Ethical challenges to Medical Professionalism: Zimbabwe 2006

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Introduction

In recent years organisations of doctors in many countries have become concerned with the concept and practice of professionalism. In this article I apply these concerns to local circumstances in Zimbabwe, aiming to identify the most important areas.

What is a profession?

Many definitions exist for this elusive concept. One helpful one could be a self-disciplined group of individuals who hold themselves out to the public as possessing a special skill derived from training or education, and who are prepared to exercise that skill primarily in the interests of others. Contained in this are:

- The idea of self-regulation within the profession.
- The recognition of skills and knowledge specific to the profession.
- The acceptance within the profession of altruism, qualified to be used 'primarily' in the interests of others.

Professionalism for medical practitioners, therefore, implies the practice of medicine according to and within circumscribed principles such as the above. There are, of course, other ethical principles which apply to the interaction of individual practitioners with patients (commonly quoted are beneficence, autonomy and justice), but in addition doctors universally bind themselves to the rules and regulations of their professional body. It is these which ensure that there is a standard of behaviour among doctors that justifies the trust which the public puts in them.

What is wrong with the profession?

A number of factors contribute to what is widely perceived as diminishing trust by "the public" in the medical profession, especially in developed countries:

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1. Literacy and levels of understanding of science by individuals which have improved greatly in the last century. Patients, therefore, ask for (and sometimes do not receive) clear explanations for the reasoning and decisions made by their doctor, leading communication breakdowns and suspicion.
2. Education has led to a more widely held mechanistic model of sickness – "if there is something wrong then it can be fixed – like a motor car" – and less belief in the doctor as an authoritative healer. In this view he has no special powers other than those conferred by his knowledge, which can be gained by others, for example by consulting the internet or reference books.
3. There have been increasingly aggressive interventions in the practice of medicine which challenge traditional notions of living and dying, and sometimes confront religious beliefs or other moral viewpoints.
4. In some countries there is a widespread adversarial behaviour of the legal system and adjudication of errors, leading to the practice of defensive medicine and the emergence of aggressive litigation.
5. There has been wide publication in the mass media of errors and malpractice by medical practitioners, combined with the portrayal of medical practitioners as often being greedy, egotistical and uncaring as found in newspapers, books and television.
6. In many countries (e.g. the USA) there are health systems which fail to provide adequately for the economically and socially disadvantaged.
7. In the 21st century the medical profession is large and diverse, with many different faces and no universally identifiable characteristics.
8. In the same way medical practice is complex and divergent, and medical practitioners are often uncertain of their allegiances ("am I a clinician, teacher, researcher, administrator or earner?") and priorities.

What does the medical profession say about this?

In resource-rich developed nations pressures on the profession have led to responses from professional organisations, such as the Royal College of Physicians in the United Kingdom, which sponsored a detailed report by an authoritative working party composed of senior physicians, published in December 2005. Similar work has been done in the USA and Europe. Of necessity this paraphrase of the report is severely curtailed:

The Royal College report states "medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability."

The values which doctors are committed to fall under the headings of integrity, compassion, altruism, continuous improvement, excellence, and working in partnership with members of the wider health care team. They form the basis for a **moral contract** between the medical profession and society, within which each party has a duty to strengthen the system of health care on which our human dignity depends. The most important benefit of the moral contract is that it enables the public to trust its doctors. The report states that securing trust is the most important purpose of medical professionalism. Trust – and so professionalism – operates at two levels:

1 In the doctor providing care (that is, individual professionalism).
2 In the system where that care is given (institutional professionalism).

An important new recognition is the second level, that of accepting responsibility for the systems of health care. Because there are many factors that influence the provision of health care which are outside individual doctors' influence, such as the economic environment, local and national political priorities, and the effects of epidemiological changes including pandemics, many doctors feel that their responsibility is limited to their own patients. However, in this report there is agreement that the profession has an obligation to work with and improve health systems as it finds them, as a part of its moral contract with society.

Behaviours that strengthen trust are essential to being a good doctor and are easily recognisable. They include courtesy, kindness, understanding, humility, honesty, and confidentiality; and lead to an environment of safety around the patient. A deficit in these behaviours will undermine trust. What are more controversial are some areas which in the opinion of the working party should be abandoned, and others which should be exchanged for more modern alternatives, as well as core values which should be retained.

Aspects of professionalism

Which should be abandoned	Which should be exchanged for modern alternatives	Which should be retained
Mastery	Autonomy (Of the practitioner) Appropriate accountability	Knowledge Skills Science Service
Privilege	Competence → Excellence Art → Judgement Social Contract → Moral Contract	Commitment Integrity Vocation altruism

The thrust is thus that the individual doctor cannot ignore the standards of the profession by claiming a right to use his own professional judgement, and that the profession must accept a degree of regulation by the society it practises in. In addition high value is placed on both accountability and altruism.

What are the challenges to the medical profession in Zimbabwe?

In many ways challenges to the profession reflect the society in which it operates. In this respect Zimbabwe has a truly changing and multi-faceted culture, where a traditionalist conservative largely rural backdrop has superimposed on it a growing liberal, sceptical and internationally informed urban sector. Doctors often come from one but live in the other, part of a middle class elite within a less affluent and educated whole. They therefore, fall prey to misunderstandings and divergent perceptions associated with different lifestyles, priorities and even world views. Medical practitioners usually think about ill health in scientific rational terms. Their priorities are to combat disease in their patients, but also to further themselves in their careers, social and economic status and to provide for their families. Many of their patients perceive ill health in terms of misfortune and even ill-disposed supernatural forces. Their priorities are to survive in a harsh world and to do everything it takes to further that goal. Traditional upbringing may engender respect for and faith in medical practitioners resulting in unquestioning acceptance of advice.

Because of the persistence of traditional values, trust in the individual medical practitioner appears less threatened in Zimbabwe than in Western societies. This does, however, mean that there is a risk of its abuse in circumstances where the doctor encounters conflicts between his personal and professional goals. When the conscientious practice of good medicine is hindered by structural deficiencies as well as lost training opportunities, the temptation to cut corners is great, justified by the needs of the moment. If investigations are difficult to come by, specialist opinions even more so, it becomes easy to justify offering less than ideal care **without the patient being aware of it.**

Trust in medical systems, on the other hand, has been seriously eroded in Zimbabwe. It is clear that the public health system is used only by those who have no other choice, and with apprehension. Patients and their families are willing to sacrifice very limited savings or other resources to be able to attend a private practitioner or mission hospital. The medical profession as a body should ask itself how much responsibility it has to seek to be involved in rectifying that. Cynics might argue that the profession represented largely by self-employed practitioners should not be engaged in attempting to hinder the public from voting with their feet and improving the business of private practice. I do not believe that this is either the attitude of most practitioners or in line with professionalism as suggested above.

The third challenge in Zimbabwe concerns the concept of regulation. For many reasons stricter adherence to practice guidelines and standards of care has become the norm in most developed countries, arguably leading to improvements in medical care. Although there is a willingness to improve ongoing education in Zimbabwe (as evidenced by developments in continuing professional development regulation by the Medical and Dental Council), accountability for professional activities remains minimal. Without the threat of litigation or institutional investigation there is little external incentive for professional rectitude, and much in the way of circumstances to hinder it.

Conclusions

Professionalism, which is behaviour creating trust by an organised group of practitioners, is the basis of a moral contract between doctors and society. Threats to this contract are somewhat dissimilar in developed and less developed countries, especially regarding trust in health institutions and individual accountability of medial practitioners. The concepts of medical professionalism as developed by groups working in other countries can be usefully applied to identify areas of particular importance to the medical profession locally.

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