12 minutes and moves to the next exam room. She smiles at a pharmaceutical representative holding a tablet computer and toting a rolling briefcase filled with samples. Dr. Martinez distributes those samples liberally to help her patients who struggle to afford their prescriptions. Normally, the doctor would pause to greet the representative, but she needs to see the next patient before doing so. Dr. Martinez would like to complete her scheduled visits by the early afternoon in order to meet a small group of medical students at the nearby school to discuss techniques in physical diagnosis.

Today’s doctors enjoy unprecedented access to medical knowledge and therapeutic options. The wealth of clinical understanding is more readily available in formal medical education and through online resources, digital pharmacopeias, and pocket references. But doctors are also more openly introspective on the nature of the profession through reflective writing, subjective surveys of attitudes and perspectives at all levels of training, and debriefings for medical teams following emotionally challenging care experiences (Donohoe 2002; Furnham and McGill 2003; Redinbaugh et al. 2003; Shapiro et al. 2006). Indeed, the very concept of medicine as a calling is being questioned. Young would-be practitioners are choosing careers in the business of medicine over the practice of medicine—consulting, pharmaceuticals, insurance, medical administration. Veteran physicians are also moving into these pursuits and they may cite how things used to be and job dissatisfaction as motivators (Pathman et al. 2002; Zuger 2004).

Despite doctors’ seeking careers outside of clinical care, more doctors are practicing in the United States than ever before, and, while the majority of physicians are white, minorities are increasingly represented. Female matriculants to medical schools surpassed males for the first time in 2003, and women represent 25% of practicing physicians (Levinson and Lurie 2004). Foreign medical graduates compete effectively for residency positions in most specialties. Specialization is the order of the day, although general practitioners continue to emerge from family medicine and primary care training programs to work in the community. The landscape has changed.

The public enjoys dramatically improved access to medical information—admittedly of varying degrees of accuracy—through the media and the internet. Medical decision-making is being analyzed through lenses of increasing acuity. Now that doctors can do more, they fear repercussions of not doing enough, errors of omission. “Defensive medicine” comprises the practice of treating lia-
bility risk as well as the disease at hand; physicians may order additional tests to reassure patients or may avoid patients at higher risk of bad outcomes (and presumptively higher risk of filing suit) (Kachalia et al. 2005). Coping with uncertainty is one of the core behaviors of professionalism, and constant advances in understanding demand intellectual vigilance. But cogent forces have placed some doctors on the defensive, as they view staying up-to-date as a survival tool instead of a fundamental aspect of their practices (Millenson 1997). The sense of accountability and the opportunity for reflection on medical decisions fundamental to professionalism are threatened by such a harsh environment. Recent efforts to remove the specter of punishment from error-reporting processes and to assuage underreporting of errors demonstrate a continuing commitment by the profession to preserve its ideals (Lehmann et al. 2007; Taylor et al. 2007).

Issues of professionalism supersede events specific to the doctor-patient interaction. Medical school career panels now include discussions of work-life balance. Lifestyle has become an issue of conflict between trainees and trainers just as it has become the topic of investigation; trainees and medical students are influenced by issues of income, locale, flexibility of hours, and familial obligations (Maiorova et al. 2008; Newton et al. 2005; Orpin and Gabriel 2005; Sanfey et al. 2006). House calls have drastically reduced in prevalence, although they have not disappeared (Meyer and Gibbons 1997). The increased use and reliance on technology in the setting of sound clinical decision-making has created the impression of doctors as technicians. Trainees balance the necessity of developing physical exam skills in the context of emerging, disruptive technologies. The doctor who spent hours at the patient's bedside in crisis might instead be effectively and successfully treating multiple critically ill patients in intensive care.

Physicians practice in the midst of calls for health-care reform and increased activism. Doctor-patient interactions are more informal, and professional courtesy may still translate to “VIP treatment” but no longer to “no charge.” Interactions with representatives of affiliated industries—pharmaceuticals, device development, and so forth—and studies demonstrating impaired decision-making in the setting of reciprocity have limited what representatives of Big Pharma can do to educate and entertain doctors (Schneider et al. 2006; Wazana 2000).

Physicians are surrounded by changes in their profession, but what of professionalism? The medical community seeks an open discussion on the topic, a concept whose principles "are really like the bricks and mortar that ultimately build a framework of good medicine" (Stevens 2007). Metrics of professional behavior and hundreds of studies of professionalism as early as medical school admissions contribute to the literature (Reddy et al. 2007; Smith 2005).

Beyond the research, the writing, and the discussion, professionalism is most important in its impact on the quintessential act of medicine—doctors treating patients. The account of Dr. Martinez is no singular occurrence. It contains aspects of days in the lives of tens of thousands of physicians across the country. This simple outpatient visit resonates with doctors and patients alike partly be-
cause it is relatively ordinary. In fact, it is easy to take for granted the demeanor, attitude, and behavior of the doctor for precisely this reason. Dr. Martinez effortlessly combines core humanistic values and her involvement and understanding of scholarship in her conversations with her patients. Her commitment to excellence includes her desire to combine her medical knowledge with her compassion, to make this visit a normal part of life for a young girl. By so doing, Lucy will be accustomed to an aspect of her health that will always be her condition but need not be her illness.

In any system of training that relies so heavily on experience and apprenticeship, discord between trainers and trainees cannot be avoided. Unprofessional behavior (making disparaging personal remarks about patients, discussing protected health information in public places, inappropriate use of alcohol and recreational drugs) and, indeed, the very discussion of professionalism are exacerbating the generation gap in medicine (Reddy et al. 2007). Professionalism cannot be ignored, and entrants into the medical profession must be willing to engage on some level in the conversation. Medicine will never again be the lifestyle-unconscious field that veterans refer to as the “age of heroes.” But recent medical graduates also cannot assume that earning a degree means they know what they need to know about earning a patient’s trust and providing the best care, even when therapeutic options beyond palliative care have run out. In the next 50 years, this professional schism must be negotiated. If it is not, doctors in 2050 may actually be no more than technicians, as patients become increasingly more interested in “what the test shows” instead of “what the doctor has to say.”

2050s

Scanning the morning’s appointments on her digital assistant, Dr. Elisa Tang hugs her children before they hurriedly grab their bags and run outside to the driverless automated bus. Dr. Tang logs into the electronic medical records (EMR) system for her hospital from home by glancing into a scanner on her computer which recognizes her retinal imprint.

A cardiac electrophysiologist, Dr. Tang opens her “virtumail” while simultaneously selecting the remote diagnostics that have been transmitted from her patient’s devices overnight to servers for the clinical information system (CIS). She makes minor adjustments, which will be synced with her patients’ miniature “cardiosupportive” devices overnight.

Dr. Tang dictates to her digital assistant as she travels to the medical center. The audio files sync to the dictation service through the CIS at the hospital. Automated transcription follows with remarkable accuracy. Advances in communication have permitted Dr. Tang and her colleagues to accomplish more from diverse locations, but she wonders if they substitute for seeing patients in clinic. As she arrives at clinic, she recalls the words of a professor in medical school: “Touching will always be the bond and bridge between doctors and patients that is the therapeutic catalyst.”
When Dr. Tang considered going to medical school, she was told doctors just didn’t do as much anymore. Along with electronic records, genechips, and advances in tissue engineering like artificial cartilage, society has seen other major steps: robotic-assisted surgery is commonplace, and neutron imaging has become clinically feasible, improving yield in diagnosing breast cancer among other diseases more easily missed by other modalities. The entire light spectrum is now utilized to test noninvasively for and assay almost every component previously available only from blood or biopsy material.

The traditional physical exam is obsolete, but “laying on of hands” is still a central tenet of the doctor-patient interaction for Dr. Tang and her colleagues. Technology can keep track of every potential drug interaction in the pharmacy, but it still cannot triage very well. Improvements in speech recognition have made automated translation a developing reality, but software cannot read a patient’s face and choose the perfect words with which to deliver bad news. Widespread use of subjective patient surveys following clinic visits and hospital stays in Dr. Tang’s medical system continue to demonstrate that patients value the time with their doctors above any other aspects of their visits.

As the information network worldwide expanded, doctors found new avenues into homes. Dr. Tang has primary care colleagues who make “house calls” through virtual conferencing. Patients can be seen frequently using biometric systems set up by home health care. Patients still come into clinic, but doctors have found these home systems more efficient and more convenient to ensure follow-up.

Dr. Tang arrives at clinic and greets her nurse, Patricia. “You have two patients waiting, Doctor,” notes Patricia, as Dr. Tang sits at a computer in the workroom. “Both have chips—I scanned them already.” Dr. Tang nods and thanks her.

Not all patients have agreed to the recently introduced MedChip program—“your medical history in the palm of your hand”—microchips with solid-state memory inserted into the distal radii. Providers need only wave a scanning wand over the chips to download aspects of a patient’s medical record to clinical information systems. Emergency medical services throughout the country are major proponents of the new system. Early data has shown that patients tolerate MedChip implantation well and generally forget they even have the devices. Dr. Tang has seen some patients shudder when she asks them if they have MedChips as they describe their privacy concerns. She supports the system because it allows her to spend more time talking to patients about their chief concerns for that visit instead of simply rehashing lengthy medical histories and medication lists. It also allows providers to avoid repeating recent, costly, and potentially identical evaluations at unaffiliated facilities.

Dr. Tang carries no paper chart into the exam room and simply activates the touch-display on the wall as she enters. She uses these displays to illustrate some of her favorite images describing the cardiosupportive devices and procedures that she recommends for her patients. With the displays, patients participate more actively in their visits than in the days of the prescription pad, because they see images of all of the medications that “the doctor thinks they should be taking.” Dr. Tang has learned to engage her patients more effectively as a result of these
advances. As far as she is concerned, any technology that gives her more time to see and talk to patients instead of charting, billing, or simply writing about patients has a place in her clinical practice.

Five decades from today, the technological landscape will represent many advances in all aspects of care. It will be all the more crucial for doctors to be able to communicate these advances to patients in the setting of an increasingly complex array of options. The tenets of professionalism outlined for Dr. Chapman in 1950 will still hold true for Dr. Tang in 2050. Compassion, integrity, competence, and critical thinking will all be foundations for the practice of medicine. The need to balance the advancement of medicine with societal need and a sense of accountability will be even more important as the unprecedented wealth of medical, pharmaceutical, and technological options will demand the vigilance of physicians in every aspect of their practice. As their tools help them treat disease as never before, they will require more confidence in their knowledge and abilities to interpret vast amounts of data and to be able to connect with patients beyond the machines, the pills, and the lab tests. Practitioners must prevent doctor-patient interactions from becoming sterile, mechanical, technology-driven processes. Therefore, those nine core behaviors of professionalism will be even more critical for doctors 50 years from now.

The concept of personalized medicine will impact therapeutics and pharmaceuticals. Patients will come to expect medication tailored to their particular receptor maps through pharmacogenetics. Quality assurance will no longer be a topic of controversy, discussion, and heterogeneous implementation. It will be prerequisite to ensure patients are receiving care that, more than ever before, is truly “designed” for them. The widespread reporting processes described in Dr. Tang’s medical system should lessen the tension between doctors and patients. Doctors will be less reticent to admit medical error or suboptimal outcome, and patients, who in the past may have sought legal reparations, will be satisfied with honest apology. Patients will also be more apt to believe steps are being taken “so it won’t happen again.”

The nation will represent the most diverse population in history, and cultural competency will be as basic as knowledge of anatomy and physiology to medical education. Underserved areas will be the last to benefit from many improvements to the scientific standard of care. But attention to reaching these areas taken by current trainees will set a precedent for future generations. Primary care will not disappear, particularly as the advancements become more commonplace and costs associated with them decrease. Primary care doctors, free clinics, and nonprofit organizations will be able to redirect these resources to underserved areas over time.

As device and imaging technology becomes more miraculous, the perception of “doctors as technicians, mechanics, tradespeople” may only worsen among some patients. But the end result of these advances remains improved therapeu-
tic options, better outcomes, and stronger bonds between the beneficiaries of all of these changes—doctors and patients.

Regardless of the time period involved, professionalism imbues medicine. It simply takes different forms over the years. Professionalism was not directly discussed in the 1950s, but it remained a combination of mastery of current medical knowledge enabled by contemporary technology and delivered with compassion, humility, respect, and sensitivity to the needs of patients and their families. The discussion of professionalism occupies research, academics, and clinical practice today, but its basic characteristics are not so different. Fifty years from now, professionalism in medicine will still be personal, tactile, humanistic, supportive, and helpful whether the problem at hand is grave or trivial. Dr. Chapman would be surprised about many elements of Dr. Tang’s practice, just as she would be amazed at his ability to practice so effectively in an era of relative technological unsophistication. But both would immediately recognize the traits they hold in common: love of the craft, commitment to their patients, competence, compassion, facility in communication—simply put, those qualities that make them both not only great doctors, but true professionals.

References