The focus of medical professionalism has recently transitioned from expertise to social contract, emphasizing a need for health professionals to adjust their functional roles in line with societal expectations [1]. However, reform of the healthcare industry normally hinges on policymaking in national insurance and other schemes relevant to social well-being. Consequently, when doctor-patient relationships become straightforward, society at large seeks to determine whether health professionals are invariably altruistic or simply self-serving in their professional conduct [2].

The term “medical professionalism” has emerged from extensive sociological research. In the 1980s, sociologists found that many medical issues arose from the poor management of health-care systems, attributing these issues to failures on the part of governments, private healthcare providers, and health policies. Still, social expectations remain high for health professionals in their dual role as scientists and altruists [3].

Socialization refers to a process in which a person accepts (or adapts to) the sociocultural norms of a community and develops personal beliefs about them. As such, professional socialization can be seen as a process in which an adult develops the skills and knowledge to perform a job and a sense of belonging to the culture of his or her organization [4].

Professional socialization empowers certain occupations and their practitioners with a high level of authority and autonomy [5]. The term “professional” indicates the privileged social status conferred on such occupations as teachers, physicians, and lawyers because the barrier of entry into those professions is consistently high. Not every occupation guarantees a “professional career,” which requires specialized training and ability to introspect in line with social expectations [6].

Sociologists state that medicine is characterized by professional originality [7] because it requires years of specialized training in professional knowledge [8] and boasts cognitive exclusiveness. This profession has the following attributes [9]: (a) constructivism (in replacing apprenticeship), (b) professional authority (the individual served is a client, not a customer), (c) social recognition (as established by accredited educational institutions that administer qualification programs and examinations), (d) jointly espoused work-related ethics or beliefs, and (e) a professional culture (when working in unison, all members are recognized as a team, such as a team of resident physicians).

The professional socialization of physicians involves several crucial role-shaping processes. For example, a medical school or teaching hospital can be compared to a social system whose structure, functionality, and culture induce gradual changes in the personality of physicians; moreover, it exhibits a bureaucratic orientation, is built on rational organizational management, and operates hierarchically [10]. This system follows a set of rules and procedures and emphasizes a top-down allocation of power. Social change or internal conflict causes power reallocation within the system, as well as changes in social norms and values internalized by individual members [11].

In 1999, Cruess proposed medical professionalism as a social contract, suggesting that society confers the titles of healer and professor on physicians [6]. The healer is a social role for persons capable of using medical procedures to treat patients. To be publicly recognized as a physician is to fulfill the commitment or social contract between society and the medical profession (i.e. achieving professional competence in medicine). Thus, professionalism can be defined as the alignment of job-specific attitudes and behaviors with social expectations [12].

Medical anthropologists focus on the conflict and reconciliation between the individual and society, depicting the healthcare system as a means of sociocultural adaptation [13]. The healthcare system is a social system and cultural model that evolves from conscious behavior with the purpose of promoting human health [12]. It involves beliefs, actions, and scientific knowledge necessary to achieve this aim, as well as...
as the contributions of its members [12]. Moreover, social anthropologists observe the individual and society in the same cultural context; this indicates that culture connects both agency and social structure [14].

Practicing medicine involves healing as more than doing a job, and its core values are moral ones [15]. That is, health professionals should not exploit their medical knowledge to build therapeutic relationships on false pretenses or for personal gain. Moreover, diseases are understood and treated differently from culture to culture and from region to region; each culture develops its own understanding of diseases over time, resulting in distinct treatment methods [12]. Some health professionals adopt prudent therapeutic approaches to long-term illnesses; if they put on a “professional mask,” they may shield themselves from the persistent demands made by patients, losing the opportunity to learn how patients experience their illness.

From an anthropological perspective, it is only through deep reflection that health professionals whose jobs involve ethical issues can remove their professional masks. Moreover, as society becomes increasingly heterogeneous, they should develop cultural competence and learn to identify with other people [16].

Medical sociologists tend to focus on the social functions involved in the division of labor in the arena of social development (e.g., Durkheim’s concept of social facts) [12] whereas medical anthropologists interpret cultural influences on career development to elucidate human nature within cultural contexts.

Clinical instructors should reflect on whether their teaching leads to their students being professionalized with instrumental rationality but lacking value rationality [12]. Moreover, the practice of medicine should necessitate an understanding of the contemporary social landscape because it involves not only using scientific methods but also evaluating the impact of human and cultural factors on patients and treating the physician–patient relationship seriously.

In summary, we can expound on medical professionalism from different perspectives and from social and cultural contexts to inform the objectives of clinical education. By acquiring a comprehensive understanding of the social landscape, researchers can better understand the relationship between medical professionalism and education within this belief system, thereby revolutionizing its theoretical framework.

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Conflicts of interest
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