Professionalism, Ethics, or Both?
Does It Matter?

By Howard Brody

For many years, it has become commonplace to include courses in ethics in the curricula of health professions students. More recently, lectures and materials on "professionalism" or "professional behavior" have made their appearance. Are these the same thing or different things, and does it matter? We, the faculty of the Center for Ethics and Humanities in the Life Sciences, propose that they are basically the same thing, but that calling "it" by the two different names highlights different features. It is desirable that we become more clear in our terminology if students are to take away the correct message.

A very brief historical sketch may put the two bodies of content into perspective. Much of the current teaching that is called "ethics" or "bioethics" developed around 1970 and found its way into the curriculum in the later 1970s and 1980s. In its simplest form, "ethics" seemed to have emerged from the explosion in medical technology—organ transplant, ventilators, intensive care units, the promise of genetic screening and engineering. Previously, it might have seemed that the ethical behavior of the young physician could be assured by two factors—select the right applicants for medical school; and let them emulate the behavior of their older, revered professors. But the new technology altered this equation—the old professor and the young student, however well-motivated, might be equally perplexed as to when and how to use these new technologies. Moreover, it seemed increasingly unlikely that one would find the answers merely by rereading the Hippocratic Oath.

So ethics courses arose to address how to handle the new dilemmas of modern medicine. But a new development arose in the 1990s: medical schools discovered a veritable epidemic of cheating on exams. How could this have happened, when ethics courses had been taught as part of the curriculum for many years? Some argued that in their zeal to address the most interesting and troublesome dilemmas, the ethics professors had forgotten to address some of the basic issues around professional virtue and character. Moreover,
to the extent that the ethics course was
grounded in ethical principles and rules, topics
like virtue and character were pushed to one
side. So it then became popular to propose
new curricular experiences in “professional-
ism” to supplement what was going on in the
ethics course.

Today our MSU students may attend
different courses in “ethics” and “professional
behavior.” Do they fully understand the
relationship between them? Can we as faculty
do a better job of explaining how they relate?

We start by assuming that “ethics” and
“professionalism” (at least as they relate to the
education of the future health professional)
are essentially synonymous. There is some
“thing” that one could call by either term.
Does it then make any difference what we call
that “thing”? Why not just pick one term and
stick to it? Both “ethics” and “professional-
ism” concern the question, “How can I
embody the best standards in my professional
life?” But that question embraces a wide
variety of subsidiary questions and challenges,
all of which must somehow be addressed if the
larger goal is to be achieved. One such ques-
tion is, “Can I embody the best standards in my
professional life if I view my professional life
as somehow divorced from my life as a
whole?” As their usage has evolved recently,
“ethics” and “professionalism” tend to point to
different strands of this web of questions.

To what do we call attention by the
term “ethics”? First, ethics particularly focuses
on the need to give good reasons to defend
moral choices and behavior. If teaching “pro-
fessional behavior” ever becomes mere ser-
monizing, in which students are told how to
behave but are never allowed to question the
rationale behind the rules, we have betrayed
professional ethics. True, there is usually very
little of real interest to be said on one side of
the argument over professional behavior—the
“ethical” defense of cheating on exams consists
of hardly any content. But to refuse even to
consider argument and reason is to send the
wrong message about how professionals ought
to think about their duties and roles.

Second, as we noted, at least some ethical
problems come in the form of dilemmas, and at
least some ethical wisdom comes in the form of principles and rules. When this happens, it is helpful to invoke the standard vocabulary of ethics. There are still a great many issues in end-of-life care that can be resolved appropriately by appeal to respect for patient autonomy, for example.

Third, much discussion of professionalism is at its root a discussion of professional virtues. Even though virtues may have been neglected in health care ethics, virtues are still historically a part of ethics and a legitimate subject for ethical inquiry and analysis. In many ways, “virtue ethics” is the bridge between “ethics” and “professional behavior.” Bringing virtue back into discussions of ethics can help us with both “dilemma ethics” and the development of a proper professional attitude and behavior. A professional who has carefully inculcated the proper virtues will have an easier time resolving dilemmas, and doing the right thing when the right thing is hard to do.

What benefits accrue when we label the “thing” as “professionalism”? A problem here is that a large literature has now evolved about “professionalism” despite the lack of a single, clear definition of this term. Still, some general trends can be noted.

To some extent, teachers of ethics have been guilty of focusing on issues that present the greatest difficulty and hence the greatest intellectual interest. A good deal of professional behavior is mundane, repetitive, and undervalued—the sort of behavior that feminist ethics has labeled “housekeeping.” But “good housekeeping” can be as important as knowing how to resolve tough ethical dilemmas. Indeed, sometimes “good housekeeping” prevents the tough dilemma from arising in the first place. “Professionalism” may provide needed balance between the “sexy” dilemmas and the “housekeeping” issues.

It is common to find in discussions of “professionalism” a more psychodynamic model than one typically sees in ethical analysis. “Professionalism” is often used to label those things that help secure good mental health and prevent burnout, for instance. To the extent that “ethics” has become unnecessarily divorced from the social and behavioral sciences, tilting back in the direction of greater psychological awareness may be a good thing.

“Ethics” (to the extent that it has tended to exclude virtue ethics) has traditionally focused on the here and now—what do we do in this situation? “Professionalism” more readily incorporates a developmental perspective. Where am I on my journey from layperson to fully-accomplished professional? What do I have yet to achieve to incorporate my professional values seamlessly and effortlessly into my everyday “autopilot” behavior? Students need to be able to reflect on their developmental journey into professional life as much as they need to resolve tough cases. Students and faculty together need to explore such potential challenges to professionalism as today’s business- and “productivity”-oriented health care settings.

“If teaching “professional behavior” ever becomes mere sermonizing, in which students are told how to behave but are never allowed to question the rationale behind the rules, we have betrayed professional ethics...”

“Ethics” may tend to depersonalize the professor, the student, and the institution. The answer is the correct one because reason says so, not because a person in authority says so. “Professionalism” brings the teacher back into the equation as part of the larger institutional context. Is our school providing an optimal environment for professional development? If students see their faculty and staff acting in unprofessional ways, and the school seems to condone or even encourage that behavior, the
institutional level is not properly teaching “professionalism.” The importance of consistent and positive role models is more clear under the rubric of “professionalism” than under “ethics.” We don’t mean by this that role-modeling is of no value in the ethics classroom. The ethics teacher who is always careful to provide good reasons for what she says whenever challenged, and who listens carefully and respectfully to any student who offers a contrary viewpoint, is role-modeling good ethical behavior just as much as the physician on ward rounds who is equally courteous to the patients, the students, and the nursing staff models good professional behavior.

We conclude that there is a proper role in health professions education for both “ethics” and “professionalism.” We serve our students best when we make these connections as clear as possible. The language of professional virtues may be the most important bridging concept to clarify the connection. Our long-time colleague Martin Benjamin likes to advise that good teaching consists of, “Say what you are going to say; say it; then say what you’ve said.” In other words, good teaching involves a certain amount of flag-waving and finger-pointing. This requires not merely teaching something to the students, but clearly labeling what you have been teaching. We need to take this lesson more to heart as we develop new curricular models for ethics and professionalism.

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The Center Welcomes...

This semester, CEHLS would like to welcome Doris Teichler Zallen, a visiting scholar working in bioethics and genetics. Zallen is a professor of Science and Technology Studies as Virginia Tech’s Center for Interdisciplinary Studies. As an expert in genetic technologic and bioethics, Zallen has served as a member of the NIH Recombinant DNA Advisory Committee and the Subcommittee on Human Gene Therapy, and works to develop policies and guidelines for human genetics research and its clinical applications. While here at Michigan State University, Zallen will be continuing her research interests. On March 12, 2003, Zallen will take part in the CEHLS’s Spring 2003 Brown Bag Series (for more information, see page 8).

With all the attention given these days to human cloning, or to organs derived from embryonic stem cells, or to designer children, it would be reasonable to conclude that the serious ethical and social concerns arising in genetics are connected only with these new areas. But that is not the case. As Zallen argues, it is the more commonplace, ‘humdrum’, applications of advances in genetics that are raising some demanding ethical dilemmas and policy challenges. Zallen has come to the Center to study the issues surrounding the newest type of DNA tests—tests that search for genes that can make individuals more susceptible to disorders such as breast cancer, colon cancer, heart disease, and Alzheimer’s disease.

According to Zallen, “the Center provides a unique research opportunity. Here, I can join the expertise of genetic professionals with the real-world experience of individuals who are candidates for these new genetic tests in an environment in which bioethical issues are actively being explored, evaluated, and addressed.”
Inner Selves, Outer Selves, and Professionalism

In his lead article for this issue, Howard Brody discusses the relationship between professionalism and ethics curricula in medical training. *InkLinks* examines two particular, and quite different, aspects of professionalism.

*InkLinks* is a regular column giving voice to readers, their research, their scholarship, their thoughts, and their activities. We welcome your contribution.

—JA

The Inner Self: Physician Health and Professionalism

As one who has practiced psychiatry for many years, my journey to the arenas of ethics and professionalism has been peripatetic. Returning to Kalamazoo, where I had done my internship, was rewarding but also surprising: a number of my former preceptors asked to see me as patients. My work with them led me to wonder more about “impairment,” and eventually I became involved in a number of committees, studies, and conferences on topics like chemically-dependent physicians and physician well-being. Internationally such topics are bundled together under the concept “physician health.” My interest could be summed up in the question, “What promotes longevity and satisfaction in medical practice?” Now, having become involved in medical education, I put the question this way: “Can we inoculate our students, to help them have long, productive, and satisfying careers in medicine?”

Does ethics education help accomplish this? Listening to practicing physicians over the last thirty years, I have seen that they become distressed when their values are pinched by shifts within the practice environment, especially if they have no way to express their discomfort. So, exploring values and developing tools for addressing these conflicts seems essential. Young physicians need to do this to protect themselves and their patients.

Do “professionalism” programs also help inoculate medical students? That is less clear, for me. It seems ironic that we are discussing professionalism as the distinct boundaries of our professions are more blurred, at a time when fewer physicians are individual entrepreneurs, more are employees. If the concept of ‘professional’ has something to do with autonomy in practice, with a requirement that we develop skills for observing the self and measuring our performance against some unspoken but carefully developed internal criteria for thoroughness and excellence, then we are asking this at the same time that we are ceding more and more of that authority to oversight agencies.

What do our students need in the emerging practice environment? At times they seem afraid of being overwhelmed by our expectations, by the sudden transitions we expect them to make into this fast-paced and increasingly complex medical practice environment. They also strongly wish to protect their patients, whom they see as vulnerable. But students may not be able to articulate their own sense of vulnerability, their concerns about whether they can (or even whether they should) protect themselves. “Professionalism” programs need to help students explore their ethical concerns, but also to encourage them to discuss the personal meaning they find in medical training. Do they feel that they are

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changing? When they are wounded (saddened, or disillusioned, or angered, or terrified) by what they see, how do they cope? How do others cope? This kind of discussion can help students respond, and not just react, to the potentially overwhelming experiences of their education. It can help them create bridges between who they were and the physicians they are becoming.

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Keeping Up Appearances: Grooming and Professionalism

Howard Brody points out that one important link connecting the “ethics” strand and the “professionalism” strand is the commitment to avoid sermonizing about professional virtues. Or at least, to avoid the sort of sermon which bears no burden of defending the virtues being extolled and which is blind to the complexities of their interpretation. This is not just an intellectual imperative. Sanctimoniousness or the invocation of mere authority is a turnoff, guaranteed to effect no genuine commitment by students to embrace the virtues as their own.

It is, therefore, a bit dismaying to discover how seldom in the professionalism literature one finds sustained, reasoned arguments on behalf of any virtue, or any attempt to refine our understanding of particular virtues in the crucible of critical reflection about their application. Instead, one gets a list of them, all taken to be unproblematic for present purposes.

The trouble is, they aren’t all unproblematic, even if our present purpose is simple incalculation. Take “cares for self appropriately and presents self in a professional manner (cf. [sic] demeanor, dress, hygiene)”, which appears in the seemingly exhaustive list of “Professionalism Behaviors” compiled recently by a AAMC/NBME task force. Instructions on how to dress are routinely given to students as they embark on their clinical experiences (shirt and tie for men; no halter tops; lose the nose ring), and these dictates are presented as matters of “professionalism.” If students usually comply, but do so complacently, or resentfully, they will have learned nothing about the virtue of grooming—only the vice of going along.

So why is grooming a “professional” virtue at all, and what should it have to say about a student doctor’s wardrobe? Beyond a certain crude level of cleanliness, what counts as “good” grooming and “appropriate” attire varies notoriously with the social context. Nose rings get no stares at raves. Why should they be unprofessional for doctors at the hospital?

To be credible, the answer needs to connect grooming and dress to central goals of the doctor-patient relationship. (This strategy harks back to Aristotle’s conception of the virtues, which were virtues to the extent that they served the goal of enhancing human happiness.) These require us to make some judgments about what the nature of that relationship should be. At least in the Anglo-American tradition, doctors saw themselves as members of an elevated class, an aristocracy of gentlemen. The doctor’s dress and grooming served as markers of class, which put the physician in a position of social authority, at least with his “lower class” patients.

Today, the doctor’s social authority is a fading memory, and its blunt exercise with patients is morally suspect. Instead, we need to place the virtue of grooming within the context of a less paternalistic ideal, which emphasizes the importance of communication over compliance: doctors need their patients to feel comfortable, rather than intimidated or put off, and they need for their patients to find them trustworthy. The shirt and tie, the slacks and blouse, are the innocuous costumes least likely in our culture to set off alarm bells in patients which can impede their interaction with the physician or medical student.

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Center News & Announcements


Len Fleck did the noon conference at Hurley Medical Center in Flint, MI, under the title "Two Cheers for Medical Paternalism" (Jan. 2003).

Tom Tomlinson spoke on "Ethical Aspects of Medical Mistakes" to surgery residents at McLaren Hospital, Flint, MI (Dec. 16, 2002).


Len Fleck delivered two lectures for the second Annual Bioethics seminar at Mid-Michigan Medical Center in Midland, MI, under the titles "When is Enough Enough?: Medical Futility and End of Life Decision Making" and "Death by Chance or Choice" (January, 2003).

Judith Andre presented "The Moral Work in Public Speaking: Bioethicists, Boundaries, and Borders," as part of the 6th World Congress of Bioethics, Brasilia, Brazil (Nov. 2, 2002).

Len Fleck did a workshop for seventy orthopedic surgery residents in Troy, MI, under the title "Ethical Challenges in Orthopedic Surgery: Five Cases" (Jan. 2003).

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(Inklinks, from p. 6)

It is not the conventionality of this attire that makes it good, nor its association with a social class. It is the larger purpose the conventionality serves. And so the attire can change as the purpose permits or requires it. A physician who finds herself with a large number of Muslim patients may need to lower the hemline on her skirts. The psychiatrist trying to help disaffected youth might be better off ditching the tie (or keeping the nose ring). The virtue of grooming is not the virtue having a certain wardrobe. It's the virtue of always asking, how can I best connect with my patients?

The answer to that question is not always obvious, and may require experimentation, rather than conventional thinking. Other complexities arise when we confront the physician's need to also have a personal style, not to merely be another Man in a White Flannel Lab Coat. Some decisions will need to be made, for instance, about whether and how to accommodate patients whose alarm bells are set off by ill-informed prejudice (guys with beards are: a. commies; b. hillbillies; c. hippies; d. all of the above).

All of a sudden the virtue of grooming has become more than it appeared to be. Let's be sure to give students the ethical sophistication they need to really apply it—and the other virtues—to their professional lives.

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Center for Ethics & Humanities in the Life Sciences
Coming Events

The Center for Ethics and Humanities
Spring 2003 Brown Bag Series

Doris Zallen, Ph.D., M.P.H., Professor of Science & Technology Studies, Virginia Tech
12:00 Noon, March 12, 2003, C-102 E. Fee Hall (Patenge Room)
The “Genetic Grapevine”: A Pathway for Genetic Decisions

ABSTRACT: It is generally assumed that genetic information is effectively conveyed to consumers through the usual interlocking medical networks — networks involving family physicians; specialists who treat individuals with genetic disorders; and genetic professionals, such as genetic counselors. However, in an extended series of interviews carried out with people who were dealing with genetic disorders in their lives, it became apparent that another pathway exists whereby genetic information is acquired and distributed, and which is called upon when genetic decisions need to be made. This informal, but nonetheless powerful, mode of information sharing is what I have called the “genetic grapevine”. My talk will describe the genetic grapevine, its strengths and shortcomings, and the challenges that it presents to the medical community. Participants at this session will gain an understanding of the ways in which genetic information is acquired, interpreted, and used by consumers as they make decisions about matters such genetic testing. Participants will also gain an appreciation of the ways in which genetic information differs from other types of medical information and the responsibilities that the special status of genetic information presents to the practicing physician and to policy-makers.

For CME information, as well as other Center activities, please visit our website at http://www.bioethics.msu.edu/.