Medical professionalism requires that the best interest of the patient must always come first

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YES

Patient welfare has been central to every declaration of medical professionalism and medical ethics from the oath of Hippocrates to the recent Physicians' Charter.[1,2] The latter is a combined statement from the European Federation of Internal Medicine, American College of Physicians, American Society of Internal Medicine, and American Board of Internal Medicine. It reaffirms the fundamental principles that physicians' professionalism lies in 'placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health'.[1,2] The continual need to re-state the 'universal truth' of patient centrality can only be because current practice is seen to fall short of ideal, and principles need re-interpretation to be relevant in an increasingly complex and changing world.

That practice often falls short of ideal is clear and uncontested. In part this is due to the shortcomings of doctors-as-human. In part it is due to the health care environment that includes radical increases in technology, changing market forces, problems in health care delivery systems, bioterrorism, and globalisation.[1,2] In recent decades, managerial ideology has infiltrated health care and driven economic efficiency over effectiveness and quality. The tools and methods of business science and managers were applied in attempts to solve complex problems within the health sector. Medical professionalism became subsumed by these values, which has negatively affected morale.[3] Marmor contends that 'modern medicine's most prominent topics—cost, quality, access, and organisation—are marked by linguistic muddle and conceptual confusion'.[4]

If medicine is to be governed by a philosophy rather than a balance sheet[3] and doctors are to reassert the values of patient primacy, a focus on the re-organisation and re-valuing of medical work is vital. The numerous specialties and subspecialties within medicine no longer meet the health needs of the growing number of patients with chronic and overlapping conditions.[5] Plochg, Klazingal and Starfield,[5] among others, have argued that by instilling in the medical profession the belief that population health needs should be the leading principle for the professionalisation processes within medicine, professional models of care could be transformed in ways that better serve patient populations with complex and/or chronic illnesses. There is an increasing awareness of the need for medical professionalism to be reoriented towards ageing populations, multimorbidity, accelerating costs and the anticipated health workforce crisis.

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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.

Whilst the direct physician–patient relationship is important, the Physicians' Charter promotes equity in the provision of health care resources and is intended to be applicable to different cultures and political systems. In a New Zealand context, this mandates specific attention to equity for Maori and Pacific populations. Alongside the principle of primacy of patient welfare (a dedication to serving the interest of the patient), and of no less importance, are the principles of patient autonomy (physician respect for patient autonomy, honesty with patients, and actions that empower patients to make informed decisions about their treatment) and social justice (the medical profession must promote justice in the health system, including the fair distribution of resources, and physicians should work to eliminate discrimination in health care). The Charter promotes competence, confidentiality, honesty, appropriate relationships with patients, improving quality and access to health care, fair distribution of resources, integrity of scientific knowledge, trust, and professional responsibilities.[1,2] It is through a longstanding commitment to promote public good that the medical profession has been given the right of self-regulation and accepts the responsibility that comes with professional status. Individual physicians are being asked to reaffirm the fidelity of medicine's social contract through a commitment not only to the welfare of their patients, but also to the welfare of society through actions that improve the health system.

The medical profession has a central role to play in the way medicine and health care is organised. The coordination of care and teamwork that 'puts the patient first' are features of a well-performing primary health care system that reports better health and equity outcomes.[6] Although competition between professions, such as nursing and pharmacy, and between medical specialties has been inherent to the professionalisation process, there are interdependent relationships that must be built and maintained if good care is to be delivered over time and in different settings. Furthermore, the health system is recognised as a determinant of health, 'influenced by and influencing, the effect of other determinants of health'.[7] Physicians have a fiduciary duty to their patients because the asymmetry of knowledge and clinical information favours the physician. Patients often feel vulnerable, and those with chronic conditions can experience the compounding jeopardy associated with poverty, ethnic minority status, and older age.[8] Physicians in primary health care require knowledge, skills and competence if they are to assist patients to navigate the health system. Patients repeatedly state the qualities they value most in their doctor include listening to their most important concerns, respecting their beliefs, and assisting them to engage in their own care.[9] Redefining medical professionalism to better respond to the changing health needs of individuals and populations promotes good doctoring and is the only legitimate route to securing the long-term place of medicine within the future health system.

My perspective is that of an academic nurse with considerable experience in undertaking research with patients and families about their experiences of living with chronic illnesses and their expectations of health professionals, including doctors. In addition, I have institutional responsibilities for monitoring and promoting equity, which is a strongly held personal principle.

References

1. Medical Professionalism Project. Medical professionalism in the new millenium: a physicians' charter. Lancet. 2002;359:520–22.
2. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians–American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med 2002;136:243–6.
3. Horton R. The doctor's role in advocacy. Lancet. 2002;359:458.
4. Marmor TR. Fads in medical care policy and politics: the rhetoric and reality of managerialism. In: Marmor TR, editor. Fads, fallacies and foolishness in medical care management and policy. Singapore: World Scientific Publishing; 2007. p. 1–26.
5. Plochg T, Klazinga NS, Starfield B. Transforming medical professionalism to fit changing health needs. BMC Med. 2009;7:64. DOI: 10.1186/1741-7015-7-64.
6. World Health Organization (WHO). The World Health Report 2008. Primary health care: now more than ever. Geneva: WHO; 2008. p. 119.
7. Commission on Social Determinants of Health (CSDH). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the CSDH. Geneva: WHO; 2008. p. 247.
8. Sheridan NF, Kenealy TW, Kidd JD, Schmidt-Busby JI, Hand JE, McKillop AM, et al. Patients' engagement in primary care: powerlessness and compounding jeopardy. A qualitative study. Health Expect. 2012;Epub 2012 Oct 4. DOI: 10.1111/hex.12006.
9. Sheridan N, Kenealy, T, Salmon E, Rea H, Raphael, D, Schmidt-Busby J. Helplessness, self blame and faith may impact on self management in COPD: a qualitative study. Prim Care Respir J. 2011;20(3):307–14.