Healthcare Professionalism-Realities and Resuscitation

Healthcare professionals in general and doctors in particular are usually ranked highest and enjoy the most respectable place in the society. This is because of the professional sanctity in which they deal with physical and emotional well being of humans - the best of the creatures on the face of earth(Chapter 95," Al-Teen" verse No. 4 Al-Quraan " undoubtedly, We have made man in the fairest standing"). It is, therefore, morally expected that those engaged in this noble profession will display humanly possible highest levels of all traits of medical professionalism throughout their professional career. Professionalism is the moral understanding among professionals and public that gives concrete reality to this social contract.[1] It is based on mutual trust. In exchange for a grant of authority through licensing and credentialing, professionals are expected to maintain high standards of competence and moral responsibility. Medicine depends on more than competence and expertise, essential as these are. It cannot function as an institution without good faith on the part of provider, patient and the public as a whole. The root of the public trust is the confidence that physicians will put patients' welfare ahead of all other considerations, even the patients' momentary wishes or the physicians' monetary gain."Medicine must always be treated as a public good, never as a commodity." A professional is not required to ignore material considerations but is expected to subordinate financial gains to the higher values of responsibility to clients and to the public interest.[1]

The ascendant ideology of the time, however, has promoted the culture of free markets in all fields of social life. The underlying idea is that people will be better off if they are searching for the best "deal." In the larger social environment, however, this change has brought disturbing effects on professionalism. These are most evident in the US,[2] to some extent in Canada,[3] and Britain but not unknown in rest of the world.[4] It has transformed the traditional doctor patient relationship of care and trust in to questions of cost and benefit. It is generally observed that the doctors working in both public and private sector, pay more attention to and are more altruistic towards their private patients,[5] compared to their clients in public sector. Although non-financial (but having deep rooted financial implications in the long run) incentives such as status and recognition, strategic influence, control over work and professional opportunities have been identified as contributory factors,[6] the main reason why individuals carryout dual practice in the health sector is to supplement the income they derive from public work.[4,7]

Not only this, it has been observed globally that lust for monetary gains has prompted medical practitioners in conjunction with pharmaceutical industry to prescribe and promote unnecessary drugs.[8,9] Also patients are offered tests and procedures supported by little evidence of their clinical and/or cost effectiveness. These traits erode both the scientific underpinnings of medical practice and professional ethics.[10]

As a natural outcome, health care delivery is being transformed from a mutually rewarding and trusting[11-13] professional service delivered with dedication, compassion and concern, to the sale of a commodity in an adversarial marketplace. Professional satisfaction from patient care is being eroded and increasingly replaced by lust for monetary rewards[14] and true altruism is being replaced by pseudo professionalism. Though we have gone too far in this regard but there is always a way to return. Are we ready to return? Such an alarming situation warrants immediate and planned resuscitative measures to resolve this vital issue provided all concerned are made to realize its gravity and persuaded to join hands to revert the deteriorating ethical values. Effective policies by government, continuous role play by media and appropriate action by the assessment; credentialing and regulatory bodies are needed. But above all, it is the personal motivation of the doctors in remembering the oath upon becoming a doctor, respect for ethics and religion.

It may not be logical to put a ban on private practice; rather it should be explored as an opportunity to solve this problem e.g. through self-regulation whereby significant weight is given to an individual's reputation as a doctor in public practice, which influences his or her income-generating capacity in private practice. In this regard, the role of professional bodies should be to link accreditation, certification and other means of performance assessment with certain core competencies and participation in various activities within the public sector. The incentive created enables competitive pressures within private practice to spill over into the public sector in terms of improved quality, because a fall in quality in an individual's public sector work is translated into reduced private practice earnings.[7]

Reference

1. William M S. Medicine under threat: professionalism and professional identity. CMAJ. 2000;162(5):673-5.
2. Laura K Altom LRC. Pay, pride, and public purpose: Why America's doctors should support universal healthcare. Medscape General Medicine 2007; 9(1):40.
3. Flood CM AT. The illegality of private health care in Canada. Can Med Assoc J 2001;164:825-30.
4. Gruen R AR, Begum T, Killingsworth J, Normand C. Dual job holding practitioners in Bangladesh: an exploration. Soc Sci Med 2002;54:267-79.
5. Gadit AAM. Corruption in medical practice: How far have we gone? . J Pak Med Assoc. January 2011;Vol. 61(No. 1):93-4.
6. Humphrey C RJ. Motivation and values of hospital consultants in southeast England who work in the national health service and do private practice. Soc Sci Med 2004;59:1241-50.
7. Stephen Jan YB, Manuel Jumpa, Qingyue Meng, Norman Nyazema, Phusit Prakongsai, Anne Mills. Dual job holding by public sector health professionals in highly resource-constrained settings: problem or solution? Bulletin of the World Health Organization 2005; 83(10):771-6.
8. R.K. Bansal SD. Unethical relationship between doctors and drugs companies JIAFM. 2005;27(1).
9. M A. Drug Companies and Doctors: A story of corruption Source: New York Review of Books (Online) (Cited 2010 July 9) Available from URL: http://wwwbiopsychiatrycom//drugcompanies-d. 2009.
10. Martin Donohoe M, FACP. Luxury Primary Care, Academic Medical Centers, and the Erosion of Science and Professional Ethics. J GEN INTERN MED 2004;19:90-4.
11. J I. The American health care system. N Engl JMed. 1992;326:962-7.
12. AS R. Shattuck Lecture. The health care industry: where is it taking us? N Engl JMed. 1991;325:854-9.
13. GD L. Countdown to millennium balancing the professionalism and business of medicine: medicine's rocking horse. JAMA. 1990;263:86-7.
14. Solomon R B, MBChB, FRCP. Global Disparities in Health and Human Rights: A Critical Commentary. American Journal of Public Health. February 1998;Vol. 88:295-300.

Dr. Malik Muhammad Hanif
Department of Dermatology,
Sheikh Zayed Medical College/Hospital,
Rahim Yar Khan.