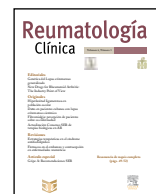




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Letters to the Editor

It is necessary to develop medical professionalism

Es necesario desarrollar el profesionalismo médico

To the Editor:

Many years in the medical profession are required in order to acquire the skills and technical dexterity necessary to perform well as a doctor and, after the training years, we must continue to work in order to be “good professionals”. However, much of the training we have received has been based on teaching schemes implemented for many years, while Medicine—doctors, students and patients—and society itself have changed dramatically. In this respect, David Stern and Maine Papadakis¹ recently stated:

“When teaching students our core values we must consider the real world in which they will work and live. The concept of education should include not only lectures in classrooms, discussion groups, laboratory sessions and patient care in consultation, but also discussions in hallways, cafeteria jokes and talks about “big cases” on the way to the parking lot. This broad concept of education includes three basic actions: creating expectations, providing experiences and evaluating results”.¹

Doctors have been central figures in human societies, with different nuances, throughout the centuries. However, the role which the medical profession has developed in society in recent years has decreased its relevance. There are several factors which influence this. The social environment has changed dramatically: population growth, demographic changes, rapid scientific and technological advances, speed of communication and access to information are examples of social transformation. The role of the pharmaceutical industry and the budgetary pressures experienced by health systems are also noteworthy.

These factors seem to favour the development of technical skills at the expense of humanism, so it is necessary to spread the precepts of medical professionalism.

In the early years of clinical contact the character of aspiring young doctors is very impacted by witnessing, for example, the first patient who dies as a result of a heart attack—with the look of anguish of one who feels close to death—or the uncertainty in the wet eyes of a mother whose child is lying on a stretcher in the ER service, unable to move his legs after an accident. Through experiences like these, young doctors begin to understand that medicine is not just science, but that there is something else which is not in the books. However, the tests they must face do not ask anything about these disturbing experiences. Gradually, without noticing it, drowned in the maelstrom of knowledge to be learned because it will be evaluated, sensitivity to pain becomes lost and, consequently, human suffering becomes an everyday thing, a part of the landscape. Later, in graduate school and during professional practice, it seems that knowing everything possible about a disease is what matters most...without the need to know the patient.

It is necessary to correct this professional bias, particularly when treating a patient suffering from a chronic or life threatening disease. However, the effects of disease on a person and their environment are not sufficiently evaluated and even less cared for. It is not enough for a doctor to fill in an assessment application for the Department of Medical Psychology or Social Work, but instead, during the few minutes of consultation, he must convey confidence, understanding and support, so that in this way the patient has hopes that he will be helped to identify an intended alternative to his existence.

The challenge is not simple but the task is possible. An example of its feasibility is found in the ideas of Viktor Frankl,² who described the need to search for the meaning of life in those who perceived it as limited in quality or duration. Despite illness and all the limitations it imposes, there is always a place of inner freedom, the disease does not override freedom of behaviour choice. If the physician remains aware of this with the patient, he can witness the courage of many of them in enduring suffering, the feat of getting up day after day with the intention of winning, that day, from the disease. Dealing with it rather than just worrying about it. It is precisely that area of freedom which no one can take away, says Frankl, that gives existence its intention and meaning. Discussing these concepts in the new context of teaching proposed by professionalism may help doctors to return to a proper relationship with their patients.

The Royal Academy of the Spanish Language³ defines professionalism as: “the cultivation or use of certain disciplines, arts or sports as a means of profit”. The World Federation of Medical Education⁴ further described the concept, particularly medical professionalism, as: “the knowledge, skills, attitudes and behaviours expected by patients and society from individuals during the practice of their profession. This includes concepts such as lifelong learning skills and maintaining competence, expertise in information management, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice and respect”.

For obvious reasons, knowledge and skills are the main aspects of a university curriculum. However, it should be noted that the previously mentioned definition gives relevance to attitudes. The attitude of a physician towards a patient in daily practice should be an essential element in the analysis of medical humanism, because it reflects a way of behaving in everyday activities and, to paraphrase Montaigne,⁵ “to judge a man’s success it is especially necessary to monitor his ordinary actions and catch him in his everyday suit”. In order to truly fulfil this requirement of the definition, it is necessary to incorporate these ideas into the educational process so that the values of medical professionalism are inserted into the “real world” of medicine.

The International Federation of Medical Education refers to the ethical behaviour of individuals. It is not enough that the group (society, school, association) has a Code of Ethics but group members must be committed to behave according to it. Progress in medical science has generated many ethical questions—called “evaluation perplexities” by Savater⁶—among doctors, but also among policy makers, religious and social leaders and so on. Ethics is not only a certain type of

behaviour pattern, but also an intellectual inquiry with practical implications which, in medicine, respond to issues such as family, reproduction, death, or the treatment of patients.⁶ Ethical behaviour must be proactive. It should not be considered only as a psychological boost, as “goodwill”.⁷ It is an intellectual analysis and, therefore, its discussion should be encouraged and not left to the “good conscience” of the medical class. It is in this context—perhaps it could be called Clinic Ethics—that medical professionalism is defined. Its fundamental principles⁸: the primacy of patient welfare, the principle of patient autonomy and the principle of social justice, should be present in the minds of all teachers, students and practicing doctors.

The profession, as proposed by the American Board for Medical Education, should include the creation of expectations, such as informing about policies and procedures which define professionalism,¹ including outlining appropriate responses to unprofessional conduct. It should also provide experiences, such as courses on ethics, problem-case discussions or gaining experience in underprivileged communities. It is also convenient to evaluate the results, and advice from each specialty should have an active role against unprofessional conduct, considering that both the safety of public health and the trust of the public in our profession are at stake.

The quote from Kant remains true: “*Sapere aude*” (“dare to know”) in the sense of avoiding self-imposed tutelage, of using intelligence without the need to wait for a guide to mark

directions, but now emphasizing humanism in the exercise of the medical profession.

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