

The physician as a professional and the moral implications of medical professionalism

The origin and moral nature of the medical profession

A profession is by definition “an occupational group made exclusive by reason of its ... expertise.”¹ A society that recognises the value of health spends enormous amounts of resources to enable the best available people to acquire specialised medical knowledge and skills, and collectively to become a medical profession for the promotion and protection of its citizens’ health. Medical professionals (MPs) are given monopoly over the uses of their expertise, and they exercise extensive autonomy in most professional matters, such as setting standards of patient care, self-regulation, accreditation, payment schemes, size and number of hospitals, etc. In return, MPs are held accountable to patients and society. This is achieved through “professional ethics” that regulate a wide range of professional conduct of which three types are of exceptional importance: preserving the focal values of the medical profession, protecting the patient-physician relationship (PPR), and promoting the patient’s best interest.²⁻⁴

The patient-physician relationship and the patient’s best interest

Because the central value of the medical profession is to promote health, a MP can usually only practically achieve this value by enhancing the health of a particular patient or a small group of patients in his or her practice. The implication is that a MP’s primary professional obligation is narrowly focused on the patient seeking his or her service and the PPR established between them. This explains why PPR is the cornerstone of the medical profession (although under certain circumstances, a physician may have obligations to other patients in an institution or to society as a whole, the unitary PPR remains primary). Furthermore, as part of modern professionalism, MPs are committed to serve the patient’s best interest within the context of the PPR, and if necessary, to sacrifice their own interests in order to achieve this goal.

Three reasons for this “obligation of effacement of self-interest on the physician ...” have been proposed. First, the presence of an ill, dependent, vulnerable,

and exploitable patient constitutes such a moral claim; second, the MP holds the expertise and knowledge in trust for the benefit of the patient; and third, the MP has made a public promise to promote the interest of the patient.⁵ It is not clear to what extent a MP is obligated to efface his or her self-interest, but in practice, most western societies expect MPs to make some, though not necessarily extreme, sacrifices.

Priority of patient interest as principle of fidelity

The commitment to the primacy of patient interest is formalised in the ethical principle of fidelity, which, in addition to upholding medical standards of care and promoting the patient’s welfare and values, requires (1) MPs to put the patient’s interests ahead of other persons’ interests, and (2) effacing physician self-interest that conflicts with patient interest.⁶ Some argue that MPs have the moral obligation of fidelity and the obligation is grounded in the definition of medical professionalism, because MPs project images and promises that create an expectation that the public interests will be protected and given priority.^{7,8} From this view, MPs should treat fidelity as an affirmative moral obligation.

Serving the patient’s best interest: altruism or obligation?

Nevertheless, many MPs continue to regard medicine as an altruistic profession, implying that to give priority to the patient’s best interest is not necessarily a professional obligation but a personal expression of altruism. An interesting study in the US reported that 68% of the 1121 surveyed physicians felt obligated to treat AIDS patients, even though most of them would not if they had a choice.⁹ This suggests that the majority treated AIDS patients either because of the obligation of fidelity, or the obligation to act for the benefit of others (beneficence), rather than altruism. Even though fidelity, beneficence, and altruism may lead to the same consequence of acting to benefit the patient and not the self, fidelity and beneficence are the physician’s obligations while altruism is not. In putting patients’ interests ahead of his or her own, an altruistic MP is noble and compassionate, but the undertaking is strictly optional and supererogatory.

Another physician not so disposed is under no obligation to act in the same manner. However, in light of the society's goal to create the medical profession, and all the privileges granted to MPs, altruism cannot be the standard of medical professionalism. Altruism is always a desirable quality in the MP, but as a professional standard, it must take the form of an irreducible, moral, and professional obligation.

Medical professionalism and conflicts of interest

Failure to uphold the primacy of patient interest is the main reason for the decline of medical professionalism in the West, particularly in the US. Specifically there are charges of MPs putting their own interests ahead of patients' interests in two types of transactions: physician ownership of medical facilities, and accepting financial incentives from managed care schemes, for example, 'health maintenance organisations'. Physician-owned medical facilities potentially foster over-utilisation of marginally useful medical services, whereas accepting financial incentives from managed care organisations foster under-utilisation of medical services that are needed. Both entail conflicts of interest between physicians and patients, undermine patient interest, and threaten the PPR itself.^{10,11} While 'managed care' is not popular in Hong Kong and China, cost containment is equally pressing in this part of the world, and adoption of health care schemes that create conflicts of interest between patients and MPs is certainly possible. Likewise, while physician ownership of medical facilities may not be as prevalent here as in the US, the entrepreneurial spirit and free market ideology are just as lively, and temptations to turn professional medicine into a personal enterprise abound. Medical professionals must be reminded that to allow their own interests to undercut patients' interests in the context of the PPR falsifies medicine as a moral profession and reduces physicians to morally neutered technicians.

Medical professionalism in contemporary Chinese societies

How well can western medical professionalism be applied in Hong Kong and China that have a distinct cultural tradition? On the whole, the ideal of medical professionalism has been firmly adhered to in Hong Kong due to the British rule (1841-1997), as set forth in the *Professional Code and Conduct for the Guidance of Registered Medical Practitioners* published by the Medical Council of Hong Kong (revised in November 2000). In Mainland China,

medical professional bodies have also been formed and professional ethical standards are acknowledged. In the *Norms and Implementation of Medical Ethics for Healthcare Workers* (醫務人員醫德規範及實施方法) published in 1988 by the Health Ministry of the People's Republic of China, ethical norms are established for the explicit purpose of "improving the quality of the healthcare workers' *professional ethics*." The document goes on to state: "medical ethics, ie the professional ethics of healthcare workers, is a quality of the mind that each healthcare worker should have. It is the summation of the relationships between healthcare worker and the patient, society and other healthcare workers."¹²

It is important to note that this governmental document refers to medical ethics as a "professional ethic", suggesting that Mainland Chinese officials consider medicine as a profession regulated by a set of ethical norms. Even though the document does not explicitly stipulate the primacy of patient interest or the principle of fidelity, it is significant that the PPR is put first on the list of health care workers' professional relationships. It indirectly affirms that even in a Communist society, the medical profession's focal values are placed on individual patients rather than the community. In addition, the Chinese Medical Association explicitly declares in the *Medical Ethics Manifesto* (中華醫學會醫學倫理學分會宣言)¹² [1988], "in order that the physician's interest is integrated with the patient's interest, *the interest of the patient has priority*." Hence, it is reasonable to conclude that medical professionalism, with its twin ethical concepts of PPR and primacy of patient interest, has been widely accepted by the Chinese society and health care workers.

Medical professionalism and traditional Chinese medical values

There is also no evidence to suggest that western ethical ideals pose particular hardships for Chinese practitioners of western medicine due to cultural differences. On the contrary, many Chinese moral values resonate well with western medical ethics. In Chinese tradition, there has always been a special connection between morality and medicine. From ancient times until the 19th century, most Chinese scholars were trained in Confucianism (morality) and medicine: the former to become the emperor's minister to "heal" the country, and the latter to heal human bodies. Chinese scholars used to say, "If I cannot become a good minister, I will become a good physician." (不為良相，必為良醫) The connec-

tion between Confucianism and medicine is evident in the first principle of Chinese medical ethics: "Medical practice is a practice of benevolence" (醫乃仁術).¹² The Chinese term "ren" (仁), translated to the English term "benevolence", refers both to virtuous attitudes of sincerity, fidelity, and compassion, and to moral acts of treating others with dignity, beneficence, and justice. An ancient Chinese medical text dated about 500 BC, *The Classical Internal Medicine of the Yellow Emperor* (黃帝內經),¹² states, "The medical occupation is reserved only for great sages" (大聖之業),¹² because only sages are able to identify with patients' suffering and to treat them with the heart of benevolent persons. Kung Tinxiang (龔廷賢, 1522-1619),¹² a respected physician of the Ming Dynasty, says, "The first and second of the ten pre-requisites of a medical expert is respectively to have a benevolent heart and to master the teaching of Confucianism" (一存仁心, 二通儒道)¹² in order that the healer will "regard the patient's illness as his own" (視人之病猶己之病)¹² and will "have the heart to save the patient's life *without regard for one's own interest*" (業醫者, 活人之心不可無, 而自私之心不可有).¹² Thus, it is safe to conclude that in the Chinese cultural tradition, physician benevolence and primacy of patient interest have long been part of Chinese medical morality, even though the concept of medical professionalism has only been a recent addition from the West.

EC Hui, MD, PhD
(e-mail: edwinhui@hku.hk)
Medical Ethics Unit

Faculty of Medicine
University of Hong Kong
Pokfulam Road
Hong Kong

References

1. DT Ozar. Profession and professional ethics. In: WT Reich, editor. *Encyclopedia of bioethics*. Rev ed. New York: Simon & Schuster Macmillan; 1995:2103-12.
2. Medical professionalism. *CMAJ* 2002;167:539-44.
3. Collier BS, Klotman P, Smith LG. Professing and living the oath: teaching medicine as a profession. *Am J Med* 2002;112:744-8.
4. Gruen RL, Arya J, Cosgrove EM, et al. Professionalism in surgery. *J Am Coll of Surg* 2003;197:605-8.
5. Pellegrino ED. Altruism, self-interest, and medical ethics. *JAMA* 1987;258:1939-40.
6. TL Beauchamp, J Childress. *Principles of biomedical ethics*. New York: Oxford University Press; 1994.
7. C Fried. *Contract as promise: a theory of contractual obligation*. Cambridge, Massachusetts and London, England: Harvard University Press; 1981.
8. Furrow BR. Forcing rescue: the landscape of health care provider obligations to treat patients. *Health Matrix Clevel* 1993;3:31-87.
9. Gerbert B, Maguire BT, Bleecker T, Coates TJ, McPhee SJ. Primary care physicians and AIDS. *JAMA* 1991;266:2837-42.
10. Council on Ethical and Judicial Affairs, American Medical Association. Conflicts of Interest. Physician ownership of medical facilities. *JAMA* 1992;267:2366-9.
11. Financial incentives to limit care: ethical implications for HMOs and IPAs. In: *Proceedings of the House of Delegates, 139th Annual Meeting*; 1990 Jun 24-28; Chicago, United States.
12. E Hui, ZZ Du, editors. *Medical ethics dictionary [in Chinese]*. China: Chengzhou University Press; 2003.

Corrigendum

"Jervell-Lange Nielsen syndrome in a Pakistani family" (December 2004;10:351-4). We have been informed by the authors of this paper that the full list of authors should have been the following:

LK Yuen, MB, BS
CW Lam, PhD, FHKAM (Pathology)
NC Fong, MMedSc, MRCP
PM Tang, MRCP, FHKAM (Paediatrics)
CC Shek, MRCP, FHKAM (Paediatrics)
YW Chan, MD, FHKAM (Pathology)
CB Chow, MB, BS, FHKAM (Paediatrics)