Professionalism: Yesterday, Today, and What Comes Tomorrow in a Relentlessly Changing World

Olaoluwa Oladipo Fayanju, MD, MS, FAAFP; Introduction by Richard L. Byyny, MD, FACP

Introduction

Richard L. Byyny, MD, FACP

Since its founding in 1902, the Alpha Omega Alpha Honor Medical Society has recognized professionalism as one of its core tenets. While not explicitly mentioned in the organization's mission, none of the components of the AΩA mission can be considered individually or without distinct regard to professionalism.

Election to Alpha Omega Alpha is an honor signifying a lasting commitment to medical professionalism, leadership, scholarship, research, and community service. A lifelong honor, membership in the society confers recognition for a physician's dedication to the profession and art of healing.

AΩA has stayed true to its founding principles, the AΩA motto: "Be Worthy to Serve the Suffering." AΩA continues as an interdisciplinary organization with a distinguished history of service to medicine, the profession, society, and patients. In 2020, AΩA amended its Constitution to emphasize the characteristics of excellent physicianship – trustworthiness, character, caring, knowledge, scholarship, proficiency in the doctor-patient relationship, leadership, compassion, empathy, altruism, and servant leadership. AΩA continues to foster the scientific and philosophical features of the medical profession; to look beyond self to the welfare of the profession and of the pubic; to cultivate social mindedness, as well as an individualistic attitude toward responsibility; to show respect for colleagues; to foster research; and in all ways to ennoble and advance the profession of medicine.

Medicine is based on a covenant of trust, a contract with patients and society that stands on the foundation of trust to create an interlocking structure among physicians, patients, and society that determines medicine's values and responsibilities in the care of patients and improving public health. These values start with the

precept of do no harm. This also includes a simple basic code of conduct that explicitly states: no lying, no stealing, no cheating, and no tolerance for those who do. It is also based on the Golden Rule, or ethic of reciprocity, common to many cultures that one should treat others as one would like others to treat them.

In 2000, the Royal College of Physicians and Surgeons of Canada (CanMEDS) stated it well: "Physicians should deliver the highest quality of care with integrity, honesty, and compassion and should be committed to the health and well-being of individuals and society through ethical practice, professionally led regulation, and high personal standards of behavior." [1]

Professional expectations for all physicians include:

- Adhere to high ethical and moral standards–do right, avoid wrong, and do no harm.
- Subordinate personal interests to those of the patient.
- Avoid business, financial, and organizational conflicts of interest.
- Honor the social (professional) contract with patients and communities.
- Understand the non-biologic determinants of poor health, and the economic, psychological, social, and cultural factors that contribute to health and illness–the social determinants of health.
- Care for all patients regardless of their ability to pay, and advocate for the medically underserved.
- Be accountable, both ethically and financially.
- Be thoughtful, compassionate, and collegial.
- Continue to learn and strive for excellence.
- Work to advance the field of medicine and share knowledge for the benefit of others.
- Reflect dispassionately on personal actions, behaviors, and decisions to improve knowledge, skills, judgment, decision-making, accountability, and professionalism.

AΩA has a long-term commitment to medical professionalism best practices. Caring for patients in an ever-growing complex profession and caring for patients in a complex and disjointed health care system requires professionalism, leadership, and collaboration to provide safe, effective, patient-centered care. This can only be accomplished by incorporating the key components of medical professionalism—altruism, dependability, responsibility, trustworthiness, honesty, integrity, collegiality, and respect. However, this can only be accomplished through fidelity and commitment to the profession and its professional values.

AΩA's efforts in medical professionalism are a work in progress, and we, as physicians, are continually learning about medical professionalism and how to maintain and improve a standard of physician behavior and patient care. In 2011, AΩA sponsored and hosted a think tank meeting on medical professionalism which brought together experts in medical professionalism to review and discuss the status of and challenges impacting medicine, health care, and medical professionalism.

The meeting participants recognized that there was insufficient evidence to inform best practices in medical professionalism. This was especially true for interventions and remediation strategies of lapses in professionalism and professional behaviors. The meeting resulted in the publication, "Perspective: the education community must develop best practices informed by evidence-based research to remediate lapses of professionalism." [2]

Following that initial think tank, AΩA committed to hosting a biennial conference on medical professionalism best practices with the outcome of each conference being the publication of an AΩA monograph. AΩA monographs on medical professionalism best practices have been published and distributed widely in hard copy and electronic formats in 2015, 2017, 2020, 2022, and 2024.

These topical, timely, and relevant monographs can be accessed through the AΩA website under the Resources tab, or through this link: https://www.alphaomegaalpha.org/monographs/. Hard copies may be ordered at info@alphaomegaalpha.org.

The following article is a reprint of Chapter 3 in the most current AΩA monograph, "Medical Professionalism Best Practices: Professionalism in a Relentless World," by Olaoluwa Oladipo Fayanju, MD, MS, FAAFP. Dr. Fayanju was part of the 2023 conference, and his presentation at the conference from which his chapter is adapted is especially pertinent in a time when society is looking back while also looking forward through an ever-changing lens.

References

1. Puddester E, Flynn L, Cohen J, editors. CanMEDS Physician Health Guide: A Practical Handbood for Physician Health and Well-being. Royal College of Physicians and Surgeons of Canada. https://medicine.usask.ca/documents/pgme/CanMEDSPHG.pdf.

2. Papadakis MA, Paauw DS, Hafferty FW, Shapiro J, Byyny RL. Perspective: the education community must develop best practices informed by evidence-based research to remediate lapses of professionalism. Acad Med. 2012 Dec; 87(12):1694-8.

Professionalism: Yesterday, today, and what comes tomorrow in a relentlessly changing world

Olaoluwa Oladipo Fayanju, MD, MS, FAAFP

The White Coat Ceremony has become such an accepted rite of passage into the medical profession that most new, and most more-seasoned, physicians are unaware that the ceremony is a recent invention. The first White Coat Ceremony took place at the University of Chicago's Pritzker School of Medicine in 1989, but the first official White Coat Ceremony was established under the auspices of the Arnold P. Gold Foundation in 1993 at Columbia University.[1] Back then, Dr. Arnold Gold,[2] a renowned neurologist and beloved physician-teacher known for his charismatic, humanistic, and patient centered-commitment to medicine, had first-year medical students engage in the donning of short white coats and the storied, but far more ancient rite, of medical professionalism: the recitation of the Hippocratic Oath.

Ceremonies and oaths that originated from thousands of years ago may seem out of place in most fields, but they are some of the foundational and demonstrative ways doctors define their profession, demonstrate fidelity to their values, and show their commitment to colleagues and patients. These moments matter because they celebrate the different roads that brought each student to that moment, and because of the symbolism of what lies ahead. The ceremonies and oaths transform the participants and enshrine them in a unique fraternity. One is no longer just a person, but a medical professional imbued with the formidable responsibilities and pressures of conducting oneself in a manner that aligns with values and standards developed over the course of three millennia.

However, for many students, colleagues, and peers, the expectations of the profession are incongruent, vague, and incompatible with modern times. Modern definitions of professionalism, although shaped and formed by medicine's forebears, are primarily the product of a mostly male and mostly white profession that possesses a world view that does not neatly align with an evolving and increasingly diverse fraternity of clinicians.

The current state

How did we arrive at our current state of medical professionalism, and what does the future hold as we train, teach, learn, and treat patients in an ever-changing world? Like any thorough physician, the factors that now define medical professionalism are:

- Practicing patient-centered care that prioritizes the health and well-being of patients, respecting their dignity and caring for their needs.
- Maintaining an ethical practice that adheres to principles of confidentiality, informed consent, and honesty.
- Fulfilling a social responsibility that recognizes the unique and essential role of physicians lending their voices to issues that worsen disparities, reduce equity or negatively impact public health.
- Cultural competency that demonstrates an understanding and respect of cultural differences to ensure effective communication and high quality care.

Historical evolution of medical professionalism: Hippocrates

The foundation of medical professionalism in ancient Greece is rooted in the teachings of Hippocrates (c 460–370 BCE). Hippocrates, widely known as the Father of Medicine, articulated the key principles that in his time defined medical ethics and professionalism, and are central to how we define the concept today.

Beneficence

The principle of beneficence mandates actions that promote the well-being of patients and is central to the Hippocratic Oath's directive to "benefit the sick." This principle is not merely about avoiding harm, but actively contributing to the health and welfare of patients, and emphasizing the altruistic foundation of all medical practice.

Non-maleficence

Non-maleficence is commonly understood and interpreted as "First, do no harm" (*Primum non nocere*). Similar to the beneficence principle, it underscores the importance of considering the potential harm of any medical intervention and the ethical obligation to avoid causing harm to patients.

Confidentiality

Confidentiality is another cornerstone of Hippocratic medicine and the clearest connection to concepts of trust in the oath. The oath includes commitments to respect the privacy of patients' lives and conditions, and recognizing the trust placed in physicians by those they treat. Today, the modern concept of patient confidentiality, emphasizing the protection of patient information

within the health care setting, is one of the more practical day-to-day embodiments of this principle.

Taken together these principles—with their focus on ethics, compassion, and patient care—provide the symbolic and practical underpinnings of an oath that defines the medical profession's commitment to high ethical standards.[3,4,5]

The advent of medical science and medical professionalism: 5th century BCE-18th century

Across the span of history, between the time of Hippocrates (the 5th century BCE) and the birth of the modern era in medicine, professionalism, while grounded in Hippocratic principles, evolved. After Hippocrates, Galen (129-26 CE), a medical scholar and polymath who wrote on medicine, anatomy, physiology, linguistics and philosophy, was a major influence on successive generations.[6] In medicine, Galen's enduring legacy goes beyond his writings, which would define the art, if not the science, of medicine well into the 17th and 18th centuries. Galen wrote how even with a vast amount of information, the ethical challenge of medical decision-making persists and is made more difficult by the highly variable nature of outcomes, even when best practices are implemented. Galen advocated for an approach to medicine that recognized the limits of human knowledge (and his limited scientific understanding) and aimed to get as close to the ideal of comprehensive understanding as possible. As such, his arguments against purely empirical approaches to medicine were combined with a belief in the need for philosophical observations and theoretical innovation to address novel or uncertain pathological conditions.[7] These were by no means comprehensive or perfect principles (later scholars would refute the lack of evidence and errors in his anatomical conclusions), yet they remain relevant in contemporary medicine and guide professional standards, especially in the face of new diseases like HIV/AIDS in the 1980s and, more recently, COVID-19.

The Middle Ages witnessed the consolidation of Galenic and Hippocratic principles with Islamic scholarship and Christian theology that led to a blend of influences, such as the use of herbal remedies, and how medical care was provided in monastic settings and early hospitals. Public perceptions of the medical profession came under scrutiny and increased pressure as crises like the Black Death ravaged populations in Europe, Western and Central Asia and North Africa.[8,9] In the face of such catastrophic events, explanations for the pandemic, specifically, and physiological processes in general, turned to the supernatural, with many seeing the plague as divine punishment for sins. These events took the profession backward even as innovations made necessary to combat the plague–more effective quarantine practices, increased attention to sanitation, a nascent public health infrastructure—first emerged.[10]

In the Renaissance (c. 14th—17th centuries), reassessment of old texts and past doctrine further changed the practice and teaching of medicine. Andreas Vesalius (1514–1564) would do work that represented a seismic shift in the medical world, emphasizing empirical observation over reliance on ancient texts which lacked the rigorousness of a more scientific method. As the Scientific Revolution took hold in the 17th century, William Harvey would build on the work of Vesalius as he and his contemporaries introduced empirical methodologies and experimental techniques.[11] Harvey's insistence on empirical evidence, and his methodical approach to disproving Galenic anatomical and physiology conclusions, highlighted the importance of skepticism, inquiry, and the continual testing of hypotheses within medical practice. These principles became integral to the evolving definitions of medical professionalism, emphasizing the need for ongoing learning, adaptation, and the application of scientific methodologies to clinical practice. His work challenged physicians to reconsider their understanding of the human body (he successfully demonstrated the presence of the human circulatory system through extensive dissection of cadavers), hastening a move away from speculative medicine toward a more rigorous, evidence-based practice. This shift necessitated a re-evaluation of the medical profession's role from protectors of what was considered accepted know-how and practice to pioneers of scientific discovery and innovation.

Edward Jenner's discovery of the smallpox vaccine in 1796 was transformative for its approach to disease prevention and for shaping the future of professional medicine. For Jenner and his contemporaries, the practices and educational structures of medicine were already rapidly changing. Divisions between traditionally trained physicians and surgeons, who often gained their medical knowledge through apprenticeship, began to recede and be less distinct.

New teaching hospitals in Europe and in the United States—the first at the University of Pennsylvania, founded in 1765 on the eve of the American Revolution—emerged as centralized, and increasingly respected destinations for learning and collaboration. These new

institutions and the introduction of Jenner's vaccine, were landmark achievements for the profession and for the credibility of medical science. This was a pivotal moment that demonstrated, as Harvey had done a century before, the value and importance of scientific innovation in medical practice and professionalism.[12]

Formalizing medical education in the U.S., the rise of academic medicine and impact of the 1910 Flexner Report

The advances of medical education and professionalism witnessed in the U.S. at the end of the colonial era were part of a larger movement in the new nation. In the United Kingdom and in America, doctors sought to create educational and professional institutions like medical schools and medical societies that gave doctors more distinctive and exclusive status.[13] However, at least in the U.S., the influences of the burgeoning democracy would run head first into the inegalitarian desires of the American medical profession.[13]

As Paul Starr described in his seminal work, *The Social Transformation of American Medicine*, the most common construct of life in the first century of the U.S.—largely agrarian and self-reliant by necessity in both rural and urban locations—also lent itself to resistance against authority with much of the public "refusing to grant [the medical profession] any privileges" while "asserting their own rights to judgment in managing sickness." [13] Even with advances like the smallpox inoculation, some medical professionals, and the lay public, questioned whether therapies were effective and whether it was wise to keep the knowledge and trust of treatment in the hands of a few.

Three spheres of practice emerged that divided medical care for most of the 19th century: the medicine of the domestic household, the medicine of the physicians, and the medicine of the layhealers.[13] Domestic medicine was practiced in the home and often by members of the family with no training. It was reliant on traditional remedies and basic practices that were passed down from one generation to the next with simple cures and therapies at their foundation. Formal training or instruction was dependent on texts like William Buchan's *Domestic Medicine,* and John C. Gunn's 1830 book of the same name. Lay medicine was also practiced by people without formal medical training but who possessed knowledge and skills. They included midwives, herbalists, and community-based providers who had practical experience. Domestic and lay medicine, unlike physician medicine, was practiced primarily by women, and Black men and women, and was open and accessible to a much larger proportion of the population.

Meanwhile, physician-based medicine grew, and the institutions that defined it—medical schools and medical societies—sought the means to protect, enhance and codify the professional status of the American medical doctor through the authority of medical degrees, credentials, and licensure. Initially honorific, the first law requiring a license for the practice of medicine was issued by New York City in 1760. Following independence from Great Britain, new states extended to medical societies the authority to grant licensure but it had little impact or real power to guarantee the quality or efficacy of practitioners or the care they rendered. No standards were established for medical school curricula or the duration of training, and because medical societies and medical schools were paid by those seeking either licensure or degree, respectively (with payment withheld by the applicant if they were denied or failed), this system created a perverse incentive that undermined the profession. Also, the rise of medical societies and licensure accelerated, and made permanent, the exclusion of women and all but a relative few minorities from physician medicine for much of the 19th century and well into the 20th century.

As the U.S. continued through the middle decades of the 19th century, an era marked by regional division, the Civil War, and the abolition of slavery resulted in a crisis of credibility in the medical profession that mirrored the tumult that the nation was enduring. The proliferation of medical schools and easy access to degrees, saw the ranks of the American medical profession continue to grow but without standards or unifying institutions. Quackery and fraud was prevalent, which further degraded the reputation of the profession. The founding of the American Medical Association (AMA) in 1847 was a response to the discontent of physicians who saw stagnation in their status and feared further erosion. The AMA sought to raise and standardize requirements for medical degrees, support scientific advancement in the field, codify medical ethics, and improve public health at a time when licensure standards were being repealed due to the perception that they were ineffectual and anti-democratic.[14] The early AMA had little substantive influence until much later in the 19th century and did so only after overcoming the internal strife that had torn apart the profession for most of the preceding century.[13] Rivalry, and the battle for the legitimate ownership of

medical professionalism between the regular allopathic physicians, the growing homeopathic movement, and later osteopathic practitioners, gave way to consolidation of medical societies and ultimately the primacy of the AMA. Concurrently, the reform of medical education, beginning at institutions like Harvard and Johns Hopkins, took form as medical instruction in the U.S. began to reflect what was emerging in Europe where laboratory sciences such as physiology, chemistry, histology, pathology, anatomy, and bacteriology grounded new students in the fundamentals of medical science.

Once it had established its primacy over the American medical profession at the start of the 20th century, the AMA would be instrumental in reforms and changes that would define the next 120 years of graduate medical education. Starting first with the Council of Medical Education in 1904, the AMA established the minimum standards for entry into medical school, and the standard curriculum required during the four years of training. In 1906, the AMA categorized all 160 medical schools in the U.S., assigning each to different classes. Class A schools represented what was considered the best most comprehensive institutions; Class B consisted of schools with challenges, but which were deemed redeemable; and Class C schools were considered beyond salvageable.

The results of this analysis were given to an outside group, the Carnegie Foundation, to conduct a follow-up study, and to provide recommendations. Led by Abraham Flexner, the study and the report he published in 1910 had a profound and lasting effect on medical education. Thanks in part to his report, the number of medical schools decreased from a high of 165 in 1906 to 131 by the end of 1910.[15] While multiple factors including the changing economics of licensure fees, and tuition, and rising direct and indirect costs, led many schools to close, the report is credited with improving the quality and consistency of medical education, and imposing stringent admissions criteria.[16]

Less discussed was the impact of the report and the school closures in making American medicine less socially, racially, and economically diverse than it already was. Of the seven predominantly black medical schools that existed before the Flexner report, only two (Howard and Meharry) remained after the report's publication. Flexner's own views on race, and his belief that African-American physicians were not needed beyond the "sanitary" needs of the community contributed to significant setbacks in the training of Black physicians, and reinforced existing inequalities in the U.S. medical and health care system.[17] Taken together, more stringent admissions requirements, the higher cost of educating medical students, the opportunity cost of residency training combined with deliberate policies that discriminated against Blacks, Jews, immigrants, women, and really any person of lower socioeconomic status ensured that the ranks of American medicine were dominated by white men. It was not until the middle of the 20th century that changes spurred by the Civil Rights movement began to reopen the doors of medicine to people of more diverse backgrounds.

Medical professionalism today and tomorrow: New standards for a changing nation

Over the last 50 years, medical professionalism, which had been defined largely by adherence to, and expertise in medical science; its appropriate application in patient care; and ethical standards and practices established by a homogenous social cohort, evolved to reflect the environment we live and work in today. Two contemporary forces have been key to this change.

Diversification of the clinical workforce

Efforts to increase diversity in medical schools, and the overall health care workforce, gained momentum during the 1960s through to the present day. This change has been gradual and slower than many would hope but it has persisted thanks to policy changes, scholarships and financial support to underrepresented groups, targeted recruitment, and affirmative action programs that have recognized the lingering impact of past discrimination. Title VI of the Civil Rights Act of 1964 specifically impacted the funding of institutions like medical schools, requiring the elimination of discriminatory practices, which created opportunities for minorities. Along with Title VI, affirmative action policies such as Executive Order 11246 in 1965, established requirements that health care institutions including medical schools and hospitals needed to take active steps to increase employment and education opportunities for minorities.[18]

While government has played a key role, medical schools also took organized steps to meet the moment. Since the late 1960s, the Association of American Medical Colleges (AAMC) has emphasized the importance of minority admissions, and has introduced and given support to initiatives and guidelines that promote diversity in medical education.[19] Added to that, the admissions process has

changed to consider a wide range of factors that include academic performance and life experience, leadership qualities, and a commitment to service and serving diverse communities. Permanent offices and programs dedicated to diversity, retention, and mentorship of students and faculty has also moved the profession forward.

Progress has been slow, and after nearly five decades of these efforts, there is still room for significant improvement. In 2018, 5.4 percent of physicians were Black in a population that was 12.8 percent African-American, yet when compared to 1940 when the population was 9.7 percent Black, the proportion of Black doctors was 2.8 percent. When we look at the representation among Black men in medicine there is no change in percentage of the workforce between 1940 (2.7 percent) and 2018 (2.6 percent).[20]

Influence of a diverse workforce on medical ethics and practices

Ethical standards in medicine that bring a variety of viewpoints to each decision create tremendous value to the profession and expand the scope of the definition of professionalism. Diversity enriches ethical discussions and allows for the development of comprehensive guidelines that are respectful of cultures, thereby ensuring standards are inclusive and considerate of the moral convictions of a broader patient and physician base. The growing diversity of the workforce fosters inclusivity that enables the health system to be more responsive to the needs of a more heterogeneous patient population.

Cultural competence is critical to addressing and respecting differing beliefs, values, and needs among patients of different ethnic, cultural, and social backgrounds. Research has shown that more culturally competent care is more effective care with more thoughtful communication leading to better outcomes.[21] With greater diversity has come greater trust between the doctor and the patient, particularly in minority communities where the provider and patient share a cultural connection. Patients are often more comfortable and open to discussing their medical issues with providers who share a similar cultural perspective or racial background. With greater trust, there is consequently greater engagement which facilitates more accurate health and social histories, greater adherence to therapies, both of which are essential for high quality care.[22] Addressing disparities and broadening the scope of research is also made possible thanks to a more expansive profession. Researchers with diverse backgrounds are more likely to bring a broader array of perspectives, particularly when studies are focused and relevant to underserved and minority populations. A broader focus leads to innovation and discoveries that benefit a wider segment of the population and increase the potential for improved, more equitable population-level health outcomes.[23]

Medical professionalism defined

The twin impacts of diversity, and the influence of that diversity on medical ethics and practice, has given rise to an updated definition of medical professionalism that has echoes of the past, but recognizes the realities of today. Medical professionalism is now seen through a broader, more nuanced lens that has at its core, four key tenets of patient centered care, ethical practice, social responsibility, and cultural competency.

Patient-centered care

A patient centric approach to care prioritizes the health and well-being of patients, and respects their dignity while also caring for their needs. Conceptually, it borrows from principles first articulated by Hippocrates as it fosters respect for autonomy, beneficence, and non-maleficence, while building trust. This is no small task given the fiscal and financial stakes: health care is a trillion dollar business with federal and state programs that constitute more than half of all expenditures. Programs, organizations, and regulations in the U.S. and around the world demonstrate a commitment to the concept and ideals of patient-centric care.

The Patient Centered Medical Home (PCMH) has its origins in the 1960s as a central location for archiving a child's medical history and records particularly if that child had chronic conditions like asthma or sickle cell anemia. With time, the concept evolved to emphasize a more comprehensive, coordinated, and accessible approach to primary care that is focused on an individual patient's needs. A moment of significant progress in shaping the PCMH model was brought forth in 2007, when major primary care organizations in the U.S. collectively endorsed the "Joint Principles of the Patient-Centered Medical Home."[24] Further institutional support and formalization of the PCMH model came with the inclusion of specific provisions in the Affordable Care Act of 2010, which promoted the expansion of this model across the U.S. health care system. These provisions aimed to improve care coordination, enhance patient engagement, and increase the overall efficiency of health care delivery.

Both within the U.S. and internationally, Planetree International, a nonprofit organization, has focused on advancing patient centered care by instituting a certification program recognizng health care organizations that excel in delivering care, which respects the preferences and values of patients. The certification process is rigorous and evaluates several factors including the extent to which organizations, physicians and clinicians in an organization empower patients, involve families in care, and create a healing environment conducive to well-being and health.[25]

Ethical practice

Adherence to ethical principles as a core component of medical professionalism, especially to confidentiality and informed consent, is of particular importance and relevance in the modern information age. Data flows freely and rapidly between physicians and other caregivers/stakeholders in the health care ecosystem. The advent of the electronic health record (EHR), telemedicine, and the use of big data in health care has shown the promise of new information systems and the costs that imperil the ability of doctors to stay true to this principle. EHRs improve efficiency of patient care and data accessibility, but they also increase the risk of data breaches. Organizational intentionality through the implementation of robust cybersecurity measures and strict access controls are essential for safeguarding information. Federal law such as the Health Insurance Portability and Accountability Act (HIPAA) enshrined the sanctity of the security of health records.

The rise of telemedicine, especially highlighted during the COVID-19 pandemic, has necessitated adaptations in how informed consent is obtained. Telemedicine, and care delivered outside of channels beyond the traditional face-to-face experience (e.g., eConsults), presents unique challenges for informed consent, including ensuring that patients fully understand the procedures, costs, and implications through a virtual medium. The AMA has published guidelines to help in making sure informed consent in telemedicine complies with the same standards as in-person encounters.

Informed consent for the use of patient data is also of concern, and an area where doctors must earn trust and not assume that it will be given. With the rise of artificial intelligence and the deployment of large language and large vision models to support innovation, the data of individuals—lab results, genomic and proteomic analyses, imaging results, physician notes, and diagnosis codes—will contribute to better understanding of disease, but further jeopardizes privacy and confidentiality.

Professionalism requires advocacy and support for robust data governance[26] with the implementation of strong policies and technologies to protect data privacy and security; dynamic consent models[27] that are flexible and informative and allow patients to understand and control how their data is used; and ongoing monitoring and evaluation by regularly assessing AI tools for accuracy, fairness, and clinical relevance[28] to prevent harm and ensure beneficial outcomes.

Social responsibility

Doctors must recognize the unique role they play as curators of knowledge, partners in providing care, and holders of a privileged social position to speak on behalf of disadvantaged individuals and communities. Historically, social responsibility in medicine referred to the conduct of the doctor in the public sphere, their engagement in civic society, and their support of the health of the community. Too often, we fall back on old tropes and definitions that obscure a bigger meaning and a more important necessity for professionalism. A recent article in the *New York Times* discussed the "unbearable vagueness of medical professionalism" and how medical students and residents are assessed for professionalism (and unprofessionalism) based on social media activities, facial hair or hair length, attire (both within training settings and during leisure time), and even for holding strongly held convictions on issues of the day such as with the Black Lives Matter movement and the debate over reproductive rights.[29] While the traditional views of decorum and public behavior still hold value, the definition of social responsibility has broadened and deepened, particularly with respect to how it relates to health equity and systemic issues.[30]

Modern medical professionalism emphasizes and requires a broader societal role for physicians that includes advocacy for health equity in order to reduce disparities; taking a global perspective on health and responding to crises like the COVID-19 pandemic; gun violence; and the opioid epidemic with facts and appropriate explanations for sometimes complex or arcane information. It also includes advocating for, and understanding, the impact of human activity on the climate and environment, and recognizing the link between environmental health and public health.

Social responsibility now mandates we consider the ethical use of technologies that ensure improvement in

health outcomes, does not exacerbate disparities, and does not cause new unanticipated problems.

Cultural competency

Understanding and respecting the cultural differences in patient populations, and within the profession, is crucial for communication and patient care to be successful and effective. Effective communication enables and overcomes hinderances to diagnosis, treatment, and patient satisfaction. However, it starts with an understanding of the patient's background and meeting the patient where they are. Tangible examples of this are found in interpreter services that ensure non-English speaking patients receive information in their preferred language by a clinical professional using an accurate translation, and programs like the Cross-Cultural Health Care Program that offers training and resources to health care professionals to improve competency skills by learning about the intricate interplay between cultural differences, medical practices, and traditional beliefs.[31,32]

Where do we go from here?

Understanding the historical context of medical professionalism is essential to navigating the current landscape. Our oaths are a commitment to a calling—our community of fellow physicians, and continuity with a heritage and a legacy that we should not ignore. We wrestle with maintaining fidelity to our values as the pressure of the business of health care leaves more physicians despairing for the future. Connecting to the past, however incomplete and imperfect, gives us perspective and allows us to understand that adaptation is nothing to fear. It allows us to adopt a framework for professionalism that stays true to what our aspirations for the profession will be.

The changes we will see over the next several decades will challenge us and be no less relentless than the times that proceed them.

References

1. StageClip. What is a White Coat Ceremony? https://stageclip.com/what-is-a-white-coat-ceremony/#:~:text=The%20origins%20of%20the%20WCC,Gold%20Foundation%20in%201993.
2. The New York Times. Dr. Arnold Gold, 92, Dies; Made Compassionate Care a Cause. February 2, 2018. https://www.nytimes.com/2018/02/02/obituaries/dr-arnold-gold-92-dies-made-compassionate-care-a-cause.html.
3. Miles SH. The Hippocratic Oath and the Ethics of Medicine. Oxford (UK): Oxford University Press; 2004.
4. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. New York: McGraw-Hill Education; 2005.
5. Edelstein L. The Hippocratic Oath: Text, Translation, and Interpretation. Baltimore (MD): Johns Hopkins Press; 1943.
6. Nutton V. Galen. Encyclopedia Britannica, 6 Mar 2024. https://www.britannica.com/biography/Galen.
7. Van Schaik KD. Galen and Health: Inspiration, Caution, and Some Useful Advice. Princeton (NJ): Princeton University Press, 2024.
8. Siraisi NG. Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice. Chicago (IL): University of Chicago Press; 1990.
9. Getz FM. (Medicine in the English Middle Ages. Princeton (NJ): Princeton University Press; 1998.
10. Byrne JP. The Black Death. Westport (CT): Greenwood Publishing Group; 2004.
11. Cartwright M. William Harvey's Discovery of Blood Circulation. World History Encyclopedia. www.worldhistory.org/article/2268/william-harveys-discovery-of-blood-circulation/. BBVA OpenMind. Jenner and the Discovery of Vaccination. Retrieved from https://www.bbvaopenmind.com/en/science/leading-figures/jenner-and-the-discovery-of-vaccination/.
12. Starr P. The Social Transformation of American Medicine. Basic Books, 1982, p. 30.
13. American Medical Association. Founding of the AMA. https://www.ama-assn.org/about/ama-history/ama-history#:~:text=Founding%20of%20the%20AMA,-An%20 1845%20resolution&text=Nathan%20S,the%20goals%20 of%20the percent20AMA. Accessed 7 March 2024.
14. Savitt TL. (2006). Abraham Flexner and the Black Medical Schools. J Nat Med Assn. 2006; 98(9): 1415.
15. Duffy TP. The Flexner Report—100 Years Later. Yale J Biology and Med. 2011; 84(3): 269–76.
16. Byrd WM, Clayton LA. Race, Medicine, and Health Care in the United States: A Historical Survey. J Nat Med Assn. 1992; 84(3): 273.

17. U.S. Department of Labor, Office of Federal Contract Compliance Programs (OFCCP) - Executive Order 11246. https://www.dol.gov/agencies/ofccp/executive-order-11246.
Association of American Medical Colleges. Diversity in Medical Education: Facts & Figures; 2019. https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019.
18. Howard J. Black Doctors Shortage in the US. CNN, Cable News Network, 21 Feb. 2023, www.cnn.com/2023/02/21/health/black-doctors-shortage-us/index.html.
19. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong,O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003 Jul-Aug; 118(4):293-302.
20. LaVeist TA, Nuru-Jeter A, Jones KE. The association of doctor-patient race concordance with health services utilization. J Public Health Policy. 2003; 24(3-4): 312-23.
21. Oh SS, Patel H, Veedu S. (2015). Diversity in Clinical and Biomedical Research: A Promise Yet to Be Fulfilled." PLoS Medicine. December 15, 2015. https://doi-org./10-1371/journal.pubmed.1001918.
22. Primary Care Collaborative. History. https://thepcc.org/content/history-0.
23. Planetree. Our Story. https://www.planetree.org/our-story.
24. Kish LJ, Topol EJ. Inpatients—why patients should own their medical data. Nature Biotechnology, 2015; 33(9): 921–4.
25. Steinsbekk KS, Myskja BK, Solberg B. Broad consent versus dynamic consent in biobank research: Is passive participation an ethical problem? European Journal of Human Genetics, 2013; 21(9): 897–902.
26. Char DS, Shah NH, Magnus D. Implementing machine learning in health care — addressing ethical challenges. NEJM. 2018; 378(11): 981–3.
27. The Unbearable Vagueness of Medical 'Professionalism. The New York Times. 19 Mar. 2024. https://www.nytimes.com/2024/03/19/health/medical-students-professionalism.html.
28. Kirk LM. Professionalism in medicine: definitions and considerations for teaching. Proceedings (Baylor University. Medical Center) .2007; 20(1): 13-6.
29. The Cross Cultural Health Care Program. History. https://xculture.org/about/#history.
30. Betancourt JR, et al. Cultural competence and health care disparities: key perspectives and trends. Health Affairs (Project Hope). 2005; 24(2): 499-505.

The author's E-mail address is laolu@sage.health.