Title: Humanitarianism and Professionalism-Reflections of a clinical encounter.

Abstract:

A Professional physician-patient relationship is essentially fiduciary by nature. The structure of the relationship has boundaries of trust, mutual respect and varying degrees of physical and psychological communication. In today’s world, medical professionalism provides the backbone which makes people, in their most vulnerable role as patients, trust their doctors. Medical professionalism with its set of values and guidelines also allows for transparency and accountability on part of the doctors.

If Medical professionalism provides a medium through which scientific knowledge is made explicit and builds trust, Humanitarianism attempts to provide a soft, malleable transformative experience within a physician-patient relationship. Most Professional code of conducts around the world emphasize moral duties of veracity and integrity to represent professionalism in clinical practice. The International Red Cross and the Red Crescent movement defines moral virtues of addressing need of the vulnerable above all rules and empowers its proponents to do it with neutrality and impartiality. At its face value, a patient generally expects their physician to be highly professional and humane, both at the same time. In certain situations, as depicted in this clinical encounter, being “professional” and being “human” act as push-pull forces which are aligned in opposite directions.

This paper argues that taking rigid positions with professionalism and humanitarianism may be harmful to the ethics of care in a vulnerable clinical encounter. This paper also discusses the important of patient value statements in reaching to the solution of “professional humanitarianism” as a relative meeting point rather than choosing one over the other.

Professionalism—dimensions and perspectives:

Medical professionalism rests and pivots around three major pillars-patient welfare, social justice and respect for patient autonomy(1). Defining medical professionalism based on these pillars brings forth themes or adjectives; A ‘professional physician’ is hence defined through prisms of principles (integrity, honesty etc.), communications skills (compassion, empathy etc.), health care systems (team work, professional boundaries etc) and competence (continued learning, reflectiveness etc). However, these prisms have changed over a period in time; older generation physicians would reinforce physician behaviors like spending time at work at the cost of their own personal time, the newer generation physician see inclusion of physician self-care as an important dimension of professionalism(2).

In India, the Medical Council of India in 2002 with its code of ethics and in its vision statement in 2015 attempted to initially regulate and subsequently attempted to operationalize professional conduct of doctors by introducing professionalism into the curriculum at various levels of medical education(3). However, the boundaries of professional conduct of doctors with their patients were brought into the ambit of the Consumer Protection Act in reference to the landmark judgment by the Supreme Court of India in the case of Indian Medical Association vs. VP Shantha(4). This transformed doctors into service providers and patients into receivers of service. This has had long term implications on the professional conduct of doctors and expectations of patients from doctors; on one end, the relationship is less top-down(5) but on the other end, there have been various instances of erosion of trust(6). Lapses in professionalism are seen as medical errors/negligence making responses to these lapses correctional rather than pedagogical. The down side of professionalism in medicine is obvious-exclusive, system centered managed care provided to patients who actually feel the lack of human touch in medicine(7).

The yesterday, today and tomorrow of professionalism in medicine from an inside view appears to be changing dynamically. Yesterday, most doctors chose the path with a shared perception of this being more of a vocation than an occupation. Today, most professional doctors are defined by guidelines of a contractual agreement which has set “terms and conditions”. Tomorrow, as is quiet evident from Paul Tournier’s work on Evidence Informed Health Care practices(8), it appears that the fuzzy boundaries of trust and mutual respect become even more permeable with need for sustained compassion and equity in medicine becoming a reality. The doctor of today has a professional demand to be more open in communication, be more patient centered and respect patient autonomy as a central ethical principle of medical practice. The doctor of tomorrow appears to be further involved in shared decision making but has new ethical challenges of managing subjective boundaries and dealing with conflicting humanitarian values across various cultures.

Humanitarianism—roots and branches:

Humanitarian values are an off-shoot of suffering which is universal part of human experience. If care with dignity and equality is the root to humanitarianism ethics(9), its branches are defined by principles of neutrality, impartiality and independence. Though this looks obviously unambiguous and uniform to implement, the world of humanitarians is the least perfect where adaptability and responsibility gets precedence over adherence to rules and accountability(10).

Chronic illnesses with emphasis on control over cure, medical uncertainty at each stage from diagnosis to treatment, insecure environments, discrepancies in power between stake holders in medical care, lack of optimum care and differing cultural values and perceptions of patients and health care providers further blur the boundaries for humanitarian physicians in providing care(11); the down side obviously being an over inclusive system with risk of burn out and dependent on individuals rather than systems.

Humanitarianism has always been the backbone of Care during times of epidemics and is the fulcrum of medical aid during natural and man-made disasters. As is evident from Humanitarian medical care provided in post-disaster relief in Venezuela, post war interventions in Balkans(12) or the post Tsunami medical aid in Tamil Nadu(13), Humanitarian principles of care, many a times, drives policy decisions and ensures human rights being respected and valued.

Humanitarianism and professionalism—dimensions to medical care:

A distant look at both medical humanitarianism and professionalism does show them to be valence issues in clinical medicine—both are necessary and mutually symbiotic ingredients in a real time physician-patient relationship. However, a closer look does reflect situations where professionalism gets compromised for humanitarian values. A good example of this could be the one explained by humanitarian advocate Michael Ignatieff(14). Agreeably, Humanitarianism simplifies complex problems, but reduces it to proverbial *synechdoches.* Thisdoes compromise professionalism principles of objective evaluation of the problem and suggesting solutions without bias.

The reverse, also seems to be true. Professionalism paradoxically increases the risk of errors of judgment and ends up creating blind spots within organizations. This tilts decision making in medicine to a reductionist, repetitive exercise of distinct professional groups who lay emphasis on distinct subcultures at the cost of alienation of the humanitarian values(15).

The facts of the subsequent clinical encounter brings forth the conflicting professional principles and humanitarian values while choosing the best care pathway for the patient in a routine clinical situation in psychiatric practice of a tertiary care centre in South India.

Clinical encounter:

The therapist, a professional psychiatrist listens to a sobbing mother whose son is suffering from a chronic relapsing mental illness saying: “please donot lose your humanitarian care for becoming a professional.” She is the sole care taker for her son who is undergoing yet another exacerbation of psychosis—a state wherein he becomes delusional about his own mother’s intentions and often hurts his mother physically and verbally. The therapist, more often than not, intervenes, ensures her safety, provides an environment where in she can feel validated and many a times goes out of his way to help her by arranging for sessions early in the mornings when her son is sleeping. A major reason for recurrent relapses has been the mother’s inability to assertively supervise medications-- a fact that was perceived through the humanitarian eyes of the psychiatrist as her incapability to do so; however, professionally, it is quite evident that the mother is getting increasingly enmeshed in care of her son and her under-assertiveness to supervise medications is an important reason for recent relapses. This has not gone unnoticed by the team of psychiatrists who work with the therapist and they have suggested transfer the patient to a closed rehabilitation set up where the patient would be separated from his mother and medications supervised by another professional team. This obviously has been opposed by the patient’s mother, however, her therapist also is ambivalent---his humanitarian instincts drive him to continue to be responsible for care, but at the same time, professionally feel accountable for relapses which have happened under his care.

The Dilemma:

Expertise is the foundation element of Professionalism. The Psychiatrist team, an expert in dealing with recurrent relapses in a patient with psychosis and poor insight knows that the next best option for the patient is to be in a closed rehabilitation set up with supervised care, away from his mother who is unable to supervise medications. This pull of expertise also creates a practical drift into standard professional groups and practices away from routine operationalized individual conformity.

If accountability and responsibility to professional expertise acts as a “pull” for the psychiatrist and its team to act ‘professionally’, the “push” is from the humanitarian values of dual loyalty similar to that described by the Dual Loyalty Working Group (DLWG) in 2003(16). Here, the dual loyalty is obviously between the patient’s best interests and an “obligatory” humanitarian responsibility to ensure dignity and equality of the family, especially the patient’s mother and thereby ensuring inclusive decision making.

Ethical Reflections:

“The question is”, said Alice, “whether you can make words mean so many different things”.

Lewis Carroll.

Contradictions, is but an appearance and probably the most flattering one(17). The ethical dilemma for the therapist is obvious and our purpose is to generate reflections rather than answers.

Over dependence on Humanitarianism with its roots in Care driven by independence and need to alleviate human suffering at all costs can respond with two seemingly opposite responses—apathy or advocacy. Apathy, in this case would mean dwindling enthusiasm and concern on the part of the therapist with repeated relapses of psychosis and resultant burn out. Advocacy, on the other end would mean influencing professional decisions with powerful humanitarian *synechdoche* picture of a lonely, tired mother pleading for continued help to stay with her sick son and prevent relapses.

Over dependence on Professionalism with its roots in expert knowledge, excellent communication and problem solving can respond with discretion amounting to alienation. Alienation in this case would mean detachment of the professional expert group from the distressed family and receding into professional subcultures with statements like “sending your son to the closed rehabilitation set up is the best option, now you decide” and thereby creating social barriers of communication. In the absence of a “Right” answer, an Ethical dilemma of such nature stimulate what “ought” to be done.

The probable solution: “The Professional Humanitarian”.

Humanitarian Care all around the world has benefited with professionalism—especially where in times of crisis when the core remains humanitarian care but the structure is provided by professional bodies(18). Professionalism in service sectors like medicine does and should include an active relationship between the service provider and the receiver. This ought to remain the core around which the structure of expertise needs to be build. A professional relief worker is essentially virtuous, and interestingly, it boils down to these virtues which lay down ethical standards in morally complex circumstances. These standards may be just be as transferrable or generalizable as professional standards(19), as is evident from the success of The Active learning Network for accountability and performance in Humanitarian Action (ALNAP)(9). These standards should be defined in content by humanitarian virtues and in form by professional principles. Emphasis on only form is likely to scuttle innovation and risk aversion, an option which will reduce medical profession to a top-down transfer of knowledge and advice. A professional humanitarian therapist, in the above clinical scenario, would continue to engage and go beyond a sense of duty with humanitarian principles; at the same time ensure that the family, especially the mother, moves towards taking the difficult decision of sending her son away to a rehabilitation centre. The importance of using patient value statements(20); in this case, a culturally relevant statement of not losing out on humanitarian values for professional codes reflected by the mother of the patient in this clinical encounter does put things in perspective. It helps to regulate balance between professionalism and humanitarianism and generates a meeting point relevant to the clinical encounter.

Conclusion:

Professionalism and codes of professional behavior are necessary but not sufficient to define ethical standards of care in evolving complex physician-patient relationships of the 21st century. Humanitarian values of dignity and equality can be the driving forces which, along with reigns of professional principles can guide a therapist to inclusive, shared and informed decision making in clinical practice. Adding on a subtheme to the already defined 8 principles of patient centred care by Picker(21), This clinical encounter guides the physician to use the patient value statements to drive a meeting point between professionalism and Humanitarianism

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