

# JOURNAL OF CLINICAL AND HEALTH SCIENCES

**EDITORIAL**

## Challenges to Medical Professionalism

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Medical professionalism is the basis of the trust given to doctors by the society. At the heart of it is a doctor who must ensure the well-being of patients at all times and always protect them from harm. In doing so they are expected to be competent, compassionate, open and honest, respect patient's autonomy and always guard their confidentiality. These qualities enable doctors to earn that trust, and accord them their professional status and privileges, and axiomatic of the essence of a good doctor [1]. As a concept, medical professionalism is defined with four basic characteristics [2]. They are an altruistic vocation linked to public service, adherence to defined standards and ethical codes, the ability to apply a body of specialist knowledge and skills, and a high degree of self-regulation over professional membership and work organization. Other qualities that are fundamental to the understanding of medical professionalism include advocacy and justice, leadership, collaboration and collegiality. These values are timeless but they do not operate in a vacuum, the dynamics of a society change over time leading to different demands and expectations from the medical profession [3]. Doctors therefore must be cognizant that these changing circumstances represent new challenges and require them to adjust and refine their professional values to effectively fulfill their obligation to the society. Two key issues that will be touched here are the changing landscape of healthcare in this country as it moves from public to private healthcare and the question of professional self-regulation and organization.

The more acute of the two challenges revolves around the issue of profiting from medicine against the fundamental teaching that the profession is an altruistic vocation. In Malaysia, over the last two decades we witnessed a significant change with the increasing

prominence of private healthcare, self-evident that this is a necessary growth to sustain the increasing demand by more prosperous Malaysians where public investment in health has not grown much in the same time period [4]. The ethos of private healthcare however is different to the public sector where the return on investment features considerably in many levels of decision-making even at times in patient management. When the percentage and proportion of healthcare is increasingly private, the issue is no longer an option as it affects many of us, both doctors and patients. This is a challenge to the fundamental understanding of medical professionalism that we preach. Translated largely in this country as the public healthcare services, doctors are not mandated to consider budget or expenditure against the revenue or profits generated. Granted that the growth is inevitable but the profit consideration in delivery of healthcare is a big shift, especially when medical curriculum in this country is universally devoid of issues of healthcare in the private sector and the ethics of private practice. They tend to become relevant only when a doctor wishes to start his own private practice. It is not prejudicial therefore that there is a certain perception of private healthcare practice that may not be entirely sympathetic to the profession, coupled with troubling personal accounts related to private hospitals or doctors the impression seems befitting. This is of course far from the truth as a generalization, private doctors are strictly regulated under the Private Healthcare and Services Act and Malaysian Medical Council (MMC) but changing public perception to an altruistic profession requires time and continuous efforts.

Similar quagmire afflicts the public sector as we are currently experiencing a relentless drive, by the public healthcare, to tap into private patients using

public facilities. Everyone accepts that the demand of an increasingly developed society on public services especially health would mean that more money is needed for health service delivery but there seems a cap on government health expenditure, which has remained at about half the health needs of under 5% GDP, the other half is from private [4]. It is not surprising that the fund to finance public healthcare is stretched thin and as a strategy public healthcare institutions have been encouraged to tap into private clients for full paying services to supplement their funds [5, 6]. We see many initiatives from public healthcare institutions to venture into private healthcare provision to increase their income but business results are mixed. While this is a commendable effort, but where the public and private interphases, the practices are somewhat open to question and at times riddled with ethical dilemmas. A few examples include a two-tier public system where a privately seen patient jumps a public queue, a private patient enjoys the best that both public and private can offer, in use of public resources both public and private components maybe inadvertently blurred, or as obvious as one director for both the public and private institutions and accusation of private practice at the expense of public duties. These issues are relegated to the periphery because the size of private practice in public service is small but will be a major problem once the magnitude of practice or revenue increases significantly. A different aspect of profiting from medical position or medicine is the scene of doctors advocating dubious alternative healthcare or beauty products in social or mass media, to the extent of self-advertisement or even outright factual manipulation. This is disconcerting as it raises doubt of our own ability at self-regulation by our deep sense of professionalism [7] and the perceived absence of peer scrutiny.

There is a more pertinent issue that reflects the failure at self-regulation in the provision of equitable healthcare. The quagmire of the number of medical graduates is well known to all [8] and overall this reflects our failure to plan and regulate. The public is awash with news and comments on the issue by everyone who wishes to say something but unfortunately there is very little chance that this matter is resolved from the very root that is the swift

oversupply. Since it is a deluge this has a knock-on effect on places for housemen, now on contract post, followed on thereafter by scarcity of medical officer posts and finally postgraduate training places and specialists' number. There is a need for more coordination between universities where training takes place and Ministry of Health (MOH) where service-cum-training including subspecialty attachment occurs in large public hospitals, university hospitals in the former. At times their moves are in opposite direction, overall undermining further the two duties of training and services that are so stretched and tested as they are. The public is justified to question our own ability to plan and coordinate for the best of our country, when financial resources are reduced, any wrong action is costly. The implication of this is far and wide, housemen become the victims of the system, the public are devoid of the services of large number of medical officers and more importantly our specialists' number continues to be stagnant and uneven, biased to certain urban areas resulting ultimately in inequitable distribution of health services. This is antithesis to the concept of professionalism that we teach, profess and swear to uphold.

What is also absent in public limelight is the status of university hospital (UH), initially established to serve the purpose of teaching medical students but the number, influence and impact have gone beyond the traditional core tenet of teaching and training [9]. Elsewhere in the globe UHs are usually the best hospitals and this is also true in this country where their impacts are beyond simple student teaching. The central issue of identity or ownership and to some extent direction remains contentious, they are essentially public institutions serving the public under the Ministry of Higher Education but unfortunately those core functions are not justifiably the dictum or referenced. The number of UH will soon be nine and if this issue remains it will hinder optimum output to the public in terms of health service delivery.

### **WHAT IS THE WAY FORWARD?**

Inculcation of tenets of professionalism should be viewed as a life-long process and requires constant reinforcement. Professionalism is taught at medical school cognitively and via clinical engagement where

role modelling begins in a situated learning environment in experiential fashion [10]. There is a widely agreed cognitive basis upon which this teaching takes place at medical schools and this is followed by adequate self-reflection, which will further reinforce understanding and professional characters. This is a start but it must be emphasized throughout one's medical journey, during housemanship right through to postgraduate training and in fact throughout one's clinical career especially in the private sector. Each of these steps is a big phase in the consolidation of a doctor's professionalism and any deficiency will disrupt the right process to take place. There are many issues that we all should ponder and deliberate to improve the process but to sum up this editorial a few will be mentioned. Stricter regulation and enforcement to address professional omissions, reverse shrinking role models number due to private sector migration, improve coordination of major healthcare stakeholders and promulgate evidenced based health related public policies are major issues that require serious thoughts and action or they may hinder progress in this direction.

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