Professionalism in the palliative medicine physician: How ought it best be cultivated?

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Abstract

The role of professionalism in regards to becoming a mature palliative medicine physician is explored in this essay. As a professional, the physician will acquire attributes that belong to the domains of both the professional and healer.

The doctor as professional and as healer requires the development of an ethical wisdom. In particular consideration of the concept of virtue is shown to be key to being effective in this role. The acquisition of these traits and the honing of the necessary skills may be operationalised through the repeated practice of good habits. This may be learnt and does not depend only on an innate disposition. Experiential learning and the powerful role of exemplars is crucial to this. Self-awareness, a keen understanding of compassion, and situational ethical ease will contribute to both career longevity and satisfaction.

Keywords: professionalism, ethics, virtue, palliative medicine, balancing emotion and reason

Introduction

"Whatever matters to human beings, trust is the atmosphere in which it thrives” Sissela Bok (1978)

A seasoned palliative medicine physician (PMP) provides both technical expertise and assurance to patients and carers at the end of life. In doing so the PMP is a professional with a prescribed basis of medical knowledge,
incorporating this knowledge into a wisdom that both guides practice in the short term and ensures career satisfaction and sustainability in the long term.

This essay will explore the concept of professionalism in relation to the specific context of palliative medicine. What are the parameters involved and how may they best be cultivated?

The World Health Organisation defines the palliative approach as:

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. The intention of palliative care is neither to hasten nor delay death and acknowledges that dying is a normal process (Sepulveda, Marlin, Yoshida et al, 2002)

The ethos underpinning palliative care involves a holistic appraisal of the person in their context and active management of symptoms resulting in suffering, both physical and existential. While the quest for cure of the underlying disease may have been relinquished, the provision of care is not. Non-abandonment is the essence of the palliative approach.

The Royal Australian College of Physicians (RACP) expands on this theme by delineating the professional attributes desired in a PMP:

The physician: practises palliative medicine in an ethically responsible manner that respects the medical, legal, and professional obligations of belonging to a self-regulating group with particular reference to the complex issues that can surround end-of-life care; manages the personal challenges of dealing on a daily basis with death and grief; reflects on their personal practice of palliative medicine and uses this process to guide both Continuing Professional Development and the ongoing pursuit of wisdom (RACP 2013).

The RACP's Chapter of Palliative Medicine refers specifically to professional attributes that characterise the PMP:

The palliative care physician should exhibit compassionate care of dying patients and their families, recognise the emotional challenges, grief and loss in themselves, other staff and families; exhibit a willingness to 'be with' the dying person and their family; exhibit a respectful, holistic approach to care of dying patients and their families; exhibit respect for the body after death, supporting individual religious and cultural practices; contribute to an improved awareness of the care needs of the dying among colleagues and the general community; recognise the spirituality of the dying person; display awareness for and respect of the significant cultural and religious customs that relate to palliative care, death, grief, and bereavement (RACP, 2013).

The above excerpts from the RACP’s curricula highlight several components involved in the aspiration and realisation of becoming a 'good' PMP. These include belonging to a self-regulating profession; a confidence in ethical issues and practice; and attitudinal qualities such as exhibiting compassion and being present for the dying person and their family. Through unpacking and elaborating on these domains one may understand the different strands that weave the fabric of an effective and sustainable PMP.

Starr (1982), defines a profession as: an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical specialised knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics. Scribonius defined professionalism as a "commitment to compassion and
clemency in the relief of suffering”. The latter linked this to the act and tradition of professing inherent in the Hippocratic Oath (Reich 1982).

Much has been written on the subject of medical professionalism. Pellegrino (2002), and Cruess and Cruess (2009), expounded on what it means to be a profession and a related though separate concept, what it means to be professional, as distinct from professionalisation. This is to differentiate between the act of ‘professing’ to be a doctor, and the character that emerges through daily contact with the clinic and patient.

Cruess and Cruess delineate caring/compassion, insight, openness, respect for the healing function, respect for patient dignity/autonomy, presence and accompanying as traits for the ‘healer’. They regard the following as being areas of overlap between the ‘healer’ and the ‘professional’ in terms of desirable attributes: competence, commitment, altruism, trustworthiness, integrity/honesty/codes of ethics, morality/ethical behaviour and responsibility to the profession. The ‘professional’ characteristics are deemed to be autonomy, self-regulation, responsibility to society and team work.

The Palliative Medicine Physician as Professional

The act of professing to be a doctor may be part of a ritual on graduation from medical school, or be an implicit statement inherent in conferment of postgraduate fellowship and specialty training (Macneill and Dowton, 2002, 2009). The Hippocratic Oath contains sections pertaining to the interests of patients and also the self-interest of the profession. Over successive centuries its main principles have been retained with further elaboration, as required, by historical circumstance. The Declaration of Geneva (1948) contains a physician’s oath, prompted by the medical doctors’ role in the Nazi war crimes against humanity. The physician is instructed to “not use [his] medical knowledge contrary to the laws of humanity”. These codes of conduct should not be confused with ethics per se. A professional code is a framework for both self-regulation and an appeal for credence amongst other professionals and laymen. It is essentially a set of rules counselling against behaviour or acts that will diminish the profession in the eyes of society. Trust is to be promoted and earned, and so the code clearly lays out conduct expected of members admitted formally to its circle. For instance, the Australian Medical Association's code (2006), contains several reference points: First, there is a section entitled the Doctor and the Patient, then the Doctor and the Profession, and finally the Doctor and Society. Each section enumerates principles that promote the good of the patient (beneficence), fair practice and professionalism amongst colleagues and then social justice and equity of access to health care. There is a strong emphasis on the transfer of acquired knowledge both between professionals and on an inter-generational basis, the transfer of wisdom being important for the growth and sustainability of the profession. This echoes Hippocrates' oath where one swears to "hold him who taught me this art equal to my own parents and to live my life in partnership with him….". Just recently, the World Medical Association has inserted a phrase about self-care for doctors into the Declaration of Geneva, extending the scope of the physicians’ oath (Parsa-Parsi, 2017). This amendment reads, "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard". This could be considered by some as largely symbolic, given that many doctors have never read the Declaration fully, nevertheless it does signify a new emphasis on the balancing of the health of the practitioner with demands of the profession.

While these codes of ethics are an integral part of what it means to be seen as a profession, they should not be conflated with ethics or law itself. Codes do not equate to an ethical discourse. There is no specified ethical framework underpinning each point. Duties and responsibilities, while clearly identified, carry no mark of any one philosophical origin. The basis of the principles is explicitly normative, nevertheless there is no explanation of the derivation of the principles. A threat of admonishment is implied for ignoring or violating the codes. It could be
inferred that the character of the ‘good’ practitioner does not come from within the doctor but from adherence to the external code of conduct. The various professional codes define from without and bear no nuance or consideration of fact, individual circumstance or discourse. What the codes do succeed in conveying is that the practice of medicine is situated and integrated within society. The doctor forms a two-way relationship with the patient and next-of-kin. This relationship in turn forms the fabric of society itself and both lean into each other. The doctor is a member of a profession and standards are there to protect both the patient and the doctor and the profession as a whole. The main purposes of codes are to promote the individual patient’s best interests and the interests of the practitioners themselves. Contemporary codes are framed in a language and meaning that is values-based and has shifted away from paternalism. Therefore, while it is evident that the codes of conduct indicate expected obligations of the physician to the self-regulating profession, they are necessary, but not sufficient as a moral basis of the professional entity.

Indeed, critiques of professionalism tend to be aimed at the ‘guild-like’ attributes of the profession of physician (Kerridge, 2013). As part of a covenant with society for being responsible for standards and training, the profession is granted a certain professional autonomy and the capacity to self-regulate (within legal limits). Indeed, when considering the AMA’s code of conduct, it is clear that the beneficiaries include both the doctors and the patients in equal proportions. It could be mooted that medical ethics ought to be kept outside the scope of professionalisation. The fear being that an overriding desire for professional autonomy and the exclusivity of belonging to the ‘club’, may be used to mask ‘bad’ behaviour and dampen public accountability and transparency. Professor Ian Kerridge, one of Australia’s leading bioethicists and a haematologist, referred to [RACP] whistleblowers’ concerns when he said:

> *It is more that they are concerned that in the process of corporatisation, the college’s decision making processes have been distorted – to being more risk averse and less in touch with the medical community and public* (Kerridge, The Age, 2018)

Professionalisation also carries connotations of James Bond-like imperturbability. Sir William Osler has been quoted as advocating for a form of professionalism that was charged with a coolness and detachment in relationship between the healthcare professional and the ‘clients’ they serve:

> *… no quality takes rank with imperturbability… meaning coolness and presence of mind under all circumstances.* (Osler, 1932)

Others echo Kerridge’s interpretation that professionalisation serves to distance the practitioners from the community from which they make their living and ultimately serve. While a valid criticism, its genesis may be a response to past mistrust created by strong paternalism in the medical profession and the fact that with specialization and technocracy, doctors have had to reassess their profile and image. According to Doukas (2004), this, together with a fresh approach to shared decision making and bioethical discourse, has resulted in a revival of a virtues basis to the identity of the doctor in relation to society and the individual.

Pellegrino (2002), similarly separates the role of the professional as a moral centre from the acquisition of the aforementioned “guild-like” attributes. Norelle Lickiss (2017), a retired Sydney palliative medicine physician, addresses the need for the PMP to acquire an ‘interiorized ethical sense’. This, she asserts, enables the PMP to traverse the "ethical valleys and hilltops of daily patient encounters with certainty". Moral disquiet or distress results if one is not sure of where the ethical compass points. The author postulates that the cultivation of a sound ethical mindfulness will reduce burn out and enrich the formation of the professional identity. A consideration of virtues is integral to this quest and how these virtues sit with regard to moral principles.
Virtue ethics offers a framework for addressing dilemmas and analyzing normative responses to clinical end of life scenarios. While an adequate discussion of virtue ethics is beyond the scope of this essay, nevertheless a concept of virtue is implicit in all theoretical approaches to ethics. From Aristotle to Kant and the utilitarians, a discussion of what is ‘good’, both in intention and in action, is inherent to every ethical theory. Nussbaum (1999) cogently expresses the unifying role that virtues play across all ethical theories. The virtues, in her opinion, are inextricably linked with all ethical theory and it is therefore misleading to regard ‘virtue ethics' as a category in itself.

Beauchamp and Childress (2013), well known for their ‘principles’ approach to biomedical ethics, also regard virtue as important. They conceive of a virtue as a "dispositional trait of a character that is socially valuable and reliably present in a person, and a moral virtue is a dispositional trait of character that is morally valuable and reliably present". Yet they argue that virtue and character are not enough to underpin the desired results from actions. A framework of ethical principles and rules should uphold the "rightness" or validity of actions within clinical practice. Virtues and character of the agent aid in exercising judgment when deciding the best course of action. Beauchamp and Childress nominate four principles; namely beneficence (effect good), nonmaleficence (avoid harm), respect for autonomy and social justice. It is by the specification and balancing of these principles that a decision may be made that reflects the context of the circumstance. My interpretation of how virtues and principles function together is that of a complementary nature. The correct disposition ensures that the competing ethical principles are balanced in a morally satisfactory fashion (Waide, 1988).

WB Yeats, in ‘Among School Children’, encapsulates this theme of unity poetically when he asks,

Are you the leaf, the blossom or the bole? O body swayed to music, O brightening glance, How can we know the dancer from the dance?

Virtues and principles or rules coexist together and each is required in the exercise of prudence.

While aspects of professional autonomy and self-regulation have been discussed above, particular mention ought to be given to teamwork in the palliative medicine setting.

Palliative care, like pain management and indeed bioethics itself, began as a movement occasioned by increasing deficits in healthcare resulting from changes in society and advancements in medicine. Palliative care is operationalized in an interdisciplinary setting. The PMP is part of a team comprising nurses, allied health, social workers and pastoral care. The PMP should be a good collaborator and communicator with other healthcare professionals. Each member of the team assumes predominance as the needs of the patient and family come to the fore and recede as those needs are met. This is truly an exercise in patient-centered care.

The RACP's "Physician Readiness for Expert Practice (PREP)" training program and the Palliative Medicine Advanced Training Curriculum reinforce these concepts as expected outcomes of training:

... to establish therapeutic and supportive relationships with patients and their families based on understanding, trust, empathy, and confidentiality and confidently discuss end-of-life issues with patients and their families and sensitively explore patients' concerns across physical, psychological, social, cultural, and spiritual domains (RACP, 2016).

**Palliative Medicine Physician as Healer**

The concept of healing is worthy of attention before further considering aspirational attributes desirable and indeed
how they may be taught or nurtured. Healing is defined by Mount and Kearney (2009) as a relational process involving movement towards an experience of integrity and wholeness, which may be facilitated by a caregiver’s intentions but is dependent upon the innate potential within the patient. It is not dependent on the presence of, or the capacity for, physical wellbeing. In their opinion, it is therefore possible to die healed. For the patient, periods of transition may be accompanied by chaos or disorganisation and despair. Cassells (2010), defines suffering as a specific distress that occurs when an impending destruction of the person is perceived and continues until the threat is gone or the integrity of the person can be restored. It is therefore implicit that the integrity of the person is a cornerstone of relieving suffering and thereby facilitating healing. Mount and Kearney explain that the experience is more likely if carers and providers have found ways of staying with, and being in their own experience of suffering. Healing can occur with suffering but suffering may not be prolonged if there is acceptance and healing. Healing occurs with a transformative process and involves the restoration of relationships. The doctor’s role is therefore to aid healing, where possible. This maybe through both clear and crucial conversations and also by relief of suffering, existential or physical. It has been demonstrated that patients with strong spiritual beliefs suffer less when faced with life limiting illness. Also it has been shown that patients wish to talk with their doctors about spiritual matters (Best, Butow, Oliver, 2015). A confusion between religion and spirituality in contemporary Western society is one of the barriers that have been identified in this regard (Best, Butow, Oliver, 2016). Also contributing to barriers, is an historical emphasis on the Cartesian separation between mind and body that still prevails in attitudes amongst some physicians. Physicians who have received training in the spiritual process are more inclined to explore this facet of the psycho-social-biological model of patient care. The PMP is better placed to enhance this process if they themselves have confronted and accepted their own mortality. This has a spiritual dimension that the PMP may develop as a person and as they grow in their professional capacity. It is this two-way process that is highlighted in the concept of the ‘wounded healer’ that will be discussed later when considering how may these attributes be best learnt.

It has been referenced above how the PMP is situated to be a presence or accompany the dying person and their carers. Some liken this component of palliative care to midwifery (Barbato 2013, & Quill 1996). The nursing profession, guided by an ethics of care, has this as its central tenet. The physician too may have a significant influence on this last part of the patient’s life. The patient, families and carers benefit by being guided and nurtured during this often slow and unpredictable odyssey. It may be helpful to compare a “willingness to be with the dying person and their family” (RACP 2013), with the practice of Kanyirrinpa or “holding”. This is an Aboriginal practice that is described in the context of the passage of young men to becoming initiated men. Brian McCoy (2008), describes the role of the elder men in these rites de passage. Kanyirrinpa can be extended to include other areas of holding such as nurturance after giving birth and in parenting. The components of Kanyirrinpa include dreaming, family and the land. Those involved with Kanyirrinpa exhibit responsibility and authority and nurturance. The maparn or healer uses genuine aesthetic principles to work with other stakeholders to encourage palya (well-being). Security and safety are key factors that permeate the relationship. The PMP balances scientific knowledge, educated perception, and acquired wisdom to foster peace of mind in the patient and family, to achieve symptom control and assist healing.

Gaining of wisdom and cultivating empathy, trust and a healing relationship are thus the aspirations of the mature palliative medicine physician.

How may the theory become ethical praxis?

Inui and Cottingham (2008), while dealing with undergraduate education, highlight the approach they prefer towards “self-actualisation” and professionalism. Their observation is that the environment is more impactful than learning
from books and readings. This is based on the belief that the lived experience is more powerful in promoting values-based practice than book-based tutorials. The realities of "struggling to keep balanced in precarious situations", is advocated as being where the nexus of true professional learning occurs. They promulgate the value of reflection on experience. They employ a metaphor of modes of navigation to underscore the characteristics and habits that comprise goals to be cultivated. This involves the integration of navigation of reason and navigation of feeling/emotion/perception or the aesthetic. The aim is to amalgamate the two navigation styles so that intuition, situation awareness, reflective practice, together with knowledge of facts and rules and guidelines, forms a binary yet unified *modus operandi* with which to plot one's course on the seas of professional patient care. Reason and the practice of self-actualisation will be cultivated by good habits informed by facts.

In *A Flag in the Wind*, Inui (2003) presents a fascinating and thoughtful treatise on professionalism and medical education. While medical students are selected on grounds of virtues such as altruism and compassion, it is noted that after spending time on the wards observing bad behavior from poor role models, some of these characteristics are discarded and are replaced by cynicism and self-centeredness. This inculcation does not result from lack of emphasis in the curriculum of professionalism or small group teachings, instead Inui attributes the decline to be the "hidden curriculum". This, he claims, represents a dissonance between what is taught to be the "right" way of acting and what actually occurs on a daily real-life basis within the clinic. This modelling of what actually goes on, rather than the normative idea of what should go on, is in fact the acting out of the "hidden curriculum". He describes the struggle to stay centered on values in the profession of medicine. Due to the hierarchical nature of the medical team and the all-pervading fear of a poor reference, it is difficult for a junior doctor to speak out when witnessing callous behavior by senior clinicians or other staff. Even a simple gesture such as helping a patient get dressed again or sitting beside the bed rather than looming, could impact and remind busy bosses that the patient is at the centre of the consultation, rather than their next meeting. Certainly, in the early training of a palliative physician, reflective practice might involve shedding poor habits learnt on busy surgical wards, such as the knee jerk ordering of tests, investigations and treatments that are not congruent with the palliative approach. Indeed, an acute situation in a palliative patient is often a signal for conversations about goals of care rather than reflex prescription! A PMP ought to connect with the patient and aid healing in an honest and authentic fashion. The PMP in evolution will practice self-awareness and reflective practice that should prompt honest self-examination to recognize and discard defensive practice routines that may have accumulated since medical school days.

Leach (2004) supports this approach to professionalism by describing how the move from advanced beginner to competent practitioner means less detachment and greater immersion in particular contexts. This maturity is marked by moving from "rules based behaviors to context based behaviours" and is acquired through an active process known as phronesis. Phronesis is an Aristotelian term describing the acquisition of practical wisdom. For Aristotle, it is through the regular practice of good habits that wisdom accrues. In other words, virtue can be learnt and it is honed and refined by repeated acts that aspire to a good moral character. The use of reason informs one's decision making and results in prudent acts that display good judgment.

Both McCammon and Brody (2012), and Huddle (2005) expand on the theme of whether medical morality can be taught or not. Huddle agrees that the cultivation of medical morality arises by stimulating "responsiveness to the lived mortal life". This arises because of encouragement by tacit or explicit invitation by colleges and role models in the field. He describes how ‘proper seeing’ of the ethical aspects, is the priority. This ethical way of ‘seeing’ is to be found in the everyday lived experiences. He claims that the ‘hard’ ethical cases that usually attract all the attention obfuscate, as there is often no clear answer with these cases and they distract the practitioner from the more meaningful daily events. However, Huddle alleges that the ‘unique character of moral norms’ is innate and comes from within. This contrasts with McCammon and Brody who assert that anyone can learn a habit by regular virtuous practice. It is my opinion that true ethical ease develops by the repetition of good judgments over many
cases, thus achieving an expert status. This can be learnt.

Beauchamp and Childress (2013) enumerate five focal virtues that predominate in relation to the medical professional. In addition, attention is given to the role of altruism in professionalization.

**Compassion**

Empathy involves trying to understand the other person’s physical and mental experience. Compassion is directed at the other and is the medium by which empathy and active regard for the other's state is enacted by way of acts of beneficence, to mitigate suffering be it physical or existential. Patients and carers value compassion very highly. Kim Oates (2014) describes an aspect of being a professional in terms of how one learns to "stride the narrow catwalk between aloofness and over familiarity". This is a tight-rope that the PMP learns to walk with care. At times the PMP connects at a most human level with the patient and carers by demonstrating an awareness and engagement at an emotional level. At other times the practitioner is required to be more detached in order to affect a rational impartial response. Jodi Halpern (2014) eloquently explores the issue of clinical detachment and advocates the idea of ‘engaged curiosity' when forming the therapeutic alliance with patients. She traces the history of clinical detachment from the autopsy room when the physician was advised to suppress emotion in favour of rational deliberation separated from any emotional undertow, to a concept that seeks to incorporate the emotional response by way of engaged curiosity. Here the clinician recognizes that they do not understand fully what the patient is going through but desires to learn more about the patient's experience and wishes. By becoming interested in the patient's situation the physician avoids the error of merging with the patient (a mistake when cultivating empathy), or in remaining aloof and detached. She contends that by becoming emotionally aware and reflective, the physician both establishes a more productive relationship for both the patient and the clinician. This promotes both the good of the patient and also enhances career satisfaction and longevity for the clinician (Austen, 2016 & Kearney et al, 2009). Conversely, suppression of emotion may result in an appearance of indifference to the patient's plight and is a missed opportunity for a flourishing professional interaction. Paul Bloom (2017), cautions against using empathy alone as moral guide, instead advocating for the use of rational compassion. He contends that empathy per se is subject to distortion and bias and in fact may cloud effective decision making.

**Discernment**

The second of Beauchamp and Childress' virtues relates to the ability to make the ‘right call’ or judgment. It requires one to have insight and to correctly apply knowledge and principles to the person in a timely fashion and in an appropriate manner. This requires the PMP to accurately appraise a situation, consider the nuances and specify and balance the correct approach. Utilising technical competence, ethical sensibility and expertise in unifying perception, emotion and reason, a just and context-specific opinion is formed. Aristotle’s ideal discerning physician, would understand how to act with the right intensity of feeling, in just the right way, at just the right time, with a proper balance of reason and desire (Nicomachean Ethics). A well-developed sense of discernment will be one of the motivating factors that ensure a morally sound application of the four principles.

**Trustworthiness**

Beauchamp and Childress’ third virtue is trust that sustains and upholds the other virtues. For O'Neill (2005), being
trustworthy is prima facie essential to the therapeutic relationship. In her opinion, the characteristics of being trustworthy are being honest, competent and reliable. Trust should be placed prudentially or it becomes misplaced trust. O’Neill feels that a certain vulnerability on behalf of the receiver of trust will accompany the behaviour that engenders well-placed trust. This vulnerability treads a fine line in medicine with respect of the balance of reason and emotion. The development of compassion through an ‘engaged curiosity’ rather than a callous indifference, is a vital ingredient in inviting trust. Honesty involves being open and truthful and not acting-out feigned connection but allowing authentic connection to occur. Trust previously placed in other clinicians should not be undermined as these bonds are important to the patient who may have endured many treatments before. A new relationship with the PMP must be forged that involves realistic hope and discussion of goals of care. Conversely an erosion of trust, perhaps because of previous poor communication or indifferent care, may have resulted in mistrust in the medical system. The PMP has little time to establish trust with patients and carers at this crucial, often tumultuous time, and so good communication skills and giving time to difficult conversations will be as important as any pharmacological maneuver.

**Integrity**

For Beauchamp and Childress integrity refers to the internal moral scaffolding of the clinician. Integrity means whole or complete. The person with integrity will do the right thing for the right reasons whether she is being observed or not by the swiveling panopticon of medicine. The person of good integrity is described empirically as being of "high moral fibre". They are sure of their moral values and in keeping with Primum Non Tacere, will speak up when required (Dwyer, 1994). Inwardly the person has a well-adjusted sense of self and their emotions, aspirations and limits of knowledge. Lack of professional integrity may involve breaches of professional codes of conduct, however these codes do not equate with ethical standards, as they represent the aims and rules of the professional organization to which the practitioner belongs. A conscientious dilemma may occur if the practitioner’s moral stance differs from the codes of conduct of the organisation that one belongs to or gets paid by. Such a situation could occur in palliative medicine if physician assisted dying (PAD) is legalized and the practitioner believes that this act contravenes their own personal ethical code and elects not to be the agent for this act.

**Conscientiousness**

Conscientiousness is the character trait of acting by being motivated to do right because it is right. Beauchamp and Childress (2013), differentiate this from integrity. The agent uses diligence to establish what is right and intends to do right and make the appropriate effort to do so. As was mentioned previously, this might lead one to object to being asked to perform an act that one felt was not right or not in the patient's best interests. The PMP is an advocate for the patient and their carers and should not give way to expediency or pressurized requests to supply a treatment that is deemed futile, for instance cardio-pulmonary resuscitation in the end of life setting. In the case of objecting to being a provider of PAD, in Victoria for instance, the PMP should have to demonstrate that their objection is justified and reasonable and not the result of irrational belief, whim or fancy, to be excused from being the agent responsible (Kantymir 2014). If a practitioner is prevailed upon to supply a treatment that he/she in good conscience feels is not in the patient's best interests then a second opinion or transfer of care may be indicated. This is a last resort as usually good communication with clear language and clarity of knowledge circumvent therapeutic impasses.
Altruism

The concept of altruism deserves special comment as it both illustrates Aristotle’s Doctrine of the Golden Mean, and it leans into both self-care and non-virtuous practice. Aristotle held that each virtue was to be found as a mean between two extremes of vices. Regarding altruism, the deficiency extreme is represented as selfishness and the countering extreme is that of excess, self-sacrifice. The ‘good’ physician is inoculated, from student days, with the mantra to put the "interests of the patient first", even beyond their own self-interest. This leads to much ambiguity as the medical student progresses along a career path. Some seem to be in medicine entirely for their own self-interest and pecuniary advantage. Others become subsumed into medicine and patient care, to the exclusion of their home-life and self. While there maybe secondary gain to this as self-sacrifice is deemed to be praiseworthy and saint like, this does not always lead to a healthy lifestyle and longevity in career. While complex in its nature, altruism as a virtue situated between these two extremes, is a useful practical concept. It is my observation that palliative medicine physicians, perhaps because they deal daily with mortality, display this virtue more readily than other professional specialties.

Can these virtues and ethical principles be taught and assessed or are they breathed into one at birth or by professing the Hippocratic Oath?

Both Pelligrino, and Creuss and Creuss (2015), write about professional identity formation and that once one selects one’s specialty one ‘starts to shape one’s image accordingly’. Wisdom starts with knowledge; hence it is presumed that the PMP has the requisite medical knowledge and becomes familiar with both ethical issues and health law with regards end of life decision making. This may be gleaned from courses, literature, and in preparation for postgraduate fellowships.

The micro-ethics of daily patient and carer encounters in the community and on the ward, require a different type of wisdom (Komesaroff, 2008). It is suggested here that balancing perception, cognition (reason) with the senses (aesthetic) is an art form and a skill that when cultivated leads to discernment and good therapeutic relationships. Macneill (2017), has written potently and eloquently on this very subject. Lamenting the emphasis on rationality and cognitive thought that underpins much of the traditional Anglo-American bioethical analysis to date, he calls for more appreciation to be given to the non-cognitive aspects of emotion and nuance that drive many medical processes. An ethics that includes aesthetic appreciation integrates cognitive reasoning with feeling and sensitivity in healthcare. The balancing of reason and the aesthetic adds context and richness to many healthcare related ethical encounters. Perception and aesthetic or feeling responses to ethical situations are particularly germane in enhancing nuance and specifications of a dilemma. Hansson (2002), refers to a certain ‘disinterestedness’ that is seen when the ethics of a case are discussed. This he differentiates from an indifference, and he claims that both the determination of the principles and consideration of imaginative or reflective views to be complementary and inherent in the process of teamwork seen in medical praxis.

Guillemin and Gillam (2015), also lend support to the importance of combining cognition and emotional impact. They reported a dissonance between educators teaching ethics sessions where emotions are not mentioned and their responses after using narrative ethical teachings where emotional impact is reflected on. They assert that ethical mindfulness is valuable in the formation of a professional identity. The harnessing of the emotions is part of the development of both the healing and the technical sides of medicine. In the long run this engagement of the
practitioner in both emotional and technical aspects is more sustainable than uninterrupted detachment. They describe a five-part program that culminates in moral courageousness. Narrative ethics is employed in teaching the formation of a moral identity. This they claim, will result in more empathetic and well-rounded doctor who will likely be a better role model than the technocrat counterparts. Gillan (2014), asserts that feelings are not enough to be a guide but insight gained from them enhances understanding and ethical responsiveness.

Indeed, while clinical supervision, communications courses and other didactic methods such as focus learning groups contribute to the PMP’s acquisition of professional attributes, the impact of good role models is incommensurable. Medicine is an apprenticeship-like occupation and exemplars are perhaps the most important teachers of good professionalism. Inui talks about the power of experiential learning in enhancing professionalism. In Flag in the Wind, he refers to the powerful ways of learning that doctors imbibe from the systems that they work in and also the hidden curricula of “do what we do” as opposed to the formal curriculum of “do what I say”. The aspiring PMP does well to perceive good role models and observe how patients respond to them. This should be cognitively processed incorporated habitually into daily clinical practice. Indeed, the main barrier to professionalism is widely cited as witnessing unprofessional behavior or attitudes by colleagues.

The patient of course is viewed as the ultimate teacher. The doctor-patient relationship is two-way and the interrelatedness of all transactions should not be underestimated. Again, balancing of perception, senses and reason are invoked as one reflects on the concept of the wounded healer (Kirklin 2010).

“. At the same time as the healer within the doctor reaches out to the wounded within the patient, so the wounded within the doctor reaches out to the patient for healing…..Moreover, the participation of the wounded part of the healer in the relationship is essential for its success. Without this part of his or herself the doctor cannot connect fully with the patient ….and establish trust or rapport”.

Put simply, a certain vulnerability on behalf of the healer is required for trust to be generated. Macleod (2001), a palliative medicine physician, refers to these episodes of connection as ‘turning points’, in the training of a palliative care doctor. This he explains, marks the point where the doctor begins to holistically care for the patient as well as tending to their medical needs. He uses the rather antiquated phraseology of Osler to support his premise.

I would urge upon you….to care more for the individual patient than for the special features of the disease….Dealing as we do with poor suffering humanity, we see the man unmasked, exposed to all the frailties and weaknesses, and you have to keep your heart soft and tender lest you have too great a contempt for your fellow creatures. The best way is to keep a looking glass in your own heart, and the more carefully you scan your own frailties the more tender you are for those of your fellow creatures. Sir William Osler (Cushing 1926)

The above epitomises well that the artistry of palliative medicine lies in the sensing and feeling and embodiment of aesthetic practice, in alliance with knowledge and reason. The PMP needs to be adept in sensing the physical or existential discomfort of their patient and be unswerving and accurate in where to place the conversation of the moment. The agility intuited which model of patient-physician interaction to follow, is inherent in the PMP’s practice. Respect for autonomy in practice, can be used to illustrate how the PMP uses varying models of doctor-patient relationship to approach different situations (Emmanuel 1992). Knowledge of the underlying bioethical principles and adjunct virtues renders a transition between these modes smooth and justified. The practitioner who has failed to think through the attendant ethical principles might otherwise feel an ethical unease in making these transitions fluidly. While these modes are artificially separated, in practice they overlap and often are all represented in one palliative consultation. For instance, a paternalistic approach is justified in the case of not offering a futile treatment such as cardio-pulmonary resuscitation. The physician is not obliged, legally or morally, to offer a
treatment that affords no benefit to the patient and has real harm attached. While the patient should be informed of this decision, it is not beneficial if the DNR order is posed as an optional extra, which can be chosen or refused by a patient or carer, already bending under stress and fatigue.

No examination of the role of a palliative care physician would be replete without an unaesthetic mention of constipation! The PMP, while expected to connect fully with the patient at the most human level in facing their mortality is also expected to address symptoms fully and sensitively. Constipation is a frequent and distressing symptom that cannot be ignored. An informative approach is represented by a discussion with the patient on the risks and selected treatments of the aforementioned constipation. Here the doctor is acting as competent medical expert and technocrat. The patient exercises autonomy and chooses the lesser of the evils! A more deliberative approach that seeks to inform and explain may be required in the discussion of whether or not to treat a symptom that accompanies the dying trajectory. For instance, malignant hypercalcaemia: here the doctor articulates the values of the patient together while imparting knowledge, and will implement the patient's therapeutic decision. Decision could range from accepting pharmacological intervention to lower serum calcium with attendant blood tests and therapy, to listening to the patient who says they want no more blood sampling and elect to go untreated. Lastly, in a more interpretive model, the patient and physician seek to identify the patient's often inchoate values and wishes. The doctor acts as a counselor or adviser in assisting selection of the best option for that patient and their carers. Such a conversation might involve a real discussion about dying and where the patient might prefer this to occur. In practice, these four models of the patient-doctor relationship wax and wane as the illness progresses and the capacity for purely autonomous decision making diminishes.

Summary

In summary, demonstrable professionalism is a quality to be learnt. This essay has focused on these attributes and several others considered pertinent. It is hoped that by fostering good habits acquired through deliberate practice that the physician can connect fully with the needs of the patient and carers and enhance healing and relief of symptoms. By formation of the whole values-based character the practitioner will experience fewer episodes of moral disquiet, thus promoting an enjoyable and satisfying and long career. This can be taught and a tangible value lies in becoming a role model for successors. While knowledge can be learnt and competencies tested, real wisdom is gained in the symbiotic synthesis of reason, perception, feeling and self-awareness. The assessment of this is noncommensurable and may be reflected in word of mouth recommendations, peer review and ultimately in the feedback occasioned by patients, carers and team-members.

Take Home Messages

- The cultivation of a well-informed ethical backbone will allow an ethical ease when traversing the clinical domains involving end-of-life care. A diminishment in episodes of moral disquiet will enhance career satisfaction and longevity.
- An ethical framework is best coupled with the cultivation of a virtues based character.
- The balancing of reason, emotion and perception underpins this endeavour.
- This disposition may be learnt and is best grown by regular repetition and practice.
- The role of exemplars is paramount in the honing of what it means to be professional as a palliative medicine physician.
The author completed her MBeth at Sydney University while undertaking postgraduate, junior doctor training in Palliative Medicine. The contemplation of the meaning of professionalism and an ethical base for medical practice resonated hugely with the reality of the clinical wards and corridors. In particular the specific context of end of life care and ethics and professionalism is explored. As an aside, the author had been a specialist in another discipline (Anaesthesia). The unpacking of what it means to be a doctor and how one should become a professional aided considerably with crossing the chasms between medical specialities.

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Appendices

None.

Declaration of Interest

The author has declared that there are no conflicts of interest.