The Professionalism Movement

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Organized medicine both in Europe and the United States has with a unified voice called for a renewed sense of professionalism among physicians and for an emphasis on this set of attributes in undergraduate and postgraduate medical education. In the last decade both the American Board of Internal Medicine [1] and the Association of American Medical Colleges [2] have launched major initiatives promoting professionalism, and the Accreditation Council on Graduate Medical Education in the Unites States lists professional development as one of the major goals of residency education [3]. These efforts have culminated in the European Federation of Internal Medicine, the American College of Physicians–American Society of Internal Medicine and the American Board of Internal Medicine working together to develop a Charter on Medical Professionalism [4] that seeks to better define these attributes and mandate physician responsibilities.

To date, the charter has been accepted and endorsed by over 90 professional societies worldwide (including the Israel Society of Internal Medicine) [5]. The charter is based on the overriding principles of primacy of patient welfare, patient autonomy and social justice [4]. From these principles a specific set of professional obligations are derived. As Harold Sox has pointed out in an introduction to the charter, the principle of the primacy of patient welfare dates from ancient times and is intuitive to most physicians. In contrast, the principle of patient autonomy is a product of the past century and is the basis for much of modern western medical ethics. The almost universally accepted Helsinki code on human experimentation relies heavily on this principle. The obligation to pursue social justice is in a sense the most revolutionary of the principles and for many physicians will represent an expansion of their responsibilities toward their patients and society, since medical organizations have in the past often acted more in their self-interest than for societal benefit. The impetus for these efforts in the words of the charter's authors is the fact that "the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society" [4].

Medical education

In 1999 the Association of American Medical Colleges launched its Medical School Objectives Project, in response to a widespread feeling that medical schools had been concentrating largely on the goal of the cure of disease. They pointed out that "society now recognizes the need for a broader view" [2], and the objectives of medical school education that they outlined included almost all of the elements in the charter. In preparing these objectives they cited reports by the Hastings Center, by medical educators in Canada and the General Medical Council of Great Britain, as well as the result of interviews with a distinguished group of American medical scholars. In response to these developments, American medical schools have begun to think seriously about how and where to incorporate student professional development into their curricula. In a survey of U.S. medical schools during the 1998–1999 academic year, close to 90% of the schools had some formal instruction related to professionalism [6]. Recognizing that professionalism must be taught differently than biochemistry and pediatrics, schools have been experimenting with new and innovative methodology to teach the subject. Student reflection [7], portfolios [8], workshops [9], one-on-one interviews with faculty [10], trigger films [11], and a combination of these methods, have been used to help imbue students with the attribute. We previously pointed out [12] that much of this educational effort could potentially be negated if the spirit of professionalism is not role-modeled to students during their clinical rotations. As other authors have noted, this problem is the essence of the "hidden curriculum" in medical education. Many values and behaviors that are taught to students during the preclinical years are not practiced on the wards, and sometimes the opposite behavior is subtly or overtly encouraged. If we are serious about teaching professionalism we must make every effort to ensure that its attributes and responsibilities are practiced wherever our students are found.

The new Physician Charter on Medical Professionalism is based on three cardinal ethical principles: the primacy of patient welfare, patient autonomy, and social justice

We have also suggested that the Physician Charter could serve as an organizing principle of medical schools by linking its professional responsibilities to medical education [12]. Each of its cardinal principles has direct relevance to medical education. For example, the commitment to improving quality of care could be enhanced by involving students in quality improvement projects, and the commitment to improving access to care by requiring students to perform clinical electives in underserved areas. The commitment to patient confidentiality could be ensured by

teaching students to password protect any patient information on their personal data assistants. The charter should also be distributed to students at their "white coat" ceremony to serve as a constant reminder of their responsibilities as medical professionals and should become part of the learning ambience of every setting in the medical school.

Jewish medical ethics

The Jewish ethical tradition has much to say about the fundamental principles of professionalism as espoused by the charter. Jewish tradition certainly recognizes the primacy of patient welfare, which is based on an altruistic dedication to serving the interest of the patient. The extraordinary affinity of Jews for the profession of medicine may well have its roots in the Jewish tradition of *gemilut hasadim* (performing acts of lovingkindness). According to normative Jewish Law a physician may not refuse to treat any patient, because treatment of the sick is clearly a *mitzvah* (obligatory commandment). Refusal to render assistance is decried as almost tantamount to murder. Indeed, the accepting of payment by a physician for his services was only permitted by the use of a variety of legal manipulations because, in principle, one should not be paid for required good deeds. In Asaph's oath (an ancient Jewish medical oath), in contrast to the Oath of Hippocrates, there is a specific admonition: "Do not harden your heart from pitying the poor and healing the needy." The message is reinforced in the physician's prayer attributed to Maimonides: "Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love of mankind and they can lead astray in the great task of attending to the welfare of Thy creatures."

The second principle of patient autonomy essentially empowers patients by requiring physicians to provide them with all the information about their condition and putting the ultimate decision about their treatment in their own hands. In the fashion currently in vogue in the west, this autonomy is almost unlimited, taking precedence even over beneficence. This total empowerment of the patient is not consonant with Jewish tradition, which puts much greater emphasis on beneficence and assigns lesser importance to the value of autonomy. There is serious concern in Judaism about harming patients by presenting them with bad news, particularly in a manner that may be dangerous to their health. Truth may thus be withheld at times even at the expense of autonomy if one is concerned that it may harm the patient. Furthermore, in the Jewish tradition an individual does not have unlimited rights to do with their body as he/she wishes if such action is dangerous or harmful. Therefore, at least theoretically in Jewish thinking, actual coercion of treatment might occasionally be possible, though rare indeed. In fact, more voices in the west are questioning the overemphasis on autonomy, particularly in view of the observation that sick patients are not always fully component decision makers [13]. The Israeli Patient's Rights Law is indeed unique in providing for the possibility of coercing treatment in a competent patient with the approval of an ethics committee. This is one example where the charter might reflect a cultural bias toward modern western thought which is not universally shared.

The third principle of the charter, and in a sense the most revolutionary, calls for physicians to promote justice in the healthcare system, including the fair distribution of healthcare resources. Jewish tradition does not specifically mandate doctors to play this role, but certainly this requirement would broadly fall under the responsibility of all Jews to be involved in *Tikun Olam* (to speak out against injustice, evil and poverty, and to act accordingly) and charitable works. From a Jewish ethical perspective this requirement should be lauded, and theoretically the Israeli healthcare system embodies this principle, although economic pressures have been eroding this principle of equality.

In summary, the professionalism movement is consonant with the spirit of the Jewish tradition, notwithstanding its reluctance to grant full autonomy to patients. Its intentions are laudable and its principles, which make the physician altruistically assume responsibility for the health and welfare not only of the individual patient but also the community in all its components, is a fulfillment of the Jewish mandate to heal the sick.

Critique of professionalism

Despite the almost universal acceptance in the medical community of the basic tenets of the professionalism movement, criticism has been generated in its wake. Wear and Kuczewski [14] have raised concern about the discourse on professionalism and the current learning environment in which professional development takes place. In particular they are concerned that the discourse pays too little attention to the impact of gender issues on professionalism and the inauthenticity of teaching professional development in an environment of mistreatment towards medical students. We have previously argued that we share their concern for these sensitive issues but do not see how they impact on the definition or practice of professionalism [15].

Jewish medical ethics also values the primacy of patient welfare and the pursuit of social justice but has a somewhat more limited and balanced view of patient autonomy

Others have argued that no matter how noble the intentions of the charter are, doctors of today no longer have the power to carry out its mandates. "The charter asks physicians to reassert their authority and recapture the medical high ground to improve the welfare of patients. However, this requires engaging the new authorities of healthcare: corporate health institutions such as insurers, managed care organizations, and health systems run by governments. Now they are in charge. Only by working with them can physicians meet the basic commitments the charter asks them to make." [16]

The charter has also been challenged on the grounds that it is inherently contradictory as it calls for the primacy of patient welfare

(individual rights) and the pursuit of social justice (group rights), which are mutually exclusive [17]. There is also a notable lack of a concurrent set of patient responsibilities; the physician-patient relationship should mandate obligations on both sides [18].

The charter does specify "that physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the process of self-regulation," [4] but says little about the interactions between individual physicians. These interactions and relationships are at the core of medical practice and a comprehensive ethical document needs to address them. Transfer of patient care, the incompetent or addicted physician and whistleblowing are all issues that arise daily in medical practice – and the charter is strangely silent.

Relevance to Israeli medicine

The spirit of professionalism and the physician charter have much relevance to medicine in Israel. In contrast to the United States and Europe, there has been a notable absence of the subject in the Israeli medical literature with a few exceptions [19]. In addition, recent events have eroded somewhat the public's trust in physicians and have resulted in a call for a new commitment to the high ethical standards of the profession. Legislation passed in Israel has institutionalized much of the spirit of the charter. For example, the Health Insurance Law, whose major element was national health insurance for all Israeli citizens, came into effect in January 1995. This law provided practical expression for the principles of equality and mutual aid which have always guided Israeli health policy. The Israeli healthcare system is characterized by an accessible and widespread network of community clinics side by side with modern and well-equipped medical centers. The Law assures a comprehensive and universal health basket for which every citizen is eligible. The four health management organizations are required to accept any citizen who applies for membership. Citizens pay an income-based healthcare insurance tax to which they can add a voluntary supplemental insurance fee. Hence, the principle of dissociation between payment (by income) and utilization of services (by need) is the guiding rule. The Health Insurance Law also allocated a fixed and substantial sum for research into quality in the healthcare system. Among the subjects to be evaluated are the accessibility and availability of services included in the basket of services to populations at risk.

A second significant law is the Law of Patient's Rights that was introduced into the Israeli system in 1997. Among the topics dealt with by this law are those relating to patient autonomy, such as the right of the patient over his body, the right for informed consent to medical treatment, and the right of the patient to know or not to know his or her condition.

This year the Ministry of Health and the four HMOs announced a new initiative that will hopefully bring quality of care one step forward. A new system for reporting national clinical performance measures is being implemented, based on shared clinical data of the HMOs. The new data are aimed primarily at providing the HMOs with comparative data that will direct internal quality improvement projects. The planned system will enable planning of specific programs to narrow disparities in the delivery of healthcare and enhance the principles of the charter on professionalism.

Notwithstanding these significant developments, we feel that more needs to be done. Mandatory continuous professional development and required recertification has become the norm in many western countries, and unfortunately Israel has lagged behind in this area. The charter specifically calls for physicians to engage in "internal assessment and accept external scrutiny of all aspects of their professional performance." Israeli physicians should take upon themselves the responsibility to ensure that they are delivering the highest standard of care to their patients and develop mechanisms to oversee this outcome.

Professionalism also mandates that physicians take a more public role in advocating for reform in healthcare, particularly in areas relating to social justice and fair distribution of healthcare resources [1]. Physician advocacy has been defined as "participation in improving the aspects of communities that affect the health of individuals" [20]. Doctors in Israel should continue to advocate for the health of their individual patients but also for underrepresented and socioeconomically poor communities. This is of particular importance in a heterogeneous society such as Israel, where many disadvantaged groups are lacking healthcare advocates and professionalism mandates that physicians and their professional organizations take a leading role in this arena.

The professionalism movement has much relevance to the practice of medicine in Israel and recent legislation is consistent with the spirit of the charter

Some of the criticism leveled at the charter certainly applies to the practice of medicine in Israel. Powerful forces other than physicians play a large role in the development of healthcare priorities, limiting doctors' ability to make changes in the healthcare system. Society and patients must also be expected to meet their obligations and responsibilities in a just healthcare environment.

The organized Israeli medical community should follow the lead of the Israel Society of Internal Medicine and endorse the charter and, more importantly, be guided by its principles. Medical educators at the four medical schools should strive to ensure that the values of professionalism are imbedded in their formal and informal curricula. Following the American lead, we should make the development of professionalism a goal of residency education and develop national programs to meet this expectation. Israeli medicine has always held itself to the highest ethical standards of Jewish medical ethics and western liberal thought; embracing the mantra of professionalism will help ensure that we continue to do so.

HMO = health management organization

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Editor's Note

The Editorial Board is pleased to announce that our Impact Factor has risen from 0.42 to 0.587. We have 'overtaken' many national journals – for example the Irish Medical Journal (0.524), the Netherlands Medical Journal (0.586), the Chinese Medical Journal (0.393), among others – all well-established publications. We believe that our rigorous peer, review will ensure its continual rise.

Capsule

Drug-eluting stents: optimism and concerns

Balloon angioplasty followed by insertion of a stent has been the treatment of choice in atherosclerotic coronary heart disease for more than a decade. Although considered effective in the short term, the challenge facing clinicians and researchers is the restenosis encountered in up to 60% of patients within 6–9 months of the procedure. Research is currently directed at the elution of stents with immunosuppressive and antiproliferative agents aimed at inhibiting restenosis. Clinical evidence on the use of these coated stents has accumulated in recent years. Babapulle et al (*Lancet* 2004;364:583) presented their meta-analysis of 11 clinical trials comparing drug-eluting stents to bare-metal stents. They conclude that elution of sirolimus or paclitaxel to polymer bound stents results in substantial reduction in restenosis rates (83% and 70% respectively), and a significant reduction in the need for repeated angiography at 6–12 months follow-up. In a comment letter (*Lancet* 2004;364:558) Schofer et al. point out that in most studies the enrolled patients had low to intermediate risk for restenosis, and that data are still lacking on the use of drug-eluting stents in diabetic and other high risk patients. They conclude that further research is needed to measure the long-term effects of these new and highly promising stents.

E. Zimlichman