Duties to Colleagues and Professionalism

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Introduction

In this talk I will consider:

- If doctors, and by extension, healthcare professionals have any ‘special’ moral responsibilities.
- Consider theories of medical professionalism.
- Examine whether these theories are ‘fit for purpose’

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CONTEXT OF MEDICAL PROFESSIONALISM

What is health care?

- It has been argued that health care organisations have particular ethical obligations on top of those usually required that distinguishes them from other kinds of organisation.
- Many authors have argued that health care ‘commodities’ are not analogous to other market-exchange commodities:
  - the vulnerability of most health care patients;
  - the necessity for professional excellence;
  - asymmetries of information;
  - demand is not price led;
  - demand is negotiated by the providers.

These ideas are underpinned by particular conceptions of healthcare

1. Conceptualisations of health care as a social good from which flows concerns over equity of access and justice
2. Healthcare itself is a moral practice – the goals of medicine are promoting well-being and human flourishing and medical professionals have unique obligations as professionals to promote the good of their patients

These are could be at odds with current trends in healthcare

Ethical challenges

- There are a number of possible ethical concerns that could arise as a result of the changes in medicine:
- The problem of market success/provider failure
- It is not clear what limits will be placed on competition as an end in itself
- Conflicts of interest might be created – such as a conflict between patient welfare and the profit making aims of an organisation.
- Pressure on healthcare professionals to perform – and how that performance is defined

Consequently,

- The role of health care professionals has changed dramatically
  - Less control
  - Cost-controlling mechanisms
  - More corporate healthcare
- However, there is now a greater focus on the ethical aspects of health care professionals' behaviour
- And as we talked about yesterday

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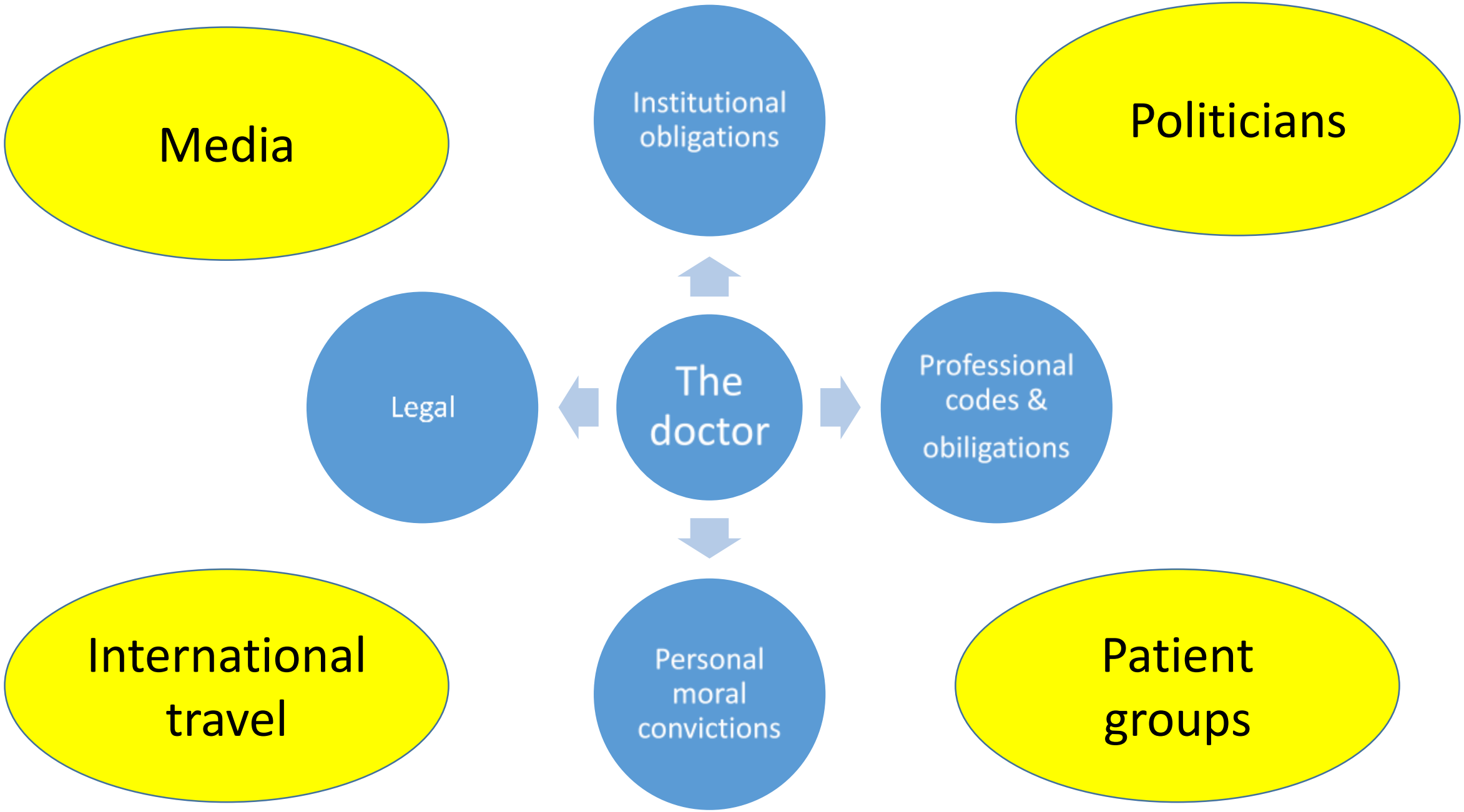
It is often systemic elements that prohibit professionals acting towards the patient as they would wish:

- lack of time for each patient;
- inadequate staffing levels;
- poor facilities;
- cumbersome bureaucracy;
- poor follow up;

Rather than any personal moral failing or lack of care.


Media
Institutional obligations
Politicians
Legal
The doctor
Professional codes & obiligations
International travel
Personal moral convictions
Patient groups

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Inspiring Spirited Challenging Ambitious

THEORIES OF MEDICAL PROFESSIONALISM

Morality and medicine

- Does medicine have its own particular morality?
- Or is it just part of our general morality?
- Does it matter?

Internal or external?

- One answer is that medicine does have its own particular morality.
- An ‘internal morality of medicine’, that is distinctive to the external morality of the wider society (Veatch & Miller, 2001).
- The debate over whether there is an internal morality of medicine was stimulated by Alisdair MacIntyre’s concept of “practice” and the claim that practices have virtues that are “internal” to them.
- A practice has its own goals or *telos*, and internal goods are generated by successfully engaging in the practice; by realising and pursuing its unique *telos*.

- This notion of a unique good or telos of an activity has been applied, by others, to the practice of medicine.
- The accounts that build on this idea of a unique, unchanging telos of medicine have been termed essentialist and have two central tenets.

    - First, that medicine has an essential character, ends, or goals that are distinctive to it; for instance, the healing aim of medicine is a distinctive goal.
    - Second, from such conclusions about the nature of medicine and a reflection on its ends and goals, it is possible to decide what should be done and to construct a medical ethic for the profession.

- Pellegrino argues that the ethics of medicine has its source in the nature of the profession, in what is distinctive about the medical profession, and the good for which it aims.
- Medical practitioners have generic obligations as healers and aim at health as a good.
- These goods are conceptualised as unchanging.
- This essentialist element is important for Pellegrino to guard against abuses committed by the medical profession, such as the Nazi medical experiments, that could be justified on the grounds that they were a reflection of the social context at the time.
- Unless medical goods are held to be set apart from such a social context, we have no leverage to argue against them.

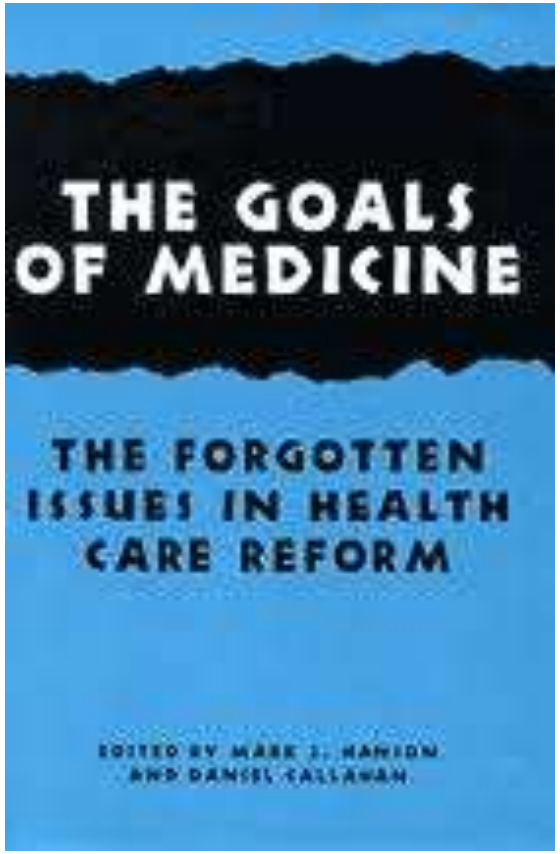
Problems with this account

- One issue is seeing the goals of medicine as unchanging, ahistorical entities; medicine becomes an inherently conservative enterprise and any change would be morally suspect simply on the grounds that is it a change.
- Brody and Miller have advanced a version of internalism that seeks to overcome this kind of difficulty encountered by essentialist accounts.
- They propose what has been called an evolutionary account

The evolutionary account

- Miller and Brody argue that there is indeed a core ethic developed on the basis of reflection on medicine's specific goals and duties,
- But,
- Propose a theory which sees the internal morality of medicine as gradually evolving in concert with wider society.
- This core ethic develops historically as a result of a dialectic or conversation between the medical profession and the larger society. (Arras)

So, what are the goals of medicine?



Hastings Center's goals of medicine project

(i) the prevention of disease and injury and promotion and maintenance of health

(ii) the relief of pain and suffering

(iii) the care and cure of those with a malady, and

(iv) the avoidance of premature death and the pursuit of a peaceful death.

Professional integrity

A further element of Miller and Brody's evolutionary account is a concept of professional integrity that follows from medicine's goals.

There are four internal duties of a doctor to ensure integrity:

(i) to possess competence in technical and humanistic skills

(ii) to avoid disproportionate harm

(iii) to refrain from fraudulent misrepresentations of medicine as a scientific practice and clinical art, and

(iv) fidelity to the therapeutic relationship with patients.

Medical professionalism

- But how is this translated into a theory of medical professionalism?
- I will argue that there are specific moral responsibilities and obligations required of doctors *qua* their membership of the profession of medicine
- These arise out of this evolving internal morality of medicine.

Practical precondition account - Rhodes

- A “practical precondition account” which says there are specific ethical precepts that all doctors have to broadly share to be able (and allowed) to practise medicine.
- There is a social practice (medicine) that has professional ethical codes that doctors have to follow on moral and legal grounds
- These have arisen out of the social context that medicine operates in

Hence:

- These are the norms without which medicine, in Arras’ words, ‘would cease to be a going concern.’ (2001:646) Arras gives the example of confidentiality, as a norm that makes the trust relationship between the doctor and the patient possible.

- These duties are different from the kind of moral duties that the person in the street might have:

‘because of its distinctive position in society, medicine has its own ethical principles that are in some notable respects different from the rules of ordinary morality, and they have a distinctive rationale.’ (Rhodes, 2002:499)

- Medicine is an autonomous practice
- And has common standards of reason and argumentation

‘Medical ethics education is…primarily concerned with inculcating medical professionalism. This involves helping students to understand the justification and content of their special responsibilities as physicians, to accept their professional responsibilities as important and overriding, to understand principles of medical ethics that are relevant to clinical practice, to learn to apply them and use them in case discussions, to learn how to reach a consensus with peers on difficult cases, and to learn how to tolerate reasonable differences in views and unavoidable uncertainty.’ (Rhodes, 2002:496)

- Rhodes argues that, ‘there is genuine consensus on the core content of the professional responsibilities of physicians.’ (2002:505)
- The two foundational principles for Rhodes are:
- First, the fiduciary responsibility of doctors, that they should act for the good of their patients; and
- Second, ‘physicians and the institutions and profession of medicine must seek trust and make themselves deserving of trust. (2002:501)

Criticisms of this account

- Veatch (2001) argues that as there are so many different medical roles, ‘they therefore have different moralities.’ (2001:629)
- Therefore, medical morality is determined solely by the doctor’s moral views and not by any aspect of medical practice itself.
- No such thing as a common medical practice and no consensus amongst doctors.
- This is a common criticism of medical professionalism theories.
- This is the many medicines thesis
- Wurm-Schaar & Fato, argue, ‘the medical profession itself appears to lack consensus regarding its core values…is fragmented into various sub-speciality organizations with their own codes of ethics and conduct.’ (2004:w1)

- Brody and Miller argue that if Veatch's contention is true, that there are many different medicines all with a different morality
- 'by virtue of what are all these disparate practices…seen as practices of medicine.' (2001:590)
- For them, Veatch's position reinstates the dichotomy between medicine as pure technique and medicine as a moral practice – a dichotomy, they argue, that needs to be broken down in order for medical ethics to be a meaningful discipline

How relevant is this account?

- In the age of ‘post-truth politics is there anything we can agree on?
- Do healthcare professionals share the same standards of decision-making?
- How autonomous is medicine as a profession now?

Modified account

- Medical morality is dependent on a wider societal acceptance as, at root, it is about the medical profession being trustworthy in the eyes of the community it practices in.
- Sullivan exemplifies this trend in arguing that medicine cannot function unless the public has trust in it as an institution:
- ‘the root of the public’s trust is the confidence that physicians will put patients’ welfare ahead of all other considerations….It is the function of medicine as a profession to safeguard and promote this trust in the society at large.’(2000:675)

- Royal College of Physicians defined medical professionalism as follows:
- ‘[m]edical professionalism signifies a set of values, behaviours and relationships that underpins the trust that the public has in doctors.’ (2005:14); and argued that,
- ‘these values, which underpin the science and practice of medicine, form the basis of a moral contract between the medical profession and society.’ (2005:15)

- Professionalism becomes associated with ethical values of practice and those values are ones that encourage and facilitate public trust in the medical profession. Therefore, these values need to be shared by the wider society.
- Therefore, the morality of medicine both reflects and is reflected in the morality of the wider community.
- They are symbiotically related

Duties

- Due to changes in medicine, doctors no longer have ‘a patient’

- They have duties to:
  - The wider system i.e. public health
  - Their colleagues
  - Their institution

- How are these balanced?

Societal duties

- Now, arguably, it is about general trust in the medical profession rather than trust in an individual that is as important
- So responsibilities could be grounded in: does this action further harm or support the reputation of the medical profession?
- Scandals and bad practice hurt all doctors