

Viewpoint: **Professionalism in Modern Medicine: Does the Emperor Have Any Clothes?**

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Abstract

The virtues that constitute medical professionalism have been aptly described in multiple position statements from professional organizations and individuals. These professional virtues depend on particular moral community traditions to undergird and sustain them. Attempts to ground these virtues in narratives intrinsic to medical practice—in the moral consensus of physicians or patients, in the self-regulating character of medicine as a profession, in the Hippocratic tradition, or in the physician–patient encounter—have been unsuccessful. Modern medicine must, therefore, look outside its own methodological and clinical practices for

grounding narratives sufficient to sustain the professional virtues set forth in the recently published professionalism statements. These professionalism statements are written to capture consensus, and they rarely acknowledge the external moral traditions on which the virtues depend, because doing so would, in a pluralistic culture, entail the risk of moral disagreement and division. The authors argue that meaningful education in professionalism must look beyond the consensus statements and deeply engage the particular cultural traditions external to the practice of medicine that sustain the professional virtues. Medical professionalism curricula

should embody an open pluralism, giving voice to diverse moral communities, encouraging critical self-exploration and discussion about the truth claims of these communities, and, if possible, facilitating the integration of students' professional development with their ongoing participation in these communities. Engagement with and participation in these sustaining moral communities would promote the cultivation of virtue capable of withstanding the economic and social threats to professionalism that are inherent in modern medical practice.

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Recent years have witnessed an explosion in the literature on medical professionalism. Within the last decade, the American College of Physicians,¹ American Board of Internal Medicine,² European Federation of Internal Medicine, American College of Surgeons,³ American Medical Association (AMA),⁴ Association of American Medical Colleges,⁵ and other professional organizations⁶ and individuals⁷ have

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drafted definitions and statements on professionalism. These statements collectively constitute an impressive catalogue of virtues in an era when physician autonomy and self-regulation are increasingly challenged by third-party payers, patients and their families, and external critics.⁸ Physicians are expected, among other things, to subordinate their own interests to the interests of patients (and to assume risk when doing so); to strive for excellence, knowledge, and competence; to work for fair allocation of health care resources; to treat patients, physician colleagues, and other health care professionals with respect; to avoid conflicts of interest; and to demonstrate sensitivity to other cultures.

To defend its conclusions, each professionalism statement appeals to values that are supposedly inherent to the practice of medicine, and each statement presents itself as a consensus document about the virtues necessary for good medical care. But this is, at best, ironic: the very need for these statements, as well as the large amount of energy, time, and resources dedicated to producing them, betrays the fact that the described virtues are not shared by all physicians. There is,

as Coulehan has described, a “hidden curriculum” deeply entrenched in modern medical practice, which in many ways directly contradicts the lofty ideals of the professionalism statements.^{9,10} It is also unclear whether the professionalism statements have made any difference in the actual practice of medicine.

We fully support the various statements on professionalism with respect to patient care, and we agree with the sponsoring organizations that adherence to these standards is imperative for the proper practice of medicine. We further agree that adherence to these standards is not universal among physicians and that it is the responsibility of the medical profession to self-regulate and to mandate adherence to these standards. We do not believe, however, that these statements or the well-intentioned and well-organized movements that have produced them are likely to do much to correct the problem. In this article, we will argue why we believe this to be the case, and we will propose the beginning of a solution. Our argument proceeds in four parts: first, that the professional virtues, themselves the products of particular moral community traditions,

require these traditions to establish them and undergird them; second, that modern American medicine is not currently able to generate a moral narrative sufficient to support the professional virtues without appealing to the traditions of external moral communities; third, that the professionalism statements represent the product of particular moral community traditions that they do not acknowledge and that they therefore forfeit power; and, finally, that medical education in professionalism must be openly pluralistic, listening and giving voice to the particular community traditions within which the virtues can flourish.

The Importance of Grounding Community Traditions for the Virtues

Suppose that a first-year medical student, reading the widely endorsed “Medical Professionalism in the New Millennium: A Physician Charter”¹ (referred to hereafter as the Physician Charter) for an introductory class on professionalism, asks why the fundamental principles of the Physician Charter—the principle of the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice—are, in fact, fundamental. Why, she might ask, should physicians embody a dedication to serving the interest of the patient, care about the fair distribution of health care resources, or be honest with their patients? How should the class instructor respond to her questions?

First, and perhaps most obviously, the instructor should be prepared to answer such questions with good reasons defending each of the defined principles. Indeed, the professional virtues have moral force only to the extent that good reasons can be given for cultivating them. It is not enough to tell the student “it is right because I said so,” or “it is self-evidently right.” But this leads quickly to more complex questions. Which arguments might the instructor use to defend, for example, the principle of social justice? Indeed, how is justice defined at all? No answer can be given to these questions without recourse to *particular moral traditions* as they have evolved in *particular moral communities of discourse* in history. These moral communities consist of any group of persons who, in the context of life

together, share in practice and in theory some concept of the ends of human life and appropriate human behavior. Functioning moral communities may range in size from a family unit to an ethnic or religious subculture to (in some cases) a nation or transnational movement. The sustained moral reflection of a community over time becomes a moral tradition.¹¹ The instructor’s own answer to the student’s question could identify her as part of any number of moral traditions; for example, her response might show her (among many other options) to be a Marxist, a defender of human rights, a deontologist, a utilitarian, a Thomist, a Platonist, or some combination of the above. Ethics, like all human inquiry, is historically situated. Each of the professional virtues has a history; each emerged in the context of contested and particular moral traditions; and none can stand alone apart from the moral communities in which it is rooted and from which it springs.¹²

Moral communities do much more, however, than provide good reasons for the professional virtues: they embody them. It is here, in the real-life practice of these moral communities, rather than in discursive inquiry, that the most powerful moral education takes place. Most first-year medical students are unlikely to ask the hypothetical questions posed above, not because they are already fluent in biomedical and professional ethics but because they have been formed in familial, cultural, and/or religious communities, often from an early age, to value the virtues of respect, altruism, and service. Alternatively, as Coulehan⁹ has suggested, they may have been raised in cultures in which these values are given lip service but undercut implicitly in a powerful manner. If students have already cultivated these virtues within a living moral community, formal education in medical professionalism may be largely unnecessary. If they have not cultivated these virtues, professionalism education is necessary but, unfortunately, often ineffective.¹³ The academic medical culture, as evidenced in Coulehan’s description of the “hidden curriculum,” often functions as a moral community that discourages the virtues by socializing trainees into “hospital narratives” that implicitly subvert the lofty moral ideals taught in preclinical professionalism curricula.⁹

Where, then, can future generations of physicians find the moral community traditions to ground the virtues?

Modern Medicine Lacks Sufficient Internal Resources to Properly Ground the Virtues

What arguments might teachers of the inquiring first-year student use to ground the professional virtues? Some teachers may refer to accounts of professional virtue, such as the Physician Charter¹ or the principle-driven system of Beauchamp and Childress,¹⁴ which attempt to ground professional behavior not in any particular moral community tradition but by appeal to social consensus about what is morally valuable. However, this argument fails to adequately ground professionalism for two reasons. First, modern culture is less a Rawlsian well-ordered society¹⁵ than a cacophony of different and often conflicting moral communities. Hidden behind every consensus are these particular moral communities—the “diverse cultures and national traditions” of the Physician Charter—without the presence of which no consensus could emerge.¹ Second, as mentioned in the introduction, it is unclear whether consensus among physicians or in the culture truly exists in the way assumed by many professionalism statements. Engelhardt¹⁶ has argued that much apparent moral consensus in medicine is a façade created by those who happen, by historical and cultural accident, to have been formed in similar moral traditions (e.g., liberal individualism) and that this façade would collapse if the conversation were broadened to include a more diverse array of correspondents. Are the highly principled authors of the various professionalism statements truly representative of physicians as a whole? Most likely, they are not, because they have already made the moral commitments they wish to persuade the profession as a whole to adopt. But even if such broad moral consensus among physicians could be shown to exist, it is unclear that theoretical agreement on the principles and virtues of professionalism would lead to agreement about how these virtues should be enacted in praxis. Ginsburg and colleagues,¹⁷ for example, recently reported a small study in which 30 teaching faculty of an academic medical center were shown video clips of medical students in morally challenging

situations and were asked to rate the appropriateness of the students' responses; they displayed "substantial disagreement both between and within faculty about what constitutes professional and unprofessional behavior in medical students."

Other teachers responding to the inquiring first-year student might attempt to ground the professional virtues in the self-regulating character of medicine as a profession.^{18,19} Physicians, it is argued, have been granted nearly monopolistic control over medical practice and technology, and therefore they have the opportunity and obligation to self-regulate and to define ethical practice for themselves. This sociological model, however, is controversial,²⁰ and even the theorists who advocate this professional dominance model do not argue that professional ethics can sustain themselves independent of underlying grounding moral traditions.¹⁹ (p 215) Medical ethics can clarify what justice means in the context of, for instance, an intensive care unit, but it cannot, on the basis of professional autonomy, ground the concept of justice per se.

Other teachers would answer the questions of the inquiring student by appealing to the moral traditions intrinsic to the practice of medicine. The Physician Charter, for example, argues that physicians "share the role of healer, which has roots extending back to Hippocrates."²¹ The AMA Declaration of Professional Responsibility⁴ refers to a "common heritage [among physicians] of caring for the sick and suffering." Others have attempted to ground professional virtues specifically in the particular nature of the physician–patient relationship without explicit appeal to external moral tradition.^{21–23} The possibility of a tradition-neutral, intrinsic ground for medical professionalism may seem appealing, but it is unlikely that any such ground can be successfully established. Consider the venerable Hippocratic tradition, which is sometimes cited as an intrinsic ground of professional behavior for physicians. The Hippocratic Oath, the principal document of that tradition, commits its adherents not only to "use those regimens that will benefit my patients and . . . to do no harm or injustice to them" but also to abstain from abortion, euthanasia, "us[ing] the knife," and

charging a fee for medical education.^{24,25} At best, this has been selectively appropriated in modern medicine. Only one U.S. medical school graduating class recited the Hippocratic Oath per se in 2000, whereas 59 recited a modified Hippocratic Oath, 30 recited a student- or faculty-authored oath, and 18 offered more than one oath option.²⁶ On what moral basis did all but one of the graduating classes decide which of the Hippocratic stipulations to modify or delete? It is there—not in the oath itself, but in the patterns by which the oath has been selectively appropriated and modified—that the true grounding community traditions of modern professionalism can be found. If Hippocratic maxims such as *primum non nocere* have survived, it is more because the moral traditions that currently inform medical ethics (e.g., human rights, liberal individualism) have found them useful and relevant than because they are part of the Hippocratic corpus per se. The Hippocratic ideals, including *primum non nocere*, would be inconsequential for modern medical practice if there were no living moral communities to foster, sustain, and practice them. For example, the practice of professional courtesy—treating fellow physicians and their dependents without charge—was once a common professional practice that derived from the language of the Hippocratic Oath. In the modern world of insurance copayments and managed care, this courtesy is rarely practiced and is viewed as an optional professional practice by the AMA, despite its Hippocratic foundations.²⁷

Some may reply that the Hippocratic tradition is a straw man and that these modern grounding narratives may still be defined as intrinsic to the practice of medicine. We affirm and celebrate the common heritage of caring for the sick and suffering that has been cultivated by generations—indeed, centuries—of physicians. There is much to be learned from this collective history; but is it a necessary or logical conclusion that a physician's encounter with patients who are sick will encourage the cultivation of the professional virtues of altruism, respect, benevolence, and so on? The numerous counter examples both in history²⁸ and in the present¹³ suggest otherwise. Medicine has had many embodiments throughout history, from

the Hippocratics to the reductionist physicians whom they opposed,²⁹ to the monastic physicians of the earliest charity hospitals,³⁰ to early professionals such as Percival and Gregory,³¹ to the physician–scientists of the modern academic medical center.³² In each of these cases, medical care has existed in a particular cultural milieu and has been profoundly influenced and directed by the prevailing moral community traditions of the broader culture. The experience of physicians in caring for the sick can *inform* and *influence* these broader community traditions, but it cannot *supplant* them. Working with underserved populations can strengthen our commitment to economic justice, but only if we already think that justice is a goal to be pursued; sitting with vulnerable and suffering patients can strengthen our commitment to altruism, autonomy, and respect, but only if we already believe that the vulnerable should not be exploited. Modern medicine, as it has done in the past, must look outside itself—that is, beyond its own methodological and clinical practices—for grounding narratives sufficient to sustain the professional virtues.

The Professionalism Statements Depend on Moral Traditions They Do Not Acknowledge

So far, we have suggested that the professional virtues cannot be justified except by appealing to grounding moral narratives that are extrinsic to modern medical practice. We are dismayed by how rarely this sort of external acknowledgement occurs in the recent consensus statements on professionalism. The Physician Charter is the only document to make any such acknowledgement, referencing "diverse cultures and national traditions" before positing a consensus for the principles and responsibilities it describes. We realize that the various professionalism statements are intended to be consensus statements, acceptable to and representative of a large number of culturally, philosophically, and religiously diverse physicians, and that explicit acknowledgement of grounding moral narratives external to the tradition itself would likely compromise the ability of the documents to describe a consensus. But this is precisely the quandary. The professional virtues, like spring flowers, bloom and grow most fruitfully in the

context of the particular, specific grounding traditions that originated and sustain them. Cut off from these traditions, they begin to fade and wither, to become increasingly arbitrary, anemic, and perfunctory. But explicit acknowledgement of these traditions in a pluralistic culture entails the risk of moral disagreement and division.¹¹

It is understandable that the leaders of professional societies, intent on preserving unity in diversity, would attempt to ground the professional virtues in consensus or in the practice of medicine *per se* rather than risk explicit acknowledgement of external moral, philosophical, and religious traditions. But has this strategy worked? *Can* it work? Is it possible that the true “threat to medical professionalism”³³ is not market forces, insurance companies, trial lawyers, or managed care,^{34,35} but, rather, medical students, residents, and physicians who are inadequately formed in any substantial moral tradition that would help enable them to withstand these pressures?

Professionalism and Medical Education: Fostering an “Open Pluralism”

If the professional virtues are to survive, they must be grounded in moral narratives and cultivated in moral communities that exist outside medicine as it is currently practiced. Most of this cultivation, we have argued, occurs during the decades of character formation before an individual ever matriculates in medical school. Medical school admission is partly about the selection of individuals who already value the virtues that the various professionalism projects hope to encourage. But there is still much work to be done.^{13,36} What can be done to foster the professional virtues in the context of medical education?

First, as Coulehan⁹ and others^{37–40} have argued, educators must pay close attention to the hidden, implicit curriculum of medical education—the world of call rooms, patient rooms, operating rooms, and workrooms, rather than classrooms—in which the real moral education of physicians takes place. But what about the explicit curriculum, the efforts to teach the professional virtues to medical students

and trainees? Any effective moral education of students should acknowledge that moral formation occurs primarily through participation in moral communities and only secondarily through discursive reasoning. Formal education in professionalism should at least acknowledge this and make room in the curriculum for the particular voices of these moral communities to be heard.

Explicit medical education in professionalism should be characterized by open pluralism: a commitment to explore, understand, and hear the voices of the particular moral communities that constitute our culture. We contrast this not only with exclusivism, in which the perspectives of any moral communities other than those of the instructors are consciously ignored or silenced, but also with two variants of multiculturalism frequently taught in academic medical centers. First, we wish to contrast open pluralism with melting-pot pluralism, in which the perspectives of particular moral communities are entertained but discounted as a basis for practice in favor of a more neutral common morality purportedly held by the broader culture. This least-common-denominator consensus ethic is no substitute for engagement with the particular moral traditions that sustain the virtues, and it may mask the fact that the liberal individualism, which is often presented as the moral consensus of the culture of medical practice, is a formidable, particular, and historically grounded moral tradition of its own that requires critical scrutiny. Second, we wish to contrast open pluralism with detached, objective pluralism, in which particular moral community traditions are examined as data that can help clinicians in their work with patients from particular communities without making any truth claims on the inquirer. It is important to explore cultural and moral traditions separate from one’s own, but there is no absolutely neutral view from which this can occur. Open pluralism would reject the still-common assumption that scientific empiricism is the only epistemological ground of medical practice^{41–43} and would acknowledge that all parties involved in the conversation find themselves living within one or more particular moral traditions that inform professional judgment.

A curriculum committed to open pluralism would invite students to explore particular moral traditions as they relate to health and healing⁴⁴ and would invite (particularly minority) cultural and religious leaders to address students and trainees about the particularities of their moral communities. It would also encourage respectful, charitable discussion regarding the value of the moral commitments of those communities. Students would be encouraged to acknowledge, explore, and critically examine their own *a priori* moral convictions, allowing for the recognition of orienting and substantive narratives out of which profession and professional duty can flow. Students would then be encouraged, both in discursive inquiry and in clinical practice, to integrate their development as physicians and their ongoing participation in particular moral communities. A student of a particular ethnic group might find a mentor of the same ethnic group; a Catholic student might meet with Catholic physicians and/or clergy to reflect on the theological implications of his or her practice; a student passionate about human rights might be able to work, as a student, in the developing world with mentors who share similar commitments.

We do not consider pluralism itself to be a virtue or an end in itself. The virtues are not formed by moral indecision or cacophony but, rather, by moral communities. Open pluralism is important insofar as it encourages medical students and trainees to hear the voices of actual moral communities with embodied practices of virtue and truth claims about the practice of medicine. The truth claims of these moral, religious, and cultural communities matter, and students should not only listen to these claims but question whether they are true in their professional identities and in their lives. This is a complex and difficult task, and instructors who facilitate these inquiries must model and encourage the humility, charity, and respect they hope to cultivate in future physicians.

Some may object that not all moral communities are equal, that some do not sustain, and may even undermine, the professional virtues. Would not the approach of open pluralism fail to challenge adherents of these traditions, or, worse, cause others to fall prey to

them? Take, for instance, a student principally motivated by the market-driven consumer economy (a substantial moral tradition itself) who matriculated in medical school primarily because of the prestige and high income associated with the profession and for whom lifestyle is much more important than self-sacrifice or altruism. How would open pluralism affect the development of professional virtue in this student?

In a case such as this one, the traditional approach to education in professionalism—didactic exposure to codes of ethics such as the Physician Charter¹—is unlikely to work. An openly pluralistic curriculum would encourage the student to name his or her guiding moral narrative and to consciously affirm or reject it. This would expose the student, through classroom engagement, mentoring, or shadowing experiences, to members of moral communities who do embody the professional virtues. We believe that the risk of students being influenced by particular moral traditions that did not undergird commonly held professional virtues such as altruism, justice, and honesty, would be mitigated by the ability of particular traditions to come into conversation with one another and by the deeper inculcation in the virtues that many, if not most, other students would experience.

Clothing the Emperor of Professionalism

In the Hans Christian Andersen fairy tale “The Emperor’s New Suit,”⁴⁵ two swindlers convince a vain emperor that they are crafting him a suit of beautiful material that would be “invisible to any man who was unfit for his office or unpardonably stupid.” They sell the nonexistent suit to the emperor who, not wanting to acknowledge that he cannot see the fabric, appears naked before his subjects. His subjects, also unwilling to acknowledge that they cannot see the cloth, shower him with praise until a small child points out that the emperor is wearing no clothes.

In a sense, the emperor of medical professionalism, as described in the various statements on professionalism, has no clothes. There is no common consensus or morality intrinsic to modern medical practice in which the professional virtues can be firmly

cultivated and grounded. But our argument is constructive as well as critical. We believe firmly in the professional virtues, and we believe that the virtues have been, and can be, grounded and “clothed” in the rich moral, cultural, and religious traditions that make our culture so complicated, dynamic, and colorful. We propose a model of education that allows these colors to shine in their particularity by encouraging participation in communities of virtue that will allow the professional virtues to be cultivated from within rather than imposed arbitrarily from without. The emperor, we believe, *has* clothes, but we wonder: will he choose to wear them?

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Did You Know?

In 2001, researchers at the University of Minnesota Medical School discovered the genetic cause of myotonic dystrophy type 2—the most common form of muscular dystrophy in adults. This discovery was made possible with funding from the National Institutes of Health.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the “Discoveries and Innovations in Patient Care and Research Database” at (www.aamc.org/innovations).