THE VALUES OF THE PHYSICIAN

Fundación Educación Médica

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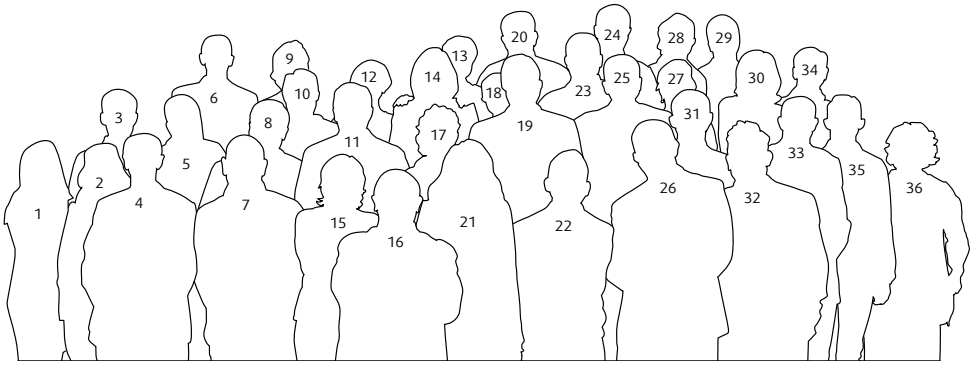
Participants in the Meeting on Values of doctors, held in September 2017 at the School of Public Health of Menorca. The foundations of this monograph were inspired by the discussions of this Meeting.



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We tend to have an idealised image of doctors but, if we are honest, we have to say that it does not strictly conform to reality. This image of the doctor is closer to a model that both patients and citizens request than to reality. Medical practice has improved in all its aspects except in the most human part – care. What's more, not only have we not improved, but we have actually got worse. Up until quite recently, in the middle of the last century, it was impossible to reach the diagnoses, the prognoses or the therapeutics we have today. Yet, perhaps because we did not have the knowledge or the means at our disposal today, doctors paid more attention to the attitudes that were undoubtedly expected by yesterday's patient and are still expected of them by patients today.

We have moved so far away from those attitudes that it is not difficult to imagine ourselves hearing a young doctor ask what we mean by attitudes. Remembering that personal relationships are important in any situation involving two people is as obvious as the fact that they are essential in the doctor-patient relationship. We are not talking about any mysterious concepts, but instead we are referring to kindness, to communicating well, to being honest and reliable, to being a model and, above all, to keeping in mind the 'care' of the patient. These inconspicuous attitudes, which are hard to measure and even more difficult to teach, were and continue to be an inseparable part of medical practice. And what are attitudes built upon? Without a doubt, there is only one answer to that : upon values.

Maybe it's not very correct to criticise scientific medicine and, of course, I won't. However, everything has its strengths and weaknesses, and scientific medicine has left to one side, neglected even, the care of the patient. We repeat in conferences and forums, we read in the specialised press and in citizen surveys that the national health system is optimal, that it is unbeatable and that we must do all we can to preserve it. And I am not going to be the one to contradict such appraisals either. But let us not forget that it is possible to tell the truth while concealing reality. Waiting lists, the ordeal of a patient who goes into hospital, the few or even no explanations that some patients are given, the unnecessary medicalisation, the compartmentalisation of a patient's illnesses – are they not aspects of this fabulous healthcare system with room for improvement?

A kind word, a caring action, a smile, a handshake, person-to-person contact may all seem trivial, but they always have an emotional impact on the patient. Reducing fear or anxiety, achieving a closer doctor-patient relationship may not in themselves be curative actions but, without a doubt, they do help in the patient's recovery.

We live in a strictly administered and specially managed social and political environment, and the health system and its professionals are no exception. Today, in public, but also in private, health care, doctors are harassed by various tyrannies of which the care guidelines and protocols, as well as the institutional goals that must be met, are a good example. Although both aspects have a sensible and positive raison d'être, we should not ignore the sometimes abrasive collateral effects that they have generated. Demoralisation and the loss of interest in training for excellence have led to a drop in the intellectual level of professionals. The objectives of the institution affect, whether we like it or not, the relationship with the patient and it must be acknowledged that this involvement is in many cases positive, but we should also admit that this is not always the case. It is not out of place to remark on the unease felt by professionals concerned about patient care when they consider how the organisation gives priority to numbers, performance and the achievement of goals over patient care and safety. It is in these moments when training in values becomes even more necessary for our professionals. When values are assumed and incorporated into the genome, we will be closer to adequately allocating the always limited resources, and we will be closer to the desired balance between caring and healing.

But whose hands should the empowerment of professionals be in? Who should lead the way so that the old values – there are no new ones – emerge again? Who should talk about excellence, integrity, diversity, individual opportunity, teamwork or tradition? Who should put medical professionalism on the agenda? The answer is easy : the professional world is responsible for all of this.

The monograph *The Values of the Physician* was placed on my desk with the request to write the prologue to it. At a time when the profession is wiser than ever in knowledge (its *philotechníē*) and weaker and harassed in its humanism

(its *philanthrōpíē*), it seems to me especially appropriate to talk about values. It is therefore feel it is an honour to further and help disseminate this initiative by the Fundación Educación Médica which will help all those concerned to reflect.

The monograph proposes 16 values that are undoubtedly timely and appropriate. There could be more, or they could have focused their attention on others, but that is irrelevant. Each of the values dealt with is of interest in itself and the reflections that the different authors, all recognised experts, put forward are of special interest to all the stakeholders involved, whether they are professionals in the health sciences, health institutions or those responsible for health administrations. All of us, professionals, organisations and institutions, have things to learn from the reflections described in the different values included in this monograph. For my part, I wish and hope for more. I would like all the stakeholders not only to read and learn from this monograph, *The Values of the Physician*, but to act accordingly and encourage the re-emergence of professionalism for the benefit of patients and citizens.

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INTRODUCTION

Why talk about a Physician's values?

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INTRODUCTION

Why talk about a Physician's values?

Why the assumptions should not be assumed

From the time they begin their medical studies physicians have a vocation and a culture of service, which lasts a lifetime. Medicine is a profession that starts with an oath imbued with values and Hippocrates is still essentially valid today. Therefore, it could seem strange that a collective such as the medical profession would have to respond to the question we are posing. However, we cannot take our assumptions as a given. We cannot assume that it is so clear that physicians have values and what these values are. Furthermore, although the Hippocratic Oath has a long historical context, beyond the principle of beneficence and non-maleficence there is little or no allusion to justice and respect for patient autonomy. It is a bilateral vision from the 5th century B.C., with physician and patient in an asymmetric and paternalistic relationship.

Much has happened in the intervening period. Today, physicians have to earn their authority, which many patients do not accept *a priori*. The physician's authority is cast into doubt even to the extent of their knowledge in the field. Patients arrive at a consultation armed with information, which at the very least has been obtained via an internet *click*. Even so, the physician has to work to establish a therapeutic alliance ; the patient visits a physician out of necessity and wants to trust. Every patient is a whole 'new world' that must be explored.

In times past, nature was viewed as an equilibrium of which one formed a part. The physician considered him/herself as a companion to the course of nature using natural processes to heal with the help of a little science. For this process, it was essential for the physician to be at the patients' side, showing understanding and accompanying them. It was a more holistic form of medicine, with the patient considered as part of nature and the illness considered as a dysfunction, a loss of equilibrium in a natural history. It was accepted that death always eventually prevailed and pain was assumed as a natural part of life.

Nowadays, the expectations with respect to medicine are probably exaggerated. At times, today's medicine is excessively technical in a

society that wants to be pain-free and has left individuals without intimate resistance. It is a medicine that has a clearly defined scientific and evidence-based component, causes and effects are known, diagnoses and clinical treatment are understood. However, the arts of caring and of conversation are still necessary. Of course, it is necessary to understand, diagnose and treat but there is also a need to embrace and to understand, from the point of view of ignorance and the enigma that individuals and their particular circumstances represent.

With so much fear and possibility, the centre of gravity is displaced, from caring to curing, from the person to the technique, from the integral to the biological, and from modesty to arrogance

For this reason, it is not surprising that in the 1980s, a psychiatrist would have to rediscover the integral aspect of people by proposing the biopsychosocial model. It also comes as no surprise that a mode of healthcare centred on individuals arose as a result. With so much fear and possibility, the centre of gravity is displaced, from caring to curing, from the person to the technique, from the integral to the biological, and from modesty to arrogance.

The biopsychosocial model championed by Engel manifests itself in the demand for a medicine focused on the patient, calling for openness and humility on the part of the physician. The attention given is for another and by another. This attention involves more than just passing through the consulting room, making a diagnosis and finding a treatment. A patient is the individual and his/her circumstances ; neither the time spent with the patient nor the medical history written by several professionals converts the relationship into an intimate one, which requires time that is not available. Maybe the family and community physician can achieve greater knowledge of their patients' lives.

Medicine is in an era of increased media attention and social networks (where patients publically evaluate the quality and personality of a physician) ; shared histories and teamwork have made the practice of medicine a more complex issue compared to only fifteen years ago. The healthcare relationship has changed, as has the environment. All this must also take into consideration conditioning organisational factors. For example, confidentiality is no longer confined to the physician's memory and the private act of the consultation, the medical history is shared, there are more professionals, including non-physicians, intervening in the process, and patients now want to participate in the decision-making process.

Nonetheless, to be a good physician requires more than the simple mastery of techniques

Nonetheless, to be a good physician requires more than the simple mastery of techniques. Sometimes there is the belief that it is a question of resources, of more time available to dedicate oneself. On many occasions this is indeed the case, and serves to resolve many conflicts with the patient. However, in other cases, difficulties arise when one loses sight of, for example, the fact that fairness also has a component of

acknowledgement (or recognition) in addition to the efficient, effective and equitable distribution of resources according to the patient's needs. This recognition is not merely clinical and biological but is also reflected in the way the patient is treated, as a unique individual that has found him/herself in the vulnerable position of needing someone to trust due to health problems.

There is no need to be defeatist or to seek refuge in pathological nostalgia. Medicine reflects the society in which it is practised. It is about recovering what has been misplaced : to discover the values of those things being lost. The rights and responsibilities of all those involved must be updated, because the need for trust in physicians is fundamental. A physician's training at a human and technical level is essential for this.

Physicians will always be needed to take care of us. From the moment physicians introduce themselves, they know that something good is expected from them. Including when bad news is being delivered, they should generate the feeling that the patient is not alone, because the arrival of the physician will at least palliate and relieve the suffering. The values by which physicians want to be characterised, the *ethos* of the physician, always includes critical thinking, technical preparation and the sense of belonging to an ancestral tradition in which the credibility of each generation of physicians has to be earned. Taking care of people is not only a question of cultural welfare, but also a question of sustainability. In contemporary, plural and progressive societies, the rapid acquisition of knowledge should bring with it an awareness of a duty to respect patient autonomy. Establishing the values of physicians is a key task to maintain trust in tradition, given the highly sophisticated and technical environment of today's medicine, which requires the careful management of finite resources.

Establishing the values of physicians is a key task to maintain trust in tradition

Medicine is a high-risk profession : work takes place in highly vulnerable environments, in ever-changing societies, with a diverse population of patients that share a common need for comfort through the words and actions of the physician. All this has to occur in a hurry. For this reason, physicians must know how to ask for permission and excuse themselves when arriving and leaving, to do or not do, and to correct. It is so important to be aware of all this and not succumb to the mechanical and bureaucratic inertias of doing, being made to do, at times without thinking or feeling empathy for the patient who is suffering, taking too many things for granted. For these reasons we should not assume that our assumptions are shared.

Because values are embodied in people and transmitted through practices

We will always need physicians to care of us. From the moment someone introduces themselves as a physician, they know that something good is expected from them. Including when delivering bad news, they should emanate calm and make the patient feel comforted because the physician has arrived and will at

least palliate and alleviate the suffering. Care begins with the way of behaving, which is always an important element.

Values play and are played out in exemplariness

Values are not merely ideals to attend to or a platonic question : values are incarnate and institutionalised. If they do not take form, they evaporate in a gaseous and liquid society, with its rituals, letters and well-intentioned codes. Values play and are played out in exemplariness. The decency of a profession involves every one of its members. The Hippocratic Oath is a ritual that reminds physicians what is expected of them. However, this oath from the 5th century B.C. does not tell the physician the best way to act in each case. Ranking, prioritising, deliberating and adapting demands more than a code of conduct. To adapt to a case, to centre and concentrate on the patient, prudential discretion should be incentivised and arbitrariness avoided. This is practical wisdom.

Values serve as guiding lights to illuminate a route ; they are like compasses which orientate the physician, those who come to them and those with whom they work. They adjust to what can be expected of them. Values have to be explicit, they have to be taught to fit to a particular case and they have to be updated to the appropriate hierarchy. They are also learnt by observing them in other people and practising them. One thing is to be aware of them and another to know what to do with them.

Physicians have always known the importance of counting on the trust of their patients. For this reason, it is difficult to understand the proliferation in Western societies of *para/pseudo*-medicine, alternative therapies and the incidences of physical or verbal assaults on the physician by the patient. Today, an integral focus on patient autonomy demands that the physician works to establish a therapeutic alliance. This depends in the first instance on the physician ; empathy, courtesy, prudence, discretion, etc. are values that are acquired through habit, in ways of behaving. For this reason, the ancient Greeks spoke of virtues.

Today, an integral focus on patient autonomy demands that the physician works to establish a therapeutic alliance

In the tradition of moral philosophy, virtues were the main preoccupation rather than values. The term ‘value’, understood as a characteristic that was positive, desirable and appreciated, is relatively new. In moral philosophy the term ‘virtue’ is progressively being substituted by the term ‘value’. However, this was not the case in medicine and the virtues of the physician were frequently spoken of. In liberal anthropology, however, virtue was converted into abilities and technical skills.

The understanding of the medical profession with an excess of individualism and hierarchy, with respect to the other professions that intervene and collaborate in the healthcare and social systems, has to be resisted. The model of the liberal autonomous physician, with a private practice, is difficult to sustain in the current managed models of medical practice. Technification and the liberalisation of contracts have dehumanised medicine and have taken for granted that two individuals, the physician

and the patient, find themselves in a situation where one of the them (the patient) requires the knowledge of the other (the physician) and an understanding of their position of vulnerability. They are not two self-sufficient autonomies. Patient autonomy also has a relational basis : the physician must understand the patient and his/her family, in addition to the other physicians with whom they work as a team, without questioning their daily work.

Physicians must be there to help ; they must listen and try to understand the patient's circumstances. If they are not helpful, if they do not possess values, the entire healthcare system suffers over such a fundamental question. The physician is a moral reference point whether they like it or not and for this reason it is vital that they are able to count upon points of reference to emulate. A bad physician is not bad only because he/she lacks technical skills, but also due to personal failings. One has to take care with everything : techniques and treatments, behaviour, looks, words and relationships. To practise values is an exercise in development and self-awareness that a physician must facilitate. Values have to be incarnate, and to practise them they have to be imbued in the working environment.

Values have to be incarnate, and to practise them they have to be imbued in the working environment.

Professional deontology is not sufficient due to the size and speed of change and the wide variation in patient types. Developing a capacity for empathy and deliberation depends on the will of physicians, on their awareness of belonging to the profession, on how their work fits into the organisation for which they give their service, and on the society where all this occurs.

Emphasis must be given to the development of values in physicians during university education, in professional societies and in the organisations in which they practise. There are no physicians without patients, or patients or physicians without the structures which allow them to find each other. Physicians do not work alone and require many structures to facilitate their work (including other professions, information technology teams and technicians). The physician above all is there to be a physician. For this reason it is important to emphasise that values, in a virtuous closed circle, not only belong to physicians but also to the institutions which accompany them.

Because a whole culture is required

A culture of support is required to accompany the student during the process of becoming a physician and to ensure that they are not corrupted during their development

In medical faculties, we have introduced the subjects of bioethics, deontology and law. Goodwill is not enough, not even with the vocation of the physicians to teach these subjects. A culture of support is required to accompany the student during the process of becoming a physician and to ensure that they are

not corrupted during their development. These assumptions can be jeopardised by a healthcare culture that is so demanding and managed. For this reason, it was important to talk about them explicitly. When we speak of values, we believe that it is a personal trait, of the personal ethics of the physician. Without doubt this is true, but it also depends on an anchoring in the tradition and culture of the organisation. Nor does it simply represent common sense ; it does not stop being a culture feeling that is forged in a community that transmits reflexive and deliberative capacity.

As the formation of a physician's character is a training in virtues, which depends on the culture of the community, it is crucial how this community receives and accompanies physicians during their training. The accompaniment that the student receives in the faculty, the tutorials they receive there and the practical training, as well as the involvement of the student all the way along the process are critical. This depends on many factors : the mission of the faculties (to train good physicians) ; the motivation and self-confidence of the physician (knowing they are well prepared and eager to learn) and the patients of these physicians (efficiency of their work) ; and society in general (health). The time spent in the faculty, during the residency period and later in professional practice are auspicious periods to acquire the values of a physician. The awareness of belonging to a community and the pride that comes with caring for the tradition are also acquired. There is no doubt that it is a source of great pride to belong to the medical profession.

Becoming a physician and exercising the practice of medicine is extremely demanding intellectually. It requires successful completion of cognitive and aptitude tests, while also requiring passion, care and responsibility. To know one's place, to expose oneself to someone baring their vulnerability and putting oneself at their service, being generous : this can only be generated through generosity.

Physicians cannot give what they are unable to give, and this depends upon the accompaniment and support that has been received, the points of reference they have had and the treatment and welcome they have received. The danger of forgetting the means, the reasons for being part of the profession, lies within the creation of highly-specialised teams without a guide : a group of professionals who are experts in techniques but with no soul or enthusiasm. Mechanisms and bureaucracy do not provide care.

Physicians should live up to the trust and responsibility that society deposits in them. It is related to an ethical commitment to the profession and the tradition that it represents, not simply an option. The Hippocratic Oath reminds the physician of a duty impregnated with vocation and affection. For this reason, the physician needs to be educated in emotional intelligence and the development of an affable and cordial character, which is as important as the rational and technical components of the curriculum. Physicians that have forged their character and behaviour in this way will be effective in the integral accompaniment of their patient and their team members.

A physician cannot function without relating to others, without a circle of trust. Deliberation and ethical reflection are as important as supervision and clinical sessions. It is important that a physician should have the space available to be able to reflect, deliberate and ponder the best decision in complex cases involving

patients, colleagues, medical visitors, etc. This will strengthen the awareness of belonging to a community and feeds back into a motivation to provide the best possible standard of care.

A physician cannot function without relating to others, without a circle of trust

The community and the culture which sow these sociological and psychological conditions are fundamental for the training of physicians. To be a good physician is also the responsibility of the faculty and the healthcare institutions that provide specialist training and provide the capacity to communicate to society that they have been integrally trained ; it is also the responsibility of the organisation that employs the physician to ensure that no harm is done to those receiving care and that during professional practice the fundamental essentials of the profession are not eroded. We must educate and have integral and helpful physicians, not relying on just their brains or their mere vocations. We should not leave this so important aspect, as values, to idiosyncrasies or personal motivations.

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PHYSICIAN VALUES AS A PERSON

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— 1 —

Respect for the autonomy and dignity of the patient/person

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Respect for the autonomy and dignity of the patient/person

Defining and delimiting the 'value' and the area of development

Respect for the dignity of the patient must be considered the foundation and the basic pillar supporting the rest of the values of the medical profession. Despite the inherent difficulty of defining the concept of 'dignity', due to its many dimensions, as a starting point we could consider it as the inherent value of a person as a rational being, endowed with the freedom to create and transform which permits them to change their life with freely taken decisions. It is an intrinsic quality for the simple fact of being a person and at the same time an ethical construct that must be endowed with meaning firstly by the person him/herself and later by society and the environment in which they develop. Other fundamental values such as personal freedom, on which the concept of autonomy is based, or the concept of 'quality of life' as a subjective perception of the individual, are derived from the concept of 'dignity'. In society, we tend to establish objective parameters, which allow us to objectify quality of life, but we should not lose sight of the fact that, above all, it is the individual who must evaluate what this means for them. This is particularly important in the context of illness or vulnerability due to health or social problems.

The concept of 'quality of life' as a subjective perception of the individual, are derived from the concept of 'dignity'

It is the task of the physician to investigate the subjective and individualised perceptions of 'dignity' and 'quality of life'. In any given situation/context one person could perceive their personal circumstances as fully dignified, while another person in the same situation, with a different level of pain tolerance or required support, etc., would not.

Medicine has traditionally assumed the power to define and identify 'quality of life' using objective parameters ; establishing scales for pain, disability and competence as well as identifying tasks in daily life, which can be used for the purpose of labelling levels of dependency. However, in the majority of cases, the individual's subjective perception of 'quality of life' or 'the dignity of their personal circumstances' is not taken into consideration.

Using the same logic, the patient-physician relationship has been based on a 'benign paternalism' in which the physician, together with other healthcare professionals, takes control of the treatment process, deciding for the patient and administering the most beneficial care and treatment based on professional criteria. Furthermore, in this asymmetrical relationship, the patient unquestioningly deposits all his/her trust in the physician, fulfilling the condition of 'infirmus' (lack of physical and psychological firmness). This justifies medical intervention that does not inform the patient or count on his/her opinion.

Since the second half of the 20th century, how patients' rights have been formulated

In the last few decades, a paradigm shift in the clinical relationship has become evident, which has occurred hand in hand with the development of bioethics and the recognition of individual rights in distinct areas of life (e.g. civil, social, political and labour rights). Health and disease have not been exempted from these changes and we have seen, since the second half of the 20th century, how patients' rights have been formulated. This process started with the universal reference documents that arose within the context of clinical investigation : the non-binding 1964 Declaration of Helsinki and the 1978 Belmont Report, followed by the Bills of Patients' Rights (the first in Spain was published in Catalonia in 1983). Later, the principles outlined in these documents were enshrined in various national laws. Likewise, these universal documents have been incorporated in the updated versions of the deontological codes of the different healthcare professions.

Thus, personal autonomy, as the expression of the principle of respect for the individual, gradually gained importance. A point of inflection occurred with the explicit recognition in positive law of the patient's right to information and informed consent in medical treatment (*Ley General de Sanidad* 14/1986). Even so, the overall dynamic among healthcare professionals and institutions is one of adaptation to this requirement as a legal imperative rather than as an ethical duty. Much importance has been given to obtaining informed consent as a formal obligation that must be recorded in the medical history. Physicians and the institutions in which they work consider it essential to be able to prove documentarily, with the patient's signature, that informed consent has been obtained. This is considered, on the one hand, as a measure of quality of care that must have a high percentage of compliance and, on the other, as an instrument for the legal protection of the physician, accrediting their good practice. However, if respect for patient autonomy is to be

really integrated in the profession as an ethical duty rather than a legal one, it has to go beyond the patient information sheet and the signing of an informed consent.

Respect for patient autonomy it has to go beyond the patient information sheet and the signing of an informed consent

Etymologically, autonomy means giving oneself norms and behavioural guidelines – 'auto nomos'. This capacity is reached as moral and intellectual maturity develops. Part of this development is determined by the age and evolution of the subject. Theories of evolutionary psychology have extensively analysed such factors. In general, autonomy is reached at a certain age, which varies according to the individual. The personal biography and individual life experience are also essential elements in the development of autonomy. The 'life-story' of an individual configures the values by which they live their life and, without doubt, forms the basis upon which every individual constructs their own autonomy. This autonomy, which begins with the freedom to choose what is considered to be best for oneself, is not free of conditions. For instance, there is the vulnerability of someone suffering from an illness or requiring assistance for health reasons – even in a preventive context – and the lack of the essential element required to truly exercise autonomy : information. Without information there cannot be a conscious acceptance or rejection of something (be it a therapeutic or a diagnostic proposal) that affects something as intimate as one's own body or physical integrity. Therefore, the unavoidable initial duty of the physician is to facilitate the exercise of autonomy by providing the patient with information. This information should be appropriate for the interlocutor, comprehensible and truthful without generating false expectations. This attribute is not guaranteed by a document such as an informed consent form, in which there is no interlocutor to interject and nobody to consult with regard to doubts, fears of the unknown and the associated risks. The true role of the physician is to accompany the patient in the exercise of his/her autonomy, without usurping the role of the patient as a decision-maker. For this reason, in the context of actual medical practice we speak of 'shared decisions' or, better still, 'accompanied decisions', given that the decision must be the patient's but with professional accompaniment if needed.

For this reason, in the context of actual medical practice we speak of 'shared decisions' or, better still, 'accompanied decisions'

This change in paradigm is still not a generalised reality in our model of clinical relationships, despite decades of work towards this goal in the field of bioethics. The inertia of generations of physicians raised under the paternalistic model carries excessive weight and it is necessary to continue the work in academia and university education to give such bioethical issues the weight they deserve.

Relationships with other similar values/principles

The value of respect for the individual, essentially their dignity, connects each and every value of the profession addressed in the present monograph if we focus on the profession as a service to the individuals we care for. But, more specifically, in the area of respect for individual autonomy, we can clearly make a link with the values of communication and confidentiality.

The importance of informing and communicating well with the patient, providing him/her with the indispensible elements required to make an informed decision, was described previously. The exercise of personal autonomy in health-based decisions requires good information to bridge the asymmetry that exists between physician and patient. In the task of informing the patient, correct communication with empathy and a commitment to 'accompany' the patient throughout the process is essential. Although some professionals already have the natural gifts required to communicate well, this is not always the case. Nevertheless, it should be remembered that good communication skills can also be learnt and it is a physician's duty to undergo training in this area. At the moment, the training provided by the university system during the medical degree, which is dedicated to a brief consideration of the clinical interview and little else, is insufficient. This issue should be given more importance because, among other things, an elevated proportion of claims and complaints in our health centres are due to the perception by patients and/or their family members of 'medical malpractice', which is often caused by an inadequate process of informing and communicating. The patient's dignity and autonomy are not respected without an adequate process of informing and communicating with the patient.

The patient's dignity and autonomy are not respected without an adequate process of informing and communicating with the patient

The physician's duty regarding confidentiality and maintaining medical professional secrecy with respect to the information they have available about their patients is another basic element which must be preserved if respect for the individual and his/her dignity is to be observed. Respecting confidentiality and the duty to maintain professional secrecy are foundations of the medical profession, as explained in the Hippocratic Oath and repeated in all deontological codes, not only for physicians but for all other healthcare professionals. A physician, no matter how good a professional they may be in their chosen speciality, is not a good physician if they do not have a clear idea of their duty to maintain confidentiality with their patients, do not give importance to the need to treat such information with care, do not take care to only make use of such information for the performance of healthcare-related tasks and do not exercise caution when sharing information with other professionals. In such cases, the result would be a breach of trust, thus compromising a key element of the physician-patient relationship.

The clinical relationship is based on the trust (*confides*) the patient deposits in the physician. The patient believes all the information he/she shares with the physician will be protected and not used at anyone's expense. Presently, it is evident that we work in teams with agile information-sharing (shared electronic medical histories, e-health applications, telemedicine, etc.) but this does not mean that the restrictions on the use of confidential information (not sharing confidential information with anyone not directly involved in the process, encryption to protect patient identity whenever possible, etc.) are any less clear or relevant. Good physicians, respecting the dignity and autonomy of their patients, must also be very aware of their duty of confidentiality.

The importance of the person/professional/society

For physicians, respect for the dignity and autonomy of the person they are attending, in addition to a legal requirement, is one of the first ethical and deontological demands. The healthcare system and our physicians, as the principal actors, are held in high esteem by society. Aspects related to the way patients are treated, the communication of information and consideration for the opinion of the patient are considered highly important, as demonstrated by surveys evaluating satisfaction that have been undertaken (for example, in Catalonia). The results of such surveys are useful to identify weak points in need of improvement.

Traditionally, the figure of the physician is one of the most socially respected professions along with schoolteachers, judges, mayors, etc. This was especially true for small towns and rural communities. Nowadays, with the development of medicine and new models of healthcare, which have to cope with high demand and associated hyper-specialisation, a certain amount of dehumanisation of medicine has occurred with a loss of professional prestige as a result. On many occasions, the physician is no longer the point of reference for the patient. Depending on the specific process involved, the patient can have many points of reference and the physician may not even be the person in whom the patient has the most trust. It is necessary to regain this bond of mutual trust through a vision centred on sharing and accompanying the patient rather than tutoring and directing them. From the point of view of respect for the individual and their prominence in taking decisions, society demands this role of the physician.

Implications in daily work

Respect for the individual, their dignity and autonomy, should be observed in the daily work of the physician, whether in the consulting room, the operating theatre or during a physical examination. Every act of care should carry this respect with it by default, forming a natural part of the physician's daily work, requiring no additional effort or overreaction.

The process begins by listening attentively to

the patient at the initial and successive visits, followed by the subsequent disclosure of complete and truthful information to the patient, which includes not only the proposed therapy or diagnostic test but also the possible alternatives and, as it should always be an option for the patient, the consequences of not doing anything. The process ends with the offer to address any doubts and dispel fears without providing false information along with accompaniment in their decision-making process. An analysis of a physician's day-to-day work can reveal many situations, moments or actions undertaken that do not comply with these parameters, for example : listening to the patient while entering data on the computer without making eye contact, undertaking a physical examination while having a conversation with colleagues without respecting the patient or considering their feelings, or taking as given that decisions regarding a patient will be made by the family without counting on the opinion of the patient him/herself.

It has to be acknowledged that, in the daily work of the professional, there are countless details to correct and improve. Little by little, medical praxis should be orientated towards greater respect for the individual in every context and circumstance. It is also true that, amongst other circumstances, the pressure that certain healthcare services are under and the demands on time do not make this task as easy as could be desired. Even so, these working conditions, which represent the real situation and are clearly improvable, are not a sufficient argument to avoid the need for self-criticism and improvement. With a will to change and adapt to the new paradigm, the integration into the medical profession of the value of respect for the individual has to take place through the daily actions of the physician.

Consequences of a lack of consideration

Not taking into consideration respect for the patient in the practice of medicine represents a violation of an essential ethical duty

Not taking into consideration respect for the patient in the practice of medicine represents a violation of an essential ethical duty. Physicians have a duty to their patients, which does not imply acting from the decades-old viewpoint of benign paternalism. To be coherent with an evolving society, the physician should play a supporting and accompanying role with the patient as the central player in the process of care. In the 21st century society of democratic countries, the rights of the individual have been developed on many levels. Especially in the younger generation, the future of our society, there is a growing awareness of the rights associated with various aspects of life. In this context, to practise medicine from a model that is not based on respect for whom one attends to and cares for is ethically reproachable. The medical profession should advance alongside social progress, not only knowledge-wise but also by modifying behavioural guides.

Not respecting the patient can also result in judicial consequences, given the explicit recognition of the rights of the patient in Spanish law (*Ley Básica Estatal 41/2002*, which concerns patient autonomy and has homologous laws in the Spanish autonomous communities). A breach of this legal mandate can lead to prosecution. In fact, as mentioned earlier, a high percentage of claims against physicians are based on a lack of provision or deficiency in the communication of information, the absence of informed consent in situations where it is mandatory or medical errors resulting in unexpected negative consequences that were not communicated. The foundation of such claims is largely based on the legal obligation to respect patient autonomy as stated in the legal text.

Therefore, lack of respect for this value not only means that the physician is behaving in an unethical manner but is also potentially liable for prosecution, with negative consequences at all levels.

Individual and collective benefits of correct observation

In contrast, the physician who always respects the dignity and autonomy of the patient exhibits an ethically correct and legally responsible pattern of behaviour. At the personal level, all the physician's activities are centred on the patient, incorporating their opinion and accompanying them in their decision-making process and respecting their decision even when disagreeing with it. Patients will see in their physician the point of reference for their health problem, generating a bond of mutual trust and complicity for the benefit of both parties.

However, respect for the decisions of the patient has a deontological limit that should be mentioned : the physician will not be obligated to follow instructions or demands from the patient that contravene clinical criteria, forcing them to take contraindicated or unjustifiable actions. If the physician is subjected to such demands, they are within their rights to delegate their tasks to another professional due to the loss of trust and therapeutic bond with the patient.

At the collective level, the physician who respects the dignity and autonomy of the patient adheres to the ethical and legal standards demanded by the profession. At the same time, respect for these values meets the legitimate expectation of society that physicians should take these values into account, respecting decisions and/or preferences of the patient and demonstrating the capability to integrate this (along with a consideration for the life values of those affected as well as the nonclinical context and necessities of the patient) into the therapeutic and diagnostic strategies proposed.

Physicians who show respect for their patients are good physicians if, additionally, they fulfil their responsibility for correct training along with the continuous updating of knowledge and professional expertise.

If all physicians acted according to these principles of respect, perhaps some of the somewhat diminished prestige of the profession could be

recovered, with higher levels of individual and collective welfare as a consequence.

Final ideas

The patient care model that must be promoted and consolidated is one that positions respect for the individual as the primary essential value. Respect for personal dignity can only be subjectively defined by individual perception during a process of health or illness. The duty of the physician is to explore this subjective perception, always starting from a position of maximum respect for the autonomy of the patient which will be reinforced during the decision-making process. In this process, which culminates in the exercise of personal autonomy, the physician has the ethical and legal duty to accompany the patient, communicating correctly and providing adequate information. This generates trust and complicity with the patient. Physicians cannot and must not impose their criteria or condition the will of the patient, although they should advise patients of what they believe is in their best interests in an honest and transparent manner, always showing respect for the individual and his/her decision, including when they do not agree.

We are still in a process of evolution towards this paradigm of professional excellence, which requires changes in mentality and working dynamics in addition to improvements in working conditions (time, space and training).

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Compassion

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Her work as a professor and researcher is focused mainly on the field of applied ethics. Her most relevant lines of research refer to the foundations of bioethics, genetic engineering, professional ethics, care ethics, education in bioethics and, more recently, narrative bioethics and neuroethics.

She has always been interested in the educational aspect of the transmission of knowledge, and training in values for citizen coexistence. She conceives bioethics as something broader than just professional ethics, indeed as an ethics of life, and therefore a space for reflection on civil ethics. Likewise, the cerebral mechanisms underlying knowledge and decision-making, as well as the role of emotions and convictions in human actions are one of the topics which she is currently working on, because it involves a concern for the philosophy of science, epistemology, neuroscience and ethics.

She is a guest professor of numerous master's degree and specialized training courses in Bioethics. She is President of the Association of Fundamental and Clinical Bioethics, Vice President of the Ethics Committee of the Research Institute on Rare Diseases, of the Carlos III Health Institute and a member of the Ethics Committee of the Alcorcón Foundation University Hospital. She is also a member of the CASER Ethics Committee and of the Ethics and Good Practice Group of the Spanish Fertility Society. Additionally, she also belongs to the scientific councils of several journals, and directs the Complutense Journal on Bioethics.

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Compassion

The term 'compassion' comes from the Latin *compassio*, translation of the Greek word *συμπάθεια (sympathia),* a term composed of *συν* + *πάσχω* = συμπάσχω, or 'to suffer together'. Compassion is to abide with, which implies not being indifferent to what happens to other people, wanting to help or collaborate to alleviate suffering. Given the vulnerability of human beings and as a responsible commitment to the world, compassion is the appropriate ethical response. We will analyse below this starting point of compassion—the vulnerable condition of the human being—and then refer to the appropriate ethical response, which requires differentiating compassion from other related values such as empathy ; finally, we will address the professional challenges involved for doctors.

The vulnerable condition of being human

Human beings are fragile and vulnerable. This is an anthropological condition from which we cannot escape. Being vulnerable implies the possibility of suffering harm, being in a threatening situation which, to a certain extent, is consubstantial with life. Thus, it implies being susceptible to receiving or suffering something bad or painful, such as a disease, and the possibility of being physically or emotionally harmed. People can be injured in many ways, and although we usually have a basic trust in staying alive (which is essential to carry out our life goals and look to the future), we are also aware of that fragility.

Social conditions can also render human beings vulnerable while limiting their chances of facing adversity. For example, if someone lives miserably without basic hygiene and sanitary measures, they will probably have more chances of contracting diseases. The main issue is not that the person is more fragile than others but that their conditions place them in a situation in which they have fewer defences against threats and danger.

Fragility is also present in the face of 'moral evil', harmful in another way, which can be more damaging, despite the lack of physical marks. These are situations where one is a victim of injustice, discrimination, inequality, or of any other situation where in not being able to practise a value has been harmed or has become more fragile or has had their lives and their goals impeded.

Vulnerability refers to the possibility of suffering, illness, pain, fragility, limitations, temporality, and death.

The ethical response of compassion

The intrinsic vulnerability of human beings leads us to identify with the suffering of other people. We observe our own experience and the suffering and frailty of others and thus discover our shared humanity, understand the feelings of others, and would want them to help us if we were in their situation. Recognising our human equality elicits a feeling of compassion or 'abiding with' the other's own suffering. Acknowledging we can all be victims supports the idea of equality and ancient moral teaching : the golden rule mandating we should do unto others what we would have them do unto us. Therefore, it invites us to action to avoid or alleviate suffering.

The ability to recognise others as equals and understand their feelings lies in 'mirror neurons', responsible for interpreting the actions of other individuals. When we observe someone doing something, the same area in our brain is activated as if we were doing the same action. This underlies the ability to understand others, imagining ourselves in the same situation. Therefore, neuroscientists such as V.S. Ramachandran or G. Rizzolatti affirm that these mirror neurons are 'empathy neurons' because they allow us to understand the emotions of other people and the reasons for their actions. The ability to place ourselves in the perspective of other people, understand what they do, why they do it, and how they feel is what we call empathy. It is about putting oneself in someone else's place to see the world from their point of view.

In addition to biological components, cultural, and learning elements are essential to developing empathy

In addition to biological components, cultural, and learning elements are essential to developing empathy. Very individualistic or cultural environments promoting emotional distance and anonymity, where friendship, help, kindness, solidarity, etc. are not nurtured, will probably lead to less empathetic people. However, cultures based on the human relationship of mutual help, attention to those with more needs, an understanding of the other's situation, and non-indifference to their suffering will result in more empathetic and compassionate people.

This means that these attitudes can be promoted and nurtured. Some studies show how the capacity for compassion can be modified through, for example, meditation. In this sense, mental techniques such as 'loving kindness training' can be used, fostering kindness towards people and showing a beneficial impact on feelings of positive affect, developing personal resources, and a state of well-being, which translates into a greater provision of help towards strangers and a more altruistic and pro-social attitude. This means attitude and the ability to feel the suffering of another can be modified, even generating changes in the brain (in the areas concerned with emotions). Thus, it is essential to pay attention to how we nurture and promote compassionate behaviour. It is clear that educational models, promoting values of altruism or collaboration, include compassion as an essential element to support action and generate commitment with their

development and promotion. Compassionate people not only feel concern and sympathy towards vulnerable people but also adopt an active attitude of help in the face of suffering, understanding indifference is not possible. This implies compassion is intertwined with other fundamental values, such as peace or justice, because understanding another's pain implies an option for non-violence and concern for situations that cause greater vulnerability. From the point of view of personal development, this means favouring the deployment of sensitivity and the ability to respond to suffering.

However, it should be kept in mind that empathy and compassion are different, as empathy refers to that ability to understand the emotional state of the other, 'putting oneself in the other's place', while compassion usually includes that understanding, but, above all, is an authentic feeling of shared pain, to which is added the sincere desire to alleviate suffering.

It is also necessary to differentiate compassion from sympathy or emotional closeness to the feelings of the other person. Sympathy can generate reactions of emotional attunement, which in doctors can endanger the necessary distance protecting the professional from the wear and tear caused by contact with suffering and lead to losing equanimity in their decisions because of excessive emotional involvement.

Compassion specifically deals with actions to alleviate suffering, once recognised. It is not extravagant commiseration or a feeling of pity, nor is it an understanding driven by empathy or the identification with the emotions of the other caused by sympathy but an authentic value of humanity based on the recognition of suffering, participation in suffering, and altruism requiring benevolent aid.

Compassion specifically deals with actions to alleviate suffering, once recognised

Compassion implies recognition of the other human being as someone equal to oneself, vulnerable and susceptible to being hurt, demanding attention and a response. It is opposed to selfishness and cruelty and opens a space for human help and collaboration. It is a fundamental ethical category in Buddhism, for which all beings are connected ; love and compassion towards all living beings is a way to achieve wisdom and happiness. In Christianity, it is also considered a virtue to be developed since it implies considering the help of one's neighbour as a fundamental value.

Given the vulnerability of human beings, an ethical response is necessary : compassion. Frailty opens the solidarity dimension, bringing into play a response of caring attention. Compassion can be practised as caring for others and responding to their needs or requests. The care given freely to the vulnerability of the other, seeking their welfare, is a way of communicating between beings, recognising the other as an equal, someone who deserves to live. This implies the recognition of suffering and involvement as a commitment to action, helping those in a disadvantaged position to change or overcome that circumstance.

Reflecting on care in human life is not new. Philosophy has analysed this issue from its anthropological importance, and ethics has also

been concerned with attitudes of care, solicitude, and benevolence, highlighting their deep moral significance. Some traditions and proposals of the history of philosophy worth mentioning are, for example, in the twentieth century, authors such as M. Heidegger, E. Levinas, or P. Ricoeur, showing how a reflection on human beings cannot be constructed without paying attention to their weakness and to the roots of their caring behaviour of helping others.

In the social and health professions, care as an adequate response to suffering has also received considerable attention, especially from nursing. In the characterisation of care, compassion occupies an important place, as a virtue to be developed to respond adequately to suffering and as a moral responsibility for the suffering of people.

Compassion as a professional value

Developing sensitivity to suffering and the ability to respond to it is an ethical requirement. Compassion is the commitment assumed because of the recognition of equality in the face of vulnerability among human beings, demanding full collaboration and selfless help. In bioethics, reflecting the tradition of the medical profession, this obligation to respond to the suffering person is expressed in the principle of beneficence, which requires considering the welfare of the patient and acting to promote it.

Although Beauchamp and Childress consider compassion a virtue to be developed in parallel

Developing sensitivity to suffering and the ability to respond to it is an ethical requirement

to the observance of the principles —confused with sympathy and understood as an action with emotional implications that can 'cloud' the judgement of the professional— beneficence implies, in its most general conception, a commitment to the welfare of the person, requiring an ethical foundation based on recognising the other as a subject with dignity deserving help. Note that, as meant above, the basis of that recognition is the vulnerability of the human condition, making us equal and arousing action. Therefore, human recognition occurs before claiming rights, affirming that compassion is a fundamental value connected to emotion and sensitivity, more radical than any theoretical obligation, but also a rational task because of its demand and promotion, justifying its practice.

Moral responsibility for the good of the patient means to help as long as the patient's autonomy is respected, that is, non-paternalistic beneficence

Beneficence must respect and accept the patient's value system ; therefore, action based on compassion cannot dictate a good act without incorporating the perspective of the affected person. Thus, moral responsibility for the good of the patient means to help as long as the patient's autonomy is respected, that is, non-paternalistic beneficence.

Aiming to restore the space of beneficence to avoid excessive emphasis on autonomy, E. Pellegrino notes the purpose of medicine cannot be other than for the good of the patient. Three reasons support this conclusion : first, the intrinsic vulnerability of human beings, making them susceptible to illness ; second, medical knowledge is a patrimony of humanity held by doctors only to be used for the good of sick people (so, not for personal benefit) ; and third, the medical profession is a commitment to serve the sick—an alliance of mutual trust imposing moral obligations on the professional. Hence, the fundamental principle of medical ethics must then be beneficence, or what Pellegrino and Thomasma call beneficence in trust.

The fundamental principle of medical ethics must then be beneficence, or what Pellegrino and Thomasma call beneficence in trust

Although the paternalistic scheme is already abandoned and respect for patient autonomy is irreversible, these authors consider that the clinical relationship still is necessarily asymmetric ; therefore, the responsibility falls on the clinician. This implies that it is possible to formulate virtue ethics in professional ethics by reaching a consensus on the ends of medicine. In plural societies with different value systems and ideas of welfare, conflicting lifestyles and personal purposes are proposed, making it difficult to agree on one single concept of good for human life. However, it is possible to aspire to an agreement about the internal good or the purpose of the profession.

The clinical relationship still is necessarily asymmetric ; therefore, the responsibility falls on the clinician

The professional must be a virtuous person, worthy of the patient's trust, who uses their medical knowledge for the good of the patient (and not for their own gain, prestige, or power) and who does not take advantage of patients in their situation of weakness and dependence. In Pellegrino's opinion, the clinical relationship is characterised by the vulnerability of the patient, the unequal relationship between doctors and patients regarding knowledge and power, and the professionalism of the doctor with regard to providing the best care to patients seeking their help. These characteristics result in a doctor-patient relationship based on help and trust. To act appropriately in this context, the doctor must develop a series of virtues, including compassion :

- *Fidelity to the promise :* maintain the patient's trust ;
- *Benevolence :* seek holistic patient welfare ;
- *Abnegation :* make sacrifices to ensure the good of the patient. Sacrifice personal interests to focus on medicine, in fidelity to the commitment assumed ;
- *Compassion :* 'abiding with' the patient's suffering and pain and adapting treatment to the patient's particular situation. This condition precedes care and involves consideration of the patient as a person. Compassion has an emotional component (acting in the most beneficial way for a specific patient) and a moral component (disposition to understand intellectually the singularity of the patient) ;

- *Intellectual humility :* recognise the limits of knowledge and admit ignorance honestly ;
- *Justice :* give everyone what corresponds to them by right, treating equal cases equally. It is fairness but also adjusted to the specific needs of the patient ; commutative justice with the patient (strict equality between individuals) ; distributive justice with society (that is, equality based on proportionate distribution, as suggested in managed care) ; and
- *Prudence :* right reason in deliberation and action. Discernment and decision in areas of uncertainty, guided by a reasonable and balanced choice, seeking the most effective means to achieve the objective : total patient welfare.

The ability to recognise, analyse, and resolve ethical issues arising in the clinical relationship is, according to this author, as important as scientific knowledge. However, this capacity derives from understanding that the end of medicine is a healing action for a human being, that is, the importance of knowing the patient and their values framework. To a large extent, these are elements of compassion, understood as something beyond empathy involving the understanding of the experiences of illness as unique to the patient and, from there, collaborating in decision-making adjusted as much as possible to that personal dimension. The doctor must know how to take the necessary distance to not lose objectivity in technical decisions, to approach the patient and help her or him in the decision.

The doctor must know how to take the necessary distance to not lose objectivity in technical decisions, to approach the patient and help her or him in the decision

Considering this perspective, the development of compassion is part of the humanisation of medicine, as an essential element to understand suffering and collaborate in seeking the good of the patient. Without this commitment to compassion, the medical act would be merely technical, lacking in the human dimension of caring and attention, which gives it meaning and purpose.

According to the above, compassion is a fundamental value for people's lives, medical professionals, and human coexistence. To a large extent, compassion refers to the radical immersion in a context of relationships with others, where there is recognition among equals and solidarity and care in the face of vulnerability. In medicine, compassion is considered a virtue to be developed to care for the good of the patient, considering their background and set of values, to enhance their autonomy and life goals. However, compassion is also a demand for responsible action requiring a complex balance of sensitivity to suffering, the possibility of feeling with others, taking the necessary distance not to hinder clinical judgement, recognition, and respect for people, and the commitment to appropriate action derived from prudence and practical wisdom.

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— 3 —

Emotional self-awareness (acknowledging and understanding one's actions, personal motivations, and emotions; knowing oneself)

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Emotional self-awareness (acknowledging and understanding one's actions, personal motivations, and emotions ; knowing oneself)

The practice of medicine before the explosion of knowledge, the emergence of many technologies applied for the diagnosis and treatment of diseases, and the massive increase in medical students since the middle of the twentieth century meant the therapeutic action of the physician included the doctor-patient relationship. Often, medicine as science could do little, but accompanying patients, relatives, and carers was an important part of medical practice. It was also about alleviating mental suffering, not just physical pain. The doctor established a therapeutic relationship organically, and it was part of their task to maintain and strengthen it.

Being a 'good' doctor requires having adequate knowledge and skills, but there is also a need to establish and maintain a therapeutic relationship with patients and their carers. Establishing this relationship involves an interaction of the emotional spheres of doctors and patients. Being aware of one's own emotions and motivations allows the clinician to consider the emotions and motivations of others. Building a therapeutic relationship is an essential part of professional practice and an essential attribute of being a professional.

Being aware of one's own emotions and motivations allows the clinician to consider the emotions and motivations of others

Definition and delimitation of emotional self-awareness

Philosophy and various branches of psychology share the widespread view that there are important relationships between emotions and values.

Values are moral convictions inherent in the person, involving a judgement about what is right, good, or desirable. They are the link between beliefs and behaviour. Each person has their own value system, and values are the compass according to which each one lives in the world and behaves. In short, values are the core of identity, of the self.

Values arise from the social environment of the individual : their family, school, social context, studies, work, and religion ; therefore, different values prevail in different cultures.

Values are not static, they change over time ; therefore, it is necessary to review them to respond to what one is seeking or wants to achieve. Even from learning and by implementing social skills and competencies, new values can be consciously acquired, bringing the individual closer to the objectives they want to achieve. These will guide the plan of action, achieving not only changes in behaviour and routines but also in identity.

Emotions are transient reactions to a stimulus, such as a situation or thought. They are neither good nor bad ; they all play an adaptive role and are thus necessary. They are universal, and like values, emotions are guides in the lives of people.

The word emotion derives from the Latin *emotio, emotionis,* which means something like moving from one place, setting in motion, leaving. In some way, emotions are the driving force of people and are related to the intrinsic motivation to act.

Emotions are signals that provide information about whether one's life is consistent with values or not. Emotions help a person be aware of how they are or how they feel at a given moment or how they face a certain action. By understanding the underlying emotion that causes a particular effect, one can discover whether ones' actions are consistent with the values one claims to have.

In the nineties, D. Goleman's book on emotional intelligence caused an upheaval. Self-knowledge

Emotions are signals that provide information about whether one's life is consistent with values or not

is one of the basic foundations of developing emotional intelligence. For this purpose, it is essential to know one's personality and emotions and how they appear to others. Only in this way can emotional intelligence be enhanced drawing from resources and opportunities because one is aware of them, able to understand one's own reality. Goleman argues that emotional self-awareness is a skill that allows one to connect with underlying beliefs, assumptions, and values, knowing what leads to them. This connection helps one to be aligned with true motivations. It is essential to communicate feelings to other people.

Self-knowledge is one of the basic foundations of developing emotional intelligence

For Goleman, emotional intelligence consists of five fundamental abilities :

- *Knowing one's emotions :* being aware of one's emotions ; recognising a feeling in the moment when it occurs. A disability in this sense leaves a person at the mercy of uncontrolled emotions ;
- *Managing emotions :* the ability to manage one's feelings to express them properly is based on the awareness of one's emotions ;
- *Self-motivation :* an emotion propels an individual towards action. Therefore, emotion and motivation are intimately interrelated. To

direct emotions and the resulting motivation towards achieving objectives is essential for paying attention, self-motivation, managing oneself, and performing creative activities. Emotional self-control involves being able to delay reward and control impulsivity, usually present in achieving many objectives. People who possess these skills tend to be more effective in undertaking activities ;

- *Recognising the emotions of others :* for this purpose, the capacity for empathy is fundamental, also based on emotional self-awareness. Empathy underlies altruism. Empathic people can grasp and interpret subtle cues indicating what others need or want ; and
- *Establishing relationships :* establishing good relationships with others requires the ability to manage the emotions of others. Social skills and competencies are the basis of leadership, popularity, and interpersonal efficiency. People with these skills can interact smoothly and effectively with others.

Relationships with other values

Being aware of the relationship between values and emotions and how they can vary helps to understand that if values are practised and actions are performed in accordance with them, one can detect what one does not like and what is not being done and redirect actions towards the objectives to be achieved.

Emotional self-awareness would not be so much a value in itself but rather a need to improve the relationship with others (other professionals or patients) and oneself. It is completely necessary to ensure coherence between behaviour and the values to be protected. The first step in understanding others is to become self-aware.

Values and emotions are intertwined

Values and emotions are intertwined, and this is understood by observing consistency between actions and the values proclaimed. When values and actions are aligned, the person feels balanced and at peace with oneself. However, when something not consistent with one's beliefs and values is done, the person feels bad, dissatisfied, frustrated and stressed and can even get sick.

Importance for the person, the professional, and society

Self-awareness is the ability to recognise one's emotions and how they affect mood and behaviour. It is about consciously putting into perspective their own actions and thoughts ; it is the first step towards changing behaviour and improving, changing inappropriate behaviour, or regulating the expression of emotions.

Clinicians aware of their own emotions, of how they affect them and the people around, are better able to act with emotional self-control. This shows in their behaviour as a sense of calm, clarity, and open communication. Emotional self-control is not the suppression or denial of emotions. Self-control derives from the

awareness and acceptance of one's emotions and feelings and, from here, their management on a day-to-day basis.

Clinicians aware of their own emotions, of how they affect them and the people around, are better able to act with emotional self-control

Health professionals, consciously or unconsciously, deal with death anxiety projected by patients. The mildest illness or disease connects a person with her or his mortality to a greater or lesser extent. This reality leads to health professionals being defensive, often not paying attention to the emotions expressed by patients and suppressing their own. There are also defence mechanisms for these situations at the organisational level. A classic example in the analysis of organisations is the way that nursing activities are partitioned by tasks. One person administers the medication, another, later, takes the patient's temperature ; at another time, they perform hygiene tasks, etc. Task partitioning implies that care is also fragmented, preventing the patient being viewed as a whole person, complete with all their anxieties. Emotional self-awareness can help manage these situations. When health professionals relate to their own emotions, identifying and accepting them without judgement, they are likely to relate to the expression of the emotions of patients and family members.

Emotional self-awareness also allows a doctor to establish a relationship with the patient, which, when good, will help throughout the clinical process. Relationships involve emotional bonds. The therapeutic relationship bond implies a beneficial effect on the patient's health. The importance of a therapeutic relationship has long been recognised in psychotherapy, but recent interest in patient-centred care has shown that it yields better results and provides better mutual understanding. The best results include, among others, improved patient satisfaction and improved care of chronic conditions with greater treatment adherence.

An essential aspect of the therapeutic relationship is the recognition and understanding of personal beliefs and value systems of the individuals involved, both health professionals and patients. There may be differences between these systems, resulting in a strong emotional reaction in the clinician. This can influence their decision-making and subsequent actions. Recent neurocognitive research suggests effective reasoning is largely unconscious, in which logical information processing is modulated by emotions. For example, anger towards a patient may give rise to a different response from that which would have resulted from establishing empathy with the patient.

Developing or increasing emotional self-awareness

The first step to understanding others is to develop self-awareness and self-knowledge

The first step to understanding others is to develop self-awareness and self-knowledge. These are the foundations for developing

emotional intelligence : knowing their own personality and emotions and how they appear to others. Only in this way can emotional intelligence be increased by using resources and opportunities, by being aware of them, and by being able to understand their own reality.

Experience alone without reflection does not ensure learning

Since the nineties, it became clear that the most effective way to learn from professionals is reflective practice. Experience alone without reflection does not ensure learning. Strategies and evaluation systems were established to promote reflective learning, and even today, this continues to be the greatest challenge, as it is one way of 'learning to learn'. Guided reflection by a supervisor or mentor is useful for this approach to reflection because underlying beliefs and assumptions can be identified and challenged.

Authors who have worked on reflective learning emphasise precisely the topic of interest : in reflection, we must explore our own emotions and those others might experience. Reflection, when done with the help of another person (peer, tutor, etc.), occurs in two ways : oral and written. In both modes, there is a moment of deep learning about oneself, consisting of putting into words what one felt or is feeling. Often, after an emotional impact, there is an initial emotional numbing in which the person seems to feel nothing. Physical sensations may occur, but they are not associated with a specific emotion. This can lead to confusion because, not perceiving the emotion itself, the reaction may not be consistent.

In reflective practice, when implemented with the support of another person (equal, tutor, etc.), it is necessary to recount what happened, either orally or in writing. The story forces the person to choose words. By narrating the story, the person can realise to what extent they have clear ideas about their emotions.

One of the most used instruments to encourage reflection among professionals in training is a learning journal or portfolio

One of the most used instruments to encourage reflection among professionals in training is a learning journal or portfolio. A learning journal includes stories about so-called critical incidents. Critical incidents are specific situations that have emotionally impacted the student or resident, either because the situations have not been resolved adequately, resulted in an unexpected achievement, or just touched the emotional side of the person in some sense.

Reflection deals with the systematic analysis of past actions to introduce changes in future actions

Reflection deals with the systematic analysis of past actions to introduce changes in future actions. The scientific literature provides us with instruments, usually rubrics, allowing us to evaluate this ability. The evaluation of reflection emphasises its importance, as these contents should be part of all curricula and specialisation programmes.

In learning and developing professional attitudes and values, two aspects play an essential role : learning from models and the culture of the organisation where learning takes place. Therefore, it is not so much about being aware of them but seeing how the professionals apply them by observing their behaviours. It is very common in human behaviour to act differently from what is stated, hence the Chinese proverb 'do what the teacher says, not what they do'.

Reflective practice should be introduced explicitly and systematically so that health personnel and residents across all organisations develop their reflective capacity and gain emotional self-knowledge

While reflective practice and exploring one's emotions remain circumscribed to degree and specialised training but are not part of the daily work of doctors, the implicit message is that these things are not so important. This practice should be introduced explicitly and systematically so that health personnel and residents across all organisations develop their reflective capacity and gain emotional self-knowledge.

Consequences of its lack of consideration

Before, learning to establish a therapeutic relationship occurred alongside a teacher while watching them practise. This relationship is being lost little by little, and medical professionals may come to think that addressing the emotional dimension of a person has nothing to do with them. For this relationship, they often delegate to other professionals, mainly nurses but also psychologists, social workers, etc. A phrase illustrating this tendency is that pronounced by Moisés Broggi shortly before his death (2012) : 'nowadays doctors cure more, but comfort less'. From a biomedical point of view, diagnosis and treatment are better than before, but the emotional dimension in the doctor-patient relationship is being forgotten and replaced by the technological dimension.

Judging from medical curricula, specialised medical training programmes and the content of continuing education activities the emotional dimension practically does not exist

This absence of an emotional side is also observed in education and health care organisations. Not paying attention to emotions or to the emotional sphere of people entails suffering not only for patients, relatives, and carers but also for students, residents, and professionals. Often, only learning within the family, at school, and through experience allows clinicians to consider the emotional sphere of their patients and other professionals with whom they work, managing their own emotions and better understanding those of others. Judging from medical curricula, specialised medical training programmes and the content of continuing education activities—in which the emotional dimension practically does not exist—we could say we are immersed in a period of emotional impoverishment.

In light of the mandate of this chapter, some keywords were searched in the deontological codes of the Council of Medical Colleges of Catalonia (CCMC, for its acronym in Spanish) and the Collegial Medical Organisation. The keywords searched were emotion, emotions, emotional, and emotive. The search in the code of the CCMC yielded no results. Not a single mention related to emotions. The search in the code of the Collegial Medical Organisation yielded one result. In article 49, section c), it states : 'Ensure information processing is sufficiently clear and detailed with no coercion—emotional, economic—or any other vice of consent'. From this section, it is deduced that, despite mentioning 'emotional', the term is not related to what is being discussed in this chapter.

We are all aware of the great speed at which everything is changing. Sometimes doctors believe their role in society is immutable. However, research is already showing that artificial intelligence is better at diagnosing cases of diabetic retinopathy or malignant melanoma than is an expert ophthalmologist or dermatologist, respectively. Treatment of different conditions increasingly tends towards a multidisciplinary approach. What can doctors contribute to the health care of people as an added value to maintain this current central role? Most likely, the relational part will be the most difficult to replace with machines. Having an expert, trustworthy person accompany the patient and help integrate what is happening, be aware of their options and make informed decisions appears to be a possible scenario. Some people warn that the implicit social contract between the medical profession and citizens is at risk of breaking. If physicians do not attend to their own emotional dimension and, consequently, to that of their patients, they risk going from being considered professionals to merely qualified technicians.

If physicians do not attend to their own emotional dimension and, consequently, to that of their patients, they risk going from being considered professionals to merely qualified technicians

Conclusion

Emotions are part of the human being and cannot be neglected in caring for the health of people. Emotional self-awareness is essential for knowing oneself and to understanding others better.

Emotional self-awareness allows us to improve our approach to the emotional dimension of patients and build a therapeutic relationship with patients, relatives, and carers.

Reflective professional practice is essential for developing emotional self-awareness by bringing awareness to one's emotions and helping to understand those of others. Reflective practice is also a model for professionals undergoing training who can learn the method.

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Receptivity

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Born in Terrassa in 1949, she holds a Degree in Medicine and Surgery from the Universitat de Barcelona, specialized in Internal Medicine and Nephrology, and a Master's Degree in Bioethics from the Borja Institute of Bioethics at the Universitat Ramon Llull. Her work has been largely dedicated to assisting and improving the formation of Specialized Health Training, especially in the crosscutting areas of training such as bioethics, communication, etc.

From 1997 to 2015, she was devoted to developing and implementing the transversal training of future specialists and developing quality indicators for Specialized Health Training.

In 2009 the Institute of Health Studies of Catalonia appointed her member of the Specialized Health Training Advisory Group for the Development and Operation of the Advisory and Executive Structures, assigned to the Autonomous Communities for Health Training. From 2010 to March 2015, following appointment by the same institute, she was a member of the Specialized Health Training Advisory Group devoted to preparing the Teaching Management Quality Plan.

In May 2006 she was appointed member of the National Commission of Nephrology by the Undersecretary of Health and Consumer Affairs of the Ministry of Health and Consumer Affairs, and continued to carry out those duties until May 2015, as well as being named member of the Working Group of the Medical Branch in October 2010 by the Director General of Professional Planning, Cohesion of the National Health System and Higher Inspection.

She was also President of the Ethics Committee of the Althaia Foundation, of the Xarxa Assistencial i Universitària de Manresa from 2002 to June 2016.

She organized and participated as a speaker at the annual Bioethics Seminars of the Althaia Foundation, Xarxa Assistencial i Universitària de Manresa from 2009 to 2016.

Likewise, she organized and participated as a speaker at the 9th Conference of Healthcare Ethics Committees of Catalonia, 2014.

She participated as a lecturer on the course 'Care for Complex Chronic Patients' in nursing training taught in 2013, 2014 and 2015, as well as a lecturer on the courses 'Espais de reflexió i diàleg bioètic a l'àmbit assistencial' (Spaces for thought and bioethical discussion in the field of healthcare) of the same Foundation for healthcare professionals.

She has participated as a guest professor in the subject 'Professionalism, the values of physicians' from the 2012 course to date, which is part of the Bachelor's Degree in Medicine of the Universitat de Barcelona.

She has also been a member of the Deontology Commission of the Medical College of Barcelona since March 2014.

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— 4 —

Receptivity

Definition of the value ‘receptivity’ and delineation of the framework where it will be developed

Receptivity is the ability of a person to listen, accept, welcome, receive, manage, and coexist with other people who have different ways of thinking and acting, without reservations or pretexts, even if the thoughts and actions are different from those of oneself. It is the value of asymmetric equality because of the uniqueness of each person.

Receptivity, together with the other values, forms a person’s way of being and the ideal where a person feels connected. Values are translated, expressed, and support attitudes, and these are the acquired and stable predispositions that will guide the way of acting in a concrete and specific situation.

If values guide the conscience and behaviour, receptivity, as a value, is visible through the daily actions of the people and influences them decisively, transcending through the coherence between thinking and doing and between the latter and communicating.

Receptivity, like all values, has a universal and an individual dimension. The individual dimension is not the mere concretion of the universal but something with its own structure and situation. In this way, each case will require a specific response. In two apparently identical situations, actions may differ completely because of the unique character of each interpersonal receptive relationship.

The action derived from a receptive attitude is an open, subtle, and listening attitude ; it is the reception and recognition of the other, where the other is the protagonist, whoever they may be

The action derived from a receptive attitude is an open, subtle, and listening attitude ; it is the reception and recognition of the other, where the other is the protagonist, whoever they may be. These actions are not just passivity because passivity is inactivity, nor are they indifference because that would mean disregarding the other. A receptive attitude enables proximity, not as a physical concept of being near but as a synonym of being next to the other, paying attention to what they say and feel.

In receptivity, it is necessary to incorporate the concept of respect, which Richard Sennett translates as the psychology of autonomy, which implies accepting from the other what one does not understand or accepting others without questioning how they are or what they think.

The terms user and customer imply symmetry in the doctor-patient relationship, as if it were a contractual relationship between the parties, which is not the case given the asymmetry of power implicit in the condition of the patient

Receptivity as a value has special importance in the care of sick and vulnerable persons seeking help and wanting to be cured of their illness or relieved of pain when, according to medical praxis, a cure is not possible. The act in which a sick person asks for help can take place in a health institution or in a patient's home and has its culminating moment in the doctor-patient encounter as the vulnerable person desires to be relieved of the pain she or he suffers due to the illness. The doctor-patient relationship is not a doctor-user relationship—the user as a person using and enjoying a certain service—or a doctor-customer relationship— the doctor as a person marketing a service. The terms user and customer imply symmetry in the doctor-patient relationship, as if it were a contractual relationship between the parties, which is not the case given the asymmetry of power implicit in the condition of the patient.

Relationship with other values

Receptivity as a value manifests itself in the relationship between people and their actions or omissions and is unique because it coexists and is practised together with other values. In health care, a doctor who incorporates receptivity will become more sensitive to needs, both those in their daily lives and health care practices.

The following are values to be considered, among others, that are described as important and determinant in a doctor's behaviour as a person in relation to a receptive attitude :

- *Flexibility and tolerance*. Flexibility as a value is the attitude that enables a person to adapt to different situations in life and not hold onto things as always being the same. A flexible person needs to have an open mind to new situations or circumstances, offering opportunities for change. Tolerance is a value demanded from every open-minded person, which is not synonymous with accepting or sharing the totality of the other. It is the ability to know how to listen and accept others, valuing different ways of thinking, having respect for difference, and allowing others a different way of being and acting. Flexibility and tolerance must be practised both with patients and oneself.
- *Listening and welcoming*. Listening and welcoming are values implied in receptivity. A welcoming attitude will provide a patient with a physical place and an environment, where she or he can comfortably express themselves with or without barriers. This encounter will depend

on establishing active listening to know their needs and preferences and understand them. Effective communication requires enough time and the explicit will to know. To practise proper listening, it is unnecessary to agree with the patients' messages but to perceive what they say and why they say it ; it is completely wrong to give the impression of malicious listening.

- *Trust and hope*. These two values coexist in medical praxis if the attitude is one of receptivity. A patient trusts the doctor when perceiving their scientific-technical competence, decision-making capacity, and evident human skill. Trust is a positive force that helps a patient move forward and offers them security in the face of uncertainty because of the different courses of the illness. Trust will be translated into hope by being able to offer healing possibilities, pain relief and help to accept the difficulties. Hope can only be transmitted from receptive proximity, not physical proximity. To hide the difficulties that may be encountered along the way is not to convey hope.

- *Honesty and transparency*. A person with an honest attitude tries to act honestly, simply, truthfully, and transparently. From their actions, they can make a critical judgement and are able to recognise their mistakes and will act following the guidelines of their conscience. In honesty, transparency is needed, manifested in the harmony between thought, discourse, and action. This harmony in action will allow others to understand their intentions and objectives. Transparency facilitates social ties and is the first value needed to establish a solid human relationship. In the doctor-patient relationship, honesty and transparency will make the latter be aware of reality so that they can decide and establish priorities about their illness.

Importance for the person/ professional/society

A receptive person is flexible and tolerant when relating to other people, without prejudice towards their interlocutor, allowing them to express themselves and feel heard. This attitude will also lead them to understand that reason is not one-sided, nor will they be influenced by the reasoning of others, but they will listen and receive reasons to make decisions. Receptivity makes a person more empathic and respectful, characteristics that will lead to a better coexistence within the family, in the workplace, and in society.

Receptivity as a value promotes reliability and 'trust' in relationships between people and is essential in the doctor-patient relationship. Trustworthiness is largely based on the technical competence of the doctor, related to knowledge, professional skills, and human skill, which translates into how medical practice is conducted from the human point of view, by incorporating a trustworthy attitude and behaviour.

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professional skills, and human skill, which translates into how medical practice is conducted from the human point of view, by incorporating a trustworthy attitude and behaviour.

Personal communication, face-to-face, doctor-patient, showing an active receptive attitude and considering the patient from a holistic perspective leads to a relationship of trust and respect. Trustworthiness leads to the reliability offered by a doctor when responding satisfactorily to the expectations placed by a patient in the face of the complex and uncertain situation of being sick. Likewise, in the spaces of the virtual doctor-patient relationship, a receptive attitude should be practised to the same extent.

A receptive attitude in the doctor-patient encounter is decisive, allowing one to build a hopeful state of mind based on the mutual relationship. Hope arises in a patient before the doctor-patient encounter. The patient has favourable expectations in the health system or the doctor because of previous information, but once the interpersonal relationship has initiated, the patient expects to be cured by the doctor, relieved of the pain, understood, and non-abandoned. The doctor, in the encounter in which trust has been established, hopes to be useful for the patient's needs.

In the social sphere, a receptive attitude provides sensitivity in various aspects, such as environmental, social, and economic problems, participating in deliberations, formulating hypotheses, and studying problems and solutions.

A receptive society incorporates the value of receptivity in its actions and thoughts, tolerating diversity and different behavioural models, admitting their way of being and doing. In practice, it favours the inclusion and coexistence of different groups. The mere fact of belonging to a society or organisation with a receptive attitude does not validate the practice of receptivity by a specific person. Non-acceptance of the diversity of thinking, doing, cultural, religious, etc., creates conflict and encourages non-coexistence.

Implications in daily work

Being receptive implies being able to deliberate with professionals with different profiles, with patients, and with different social agents when doctors, in the practice of the profession, must take part and position themselves on which action or position is the most appropriate when facing situations of non-consensus or when there is a latent conflict of values between the parties.

In this doctor-patient encounter, receptivity is present not only in the language, words and attention to their words but also in the tone of voice, gaze towards the patient, time spent, and relaxed attitude.

In the scenario of a face-to-face, doctor-patient relationship, a doctor showing a receptive attitude and considering the patient from a holistic perspective, in which all the dimensions of the person—biological, social, psychological, and spiritual—are present, will facilitate dialogue and deliberation with the patient and, thus, the knowledge by the doctor of the values associated with them that should be part of clinical decision-making. In addition, with their knowledge, they will encourage the same patient to be involved in treatment, making them participants in their healing process.

The Hippocratic model centred on beneficence/non-maleficence is currently insufficient.

A receptive attitude centred on all dimensions of the patient will foster mutual trust and respect. A patient's trust in a doctor is as important as the doctor being aware of the trust. Mutual trust resulting from a receptive attitude, together with other values, strengthens the doctor regarding decisions to be made.

A receptive attitude in the doctor-patient relationship, when trust has been established, plays a decisive role in decision-making

A receptive attitude in the doctor-patient relationship, when trust has been established, plays a decisive role in decision-making. A doctor acts considering the patient's preferences and is freed from practising medicine at the request of the patient—to satisfy their concerns—or defensive medicine for fear of litigation.

A receptive doctor practises tolerance and favours coexistence ; when exercised with mutual respect towards different values and opinions, this value facilitates interprofessional collaboration, creating synergy as a result of contributions from different professionals, opening the opportunity to know other points of view and possibilities, both in health care as in research and teaching.

A doctor's receptivity also manifests itself by answering the questions or doubts raised by the same patient or relatives in relation to other treatments based on alternative methods. The doctor must provide information about evidence, efficacy, and contraindications of the alternative treatment. In the information, they must warn of the unconventional nature, albeit complementary, of the treatment consulted, not being a substitute for any previously prescribed treatment. If the doctor does not practice alternative medicine, she or he must facilitate the patient's access to another professional who can help provide the necessary information resolve the doubts of the patient or relatives.

Consequences of its lack of consideration

A non-receptive interpersonal doctor-patient relationship will lead to a lack of trust. When there is little trust in a doctor by a patient, in addition to reducing the social value of the relationship, there is a decrease in the value of the success of the therapeutic intervention.

A non-receptive and distant attitude of a doctor towards a patient, which at first could be considered a strategy for their protection in the face of multiple concerns, can lead to a system of arrogance, where the patient is not seen as a person but as a disease.

Without receptivity in the doctor-patient relationship, the patient will not get the help needed because they cannot incorporate their values and preferences into the health care interaction. In this situation, the patient will become a spectator of their needs and can, in a certain way, be manipulated by the doctor and/or acquire an inferiority complex by relying entirely on the doctor.

Adherence to treatment advice is multifactorial, and compliance is difficult when treatment is extended. If a receptive attitude is lacking and a patient's concerns, priorities, motivations, and vital objectives are ignored by a doctor, the latter will not be able to share with the patient the responsibility of treatment advice.

Receptivity, resulting from a personal relationship, can be totally distorted or made invisible by prioritising medical specialisation as a synonym of the practice of medicine subdivided into areas and by placing excessive trust in technology and organic disease. Although sub-specialisation is necessary to develop and increase knowledge, the resulting doctor-patient relationship is often based on very narrow questioning, in which the patient only responds with monosyllables, obtaining necessary clinical data for correct diagnosis and treatment but incomplete by not considering the patient's preferences and values.

Individual and collective benefits of its correct observation

Values in general, receptivity in this case, are the driving force underlying change in actions, both personal and professional, in institutions and society that are flexible, tolerant, welcoming, and sensitive. They will be indicators of the direction of change towards human and social excellence.

Action characteristics resulting from being receptive increase the satisfaction of doctors and patients. The doctor understands and perceives the patient's personality, adapting their language, and thus, dialogue is more direct, fruitful and, as a result, more positive. Improving information and trust provides greater satisfaction for the patient and doctor.

A receptive institution or society, offering voice to the citizenship and listening to them in relation to attending health problems in their policies, will resolve these problems more efficiently

A receptive institution or society, offering voice to the citizenship and listening to them in relation to attending health problems in their policies, will resolve these problems more efficiently because of being linked to the priorities determined, without creating conflict in competing for the same resources, and will also increase the perception of quality and equality of the service.

Collective assessment, reflected in receptive deliberation, determines the prioritisation of service provision, without being sensitive to costs but to deliberation and reasoning.

Summary/final messages

Values and specifically receptivity are ideal and real qualities. They are moral requirements guiding a doctor towards a purpose to perform medical practice in a certain way. The value is the ideal to which the person feels connected, and the ideal is the model to imitate.

Values are transmitted by example, not doctrine. The strength lies in how a model is susceptible to imitation by their way of being and doing.

A doctor who wants to have a receptive attitude will have to acquire it through practice. Acquiring values is a personal choice and will determine the uniqueness of a doctor.

The practice of values needs to be continuously reviewed to provide the best response to the needs of patients, professionals, and the institution in which the services are provided, if such is the case.

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Honour and integrity

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Honour and integrity

Introduction

Honour, honesty and integrity are fundamental values that should be shared by each and every member of society. Unfortunately, this is not always the case. We take it for granted that physicians have these values, in both their professional practice and as members of society. Among the responsibilities fixed in the 'Physicians' Charter', a commitment to honour, integrity and honesty with patients is considered as a principal value, which goes beyond the patient-physician relationship.

Definitions

The first problem to be addressed is that of the terminology to use. In Spanish we usually use the terms honour, honesty and integrity interchangeably. However, if we keep in mind the strict meaning of each term, as defined by the Real Academia de la Lengua (RAE), we see that these terms do not have exactly the same meaning. These definitions are outlined below.

The RAE defines integrity as the condition of a person with integrity, such a person is straight, irreproachable and incorruptible.

When one refers to honour, it is defined as righteousness (rectitude) and respect for considered norms.

Finally, the RAE defines honesty as a quality, referring to that which is decent, decorous, modest, reasonable, fair and righteous.

These definitions allow us to appreciate some differences between the terms that we can illustrate with an example. Thus, a politician can be honourable by fulfilling their manifesto pledges and seeking to improve the well-being of the electorate without making a fortune at their expense, but cannot also be considered honest at the same time if they also lead a chaotic personal life.

However, due to the influence of the English language in which the word 'honesty' covers the concepts of both honesty and honour, there has been a generalised use of the three aforementioned terms as synonyms that the RAE has eventually accepted. For this reason when

these terms are referred to in this chapter, they are considered to have the same meaning in a broad sense.

Relationships with other values or similar principles

The value of honesty or integrity in the medical profession entails the firm adhesion to a moral code and an unimpeachable way of behaving

The value of honesty or integrity in the medical profession entails the firm adhesion to a moral code and an unimpeachable way of behaving.

Therefore, these values influence or at least should influence all professional medical activity. The different qualities displayed by a medical professional lack meaning without honesty. This is so much the case that in many treatises and reports regarding values in the medical profession, the value of honesty is forgotten as it is taken as a given. For example, the latest version of the Ethics Manual of the American College of Physicians (published in January 2019) gives a definition of the medical profession, indicating that it is characterised by : 'a) a body of specialised health-related knowledge, which members should not only apply to their patients but should teach and expand, b) a guiding code of ethics, c) the practice of putting the interests of the patient above self-interest, and d) a privileged self-regulation that is recognised by society as being unique and specific'.

Reviewing the different values addressed in this monograph, it is clear that integrity and honesty are indispensable values that are necessary to respect the autonomy and dignity of the patient, to accept, manage and listen to the opinions of others, to act altruistically and to act in an ethical and moral manner. Likewise, a professional with integrity will take care to be dependable while ensuring their level of professional competence is maintained. A professional with integrity will also maintain confidentiality. Such a professional will feel a responsibility towards society and the profession, while demonstrating a commitment to act in the interest of the patient.

In 2002, the American Board of Internal Medicine (ABIM) published a document entitled *Medical professionalism in the new millennium : a physician charter* that fixed the professional commitments a physician should meet at the start of the 21st century. These commitments are described in Table 1. It is difficult to envisage a professional without integrity or honesty meeting these commitments. Undoubtedly, honesty, honour and integrity are related, directly or indirectly, with all the qualities associated with medical professionalism.

The importance in the individual, the profession and society

The honesty of a medical professional must be evident in different areas, from the personal to the patients, the profession, society at large, the institution where they work and the administrations (health and justice, among others)

Table 1. Commitments of the Physician's Charter.
Commitment to professional competence
Commitment to honesty with patients
Commitment to patient confidentiality
Commitment to maintaining appropriate relations with patients
Commitment to improving quality of care
Commitment to improving access to care
Commitment to the just distribution of finite resources
Commitment to scientific knowledge
Commitment to maintaining trust by managing conflicts of interest
Commitment to professional responsibilities

Table 2. Areas in which the values of honesty and integrity should be evident.
Honesty with one's self
Honesty in the physician-patient relationship
Honesty in scientific/clinical investigation
Honesty in professional relationships with colleagues
Honesty in teaching
Honesty in relation to the healthcare system
Honesty and integrity in relationships with the pharmaceutical industry and the general healthcare industry
Honesty and professional bodies/societies
Honesty and the justice system

with which the professional interacts. We will briefly discuss the areas that are listed in Table 2.

A professional has to be honest with him/herself

In the first instance, a professional with honesty and integrity is one who is aware of his/her own limitations and is therefore capable of seeking help from colleagues. We should remember that the Deontological Code of Medicine (CDM) illustrates this point effectively in Article 22.1, which states that 'the physician should refrain from activities which exceed their capacities and in such cases they will propose to the patient that they be referred to a colleague competent in the area'. An honourable physician is one who is always conscious of the limits to their knowledge and competencies and takes care to keep them updated by participating in activities of continuous education and professional development, which serve to maintain professional competence.

An honorable physician is one who is always conscious of the limits to their knowledge and competencies and takes care to keep them updated by participating in activities of continuous

Furthermore, a physician with integrity is one who takes care of his/her physical and mental health, avoids the development of addictive habits and in case of illness takes the necessary appropriate steps. In Article 22.2 the CDM refers to the appropriate behaviour in case of ill health. The article reads : 'If a physician observes a deterioration in their judgement or technical ability due to age, illness or other causes, they should immediately seek the advice of a trusted colleague for help in deciding whether to suspend or modify, temporarily or permanently, their professional activity'. Furthermore, Article 22.3 states 'If the physician was not conscious of such deficiencies and has been warned by a colleague, they are obliged to inform the relevant authority and, if necessary, bring it to the attention of the relevant professional body, with objectivity and due discretion'. Acting in this way does not represent a lack of fellowship, as the good of the patients is always the priority.

Honesty in the physician-patient relationship

This is the area where, to the greatest extent, the value of honesty must be observed. Physicians with integrity are those who are truthful with their patients, beginning with a clear explanation of their area of competence, qualifications and current position.

The physician has to, in a complete and honest manner, keep the patient informed. This gives the patient the capacity to take decisions regarding autonomy, which can affect diagnostic and therapeutic procedures. This does not mean that the patient is involved in each and every decision, but rather that the patient is involved in those that are the most relevant or concern key aspects of managing the illness. The information the patient receives has to be truthful, although transmitted with prudence. As stated in Article 15.1 of the CDM 'The physician will inform the patient in a way that is comprehensible, truthful, measured and prudent. When the information transmitted is serious or involves a poor prognosis, an effort will be made to transmit the news as delicately as possible so as not to harm the interests of the patient'.

Sometimes, in trying to relay information to the patient in a way that must be truthful comprehensible, measured and prudent, the physician is not completely honest. The objective should be to ensure that patients are given information that endows them with the capacity to take decisions and exercise their autonomy with regard to diagnostic and therapeutic procedures, without resorting to 'white lies'. In some deontological codes it is said that 'a poor prognosis should be kept from the patient, but explained to family members'. This behaviour, although understandable, cannot be accepted due to the lack of honesty ; everyone around the patient knows the bitter reality, except for the central character in the situation.

Information given to patients may also refer to adverse effects, which have occurred or could potentially occur as a consequence of a treatment, error or unforeseen incident. In cases

where a patient under the physician's care suffers physical or mental injury, the situation should be remedied if possible and explained clearly to the patient and his/her family members. The need to analyse the reasons behind possible errors, rather than ignoring or underestimating them, derives from this commitment. Recommendation 11 of the guide Good Medical Practice or 'Buen Quehacer del Médico' (BQM) indicates : 'Physicians have to be honest and sincere with their patients when complications, errors or accidents occur. If a patient suffers any physical or mental injury whilst under their care, the physician should take the following steps at the earliest opportunity : a) Remedy the situation, if possible. b) Explain what has occurred as soon as possible along with the expected long- and short-term consequences'. Likewise, the honest professional should not hide from patients the fact that there are occasions when a diagnosis cannot be made with complete certainty.

Honesty in dealing with the patient also involves respecting the commitment to the patient established in the process of care, avoiding intimate relationships with patients and their family members, sexual harassment of patients and their family members, and exaggerated demands for payment or services in kind.

Honesty in dealing with the patient also avoids the practice of defensive medicine, which involves indicating tests and treatments that do not have the objective of patient benefit and the practice of specialities and diagnostic and therapeutic procedures for which the physician is not capable or certified.

A physician with integrity must maintain confidentiality in relation to information regarding his/her patients, respecting the corresponding ethical and legal framework. Article 27.2 of the CDM provides a good summary of the physician's commitment to confidentiality : 'The physician has the obligation to maintain confidential all that the patient has revealed and confided to them and all they have seen and deduced as a consequence of their work related to the health and privacy of the patient, including their medical history'. Finally, the honest physician has the obligation to adequately record all available data in the corresponding medical histories of the patients and to issue certificates and medical reports that reflect the truth. They must also take care to securely store all documentation relating to their patients, in compliance with data protection laws.

Honesty in relationships with colleagues

Honesty is manifested in relationships with professional colleagues by a commitment to share knowledge, to work appropriately with professionals from other areas as part of a multi-disciplinary team, to refrain from expressing criticism of the performance of other colleagues in their absence and to abstain from attracting patients away from other colleagues. With regard to honesty in professional relationships, Article 37.1 of the CDM should be kept in mind : 'Fellowship between physicians is a fundamental duty, only the rights of the patient have a higher priority' and Article 37.2 'Physicians should treat each other with due deference, respect and loyalty, regardless of the existing hierarchy. They have an obligation to defend their colleagues if they are subjected to attacks or unjustified complaints'. Likewise, the physician leading a healthcare team should act with honesty and integrity in relationships with other team

members. Any form of harassment of colleagues and team personnel should be avoided.

Honesty in scientific/clinical investigation

A significant proportion of medical professionals conduct tasks related to research in their respective institutions. To be honest and honourable in this area supposes compliance with the ethical-legal norms of research and avoiding participation as an author or co-author of published work in which they have not participated. Falsification of results and plagiarism should be avoided.

In this area, the recommendations given in Article 59.3 of the CDM should be taken into consideration : 'Respect for the subject of investigation is the guiding principle of clinical research. Informed consent should always be explicitly given. The informed consent should contain at least the following information : the nature and purpose of the study, the objectives, the methods used, the predicted benefits as well as the potential risks and inconveniences resulting from participation in the study. The subject should also be informed of their right not to participate or to freely withdraw from the study at any time, without any sanction'. Conflicts of interest should always be declared and in cases where this conflict could affect clinical decisions, the honest physician should refrain from participating in such a study.

Honesty in teaching

Teaching is a Hippocratic imperative for physicians. Every physician has to teach and the majority teach in universities, hospitals or primary healthcare centres. Integrity has to be observed in the development of teaching activities. This means that physicians are required to develop and maintain the appropriate competencies that facilitate their teaching obligations towards students, residents and other healthcare professionals. These tasks should be conducted with enthusiasm, commitment, punctuality and availability.

In the specific case of clinical teaching, Article 63.5 of the CDM should be taken into consideration at all times : 'Those responsible for clinical teaching will ensure that the processes of teaching and learning are conducted in such a way as to minimise any inconvenience for the patient'. Once again, the honest professional should keep in mind at all times that the interest of the patient is always the priority.

Finally, discrimination or other inappropriate forms of behaviour towards students should never be employed. All students should be evaluated in a fair and objective manner.

Honesty in relation to the healthcare system

Medical professionals they must use the resources of the system and its institutions responsibly

Medical professionals have to be honest in their relationships with the healthcare system in which they work. Therefore, they must use the resources of the system and its institutions responsibly. This is particularly important in

periods of economic crisis. They have to be capable of using finite resources in an appropriate and prudent manner, without decreasing the quality of care provided to patients.

When a physician with integrity observes an infrastructure that is inadequate for correct professional practice, Article 45.2 of the CDM outlines the path to follow : 'The physician will inform the management of the centre of deficiencies of any type, including those that are ethical in nature, which impair correct medical care. If this is not possible, a complaint should be made to the professional body and as a last resort to the healthcare authorities, before informing any other authority'.

Honesty and integrity in relationships with the pharmaceutical industry and the general healthcare industry

It is fundamentally important that healthcare professionals act with integrity in this area. Inducements of any type that could influence prescription are prohibited and conflicts of interest of any type should be declared. An honourable physician should oppose attempts to medicalise patients excessively for commercial gain. The physician should be conscious of the activities of healthcare lobbies that conduct for-profit activities, and avoid collaboration with such bodies.

Honesty and professional bodies/ societies

All medical professionals have to be familiar with and observe deontological codes. We stated at the beginning of this chapter that integrity supposes the adherence to a code of conduct. In this sense, the deontological code is obligatory knowledge and will be observed by the physician with integrity.

Honesty and the justice system

Professionals with integrity are always required to collaborate with official investigations and claims, providing the relevant information while maintaining confidentiality. An honest physician cited as a witness in judicial proceedings should act in accordance with the considerations described in Recommendation 24 of the BQM guide : 'When a physician is cited to declare before a court they should be truthful, sincere and reliable. They should make sure that the evidence presented and documentation prepared and signed is truthful. To ensure this : a) any information provided in testimony should be verified and proceed from a reliable source, and b) relevant information should not be deliberately omitted'. Likewise, Article 62.3 of the CDM provides important advice with regard to the disclosure of only the information necessary to resolve a judicial case : 'A physician called to testify has the obligation to appear before the court. In testimony, they will limit themselves to a description of the facts that, in their condition as physicians, they have seen or heard which are relevant to the case. They will maintain confidentiality wherever possible and will only reveal what is strictly necessary for the resolution of the case. In civil cases, privileged information obtained confidentially by the physician cannot be used'.

Implications in daily work

The value of honesty is present and has an effect on all professional activities. This value is constantly tested in situations that occur on an almost daily basis. To illustrate this, some examples in which these values are called into question are given below. It is acknowledged that this does not represent an exhaustive list of all possible situations that a physician could encounter.

The value of honesty is present and has an effect on all professional activities

I have committed an error that has resulted in consequences for the patient. What steps should I take?

A professional has to always act with sincerity towards patients, especially when complications or errors occur that result in harm. Any error should never be hidden. Furthermore, the physician with integrity should remedy the situation if possible and explain what has happened to the patient and his/her family members. The physician should also respond in an honourable, rapid and detailed manner to any possible complaints from patients which arise. Article 17.1 from the CDM should be taken into consideration : 'Physicians should assume the negative consequences of their actions and errors, offering a clear, honest, constructive and appropriate explanation'.

If I am not sure of a diagnosis. Should the patient know?

In this case, an honest professional should communicate this circumstance to the patient. This will contribute to the establishment of a strong patient-physician relationship.

I did not act appropriately with regard to risks that compromise patient safety

The physician should take the necessary measures to ensure the safety of the patient at all times. This ranges from the practice of strict hygiene (e.g. hand-washing before a patient examination) to avoidance of unnecessary exploratory procedures that could put the patient at risk.

I have prescribed medicines that are recognised as ineffective to avoid problems with patients

The prescription of drugs whose efficacy has not been demonstrated (or placebos) should be avoided in all cases.

I have issued medical certificates that do not reflect the reality or I have introduced imprecise data in medical histories

The physician has to be aware that false or inexact data should never be entered in official documents (medical certificates or medical histories, judicial testimonies). Apart from demonstrating a lack of integrity, possible criminal charges may result. It should be noted that it is compulsory to record any necessary changes made to medical histories.

I have issued medical certificates for sick leave without justification

The honest professional should refuse to issue medical certificates for sick leave that do not correspond to a justified illness and that have not been verified personally.

I have been offered an authorship on an article to which I have not made a contribution. I have not declared my potential conflicts of interest

A professional should abstain from signing as an author any work in which they have not participated directly or have made no significant contribution, even when it has been offered by the co-authors. It is also fundamentally important to declare possible conflicts of interest in all articles.

I have been summoned as an expert witness by a court

The physician called as an expert witness to a court should be truthful and reliable, without omitting any relevant information. Confidentiality should be maintained where possible.

I have been sanctioned for an offence related to my professional practice or I have been convicted of a serious offence

In such cases the professional body must be informed. In those instances where the professional practice of the physician is restricted, they should inform their patients and the centre where they are employed of such a circumstance.

The economic relationship with patients in the public and private healthcare systems

In their relationship with patients in the area of public and private healthcare, the physician should act with honour and integrity with reference to economic aspects, presenting fair and appropriate claims for expenses. Payments from patients outside of the corresponding expenses should not be accepted and private financial interests should not influence diagnostic and therapeutic decisions. Recommendation 27 of the BQM sums this up well : 'The physician should act honestly and transparently in their commercial and economic relationships with patients, business people, insurance companies and any other type of person or organisation'.

A healthcare company offers me a financial incentive to prescribe one of their products and offers to fund a teaching activity in which one of their healthcare products will be advertised

In this context, the physician should not accept any incentive or pressure that could influence prescribing habits. Recommendation 30 of the BQM expresses this : 'The physician should not accept or seek any incentive, gift or social attention that could affect the manner in which they prescribe medicines, treat or refer patients and order services. The physician should never offer any such incentives to their patients or to their fellow professionals'.

I criticise and discriminate against colleagues whose opinions I do not agree with

Criticism of colleagues should never be expressed in their absence.

I do not participate in periodic training to maintain my competencies

Every professional with integrity has an unavoidable obligation to periodically evaluate their professional competencies and undergo the appropriate recertification processes.

I have neglected my teaching obligations

Attendance and punctuality should be ensured and teaching skills should be updated. Students and colleagues should be evaluated fairly when required. Every physician has a duty to implicate themselves in the teaching and evaluation of colleagues, as reflected in Recommendation 56 of the BQM : 'The physician should be willing and able to contribute in all stages of medical teaching. The physician-teacher must be willing to collaborate in the training and development of other healthcare professionals'. They should also act with honesty and integrity in the evaluation of colleagues, as indicated in Recommendation 57 of the BQM : 'The physician should act with honesty and objectivity when giving references or recommendations and when evaluating the performance of his/her colleagues'.

Consequences of a lack of consideration towards the values of honesty and integrity and the collective and individual benefits of their correct observation

A lack of consideration for the values of honesty and integrity translate into a loss of confidence in the physician and deterioration in the relationship with patients, fellow colleagues, healthcare institutions and professional bodies.

A lack of consideration for the values of honesty and integrity translate into a loss of confidence in the physician

The correct observation of the value of honesty provides benefits for the professional in relation to their professional tasks and their patients. The observation of honesty and integrity by the physician also gives them respect at both the personal and professional level as well as bringing with it the satisfaction of having exercised their professional activity in an honest manner.

A physician not only performs as a physician but is a physician

A physician not only performs as a physician but *is a physician*. In their training, physicians are subjected to a transformational process where they acquire knowledge and skills and through

which they incorporate the values of the medical profession, in particular the values of honesty and integrity that we have analysed in this chapter and which should be considered in all activities. One can deduce the importance of honesty and integrity as values in those who assume the role of teaching future healthcare professionals, given the enormous responsibility as role models for their students in the different phases of the educational continuum.

Summary and take-home messages

The values of honesty and integrity are intrinsic to the majority of professional qualities.

The observation of the values of honesty and integrity facilitate the observation and compliance with the remainder of the professional values of the medical profession. In particular, these include ethical behaviour and the adherence to a code of conduct, respect for patient autonomy and dignity, altruism, maintenance of confidentiality, maintenance of professional competencies, and responsibility towards the patient, society and the profession.

Honesty has a presence in different spheres and areas such as : the personal sphere, patient-physician relationships, relationships with fellow colleagues, research and teaching, relations with the healthcare system, relations with the pharmaceutical industry, relations with professional bodies and the administration of justice, among others.

The observation of the value of honesty is essential for the correct professional practice of medicine in all contexts.

Medical professionals with teaching responsibilities, whatever their level in the process of training a physician, play a fundamental role in the acquisition of these values as they act as role models. Therefore, honesty and integrity should always guide the activity of medical teachers.

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— 6 —

Respect for beliefs, respect for people

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Her research work revolves around the development of attitudes and values during training in bioethics in the field of students and health

professionals (moral reasoning, ethical sensitivity, empathy, burnout) and the development of the 'mature minor competence'.

Since 2014 she has directed the University Master's Degree in Bioethics of the Institut Borja at Universitat Ramon Llull. She collaborates in different postgraduate courses and master's degree courses, such as the Master's Degree in Bioethics of the Chair in Bioethics at the Universidad Pontificia Comillas.

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Respect for beliefs, respect for people

Respect, delineation of the 'value' and relationship with other values and principles

'Bonasera... Bonasera... What have I ever done to make you treat me so disrespectfully? Had you come to me in friendship, then this scum that ruined your daughter would be suffering this very day. And that by chance if an honest man such as yourself should make enemies, then they would become my enemies. And then they would fear you... but now you come to me and you say : «Don Corleone give me justice», but you don't ask with respect. You don't offer friendship. You don't even think to call me Godfather. Instead, you come into my house on the day my daughter is to be married, and you ask me to do murder, for money'. (*The Godfather*, Francis Ford Coppola, 1972).

The beginning of The Godfather, one of the masterpieces of cinema, gives us one of the scenes in which the value of respect is more emphasised. Don Vito Corleone, the Godfather, speaks these words to Bonasera, who comes to ask him a favour : 'What have I ever done to make you treat me so disrespectfully'? And he continues : 'but you don't ask with respect. You don't offer friendship. You don't even think to call me Godfather'.

Respect is revealed as the main axis of the relationship, as an essential element for trust. Without respect, there is no possibility of relationship and trust.

However, respect is one of the most difficult values to explain. As St. Augustine pointed out : 'What is time? If no one asks me, I know ; but if I want to explain it, I do not know how to'. Likewise, we all know what respect or a respectful attitude is, but it is much more difficult to define.

Josep María Esquirol, in a wonderful book, *Respect or attentive gaze,* defines it as 'the ethical attitude connecting us to things, the world, and people... the essence of respect is attentive gaze'. Esquirol argues that 'the ethics of respect cannot be an escape from the world. First, because the attentive gaze is at the service of orientation, and not merely at a theoretical level, but in life... The attentive gaze is the condition to orient oneself in life. Second, the

attentive gaze is never an escape from the world because it connects us closely with the world. Whoever pays more attention, is better oriented and respects more'.

Respect is explained, then, as attentive gaze and orientation. In this sense, respect also implies recognising the other, so that respect for a person's beliefs is respect for the person.

The current importance of respect in the person and medicine

The need to build care based on respect and trust has been a constant in the history of medicine but acquires greater urgency in the present.

Currently, a misunderstood concept of evidence-based medicine, anchored in positivism, can make us believe medicine is evidence, analysis and data, forgetting peopl

Currently, a misunderstood concept of evidence-based medicine, anchored in positivism, can make us believe medicine is evidence, analysis and data, forgetting people. This forgetfulness of the person is perhaps the most disrespectful attitude in the health context.

Laín Entralgo, explained by Diego Gracia, conceptualises it clearly : 'Positivism has had in few fields such a resounding and lasting success as in medicine. In fact, medicine went from being empirical to an 'experiment' with positivism : in this sense, we are children of positivism. Previous medicine, empirical medicine, based its knowledge on mere experience, not on the experiment, that is, not on the experimental and scientific method. Experience is natural, but an experiment, on the contrary, is programmed. Experience is retrospective, and an experiment is prospective. Experience is based on the mere accumulation of similar experiences, but an experiment is not : it is programmed and designed and requires a more complex process of understanding. Positivism clear indicated that positive science had to be experimental, not just empirical. This approach dramatically advanced biology and medicine in the twentieth century.

Classical clinical medicine relies on symptoms and signs. Symptoms are defined as a subjective sensation, and signs are defined as objective data. Following the experimental method, a diagnosis must be made considering only objective signs. Symptoms are not reliable because they are not objective. Hence, positivist medicine produced two phenomena of the utmost importance : one, neglecting symptoms and two, the recession of the word. Positivist medicine becomes silent.

When medicine is reduced to signs and data, positivist medicine becomes silent, and the person, subjective and narrative, disappears. Evidence-based medicine, misunderstood, forgets the person and the word, to stay in the world of figures and data, and becomes impersonal and disrespectful medicine.

When medicine is reduced to signs and data, positivist medicine becomes silent, and the person, subjective and narrative, disappears

Consequences of disrespect

'Silent' medicine can hardly offer a comprehensive experience of being respected, and respect is unavoidable for the experience of being ill ; as Edmund Pellegrino mentioned, 'the experience of being cured is ontologically connected to that of being taken care of'.

This is where one of the enormous shortcomings of current techno-scientific medicine lies. The importance of reincorporating respect for a person by reintegrating the individual experience of being sick and the word. In the words of Javier Gomà, in '*The inconsolable*, 'the person is a temporary entity in continuous evolution ; that is why they resist being understood by the natural sciences. Only the narrative genre, which takes over the before and after, manages to perceive its flowing essence... When we want to know more about someone and ask who they are, no one thinks to answer us with a definition, always with a story : their origins, upbringing, and the vicissitudes of their lives'.

We do not describe anyone by their anthropomorphic data, genetic code, analytical data, or radiological tests ; therefore, we cannot understand anyone only with their data, even if we expand the volume of data. Quoting the philosopher Dilthey, Laín Entralgo said : 'life is not explained, it is understood. The natural sciences «explain things», but life has very peculiar characteristics. For now, it is not merely intellectual but consists of a complex of knowledge, feelings, and tendencies, given in an indissoluble unity. Life is not a mathematical treatise, so purely speculative logic is not valid'.

Disrespect in the current health context translates into a lack of listening to a person and the lack of recognition of their narratives, beliefs, and values.

However, modern medicine is undergoing a scientific and technological change not only in practice but also in teaching. An editorial in *The Lancet* defined it very well : 'The emphasis of current medical training is on the «hard» sciences : anatomy, physiology, biochemistry, pathology, microbiology, pharmacology..., but in clinical practice, doctors have to understand patients, their stories, personalities and peculiarities, to provide them with the best possible care. On this «soft» side of medicine, «hard» sciences are of little help to doctors.

As beings who are not only biological but also biographical, there is a constant search for meaning in illness and in the experience of a suffering person. In this context, scientific understanding (hard sciences) of an illness contrasts with the narrative story (only approachable by the soft sciences).

We will only come to respect a person and their beliefs from the soft sciences by knowing the person and recognising their experience of being ill, feelings, and narrative.

We will only come to respect a person and their beliefs from the soft sciences by knowing the person and recognising their experience of being ill, feelings, and narrative

Respect in the day-to-day : the name of the dog

The 'New England Journal of Medicine' published a text in 'Perspectives' with a curious title, 'The name of the dog', by Taimur Safder. The author explains how in his first emergency shift as a resident, what struck him the most was the moment when the attending physician, treating a patient with chest pain that appeared while walking the dog, asked : 'what is the name of your dog?'

He was amazed because no clinical guide or diagnostic algorithm of chest pain includes a question about the name of the dog in the differential diagnosis. However, he continues to relate how that question was decisive in his training as a resident because that question and the conversation that followed produced a transformation, perhaps his greatest learning experience : realising there was a real person beyond the patient.

At the end of the residency four years later, Safder notes it was one of the most useful experiences he had. He explains how discussing the plot of a soap opera made it easier for him to discuss with the patient the treatment plan in an environment of greater respect and trust. He also describes how listening to his patients' beliefs had allowed him to approach 'difficult' patients refusing treatment or adapt treatment to the specific needs of each person.

In fact, this question is directly related to respect for a person, that is, 'explain to me who you are'. This is respect as recognition : only if I recognise the other as an individual and different person can I offer respect.

The question raises one of the burdens of modern medicine, which is how easy it is to forget we are treating people when medical practice is immersed in data, treatment guides, tests, a multiplicity of reports, and administrative forms. People have their beliefs, narratives, priorities, passions, and prejudices, verification of 'I am I and my circumstance ; and, if I do not save it, I do not save myself', by Ortega and Gasset.

It is much easier to take distance, be unconcerned, show no respect, or not gaze attentively because knowing and recognising the other implies, also for health professionals, a certain amount of pain

Safder's article continues reflecting on his question about the dog's name : this question not only taught him to remember that patients are people but reminded him that he himself is also a person. It is much easier to take distance, be unconcerned, show no respect, or not gaze attentively because knowing and recognising the other implies, also for health professionals, a certain amount of pain.

This story clearly explains how a resident learned the value of respect and how unclear it was in his medical training.

The story is not new, at all, although verifying that deficiencies persist certainly is. Francis Peabody, in a classic article of 1927, spoke of the need for a close doctor-patient relationship, not only to generate an environment of respect and trust but to know the person because only by knowing them could appropriate diagnosis and treatment be rendered. In the words of Peabody himself, 'when we speak of a clinical picture, we do not refer to the photograph of a patient in bed, but to the impressionist painting of the patient in the environment of their home, with their work, relations with their friends, joys, worries, hopes, and fears'.

It is much easier to 'read' a photograph in black and white, fixed, stable, well-defined than to learn to read an impressionist painting. However, if the change in view is not made, we will continue to repeat ad nauseam that 'we need to treat sick people and not diseases', although the guides and protocols deal only with diseases.

Individual and collective benefits of its correct observation

In the eighties, Stephen Toulmin wrote a well-known article titled 'How medicine saved the life of ethics'. In this article, he explained how ethical conflicts had 'saved philosophy and philosophical ethics' and given him enough material to survive, at a time when this discipline was mired in circular debates.

Perhaps now, medicine needs to be saved by bioethics (together with the humanities), saved 'from becoming an applied technique or biology, extremely effective and highly specialised, although, along the way, medicine has lost its essence, its vocation to cure and care, alleviate suffering, and comfort people', in addition to losing respect for people.

In plural societies, with multiple codes and diversity of coexisting values, the best care of people can only be provided by a 'soft' approach ; in this case, care is understanding what happens to a person, why they contact the health system, and what we can deliver from inside the system. We can only understand this if we practise attentive gaze and show respect for a person.

Multiple aspects of disrespect for a person in the current health context have already been described : the depersonalisation of medicine, dehumanisation, the technification of the doctor-patient relationship, sub-specialisation, the loss of the figure of the physician in charge in multidisciplinary teams...

However, the influence of positivism (reviled in many other areas) and a poor appreciation of the concept of evidence-based medicine have been cited on several occasions.

Evidence-based medicine originated as an effort to improve the quality of care given the enormous variability in clinical practice and many clinical decisions lacking value, recognising that the individual experience of a doctor, by itself, is

not enough guarantee in current standard clinical practice.

However, the definition of evidence-based medicine coined by Sacket is 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of an individual patient'. With this, evidence-based medicine would comprise three broad areas (figure 1) : the best scientific evidence, the professional's experience, and the patient's values and expectations. The usual use of the term has increasingly been reduced only to the first area.

Patients' values and expectations are essential for standard evidence-based medicine. However, perhaps a great part of the problem is knowing how to integrate knowledge and approaches : we inherited a more complex concept of health from the twentieth century, a biopsychosocial-spiritual model, but we do not have standard models of a complex and multidisciplinary approach, except for honourable exceptions (such as, for example, palliative care teams, with an exquisite approach and respect for the person in general).

It can be repeated that the patient matters more than the disease, but necessary is an approach incorporating the recognition of both the biological and biographical dimensions, which are inseparable and interdependent.

Proliferation in the use of complementary and alternative medicines should make us reflect on the limits of scientific and technological knowledge and on the necessary wisdom

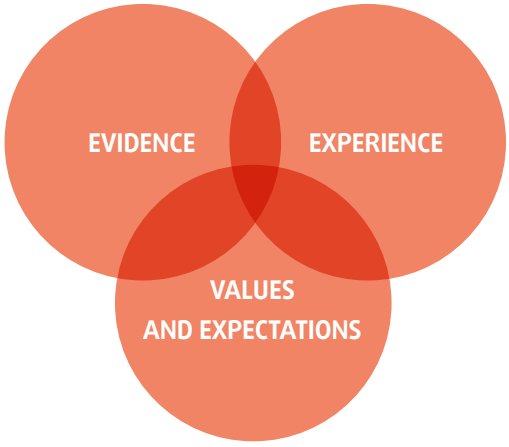

Figure 1.
The three areas of "Evidence-based medicine", Sacket-Guyatt

Some current phenomena, such as the proliferation of visits to complementary and alternative medicine providers, can reflect this quest by patients of respectful medicine. Proliferation in the use of complementary and alternative medicines should make us reflect on the limits of scientific and technological knowledge and on the necessary wisdom to approach values, beliefs, and uncertainty.

Fulford, a psychiatrist and philosopher, developed the concept of values-based practice (Table 1). Given the belief that science only deals with facts and medicine has nothing to do with values, this author defends that there are no facts without values. Recognising and learning to manage the diversity of values is essential in modern medicine.

Siddhartha Mukherjee, an interesting author, oncologist, and professor of medicine at Columbia University, is the author of two extensive books : *The Emperor of All Maladies : A Biography of Cancer* (which won a non-fiction Pulitzer) and

The Gene : An Intimate Story. Between the two works, he publishes a small book, *The laws of Medicine,* in which he narrates his experience and insights such as not expecting 'medicine to be such a lawless, uncertain world', 'it's easy to make perfect decisions with perfect information. Medicine, on the other hand, requires making perfect decisions with imperfect information' and how his 'medical education taught him a lot of data but little about the spaces between data'.

This is one of the most beautiful descriptions of medicine as an uncertain science : we know data, a lot of data, but very little (or sometimes nothing) of the spaces between the data.

Siddhartha concludes 'the abundance of data hides a much deeper and more important problem : the need to reconcile knowledge (true, fixed, perfect, concrete) and clinical wisdom (uncertain, fluid, imperfect, abstract).

Data and spaces between the data. Clinical practice cannot be reduced to data management. Thus, incorporating respect implies incorporating the recognition of a person, their values framework, and the diversity of values to deliver higher-quality care.

Final messages

Respect is the main axis of a relationship, as an essential element for trust. Without respect, relationships and trust are not possible.

Positivist medicine and evidence-based medicine can lead to ignoring people or their values framework.

Table 1. en principles of values-based practice (adapted from Fulford 2006).

Values-based practice and evidence-based medicine
1. Medical decisions are based on 'facts' and 'values'.
2. Values tend to only be 'noticed' when they are diverse or potentially conflicting.
3. As therapeutic options increase with scientific progress, the resulting diversity of human values plays a greater role in health decision-making.
Values-based practice and compassionate care
4. Patient's values occupy a central place in decision-making.
5. Conflicting values are mainly resolved by balanced evaluation, respecting all perspectives.
Values-based practice and practical clinical skills
6. It is important to be more aware of the values present in patients, carefully exploring their language, discourse, and context.
7. An increase in empirical and philosophical knowledge can help in detecting values.
8. Ethical deliberation, after exploring differences in values, can help determine the most prudent therapeutic option.
9. Communication skills are essential in values-based practice.
10. Decision-making is part of the person-centred model.

It is essential to incorporate respect for a person, their beliefs, values, and expectations to deliver higher-quality care.

Recognition, exploration, dialogue, and awareness are essential ideas to develop a greater respect for beliefs and values.

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PHYSICIAN VALUES AS A PHYSICIAN

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Moral excellence and practical wisdom

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Since the same year, he has been Publishing supervisor and Editor of EIDON, the most important Spanish-language bioethics journal.

His publications in the field of bioethics include books such as 'The good and the best. Introduction to medical ethics', 2009, 'Bioethics of responsibility', 2012, 'Consulting in clinical ethics. From Healthcare Ethics Committees to the figure of the consultant', 2019, and is the author of numerous publications on philosophy and bioethics topics in book chapters and specialized journals.

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Moral excellence and practical wisdom

Introduction

Knowledge, or even know-how, is not the same as action. Science and technology deal with the first two aspects, while ethics deals with the third. However, science, technique, and ethics can also be inseparable aspects of the same discipline. This is the case for 'medical ethics'. The reason for this unity is that medicine is a science and, therefore, theoretical knowledge, but it is also a technique and, therefore, technical knowledge. However, it is and must also be, today more than ever, practical knowledge, a way of acting and making decisions. Hence, medicine is one of the most demanding activities. It requires, first of all, good knowledge of the facts, 'clinical facts', and demands, especially, the appropriate management of 'values'. The latter is what, today, poses greater difficulties for health professionals. Good knowledge of clinical facts is necessary but not enough for optimal decision-making. Between clinical facts and possible actions, there is always a moment of evaluating what is necessary to know and to know how to manage. Only in this way can 'moral excellence' be achieved in clinical practice.

Good knowledge of clinical facts is necessary but not enough for optimal decision-making

'Medical ethics' still has another requirement. Both the knowledge of clinical facts and attainment of values must be acquired methodically. Medicine has always followed a method, but the method more representative of clinical decision-making today is deliberative. Deliberation can be individual or collective and should be about the knowledge of facts, values, and action possibilities. It is an ethical requirement that deliberation be part of the analysis of these three aspects. When individual deliberation is not enough, collective deliberation takes place. That is the essence of decision-making through different committees that now exist in every health institution, including ethics committees. Thus, both individual and collective deliberated decisions constitute 'prudent' or wise decisions. Practical wisdom is the other axis of medical ethics.

Thus, both individual and collective deliberated decisions constitute 'prudent' or wise decisions. Practical wisdom is the other axis of medical ethics

Next, we will delve into the analysis of these two current fundamental values of medical ethics : moral excellence and prudence or practical wisdom. Moral excellence deals with the quality or value inherent in health professionals working optimally, while practical wisdom deals with the value of the outcome derived from a thoughtful analysis of all the elements belonging to decision-making.

Moral excellence

Social professions have always been defined by their moral characteristics. Of them all, excellence has been the moral characteristic unchanged throughout the centuries. Today, it is a very popular term in business ethics, following the publication, in 1982, of the work 'In Search of Excellence' by Peters and Waterman. However, the term is consubstantial to ancient Greek ethics and constitutes the foundation of the Hippocratic oath and the essential value of all medical ethics.

There are certain differences between the old ethical theory of excellence and contemporary theory. The first fundamental difference is that in the ancient theory of excellence, two types of activities were commonly distinguished, 'occupations' and 'professions', and two types of ethics or morality were commonly distinguished, 'common morality' and 'particular morality'.

Common morality is that practised by most members of society, and within them, those whose activity is an occupation ; particular morality is that of professionals, including health professionals. This difference is given in part by the very valuable object they treat, the health and life of people, and partly by the special natural endowment of the people dedicated to it. Hence, the fundamental characteristic of particular morality was excellence and implied, first, that the health professional always acted for the benefit of others and not for their own ; second, that their natural endowment made them a social figure of great moral authority ; third, that because they could not be expected to act with malicious intent, they enjoyed complete legal impunity.

This ancient theory of professional excellence entered into crisis throughout the twentieth century. Two reasons might have led to it.

First, the birth of patients' rights resulted in health professionals losing part of their moral authority and, thus, their legal impunity. Acting for the benefit of the patient no longer means, for example, acting only with good intentions but also considering the consequences or side effects of decisions, in which the patient's opinion and the institution in which the service is provided must play an important role, etc.

Second, and related to the above, the people who dedicate themselves to occupations also aspire to excellence because the consequences of their activities, in an increasingly technical world, are not of lesser magnitude than the consequences

of the activities of professionals. Therefore, the modern theory of excellence blurs the difference between common and particular morality. All activities have the same morality, or at least the difference is in degrees, not levels.

Ancient and modern theories share the notion that excellence is an ideal value, an aspiration, hence the title 'In Search of Excellence'. Excellence is not an endpoint but a pathway, a way of doing things and, ultimately, a personal mode or model of optimally exercising any activity. Other authors remind us that it is something unattainable, for example, Alasdair MacIntyre in 'After Virtue' (*Tras la virtud*), published two years later, in 1984. Both in English and in Spanish, the title is ambiguous because it plays with the double meaning of '*tras*', which in Spanish means both 'after' and 'in search of', repeating, in the second case, the idea of aspiration or desire. It can be said that this second work deals with 'excellence', not 'virtue'. However, they are both the same. Both terms are translation of the Greek word *'areté'.*

Today it is necessary to understand medical ethics and, more specifically, the 'ethics of medical values' as the ethics of professional and moral excellence

The terminological change ('excellence' instead of 'virtue') reflects a change of era and, perhaps, also of ethics. If we no longer believe moral excellence comes from the natural endowment of people but from their moral education and if good intentions are not enough to perform the best action, then we must understand that ethics and medical ethics are not an exception ; it must not be 'virtue ethics' or the 'ethics of pure duty' but 'value ethics'. In other words, today it is necessary to understand medical ethics and, more specifically, the 'ethics of medical values' as the ethics of professional and moral excellence.

At present, the ethics of medical values must move beyond the problem of whether values are objective or subjective. Medical values, rather than responding to strictly medical criteria or being mere patient preferences, are intersubjective elaborations resulting from different personal and professional assessment judgements converging in the clinical context. Medical values are constructed from those judgements of estimation or evaluation of clinical or social facts, just as clinical facts are constructed from certain data, symptoms, or experiences.

The most common values in medical practice are the result of different opinions and judgements of doctors, nurses, social workers, patients, relatives, etc. Values such as health, illness, well-being, or discomfort are never objective but are related to a patient's changing clinical state and comfort. Utility or futility results from perceived greater or lesser effectiveness of a drug to control or counteract a disease. Beneficence, capacity, confidentiality, the equitable distribution of resources, etc., are other values constructed in the multiple personal and professional interrelations of clinical practice. They are constructed not only by the health professional who diagnoses and treats the illness of a patient but also by other professionals called for consultation, the patient who suffers the disease or ailment, the health institution providing the means to care for patients, and even the society itself when choosing one health model or another. The management of these values,

however, follows a certain logic that every health professional should know.

First, all values of clinical practice can be divided into instrumental and intrinsic. This is the first principle of the logic of the ethics of medical values. They are 'instrumental values' owing to their value to something other than themselves. A drug has instrumental value because it serves to cure or relieve pain. The 'intrinsically valuable' in this case would be health or the relief obtained by the drug. The same can be said of a scalpel or a computed tomography (CT) scan. Its value is not intrinsic, but instrumental. All instruments are valid as a cure, but they do not have an intrinsic value from the clinical point of view. This means that medical practice must always be guided by intrinsic values and not merely technical values. Health technologies in their broad sense undoubtedly have a value, but an instrumental value, and their unjustified accumulation can endanger intrinsic values. According to this ethic of medical values, instrumental values must always be at the service of intrinsic values, not vice versa.

Medical practice must always be guided by intrinsic values and not merely technical

Whether values are instrumental or intrinsic, medical values are constructed by health professionals in their clinical practice, and with this, they construct themselves as a person and professional, that is, the second principle of the medical ethics of values. Health professionals are committed to adding value to their clinical activity, to practise all values they discover or that arise in clinical practice. In addition, by doing this, practising the values that appear in the clinical context, not only do they do what they must, that is, they do not only what is good or optimal, but they themselves become good or better. Now, doing good or the best is what 'excellence' means. Moral excellence thus arises from practising non-moral or clinical values. This means excellence is not a direct object of practice but the indirect consequence of practising all values that arise in clinical practice. Therefore, the ethics of medical values is also an ethical theory of professional and moral excellence.

Practical wisdom

As said at the beginning, medicine involves theoretical and practical knowledge requiring the combination of science and experience. That is what the Greek term *phronesis,* 'prudence' synthesises. Now, the term prudence has been loaded with several meanings, not all positive, and has also fallen into disuse in some areas ; therefore, it is preferable to translate *phronesis* as 'practical wisdom' and to speak of prudence or practical wisdom. It is not about being moderate, cautious, but 'expert' in the analysis of the best option in a situation of uncertainty. Therefore, health professionals must incorporate this practical wisdom as a value to their clinical activity, which allows the evaluation of principles, circumstances, and consequences when making the best decision.

Uncertainty in decision-making is the basis of the cultivation or teaching of prudence or practical wisdom. Clinical judgement can never be more than probable, similar to ethical judgement.

Hence, both clinical practice and ethics share the same method, which in antiquity and today is called 'deliberation'. Prudence and deliberation are thus the two axes of practical reasoning and decision-making that medical ethics should promote. Deliberation is the search for the reasonable, while prudence is the rational decision after the process of deliberation. It is a way of reasoning, of logic, and a method or procedure.

In effect, to arrive at a prudent judgement, deliberation needs to be articulated in a decision-making procedure. This means that it goes through a series of phases, at least three. The first and most important deals with the analysis of clinical facts. Explaining clinical facts (diagnosis, prognosis, treatment) enables the analysis of values, the second phase. Ethical problems always consist of conflicting values ; therefore, identifying values supported by clinical facts is essential. Finally, the third phase is the analysis of courses of action. As values require practice, this phase involves great commitment from health professionals. It is about finding the course of action that best encompasses all values. That course of action will be optimal and thus the most prudent.

From this mere synthesis, it is worth emphasising that deliberation not only applies to the courses of action, the third phase of the deliberative procedure, but also to identifying values and explaining clinical facts. These three orders are scalar and are managed in sequence. The lack of deliberation at the level of clinical events produces biases in assessment and decision-making. Therefore, prudent judgements require much deliberation from beginning to end in a continuous process.

Prudent judgements require much deliberation from beginning to end in a continuous process

Other biases distort prudent judgement. One common bias deals with the emotional state. Because both clinical and ethical judgements are probable and thus uncertain, health professionals may suffer an anxiety crisis. Anxiety or emotional distress prevent prudent judgements and may lead to hasty decisions. This situation is controlled by introducing deliberation in decision-making, adjusting the time to the urgency or importance of the decision. A deliberated decision will always be more reasonable than a hasty or inopportune decision.

Prudence, in any case, is not a point but a decision space. This is due to the existence of normal variations both in the knowledge of facts, as in the estimation of the values, and, finally, in decision-making, due to age, sex, character, culture, etc. For this reason, health professionals must consider this variability and accept that their judgement and that of the patient can both be prudent without having to be equal.

Sometimes prudence is only achieved through collective deliberation

Finally, sometimes prudence is only achieved through collective deliberation. When facing very complex problems or large-scale decisions, health professionals must gather enough perspectives before forming an opinion or making a decision.

Conclusion

In no other age like ours has it been so necessary for medical ethics to occupy such a place in the training of medical values. Due to the introduction of new health technologies, the role of patients and family members in decision-making, and managing always-limited resources, problems are increasingly complex, demanding from health professionals both quality and moral excellence along with prudence or practical wisdom in decision-making, two fundamental values of medical ethics. It is not enough for decisions to be correct from a technical point of view or fall within the legal framework. It is necessary to imprint a dimension of quality that can only be provided with adequate training in 'values'. What is at stake in most ethical problems is a problem of values, conflicting values. Health professionals must know how to explore and identify the values present in a specific problem to make the most prudent decision. This requires education and training. Today, good clinical training or training on clinical facts does not equal good professional training. If a health professional is not adequately trained in medical ethics and, especially, in medical values, they cannot be considered well qualified for clinical practice.

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Competence and reliability

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Competence and reliability

For Ortega, the concern for values is a recent conquest of humanity ; however, he admits that this issue could not have been ignored by classical philosophers, although always hidden under the idea of 'the good'. The values framework is complex and diverse, and although values are abstract qualities, throughout history we have been shaping them with different content to improve our existence, behaviour, and attitudes. In the set of works collected in *A reconstruction of historical materialism,* Jürgen Habermas describes the history of the human species as a progressive process of reasoning, reasoning that is not only technical-instrumental but also moral-practical. In other words, societies learn not only technically but also morally.

Societies learn not only technically but also morally

Because of this 'moral learning', social values and expectations regarding medical practice have also been modified and diversified. The challenges and responsibilities of physicians, their social role and professional reality have been changing progressively. The current medical model demands a new social contract reflecting the ethical will of the community and the result of the negotiation of the latent moral conflicts derived from the values emanating from different social groups. In this context of change and of important transformations and the increase in complexity in the practice of medicine, professionalism is perceived as the new model of social contract replacing the more traditional, based on the Hippocratic oath, which today is insufficient to respond to the challenges posed by society to doctors. The Hippocratic oath was performed before Apollo, Hygeia and Panacea with the compromise to help patients ; today, doctors are committed to society and practise for the sake of citizens, healthy or sick.

Almost 20 years ago, Albert Jovell reflected on the difference between being a doctor, the profession, and that of being a doctor, the occupation. The verb 'profess' translates as a public commitment to a set of values. For Cruess, a profession is an occupation whose core element is work based on the mastery of a complex body of knowledge and skills used for the service of others. Members of a profession are governed by ethical codes and profess a commitment to competence, integrity, and selflessness, promoting the public good within their field, in this case, medicine. This commitment forms the basis of the contract between the medical profession and society,

which, in return, grants doctors a monopoly on the use of their doctrinal body, the right to some degree of autonomy, and the recognition of self-regulation. Medical professionalism obviously derives from the concept of profession and could be defined as the set of values, behaviours, and relationships underpinning the trust society places in its doctors.

In modern societies, doctors play two fundamental roles : the healing physician and the professional physician. Both roles share many aspects, but they come from different traditions and involve different commitments and obligations. The tradition of the healing physician comes from Hippocrates, and the characteristics are universally recognised. In contrast, doctors as members of a profession have had little social impact until science provided the foundation for modern medicine and the industrial revolution provided sufficient well-being so that health could be considered an accessible and negotiable good. As a result, society organised health care around the existing professions and granted them, as a counterpart to the contract, a practice monopoly, considerable autonomy, the ability to self-regulate, and remuneration. One of the attributes both physician roles share is competence.

The concept of medical competence can be interpreted in different ways. One refers to the knowledge, skills, and attitudes proper for the profession that qualifies a doctor to solve the problems posed by medical practice. A new concept of competence is part of medical training and can be defined as the degree to which a subject can use the knowledge, skills, attitudes, and good judgement associated with their profession to practice it effectively in all situations corresponding to the field of their practice. For the chronically ill, predominant in our health system, medical competence connects elements of skill and technical knowledge (to have knowledge and interest in the disease presented by the patient, to be successful in its diagnosis and treatment, and to maintain continuity of care with adequate follow-up and appropriate diagnostic tests) with other components related to communication and information.

Technical competence reflects the need to adapt knowledge and skills relevant to medical practice to the continuous advances in the health sciences; it is the search for professional excellence

Technical competence reflects the need to adapt knowledge and skills relevant to medical practice to the continuous advances in the health sciences and includes quality health care, scientific updating, participation in teaching activities and research, responsibility when making decisions and carrying out actions, and professional autonomy (without being influenced by the many environmental pressures, whether administrative or economic or by the users themselves) ; it is the search for professional excellence.

The shelf life of medical knowledge and skills is increasingly shorter as technological change accelerates ; for this reason, the need to stay current is more urgently felt by doctors than by other professionals. The average life of a ‘scientific truth’ in medicine is estimated as 50 years, and every 15 years, the number of scientific publications doubles. It is estimated that an exabyte of data is currently produced per day, while over the centuries and until the

beginning of the present century, only five exabytes of knowledge had accumulated. In Spanish universities, the area of medicine and pharmacology is second in scientific production, with 114,470 documents in the decade 2006-15. It has been conjectured that an internist would need to read 17 articles every day of the year to stay current in the field. Reasonably, this 'data overload' forces physicians to be true knowledge managers in their professional practice and to decide, with a healthy critical spirit, the appropriate use of these advances in specific patients. As pointed out by Gual, Oriol, and Pardell in *Physician for the future,* physicians must flee from scientism and take advantage of the benefits of the scientific method to incorporate into their practice only proven technological innovations. In this regard, it should be remembered health spending devoted to ineffective or directly harmful procedures can reach 20% of total expenditures according to some estimates.

This 'data overload' forces physicians to be true knowledge managers in their professional practice

It is clear that competent clinical practice involves the use of the best available scientific knowledge. Currently, it is not admissible for medical practice to ignore the existence of sources of information that would allow professional practice to stay current. However, as already said, it is easy to get lost in the vastness of the medical literature. The challenge of remaining up-to-date with this information overload and thus of being able to ensure the best possible compassionate care to patients is relieved by the easy accessibility to information, electronic data storage, and instant communication, continuous and without borders, and the emergence of movements such as evidence-based medicine, which have decisively contributed to the interpretation and critical reading of medical literature. Currently, clinical practice based on routine or on non-evidence-based opinions is unacceptable. This progress, apparently unlimited and beneficial, encourages reflection on aspects such as the fairness, effectiveness, and sustainability of new technologies. As technology is an inseparable part of medical practice, it should not lead physicians to fall into an irresistible technological fascination—commonly generating new uncertainties—nor, on the contrary, into the irrational resistance to diagnostic and therapeutic advances because of feeling more comfortable with traditional procedures. Competent doctors, with the scientific-technical and human capacity to practise the profession with quality, must be able to select the information they provide to their patients and avoid over-information, misinformation, or information confusion. In this asymmetric relationship with their patients, competent doctors must avoid a paternalistic relationship and foster deliberation, enabling patients to make decisions about their own health.

Doctors' qualification requirements are increasingly growing. Continuous advances in the health field generate high expectations in society and additional pressure in the medical profession. The inability to assimilate and select all available knowledge, the difficulties of transferring that knowledge to daily practice and to individual patients, the increase in specific training areas, specialities and sub-specialities, and the shelf life of knowledge create additional pressure

for doctors. In addition, high expectations of society in scientific progress and technological advances increase the perceived standards of doctors' competence. They are required not only to practise their speciality correctly but also to perform a variety of actions related to the knowledge of different disciplines and diverse medical skills (epidemiology, statistics, research, management, communication), requiring continuous training in all areas and periodic reaccreditation of all professional skills. The complexity of medical knowledge, its probabilistic nature and thus the uncertainty implied impose a series of limitations deserving greater social recognition. Likewise, the fragmentation of medical knowledge in specialities and sub-specialities poses the challenge of defining their contents, competencies, and impact on the homogeneity of a profession around a minimum set of structured values society can recognise. This apparent contradiction carries the risk of ambiguity in the responsibility of care provision, making it difficult to identify the doctor in charge of a patient and could be a source of errors if there is no effective coordination between the different health care levels involved in the care of a patient.

The practice of medicine in a health system based on knowledge requires learning to learn from a university education and from a work environment that promotes the generation and use of knowledge and the acquisition of professional work skills (continuous training and professional development). This implies the commitment not only of doctors but also of different organisations, scientific societies, professional associations, and the administration. Knowledge, both explicit and tacit, has a close relationship with training, attitudes, and competence. A learning-oriented attitude tends to increase the value of professionals and is a quality recognised and appreciated by patients.

Given the asymmetry of information and knowledge between doctor and patient and the situation of vulnerability in which patients find themselves, doctors must ensure compliance with the commitments made

Society desires satisfactory clinical results, obtained by practising according to the best available evidence and adequately justifying their decisions when evidence is not available. Society has expectations and assumes it cannot judge the competence underlying the medical profession and the decisions derived from the application of specialised, complex, incomplete, and undetermined knowledge. In these circumstances, doctors request the trust of society to which they offer, in exchange for the recognition already mentioned, competence to apply specialised knowledge and skills, the search for professional excellence, and staying current in their knowledge. A competent doctor is a trustworthy, reliable doctor. This trust is the essential element of the new social contract model. In fact, trust is based on two basic ideas : competence and commitment. Patients need to trust the medical profession, and providers should offer reliability. Given the asymmetry of information and knowledge between doctor and patient and the situation of vulnerability in which patients find themselves, doctors must ensure compliance with the commitments made : altruism, preference of the patient's interests, and confidentiality.

Throughout history, medicine has witnessed various cycles of moral confusion, of doubts about whether there is something specific demanding more rigorous standards of ethical integrity for those who practice the profession. When a profession 'de-professionalises', it rejects these higher moral demands and accommodates the prevailing political and cultural climate. The causes of this de-professionalisation are diverse, but one of the essential factors is associated with a deficit of professional competence and a resulting decrease in quality of care, an increase in health expenditure, variability in clinical practice, and uncertainty about the real impact of many medical practices on the health of citizens. The increase in scientific production and the paradoxical competence deficit are connected to the so-called 'risk society', which Beck defines as 'one in which the production of knowledge leads to creating situations of greater uncertainty'. Also related to the deficit of professional competence is the tendency to conceal medical errors and the automatism against professional practices in need of improvement.

One of the essential factors is associated with a deficit of professional competence and a resulting decrease in quality of care, an increase in health expenditure, variability in clinical practice, and uncertainty about the real impact of many medical practices

The confluence of the biotechnology and information technology revolutions seems to place artificial intelligence in a better position to perform probability calculations and pattern recognition and even to perform tasks that require intuition about other people. Two important non-human capabilities of artificial intelligence are connectivity and the ability to update, and in that sense, it could provide much better and less expensive health care to billions of people who do not normally receive care. Future reliability in the medical profession will depend on the ability of the medical profession to assume the values of professionalism, transparency, honesty, independence, and accountability and, ultimately, the non-negotiable commitment to professional competence.

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Confidentiality. Not disclosing patient information without just cause

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Confidentiality. Not disclosing patient information without just cause

Introduction

The duty to protect and keep secret everything a physician hears, sees, or senses about a person in their professional practice is one of the ethical principles most internalised by physicians over the centuries, with patients' rights and medical values being the most recognised and demanded by the public.

People feel or have aspects of their lives they do not want to share with anyone ... This personal stronghold is intimacy. From time to time, physicians, in their practice, must enter that personal stronghold of the patient, showing respect and acting with loyalty, committing to preserve it intact as much as possible

People feel or have aspects of their lives they do not want to share with anyone, others only with their partner, and others only with an intimate circle of family, friends, or work companions. This personal stronghold is intimacy. From time to time, physicians, in their practice, must enter that personal stronghold of the patient, showing respect and acting with loyalty, committing to preserve it intact as much as possible. The concepts of confidentiality and, thus, medical secrecy are emerging. Both must be fundamental values of medical practice.

Dr Martí Mercadal, in his book *The professional secret of the physician,* writes 'If the physician uses knowledge of the patient that is intimate, derived from the doctor-patient relationship, for any purpose other than the reason for which they have been entrusted, they seriously breach the tacit pact of confidentiality'. Further on, he states : 'The right to privacy is a fundamental right of the individual that today more than ever needs protection against uncontrolled disclosure, as modern media are based on a misunderstood absolute right to information'.

The digital universe has caused great changes in health care in a short time. Some reasons are a) easy and quick access to information for citizens and health professionals ; b) modifications in

medical record management ; c) relationships between health care teams ; and d) the globalisation of information technology, which allows storing, processing, and classifying data that when isolated are of little importance but can be used to build 'private' profiles of people.

The digital era has removed the boundaries of space and time. Personal data can travel the world in seconds, allowing possible attacks on privacy that can expand at an epidemic rate and perpetuate. Modern technology provides tools allowing more adequate protection of personal data and good traceability of who manipulates the data dishonestly and how they do it, but this reality does not eliminate the perception that the criteria for what intimacy is or isn't are relativised.

In addition, current medical practice is moving away from an interpersonal relationship, with the emergence of teamwork, shared medical records, bedside teaching, telemedicine, etc., which put the privacy of people at greater risk.

Glossary

The introduction mentioned the terms privacy, confidentiality, professional secrecy, and medical secrecy, which could be considered synonyms although they have clear nuances, which will be explained in the following brief definitions.

- *Intimacy.* Space in which people freely and privately manage their world of values (religious, cultural, political, hygienic, sexual, economic, etc.) and everything that affects them, directly or indirectly. The right to intimacy protects the unwanted interference of other people in that inner space without the express consent of the person concerned.
- *Privacy.* The right of people to determine and control what information may be disclosed about them, to whom, and for what reason. Intimate contents are all private, but not all private contents are intimate. For example, intimate issues include medical records or political affiliation, private issues include bank account numbers, and personal issues include an ID or address.
- *Confidentiality.* The right of people so that those who by their profession have gained intimate knowledge of their contents cannot disclose them without their express consent. In the health care setting, it is another element of health care quality, a duty of the health institution and each individual practitioner. Respect for confidentiality is not only the responsibility of physicians but also of other health practitioners (nurses, physiotherapists, etc.) or other professionals (lawyers, social workers, etc.).
- *Secrecy.* People's duty not to disclose the knowledge of certain data of others without their consent or legal authorisation. Secrecy is required above all from professional groups with an ethics code and pertains to so-called professionalism.
- *Medical secrecy.* Medical professionals' duty to keep the privacy of a patient hidden and not to disclose her or his confidential data for purposes other than health care while the patient does not allow it and there are no sufficiently important requirements of the public good, harm to third parties, or legal imperative. Its correct application is one of

the most appreciated values of the medical establishment ; therefore, professionals must always keep this in mind.

Confidentiality and medical secrecy

Importance of confidentiality and medical secrecy

The *Good Medical Practice* (GMP) guide, in recommendation 10, declares 'the physician must maintain the confidentiality of patients' data, always respecting the legal and ethical framework'. The Code of Medical Deontology (CMD), in Article 27.2, states briefly and clearly a physician's duty regarding confidentiality and medical secrecy : 'Medical secrecy entails for the physician the duty to maintain the discretion and confidentiality of everything the patient has revealed and entrusted and what physicians have seen and deduced because of their work related to the health and privacy of the patient, including the content of the medical record'.

Compliance is important for the following reasons :

- *Maintaining the bond of trust between physicians and patients.* If patients' right to confidentiality is not guaranteed, they may be unwilling to provide some personal data during the medical visit and even be reluctant to receive care. In modern medicine, patients understand and accept that their data may be known by those involved in their health care, but their consent is not necessarily provided for other care-related goals (teaching, research, multicentre studies, etc.) ; therefore, the patient must be previously informed in those cases.
- *If a patient allows her or his physician to disclose data in her or his medical record, the physician must be very prudent with their information so as to not damage the social trust regarding their duty of professional secrecy.* If society doubted the commitment of physicians to safeguard the confidentiality of their patients, they would request care with distrust and probably be less willing to provide information that could be important, generating risks for individual or collective health, i.e., the consequences derived from medicine without confidentiality can become serious for the patient and even society. Physicians must be very prudent in revealing the health aspects of people of public notoriety (elite athletes, artists, politicians, etc.), even if they have their explicit permission to communicate it. The CMD addresses this in Article 28.4 : 'When a health problem occurs in people of public notoriety, the physician responsible for their care or the one specifically designated for this purpose may provide information after stating that consent was provided by the person affected or guardian. The physician will be prudent in their information activities'.
- *Legal reasons.* The Spanish Constitution, in Article 18, guarantees the right to honour, to personal privacy, and to self-image. Law 41/2002, of 14 November, which regulates the autonomy of the patient and of rights and duties in terms of clinical records, indicates the need to recognise patients' rights, including the right to information on people's health, and establishes that respect for privacy and personal and individual freedom must be guaranteed,

ensuring the confidentiality of information related to the health services provided. The CMD, in Article 7.1, states 'Everyone has the right to respect the confidentiality of data concerning their health, and no one can access the data without prior consent protected by the Law' ; Article 7.2 states 'Health centres shall adopt appropriate measures to guarantee the rights mentioned in the previous section and shall formulate, where appropriate, the rules and standard procedures ensuring legal access to patient data'.

Confidentiality related to medical records

A medical record, as a file containing health care reports for a person, is care oriented but also has scientific and legal connotations. A medical record in any format, but especially digital records accessible from many places, requires measures to ensure, as far as possible, confidentiality.

If a patient's sensitive information is important, the physician should ask permission to include it in the medical record

Physicians must be very careful when entering the information received from a patient into the medical record. It must be true, ignoring irrelevant intimate details for patient care. If a patient's sensitive information is important, the physician should ask permission to include it in the medical record. If the patient refuses permission to enter important sensitive information, it is necessary for the physician to explain the potential harm derived from its absence and the benefits of its inclusion. If the physician is convinced that the patient is competent and has understood the information, she or he must respect their patient's wish, as long as it does not affect the health of third parties.

Radiological images, endoscopic images, photographs, etc., are part of the medical record and should be treated as clinical data, considering the particular risk involved when the person's face or other attributes that allow the patient's identification are visible. Physicians must be careful with subjective notes when reflecting on diagnostic hypotheses if they believe reading them could harm the patient, especially if those hypotheses are not confirmed later.

Patients have the right to know the content of their medical records, with some exceptions, as stated in Article 19.5 of the CMD

Patients have the right to know the content of their medical records, with some exceptions, as stated in Article 19.5 of the CMD : 'The physician has the duty to provide, to the patient who requests it, the information contained in their medical records and diagnostic tests. This right of the patient would be limited if we presume damage to third parties who confidentially contributed data in the patient's interest. Subjective notes entered by the physician in the medical record are their exclusive property.

Sometimes patients request that certain information be deleted from the records. Physicians, after clearly explaining the harm this request may cause, if the patient does not retract,

must comply with the request, if it does not damage third parties.

In shared medical records, every health professional with a password has access, representing a great advance in efficiency and effectiveness ; however, a trace log must be created, and in case of conflict, a professional would have to justify the need for access. It should also be borne in mind, as indicated in Article 28.5 of the CMD, that 'the death of the patient does not exempt the physician from the duty of professional secrecy'.

Basically, health centres, but also physicians who have participated in health care and preparation of the medical record, have a duty to establish the necessary mechanisms to maintain patient confidentiality in any format. This duty is addressed in Article 28.1 of the CMD : 'the medical director of a health centre or department will ensure the establishment of necessary controls so patients' privacy and confidentiality and the documentation referred to them are respected'.

Confidentiality in unconventional medical care

Although still in the minority, virtual visits or consultations through social networks are becoming more common. In remote regions, areas difficult to access due to inclement weather, and deep-sea fishing vessels, virtual consultations are an improvement due to their immediacy and often avoid expensive travel but are associated with a greater risk of invasion of patient privacy despite measures in computer programs that hinder this invasion and with national and international rules that regulate access to the information contained or disseminated via the Internet.

A second medical opinion via the Internet must also be considered in this section, in which both the first attending physician and the consultant must maintain confidentiality throughout the process.

The circle of confidentiality

The family and other people who love or care for a patient need to know the situation regarding the health of their loved one. The circle of confidentiality is the group of people to whom the physician can provide information to regarding a patient without violating secrecy—defined or limited by the patient—therefore, only the patient can decide which people are included and to what degree.

It is very common for the family after surgery or during a visit to a hospitalised patient to ask for information about their loved one's health status, the diagnosis, or the result of the surgery. The physician usually provides this information based on what they interpret as unspoken consent. This action, although common, is not entirely prudent ; the right course of action would be to ask the patient beforehand to which family member or relatives they can provide information.

From time to time, a relative or carer asks for information in person or by telephone about diagnostic tests, prognoses, foreseeable time of sick leave, etc., of the patient. The physician must confirm that the patient has provided consent for the release of this information. The release

of information must be especially strict if the information is requested by telephone or other non-contact interactions. It must be borne in mind that sometimes, this information can be harmful to the patient. An implicit sign of patient consent is the presence of certain people during patient care ; it is assumed they are trusted by the patient and members of the circle of confidentiality.

At other times, health professionals can access, out of curiosity or for other reasons even less honourable, health data of work colleagues, family members or acquaintances, and it is not uncommon to access a medical record on request because of a breach of trust by friends or physician's relatives, who ask for information about a patient without their consent. These requests should be rejected by health care professionals

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At times, patients speak a different language from that of the physician, requiring interpreters (relatives, minors, cultural mediators, etc.), who are considered 'necessary confidants' ; however, the physician must be very careful during the anamnesis when addressing aspects that may embarrass the patient, especially when the translator is a family member, and must be even be more subtle with minors, usually children or direct relatives of the patient.

Physicians may face so-called 'conspiracies of silence', in which relatives ask them not to inform the patient of the truth of their situation when unfavourable. The family tries to usurp, usually with good, but wrong, intention, the right of the person to know the reality of their situation and to exercise their right to autonomy. The owner of the right to confidentiality is the person, not their family ; it is paradoxical that those surrounding the patient are aware of the delicate situation but not the patient, who is undoubtedly the protagonist of her or his own story and left without the ability to decide.

When informing the patient, although the information may be unfavourable, the physician should never lie but try to explain the truth step by step and in a 'bearable' way for the patient. A good strategy is to answer the patient's questions, and through that interaction, the physician usually senses to what extent the patient wants to have knowledge of their situation at each moment.

Occasionally, patients reject receiving what they think may be difficult information and delegate on who should receive the information and therefore the decision capacity, delegating their right to autonomy.

Regarding the confidentiality of minors, the following CMD articles are clear.

– *Article 14.1.* 'Those over 16 years of age are considered qualified to decide about ordinary care actions'. Between the ages of 16 and 18,

adolescents have the same right to confidentiality as adults (with limited exceptions : abortion, assisted reproduction, and participating in research), a right the physician must communicate to adolescents, parents or guardians.

- *Article 14.2*. 'The opinion of a child under 16 years of age will be more or less determinant according to their age and level of maturity ; this assessment is an ethical responsibility of the physician.' The law places the responsibility on the parents or guardians ('parental authority'), which the physician must respect, but the CMD makes it clear that the opinion of the child, especially if considered 'mature' (understands what decisions to make), will be decisive, as indicated in the following articles of the CMD.
- *Article 14.3*. 'In the case of actions involving serious risk to the health of a child under 16 years of age, the physician always has the duty to inform the parents and obtain their consent. Between the ages of 16 and 18, parents will be informed and their opinion considered'. In these serious circumstances, parents or guardians are determinants, but if the physician considers that their decision may be inappropriate for the child, they can request judicial intervention, as Article 14.4 addresses. 'When legal representatives decide something contrary to the interests of the represented, in the physician's opinion, the physician can request judicial intervention'.

Shared and derived medical secrecy

Historically, the doctor-patient relationship was based on its bilateral character, without other professionals participating in this restricted circle, except for nurses. In the last decades, care is exercised by professional teams that share data to deliver quality care to the patient ; these data are recorded in the medical record by different health and non-health professionals, all sworn to secrecy, generating the concepts of 'shared medical secrecy' and 'derived medical secrecy'.

'Shared medical secrecy' is a necessary consequence of modern medicine exercised by a team of professionals and is widely technical. 'Derived medical secrecy' originates from the existence in the care process of other non-health professionals, such as management and administration staff (personnel from the administration of health centres, justice, insurance companies, occupational risks, quality accreditation, etc.), who require access to clinical documentation.

The behaviour expected from physicians in these situations is established in the CMD in Article 29.1 ('the physician must demand from their health and non-health collaborators absolute discretion and scrupulous observance of professional secrecy') and Article 29.2 ('in medical group practice, each physician has the duty and responsibility to preserve the confidentiality of all patients' data').

Physicians who communicate their patients' data to other physicians without medical care responsibility for the patients breach medical confidentiality, mistakenly understanding medical records are a shared property of the medical profession instead of referring to an individual professional duty. Article 29.3 of the CMD states : 'The physician must have a reasonable justification for communicating confidential information about their patients to another physician'.

Physicians who communicate their patients' data to other physicians without medical care responsibility for the patients breach medical confidentiality, mistakenly understanding medical records are a shared property of the medical profession instead of referring to an individual professional duty

Confidentiality and teaching

The GMP guide, in recommendation 95, states : 'the physician has the duty to facilitate the learning of medical degree students, postgraduate students, students of medical specialities, and other health professionals'. Medical undergraduate and postgraduate education is closely linked to health care practice, and this aspect must be known and appreciated by society. Special reference must be made to the residency system (MIR, for its acronym in Spanish), the most appropriate specialisation procedure for providing continuity in quality public health care ; experience has shown its effectiveness in training medical professionals while recognising that there are aspects that can be improved, like all human activities.

Teaching can sometimes cause uncomfortableness in patients. However, if the teaching aspects of health care have been adequately communicated in health centres, most patients will accept them without difficulty, and some might even feel that they are necessary participants in teaching, assuming it as a service to society (patient as 'teacher'), and that they can even benefit from it because their participation in learning implies closer attention to them.

Teaching implies physicians in training, medical students, nurses, etc., can be present in health centres, consultations, hospital rooms, or surgical rooms without the patient having explicitly consented to their presence. Sometimes, their presence could influence the clinical interview because of its intimate nature or because patients distrust their ability to maintain secrecy. For this reason, it is essential to introduce those in training and briefly explain the reason for their presence, asking the patient for permission.

Most patients are willing to participate, but if the presence of physicians in training or medical students is not accepted, it is ethically appropriate to explain to the patient that their refusal is unjustified and violates the *'principle of justice',* in terms of the duty to promote the fair distribution of health resources among all. However, accepting Article 5.3 of the CMD as the basis of medical behaviour, 'the physician owes their main loyalty to their patients, and their health must precede any other consideration...', the patient's refusal must be accepted because of the potential risk for their health generated by the probable tension in the doctor-patient relationship.

Finally, it is necessary to consider that physicians, in the public presentation of documentation, must take into account the following two articles of the CMD : Article 28.2 ('in the public presentation of medical documentation in any format, the physician will strive to achieve the absence of data facilitating patient identification') and Article 28.3 ('the presentation of clinical cases that have been photographed or filmed is allowed for teaching or scientific dissemination purposes after having obtained the explicit consent or preserving patient anonymity').

Confidentiality in areas little related to medical care

Physicians understand that they should not mention or comment on their patients in the hospital cafeteria or lifts, they should be careful not to leave computers accessible to others, and they should not comment on patients in their personal environment (family, friends, etc.) ; transgressions in the listed scenarios are not uncommon, mostly without bad intention, which does not reduce the seriousness of these infractions against medical secrecy. The CMD, in Article 27.7, states in a concise but clear way : 'The physician will preserve the confidentiality of patients in their social, work, and family environment'.

Social networks in health care are excellent communication tools, but they can raise confidentiality issues

Social networks in health care are excellent communication tools, but they can raise confidentiality issues. The GMP guide, in recommendation 51, indicates 'physicians, when informing the media, has the duty to maintain the confidentiality of their patients. They should remember their communications to friends or family through social networks can be vulnerable and accessible to other people'. For physicians, it is mandatory to protect the identity of patients not only in images and personal data but also through indirect data (health centre, speciality, relationship with the physician who publishes the information, etc.).

The ethics framework is addressed in Article 64.2 of the CMD : 'The physician cannot use any information—written, oral, or visual—in scientific publications that reveals a patient's identification. When they cannot avoid this possibility of identification, the physician must have the explicit consent of the interested party or their legal representative.'

As a final summary of this point, physicians must be very cautious when using social networks ; the concept of privacy has changed, almost disappeared for the sake of supposed transparency and freedom of expression without limits, in which everything seems to have a public character.

Confidentiality and occupational medicine

Occupational medical examinations generate information about the health status of workers that should be considered part of workers' privacy, who have the right to the privacy of their health information unrelated to the risks inherent in their work, which is also addressed by Organic Law 1/1982 which provides civil protection of the right to honour, personal and family privacy, and one's own image.

Occupational physicians should only collect data pertinent to workers' health. Any other information requires the workers' consent. Occupational physicians will be diligent when they know of particularly sensitive information :

- Addictions representing a serious risk to themselves, co-workers, the company, or third parties ; and
- Mental disorders representing a risk to themselves, co-workers, the company, or third parties.

Therefore, it is necessary to communicate only what is necessary to implement actions leading to the health and safety of workers, a necessary strategy because of the possible misuse of occupational medical examination information by the company for dismissals or labour discrimination.

The specific character of medical secrecy in occupational medicine is well reflected in two articles of the CMD : Article 31.1 ('the results of medical examinations required by law must be explained to the person examined. Only the appropriate company or institution will be informed about the work aptitude, limitations, or risks for work assignment') and Article 31.2 ('the results of health surveillance examinations will be communicated exclusively to the affected person. However, the physician of a preventive or occupational medicine centre must transmit any result useful for the patient, with their consent, to their responsible physician').

Circumstances in which there is a duty to disclose medical secrets

The CMD states in Article 30.1 that 'professional secrecy should be the rule. However, the physician may disclose the secret exclusively to whoever is needed, in its just limits, with the advice of the College of Physicians if necessary, in the following cases' :

- *Birth and death certifications.* Physicians have a legal duty to certify births and deaths, giving a true and accurate testimony.
- *If their silence leads to harm to the patient, other people, or to collective danger.* It is the decision of physicians to disclose secrets in these circumstances, and it is mandatory to request permission from patients to use their information. If a physician decides to disclose a secret, she or he will justify it by noting that the personal harm is less than the harm to others. If there is evidence of a real danger of third party infection and a patient is not willing to communicate her or his situation or take preventive measures, physicians have a duty to try to convince them to disclose the information, warning them that if they persist in their refusal, appropriate actions will be taken. This rule of the CMD coincides with Article 20.5 of the Penal Code when defining the state of necessity : 'a person acts in a state of necessity when, to avoid harm to oneself or someone else, they infringe on the legal right of another or a duty, provided the following requirements are met : a) that the harm caused is less than the one to be avoided ; b) that the situation of necessity has not been intentionally triggered by the subject ; and c) that the needy do not have, by their office or position, a duty to sacrifice themselves'.
- *When physicians are unfairly harmed by maintaining a patient's secret and the patient allows such a situation.* Even though medical confidentiality is a priority over the interests of physicians, they can exceptionally disclose the secret in the face of conflicts that may unfairly harm them and that the patient allows.
- *In the case of abuse, especially to children, the elderly and mentally disabled, or acts of sexual assault.* Maintaining secrecy in these cases by the physician must be interpreted as an unacceptable complicit silence ; therefore, communication regarding these issues to authorities is a duty from the ethical and legal points of view.

– *When called by the College of Physicians to testify in disciplinary matters.* The claims of patients or colleagues to the College of Physicians for alleged violations of the CMD require the opening of an information file, usually examined by the ethics committee, that sometimes leads to the recommendation of the board of directors to initiate a disciplinary procedure. In both cases, it is not uncommon to request the declaration of one or more physicians, who must communicate the information requested of them.

– *Even if the patient allows it, the physician will always maintain secrecy because of the importance of the trust of society in professional confidentiality.* Confidentiality in the doctor-patient relationship is extended to a doctor-society relationship, and with this perspective, prudence in information is well understood—although with the consent of the patient—so as not to damage the social trust regarding medical secrets.

– *By legal imperative :*

a) *Injury reports.* Physicians have the legal and ethical duty to report possible criminal acts (injuries, abuse, especially to children or the elderly, and sexual assaults) that they know of in their professional practice. However, the content of the injury report must indicate what is strictly necessary and appropriate for the judicial function.

b) *When acting as an expert, inspector, coroner, examining magistrate or similar.* A medical expert's report must be fair, balanced, objective, and focused on the request because medical secrecy is not contemplated by the administrative, judicial or collegial authorities that have requested the report. Physicians must inform a patient about what has been done and the conditions (expert, witness, inspector, coroner, examining magistrate) and inform them of their duty to report on the request. All of this is defined in Article 62.6 of the CMD : 'If a medical expert requires a medical examination of a patient specifically for this purpose, the expert shall communicate their personal and professional identification, who appointed them, and the mission entrusted to them, by whom, and for what and that their manifestations can be expressed in the report and made public. If the patient refuses to be examined, the expert will bring it to the attention of the appropriate individual'.

C) *Faced with a summons in a judicial process for an alleged crime that requires a patient's medical record.* The CMD, in its Article 62.1, indicates that 'the physician has a duty to attend the summons of the judges and courts ; they will assist administrations in matters that, being within their competence, result in the common good'. Here, the right to privacy of a person should not affect social well-being, which may depend on the administration of Justice ; therefore, there is a legal duty to deliver medical records by order of a judge. However, physicians will inform the judge that physicians are ethically bound to keep medical secrets and will provide only the necessary information, adjusted to the specific case. This aspect is addressed in Article 62.3 of the CMD : 'the physician summoned as a witness, due to judicial appointment, has the duty to appear in court. In the witness testimony, they will just expose the facts that they, because of their medical status, have seen or heard and are appropriate to the case. The physician

will preserve medical secrecy as far as possible and only disclose what is strictly necessary to resolve the judicial matter... '.

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Medicine and teamwork

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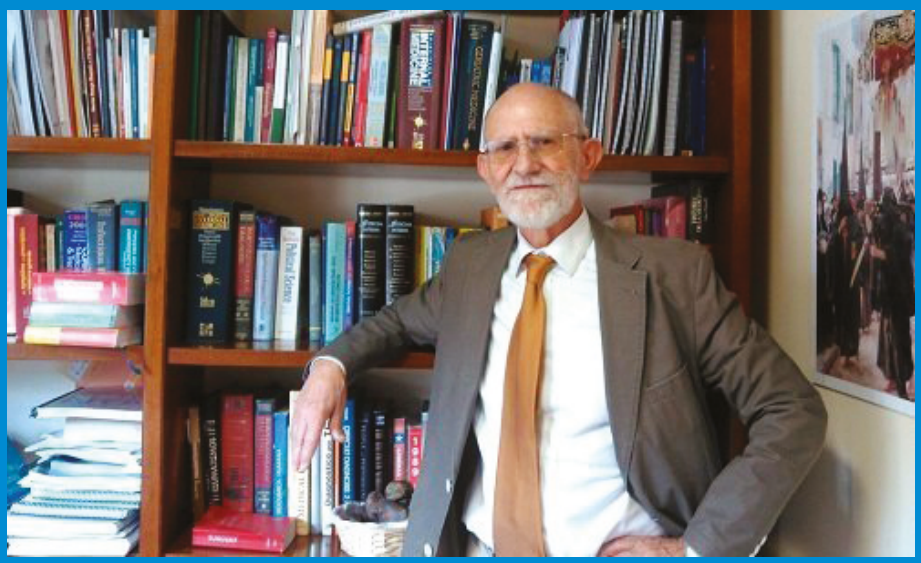

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Medicine and teamwork

The main goal of medical practice is to offer the best possible care to each patient. To achieve this goal, physicians are required to have a responsible attitude, to master, in depth, their assigned competencies, to continuously update their knowledge and skills, to be integrated into teams where they work, and to create positive synergies with their co-workers.

There is a lack of medical training in teamwork due in part to the erroneous belief that teamwork is an intuitive aspect of medical practice

In medical training, an emphasis is placed on competencies related to clinical practice, relegating to the background other aspects of professional activity, such as the attitudes and behaviours any physician must possess or teamwork. The latter domain, teamwork, is carried out in highly complex contexts ; working in teams requires learning and training in the various aspects of teamwork. There is a lack of medical training in teamwork due in part to the erroneous belief that teamwork is an intuitive aspect of medical practice. Regarding attitudes and behaviour, which all physicians must possess, they have emerged as a body of well-formed doctrine thanks to the *Good Medical Practice (GMP)* guide, published by the Organisation of Colleges of Physicians in Spain. Combining the three dimensions cited, clinical, teamwork, and appropriate attitudes and behaviours should be the central axis of 'bedside' medical activity in the twenty-first century.

Teamwork, as already pointed out, is complex and requires learning and mastering its various aspects, which is not always carried out

Teamwork, as already pointed out, is complex and requires learning and mastering its various aspects, which is not always carried out. This chapter attempts to give an orderly view of the different dimensions of teamwork and their intimate relationship with the various sections listed in the GMP guide, with particular focus on the following areas : communication and collaboration, inter- and intra-professional relationships, teamwork, safety and quality, professional practice/learning relationship as a source of continuous improvement, and health organisations and systems.

When medical teams lose this triple perspective, clinical, teamwork, and appropriate attitudes and behaviours, it is easily detected by the loss of group cohesion, and the main loser is the patient and the medical care they require.

Small-group dynamics

A basic medical team is usually composed of a small group (with a maximum of approximately 15 people), integrated into larger teams constituting medical departments, health centres or hospitals. These basic teams have multiple connections with external (other departments or hospitals) and internal (for example, nursing, pharmacy, telecommunications engineers) professionals. Understanding the dynamics of these groups is essential for promoting their functioning, which requires understanding their characteristics, their way of working, and how they make their decisions.

A small group is understood as a group in which personal relationships allow face-to-face interactions of all its members. All members work to achieve the same goal, relate to their own standards, and develop a culture and values. Relationships in medical teams are professional, their culture depends on their speciality, and they share values based on the ethical code of the profession. These three characteristics, in the National Health System, are modulated by the staff selection procedure in which positions are filled either through competition in which the decisions are made on a closed curriculum or by locum tenens positions, aspects deeply influencing the characteristics of basic medical groups.

A basic group carries out two types of activities : one aimed at achieving the goals set and another to maintain group stability. One activity predominates over another depending in part on whether the goals are meaningful to the group, appropriate, easily understood, and accepted.

Medical teams perform various activities ranging from clinical activity and research to managing relationships families, continuous training, publications, and participation in commissions, meetings, and training activities. When progressing towards goals predominates, all of these activities are apparent in team members ; however, when maintaining stability predominates, member-specific activities decrease, and overall activity is reduced to basic health care.

Cohesion (Area 5 of the GMP guide : inter- and intra-professional relationships and teamwork)

Small-group cohesion depends on the identification by its members of goals to be achieved and the way to achieve them. Cohesive groups progress towards achieving the intended goals, and when the goals are not shared, group cohesion weakens, and maintenance activities predominate over productivity.

Another characteristic of small-group cohesion is the affinity among their members. Personal empathy or agreement on the goals pursued generate affinity. However, this varies with time, and therefore, cohesion can change widely over time.

A final factor in cohesion is the mobility of group members resulting from taking other positions in other hospitals or from promotions. In the National Health System, due to its characteristics, both situations are difficult or even impossible to predict. This aspect has a negative influence over time and causes team members to shift from productivity to maintaining stability.

Team cohesion facilitates moving towards predetermined goals.

Small-group communication (Area 4 of the GMP guide : communication and collaboration)

Internal communication is another pillar in the operation of small medical teams

Internal communication is another pillar in the operation of small medical teams. It has two poles. The first pole is the provider of information, consisting of two aspects : the first is content, whose first characteristic must be objectivity, and the second is its source (for example, patients and their medical records, claims, possible errors, hospital databases, and scientific evidence) and relates to the communication phenomenon and the person communicating. The latter must know how to express themselves clearly, provide the content without personal biases, reformulate the proposals made, and address questions and discrepancies that can arise. They should avoid transmitting opinions instead of content, speaking only for like-minded people, and biasing the information according to personal interests. Non-verbal communication (for example, facial expression) can influence and bias the information positively or negatively.

The other pole is the recipient of the information. The recipient must abandon their framework of ideas in relation to the subject to be presented, practice active listening, request clarification when needed, know how to make proposals, and avoid negative body language (for example, read while another is presenting).

In addition to the possible barriers from inappropriately handling the aspects mentioned, there are two other important factors : competitiveness between group members and the role expectations they have or want to assume. Both factors can help or hinder communication. The correct attitude is to abandon the personal framework and adopt a positive pro-active role.

Good communication promotes group cohesion and vice versa.

Group command and control (Area 8 of the GMP guide : health organisations and systems)

The last aspect to be considered in small-group dynamics is the command style of the group, as exercised by those responsible (chief clinician or head of the department). This style can be divided as follows :

- *Authoritarian*. Everything happens through the team leader, who ignores the opinion and participation of team members in decision-making. This style reduces cohesion by the rejection felt by professionals of the team. Responses and suggestions can stem from aggressiveness or apathy, hindering goal achievement.
- *Democratic*. The leader decentralises decisions and promotes the participation of all team members in decision-making and setting goals. Coexistence requires little energy to maintain stability, and thus, team members can focus on productivity.

The command style influences team outcomes.

Instruments to be used in different types of medical team meetings

In any meeting, whatever the type, a sequential set of stages can be identified and summarised as follows :

- Defining a problem (the reason for the meeting or session)
- Identifying its dimensions
- Analysing possible solutions
- Prioritising solutions
- Setting goals

Frequently, these stages in clinical practice progress quickly ; however, on other occasions, they are performed meticulously, as in administrative meetings.

The meetings should incorporate, in addition to physicians, nurses and any other personnel who can contribute to a better resolution of the topic analysed.

Basic medical team meetings (Area 3 of the GMP guide, professional competence, and Area 7 of the GMP guide, professional practice/learning relationship as a source of continuous improvement)

An important activity of medical teams is the meetings in which their members must participate. This activity can be summarised in blocks.

Care sessions

- Shift changes
- Daily clinical sessions
- Joint activities with other teams

Administrative sessions

- Monitoring the team's goals and the department to which they belong
- Analysis of possible errors and claims affecting the team
- Analysis of medium- and long-term needs and a strategic plan

- Health care changes to be introduced
- New technologies
- Education and training
- Attending congresses and visiting health care centres

Scientific sessions and research projects (Area 2 of the GMP guide : doctor-patient relationship)

The description of research projects goes beyond the scope of this work, but they should be open to the whole team ; participating in research, in addition to being voluntary, involves a series of extra duties that should be transparent to team members.

Using meta-search engines, research of electronic medical records in the department and hospital should be part of the research dimensions of any medical team.

Clinical sessions (Area 4 of the GMP guide, communication and collaboration, and Area 7 of the GMP guide, professional practice/learning relationship as a source of continuous improvement)

Several useful instruments can improve team performance. One such resource is virtual databases accessible at all types of meetings. Among these databases, those presenting ordered and structured information available at that moment (for example, *UpToDate*) on a specific topic stand out. Physicians should know how to ask questions to get the right answer. This is not intuitive but requires training.

Second, they must know how to manage decision trees to analyse all the possible actions and their likely results sequentially. A decision tree is useful for making complex medical decisions. Finally, they must know the rules for interpreting test results and mathematical prediction algorithms.

Third, electronic medical records allow analysing the results of similar cases attended previously and thus taking the most appropriate course of action for a patient's situation. This search requires meta-search engines and maintaining patient privacy.

The person in charge of the meeting should ask questions to clarify the actions to be taken and, at the end, make an executive summary of the clinical goals to be achieved and measures to be implemented.

In these sessions, physicians in training should be encouraged to present clinical cases, in case they are not doing it yet.

Administrative sessions (Area 4 of the GMP guide : communication and collaboration)

In these sessions, there are different work methods that can be applied during the meeting to ensure the best results with the consensus of all participants.

- *SWOT analysis.* Through SWOT analysis, the strategy to be implemented in a project is analysed with respect to the environment and the work team itself. This analysis, in which all team members participate, examines the opportunities and threats of the environment together with the strengths and weaknesses of the team.

- *Consensus group*. A consensus group analyses the causes and solutions to specific problems or situations. The main characteristic of this technique is the participation of all those present and not allowing the opinion of the most influential group members to supersede the opinions of the rest of the group. Initially, a moderator presents and explains the goal of the meeting and collects questions, rephrases them and makes them clear. Then, the members of the team who are present (it is advised to not exceed 15 members with this technique) remain silent for several minutes to think about their proposals ; when the moderator decides that the thought process has ended, participants are asked to write on paper their ideas or proposals on the subject. These proposals are collected and transcribed anonymously on paper or an electronic board (to store all the material). Then, the discussion begins, in which each person expresses their opinion on the ideas collected. After the analysis-discussion, a secret vote is taken to select the most popular ideas-proposals. These are discussed again, and the cycle is repeated until reaching a final consensus on a concrete proposal.

  This technique requires a moderator who knows the technique well and directs interventions appropriately. As a benefit, those who have never participated in this type of meeting quickly understand the method and participate. The conclusions, when obtained by consensus, usually have the support of all participants.

- *Ishikawa's diagram*. This tool is very useful for analysing the causes of medical errors and claims (personnel, environment, working methods, team management, available technologies, and general material available). This analysis allows detecting what has failed or what can fail when a deficit is perceived in one of the branches analysed.

Other techniques are more specialised, but the techniques described are useful for most topics discussed in administrative sessions.

Progressing towards goals requires knowing and using teamwork techniques.

Research sessions and research projects (Area 3 of the GMP guide : professional competence)

As indicated earlier, this topic goes beyond the goal of this chapter. Notably, however, research related to family or intra-team relationships requires a specific type of research, qualitative research. Medical teams rarely use (or know) this type of research ; however, nurses are familiar with and undertake qualitative research. Qualitative research is essential for studying human teams, the relationships between their members and with families, and the indirect consequences befalling them with the seriously ill. This type of research is usually the great forgotten. When addressing the humanisation of medicine, the answers can only come from qualitative research.

Qualitative research should be promoted to improve knowledge of the functioning of small groups.

Impact of new information and communication technologies on small-group dynamics

Electronic medical records, which have replaced paper, facilitate the creation of mega-databases that, through a meta-search engine, allow us to reconsider many medical issues whose roots are buried in nineteenth-century medicine. A basic medical team should become aware that many answers to their questions can be derived from those databases.

Dialogue with patients is mediated by accessibility to virtual information, increasingly empowering patients and their families. Medical teams should be mindful of this reality, which will increase.

The free market world increasingly delivers more freely available diagnostic tests (for example, personal genetic profiles), and medical teams must be prepared to meet the demands of patients or healthy people interested in interpreting the results of the tests that the patient/individual requested on their own.

Video conferencing will progressively extend the concept of actual medical teams to virtual medical teams. This situation will meet the basic premise of face-to-face direct communication between all team members, who may be in the same building or thousands of kilometres away.

Video conferencing will also extend the relationship with patients who have increasingly more knowledge about health and disease. This new mode will be combined with remote monitoring systems, which are already on the market in their simplest forms.

Medical teams must adapt to this new form of virtual relationship, which will require new rules and safeguards.

Finally, a great challenge is the appropriate management of social networks, in which physicians, given their professional status, should monitor their comments and photographs to maintain ethical standards and the privacy of patients.

Final notes

The GMP guide of the Organisation of Colleges of Physicians in Spain offers a set of rules and examples to resolve dilemmas that physicians can encounter as members of a team.

Teamwork requires learning. This learning should begin when earning a medical degree. Classical teaching is individualistic and should be replaced by problem-based teaching

Teamwork requires learning. This learning should begin when earning a medical degree. Classical teaching is individualistic and should be replaced by problem-based teaching, not only to build one's knowledge but also to prepare for teamwork to achieve beneficial goals for all.

During residency training, active participation in departmental activities must include a reference model to which teamwork rules are added to clinical training. This can be achieved and enhanced through training with more or less complex simulations and the analysis of videos of medical team activities in all their aspects, including relationships with families.

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Communication

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Communication

Along with medical knowledge and clinical skills, the ability to communicate represents an essential component of medical competence. This chapter addresses the special value this ability and way of communicating have for physicians, which is intertwined with the fundamental values of clinical practice, surpassing its condition of mere 'ability', to reveal the attitudes and habits of physicians. The main features of patient-centred communication are described as a method not only to achieve diagnostic and therapeutic accuracy but also to reflect the fundamental values of current clinical practice, highlighting the intimate connection between communication and ethics.

Definition, delimitation and context of 'communication'

'Communicating' in the 'clinical relationship' is understood as the 'communication' that physicians establish not only with their patients or relatives but also with their colleagues. The term 'clinical communication' will thus be used indistinctly with previous terms.

Clinical practice has much to do with how physicians communicate (behave) with their patients, and physician's communication skills are fundamental in the development of that communication (behaviours). The rituals and rules of this relationship have been refined in the last 100 years and have gone from a respectful paternalism to collaboration for decision-making, which has been extended under the term 'patient/person-centred relationship'.

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It is important, however, to differentiate clearly 'patient/person-centred care' and 'patient/person-centred communication or relationship'. The first term refers to a type of moral philosophy prioritising values such as the consideration of the perspective of patients or their participation in decision-making. The second refers to the physician's way of communicating, to the set of actions put into play to 'focus on the patient-person'.

The value of communicating : the communication perspective

What does it mean today to communicate in clinical medicine? Consequences of communicating in clinical practice

Clinical communication is not a mere abstraction but something real, something happening in time and space

Clinical communication is not a mere abstraction but something real, something happening in time and space. It has a tangible aspect, i.e., empirically verifiable and constituted by elements such as gestures or ways of conversing, and an intangible aspect, which happens in the internal world of people in relations (the physician and the patient). All this develops dynamically, and a multitude of phenomena follow each other, sometimes in a very short period.

When physicians are involved in patient-centred communication, they develop specific communication skills (tangible aspect) while, at the same time, insert values of the modern Western medical culture (intangible aspect).

Patient-centred communication is carried out by deploying skills such as active listening, acquiring and following cues, avoiding interruptions, asking more open questions and adjusting the biomedical approach of the interview, by emphasising the personal contributions to improving clinical practice. This improvement, referred to as diagnostic and therapeutic effectiveness—especially in chronic cancer patients—increases patient knowledge and the ability of patients to address their health problems, increases therapeutic adherence rates, and makes patients feel clinically better and more content after consultations. It also has a positive impact on the sustainability and profitability of the health care system by reducing the number of diagnostic tests, re-examinations for the same disease process and referrals, and the time dedicated by professionals to patients when considering that care is not an isolated consultation but the whole medical process. Additionally, patient-centred communication diminishes the number and type of complaints and claims to physicians, producing in physicians greater well-being and less professional exhaustion.

To understand the meaning of communication, it is useful to distinguish two aspects : the content dimension, which is related to everything tangible, and the relationship dimension, which is related to the intangible. The content dimension refers to the transmission of information among the participants, such as the language and information transmitted by the messages. The relationship dimension refers to the way of relating and alludes to the intangible element, related to the creation of trust and closely linked to the experience of perceived emotional support or the impression of consensus or conflict perceived by participants.

These two dimensions, content and relationship, are also reflected in the two trends in which clinical communication is currently conceptualised : one emphasises the observable,

i.e., the development of certain actions or behaviours by physicians and patients ; the other refers more to intangible experiences, such as the reflection of physicians and patients or their self-awareness about their mental and physical processes related to communication.

The 'behavioural' approach (communication component) involves emphasising communication skills. The possibility of directly observing these 'skills' facilitates the 'objectification' of communication and its training. The skills can be acquired, measured, updated, replenished, and transmitted. However, this concept of ability alone does not allow understanding the multiple levels of experience that for physicians and patients involves 'being in a relationship' (relational component), which is the crucial aspect of the communication phenomenon in clinical practice. Conversely, without adequate communication skills, it may be impossible to achieve a satisfactory way of being in a relationship.

If the work object in the behavioural approach is empirically observable, in the 'relationship' approach, it is the internal world of participants : sensations, thoughts or desires, perception of the situation, personal values and vision of the possibilities arising from the interview, for example, the impression of being at ease, feeling connected, confident, agreeing or disagreeing, etc.

The way to check or reveal this internal world is complex. Physicians can perceive it directly and immediately through an exercise of full attention to what occurs within themselves, developing their level of cognitive and emotional self-awareness. However, the internal world of the other cannot be perceived directly and immediately except through verbal, paraverbal, and non-verbal messages, sometimes extremely subtle, which also requires, in addition to a 'mindfulness' exercise, the development of 'dialogue'. Dialogue provides a rigorous rational knowledge of what happens in the internal world of the patient, the so-called 'knowledge by rapport'.

'Conscious' physicians are easily identified by patients and colleagues because they are attentive, interested, open to dialogue, without prejudice, authentic, natural, and comfortable with many communication strategies. In interactions, this is revealed as a way of being in a relationship that shows respect for a person, attention and interest in their experiences, ideas and fears. Some authors have stated that this is related, in family medicine, to the 'patient relationship' and only secondarily to the content of medical care, the reason for consultation, or the type of health services offered.

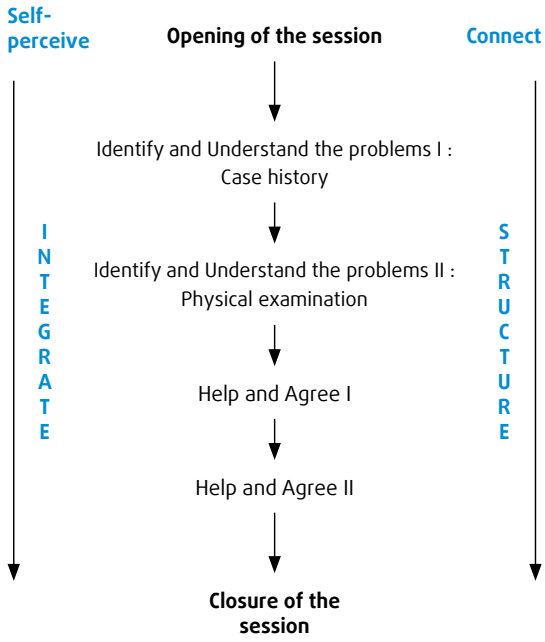
Integrating tangible and intangible communication in practice : the patient-centred clinical method

The importance communication acquires in this new context (patient-centred) entails the challenge of incorporating this 'communication' (now much more complex) into clinical methods as part of the main diagnostic-therapeutic tool of the physician. Clinical methods are based on observations of clinical manifestations and findings derived from clinical examinations and complementary tests, and for this, medical records are the primary source. Medical records are structured into specific sections traditionally obtained by physicians through a communication process almost interrogative in nature. The new

clinical method approach (now 'patient-centred') emphasises the bidirectional nature of this communication process and involves incorporating the subjective aspects of the condition (patient perspective) and considers the encounter from the perspective of collaboration for shared decision-making. Thus, the communication skills and competencies mentioned previously should be developed within a new and broader structure that has its development framework in the clinical encounter, which requires, on the one hand, and sequentially, the development of 'identifying and understanding health problems' (correlated with classic anamnesis, the exploration of the patient's perspective, and physical examination), 'agreeing' and 'helping' (explaining and planning) and, on the other hand (continuously throughout the entire interview), 'building the relationship' with the patient by listening and responding to the patient's messages to establish a bond, communication fluency and a degree of adequate understanding, self-perception to detect internal phenomena, and integration and ordering of these processes to achieve the main goals of clinical communication (Chart 1).

This approach aims to address both the content dimension (the language and information transmitted by the messages) and the relationship dimension, related to the 'being in relation' to achieve an effective clinical act. Self-perception skills allow physicians to identify emotional barriers, possible biases in clinical reasoning or personal attitudes facilitating or hindering communication (intangibles). However, aspects related to content and the communication process (tangibles) are included. Content aspects derive from traditional anamnesis, in addition to the medical record, aimed at detecting the perspective of the patient.

Chart 1. Communication tasks in a medical interview, integrating content and form (tangibles and intangibles).



Processing skills are related to the verbal, non-verbal, and paraverbal forms in which (tangible) content is exchanged. Among them, acquiring and responding to cues, checking, verifying and integrating the information provided by the patient and the reversal of what is understood regarding their situation, sharing information in a clear and adapted way, inviting the patient to participate and seeking agreement. These communication skills reflect phenomena occurring in the internal world of clinicians, such as attitudes of respect, authenticity, empathy, and active listening (intangibles), seeking to generate a way of being in a functionally effective relationship in which patients feel welcome, understood and treated competently and, thus, safe and trusting (intangibles).

The value of 'communicating' : the ethical perspective

Relationship of communication with other medical values

Like any technical development, skills pursue efficacy (in this case, clinical) ; however, even if skills are useful, they can be ethically ambiguous, used for good or bad. For example, empathic knowledge with a patient can be used to prevent the patient from feeling isolated in their illness but also provides manipulative power ; the skills needed to reach an accurate diagnosis can lead to an excessive use of complementary tests, forgetting the good of the patient ; communication may be overly paternalistic or, on the contrary, cause a certain abandonment of the patient, leaving them at the mercy of extremely difficult decisions (abandonment of the patient and her or his rights).

Like any technical development, skills pursue efficacy (in this case, clinical) ; however, even if skills are useful, they can be ethically ambiguous, used for good or bad

This means that communication skills applied by physicians must be ethically justified. This is how physician communication is closely linked to ethics. One way to observe this connection is to see the ethical justification of communication skills. To the extent skills are supported by values, they will have a category of duties, which will be morally justifiable and an effective channel to shape those values. Hence, we must start from solid professional values, which represent, if not all, at least a very important part of what is important in medical practice. These are the values discussed in the different sections of this book, of which we highlight human solidarity, medical knowledge, and trust. These values are a way of specifying the four basic values of bioethics, formulated in the form of principles : beneficence, non-maleficence, respect for people, and justice.

The intimate connection between communication and medical ethics will be clear if these values are achieved through the development of the communication tasks described in the new clinical method, which represents the communication course of action in a clinical interview. Thus, we conclude our argument emphasising the value of communication for a physician, precisely illustrating this connection between 'communicating' and 'acting ethically', through the following main communication tasks :

– Connecting by capturing and responding to patient messages is a course of action that should serve to generate trust and shape and develop human solidarity. Trust, essential for a relationship to be constructive, will be addressed below. Here, solidarity refers to a union between individuals with a legitimate purpose. Solidarity is about taking others' situation seriously and acting on their behalf. Medical practice is, by its very nature and in its best version, an active exercise of solidarity. However, some distances are not shortened only based on ideas but also emotions, such as compassion, which is nothing more than feeling a certain emotion before the vulnerability of

the other, revealed as something concerning oneself. Compassion finds us in a position of proximity to others and willing to help. Therefore, compassion puts one in an ideal position to connect in a beneficent manner.

- Self-perception is required because compassion, as a form of emotional solidarity in medical practice, consists of taking charge of patients actual or potential harm and accepting the emotional impact of a medically beneficial way for people. Adequate self-perception avoids both indifference and sentimentality, which can discourage or hinder healing action, respectively. Emotional solidarity requires understanding the situation of the other and knowing how to manage one's emotions effectively medically, making the other feel accompanied, understood, and not isolated. Allowing emotional solidarity is, therefore, a way to connect in a beneficial manner in the clinical relationship. Self-perception is also a course of action that must shape and develop medical knowledge, as a way of being updated on everything that happens during a clinical interview. This is where clinicians can detect cognitive dissonance (knowledge questions), emotional dissonance (discomfort), volitional dissonance (action questions), or even spiritual dissonance (questions of conscience), which allow identifying competency gaps susceptible to improvement.
- Identifying and understanding is a course of action that should serve to know the true reality of the patient and find the best possible action. The key issue is to address a person with certain symptoms, and, from there, see how to help them. To develop a course of action, all communication processes are essential. Rational knowledge of reality is constructed from the rigorous search of rational truths, proven through experience. Therefore, what governs all these processes is will, a desire for truth. Scientific truth is reached in different ways, depending on the work object. If the work object is something physical, the truth is derived by verifying or testing nosological hypotheses (for example, an X-ray shows if coughing is due to pneumonia). If the work objects are the experiences, preferences, desires or feelings of a patient's internal world, the truth is derived by identifying significant messages, formulating interpretative possibilities, and verifying them through dialogue (for example, the facial expressions of patients can confirm feelings of sadness and exclude other possibilities). These verification processes, which occur in a clinical interview, can be used for the patient's benefit if the truth is obtained, i.e., an adaptation between the patient's reality and the physician's interpretation. The truth places the clinician in an ideal position to help.
- Deliberation is 'a kind of investigation' in which 'he who deliberates badly, misses the mark, and he who deliberates rightly, hits the mark'. In medicine, good deliberation results in a clinical judgement according to the best possible outcome for the patient, performed with a correct procedure and at an appropriate time. The goal of deliberation is to arrive at prudent decisions, and prudence 'has as its object what is just and what is fine and what is good for a human being' (*Nicomachean Ethics,* 1143b, 20-25). It is knowledge about universals (the theoretical, the generalisable) and particulars (the data of the concrete clinical scenario) 'because it is practical and the action is related to particulars' (*Nicomachean Ethics*, 1141b,

15). Deliberation involves a shared reflection on facts, the values involved in the situation, and the best possible course of action for the patient. It is liberating for patients because it frees them from ignorance about their own illness, it helps them improve their health problem, and gives them autonomy (freedom) in decision-making.

- Reaching agreements and helping is a course of action that should shape and develop the prudential nature of medical knowledge and mutual trust because deliberation generates transparency in a relationship and contributes to strengthening the doctor-patient relationship, guiding the interview towards a certain way of being in relations, which has much to do with its character, and determining its quality and effectiveness. Connecting, agreeing, and helping are about moving towards trust, a cognitive, emotional and physical state of some certainty or security. Trust depends on at least three important factors : competence, transparency, and bond. Competence is related to a physician's ability to understand a patient's condition and experience. Transparency is closely related to shared decision-making with a patient, in which emotions can also inform deliberation, illuminating the areas and aspects that need to be addressed more closely, as preferences are constructed, obtained, and integrated. A bond is something fundamentally constructed from an attitude of human solidarity, which allows the flow of compassion, commitment to the other, and unwavering will to act in their favour.
- Integrating all the processes and structuring aspects that help achieve the main goals of each interview are courses of action that should serve to develop the values of beneficence, non-maleficence, respect for people, and justice, underlying those previously mentioned (solidarity, medical knowledge, and trust).

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VALUES OF THE PROFESSION TO BE ASSUMED BY THE PHYSICIAN

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The institutional exercise of professional responsibility

MÀRIUS MORLANS MOLINA

Màrius Morlans Molina

Former Chairman of the Ethics Committee of the Official College of Physicians of Barcelona, COMB
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The institutional exercise of professional responsibility

Introduction

Responsibility is one of the most appreciated and often missed civic virtues, not only among those who exercise power but also among citizens. If responsibility is an enforceable behaviour expected from common citizens, higher expectations are held for those practising a profession and, above all, health care professionals. Conceptualising this universal value will be the starting point to understand its meaning in the field of medicine and, more specifically, its institutional exercise as a guiding and regulating function of physicians' professional behaviour.

Responsibility, civic virtue

The etymology of words helps to understand their meaning. Here, responsibility has its root in the Latin word *respondere,* formed by the prefix *re,* which indicates reiteration, and the verb *spondere,* solemnly accepting, promising. So, responsibility implies commitment, committing oneself. This means fulfilling certain duties, being careful in decisions, and, of course, responding to the consequences.

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Victoria Camps affirms that being responsible is being able to respond to someone and wanting to do something. A socially recognised capacity or competence is needed, freely assuming the will to exercise it. Competence, commitment, and freedom are essential intrinsic values needed to exercise responsibility. In addition, responsibility responds to others, to society. As soon as one acts according to one's own conscience, it is a moral virtue exercised individually, but because it is necessary to render an account before others, it acquires the status of public virtue.

If there is a vocation that is paradigmatic and serves to illustrate the above, it is that of the professional politician. Max Weber, in his more cited than read essay *Politics as a vocation,* refers to the ethics of responsibility as the superior value of those who want to live for politics and not from politics. The ethics of responsibility is used as opposed to the ethics of conviction to justify the attitude of politicians who, because of pragmatism, renounce their ideals. Nothing is further from Weber's thought and discourse when he argues that both are complementary and that this complementarity is necessary. Hence, the suspicious Weber is scarcely read, or even worse, his thinking is distorted. He conceives the vocational politician as a person with firm convictions who acts according to them, provided consequences are acceptable. Weber's critique is a warning to prevent ideological dogmatisms from promoting actions with severe consequences.

Responsible behaviour is acting under principles and always foreseeing the consequences

Responsible behaviour is acting under principles and always foreseeing the consequences. This responsible action requires necessary prudence so that when the expected consequences do not provide the expected benefit, one refrains from acting and provides appropriate explanations. In Weber's words : 'I cannot do anything else, here I stop'. Thus, the conviction in ethical principles, personal autonomy, competence, and prudence are constitutive elements of responsible behaviour.

Institutional medical responsibility

Understanding responsibility as a commitment to someone, medical responsibility encompasses three dimensions because it is exercised before three subjects : patients, society, and colleagues. I insist on the three dimensions because they are exercised jointly ; therefore, in any professional activity, they are all present and only theoretically different. Patients cannot be cared for without competence or having access to resources provided by society. Professional practice is only possible by the social recognition of professional competence and by the resources used—financed by taxes, health insurance fees, or remuneration. For the encounter between a patient and a competent professional to be fruitful, it must comply with that triple commitment, the most important of which is the one binding the professional to that person. The duty of loyalty to the patient is regulated in all codes of medical ethics.

Considering the intrinsic relationship between the two, I will focus exclusively on the exercise of medical responsibility before, for, and with colleagues. The word 'colleague' is not used accidentally to refer to those who practise the same profession. Despite its current use as a synonym of friend or companion, the original Latin word was used in ancient Rome to identify the members of the *collegium,* i.e., those elected to exercise a public political, administrative, or priestly function. An essential characteristic of these functions is that they were exercised collectively, not individually ; therefore, I will use the term in this sense. Collegial responsibility

refers to the individual commitment that needs to be shared and endorsed by a group of colleagues to achieve its full value.

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The Colleges of Physicians were born in the middle of the sixteenth century to regulate a practice out of the reach of legislation enacted by the real power not only because of its technical complexity but also of its main purpose or motivation. The cause of that delegation lies in the profession's essence, which consists of the will to achieve excellence in practice, understood not only as a virtue but as a technical skill and professional competence. How can the aspiration to excellence be regulated? Obviously, it cannot be imposed by law. Laws can only regulate the duties required of all citizens but cannot force them to achieve excellence in practice. There are two reasons for this.

The first is that achieving excellence in practice is an aspiration, a predisposition requiring preparation and competence as necessary conditions ; however, they are not enough. The preparation and motivation of professionals who aim to achieve excellence are not assurances to obtain good results. That is why medical practice is judged by the means employed and not by outcomes—i.e., judging whether the physician is competent and has used the necessary diagnostic and therapeutic resources under the rules governing good medical practice.

The second reason lies in the difficulty of establishing the norms that regulate the standards of good medical practice, which allow the judgement of professional practice. Commitment to the profession involves contributing to the consensus on these norms and respecting them. It derives from the conviction that the necessary regulation of medical practice must be collective, not individual.

Society needs assurances about individual professionals, but the professionals must be evaluated at the beginning of and throughout their career. They can only be evaluated by those who have the knowledge and aim to achieve excellence in medical practice, their own colleagues … That is the essential function of the Colleges of Physicians

Society needs assurances about individual professionals, but the professionals must be evaluated at the beginning of and throughout their career. They can only be evaluated by those who have the knowledge and aim to achieve excellence in medical practice, their own colleagues, as stated in recommendations 92 and 93 of the *Good Medical Practice* (GMP) guide. That is the essential function of the Colleges of Physicians : guaranteeing society that medical practice is not only scientifically and technically competent but also moral and that medicine is practised with the common good in mind.

The collegiate function as self-regulation

The liberal critique of the Colleges of Physicians views them as monopolies conceived to avoid external competition and to be able to set fixed prices, thus protecting the interests of their members. Their codes are conceived as the rules of etiquette governing the social behaviour of the professionals, both with patients, conceived as customers, and with colleagues, considered competitors. Regulating professional behaviour according to the standards of social etiquette and resolving conflicts between colleagues were its functions during the nineteenth century and much of the twentieth century. The paradigm of the code of that period is *Medical ethics,* by Thomas Percival, published in 1803, inspiring the first codes of the American Medical Association.

But since the end of the Second World War, health care in Western countries has been one of the essential components of the welfare state. It is practised in large institutions and organisations where the clinical relationship loses its private status to be regulated by governments. In this context, it is legitimate to rethink the role of the Colleges of Physicians. If the law regulates the clinical relationship, what is the sense of deontological codes and their rules of conduct?

In advanced democratic societies, there is distrust in the excessive legal framing of personal relationships, gaining ground in the conviction that not everything can and must be regulated by law. The legal framing of everyday life often leads to worse consequences than those generated by the conflict resulting in litigation. In addition, citizens demand greater participation and control over issues affecting them. Self-regulation is an alternative to excessive legislation.

What is self-regulation? A social group produces its own rules of operation, not in its own interest but in accordance with the general interest. This second condition, according to Victoria Camps, is what differentiates self-regulation in self-interest, i.e., corporatism, from self-regulation committed to social interest, the common good.

Thus, the responsibility for the profession is exercised by freely assuming the decision to share, as a collective, the commitment to produce the principles and standards regulating the practice itself to the highest standards of competence, to provide adequate health care according to the general interest.

Values associated with collegial responsibility

Joining a collective having the desire to regulate professional practice when it aspires to excellence can only be the result of a free decision. This individual decision supports the moral strength of collective commitment. It is an individual exercise of self-determination by which individual practice is linked to that of the collective. It derives from the conviction that regulating such practice cannot be a mere individual concern or that laws are the appropriate instrument.

Joining an organised professional collective—the College of Physicians—implies a double responsibility : accepting peer evaluation of individual practice and participating in formulating

the rules allowing the evaluation of individual practice. This double commitment underlies the primary function of the Colleges of Physicians : to formulate the principles and rules that should govern good medical practice and to ensure compliance.

Joining a collective having the desire to regulate professional practice when it aspires to excellence can only be the result of a free decision. This individual decision supports the moral strength of collective commitment

Identifying the principles and rules of conduct of a collective is neither easy nor vain. One must confront the reticence of postmodern nihilistic thought supporting the supremacy of individual values—those of personal affirmation and self-realisation—over community values, those helping to order life in society. The possibility of arriving at universal ethical principles is questioned, resulting in relativising the concept and criterion of truth. We must start from that perception, that there is no single truth, to be able to agree on the different moral convictions that coexist in an open society.

Respect for people is the principle governing all processes of collective deliberation to identify rules of conduct. The dialogue between 'moral strangers', among those who do not share the same moral reference system, is a challenge for those who share the same profession. It is, at the same time, an intellectual and moral challenge, subjecting one's convictions to the test of consistency and coherence. There are attitudes, such as the will to belong to the collective, that foster dialogue and consensus. The intellectual interest in thinking of others as a sign of respect for others and in distancing oneself from one's personal principles and values facilitates the procedure to reach consensus.

Another precaution is to avoid falling into the scientific reductionism of believing the information obtained about the outcomes of medical interventions is enough to regulate good practice. Knowing the efficacy and effectiveness of instruments is not a guarantee of proper use. This is especially important regarding health care at the beginning and end of life.

Consensual collective recommendations must be exercised with prudence, in the Aristotelian sense of the term, as the ability to choose the most reasonable decisions, understanding as such the most appropriate to the circumstances. According to this context of autonomy, respect, and prudence, collective commitment to the rules of conduct must incorporate the right to exercise objection of conscience when the behaviour required of professionals is contrary to their convictions. This protects the rights of those in the minority and avoids the coercive imposition of the majority.

The practice of collegial commitment

To practice with competence, it is necessary to update not only scientific knowledge and technical skills but also attitudes in personal behaviour, in a context of the exponential growth of information and high expectations of

citizens regarding health. This implies a triple commitment of the collegial collective : promoting and providing continuing education, sharing knowledge, and accepting peer evaluation, as regulated in Article 7 of the *Code of Medical Deontology (CMD)* of the Organisation of Colleges of Physicians.

Today, training programmes must be explicit, with periodic evaluations and transparency in terms of results

Good professionals should be willing to continue their training as much as they are willing to contribute to training their colleagues. This is one legacy of the Hippocratic oath ; however, in that historical context, the commitment to share knowledge responded to the need to preserve the transmission of medical knowledge exclusively to the initiated, forbidding access to laymen. Today, training programmes must be explicit, with periodic evaluations and transparency in terms of results.

If the evaluation of professional competence corresponds to the collective organised as the College of Physicians, the disqualification of a colleague by another invalidates that commitment. Nothing proves the lack of responsibility of a professional more than the negative public judgement of competence by any other professional.

When the behaviour of a colleague might pose a risk to people, the protection of those people requires diligent and prudent actions. The attitude towards a negligent, reckless, or maleficent colleague cannot be the same as that towards another who is ill or suffers an addiction. Communicating a risk behaviour to the College of Physicians is not a lack of companionship but the opposite, aiming to prevent harm to people, and, therefore, more serious responsibilities, as stated in Article 22.3 of the CMD and recommendation 76 of the GMP guide. The Programme of Comprehensive Care of the Sick Physicians is a good example of collegial action to protect citizens and care for sick colleagues.

The conviction that good professionals are organised collectively to self-regulate themselves is the foundation of respect for other health professions. Health professions have their own specificity and competencies that complement and elevate medical functions. Recognising that specificity and those competencies is necessary for teamwork.

Teamwork is the ideal organisational form to respond to the complexity of today's health care. In a team, each member has her or his role, which is developed with full autonomy without hierarchical dependencies, beyond the commitment acquired when care goals are accepted. In a team, there are no hierarchies, except for the necessary leadership assumed by those most committed to the organisation and with an overall vision of its goals.

The leader is the most committed team member, not the member with the most knowledge or experience. Clinical leadership demands commitment

The leader is the most committed team member, not the member with the most knowledge

or experience. Clinical leadership demands commitment, first, to the values and expectations of people about the goals and procedures of the health institution, and second, with the other team members, to know how to accommodate these values with common goals and tasks. Leadership is exercised by fostering personal growth through professional practice, respecting individual singularities, and facilitating consensus on procedures and working methods.

Thus, responsibility as an organised collective entails a commitment to promote, update, and evaluate professional competence, assumed individually and voluntarily. This commitment implies respect for the competence of colleagues and avoids practice risks. Collaboration with other health professions based on respect for their specific competencies, complementary to medical ones, is the basis of teamwork that benefits from committed leadership.

Conclusions

The responsibility of professionals, i.e., colleagues, is exercised collectively and institutionally, i.e., collegially. However, this collective commitment is based on an essential motivation—the individual will to achieve excellence in practice—and a conviction—that this requires the evaluation of peers, colleagues, and members of the College of Physicians.

The moral authority of the collective organised as the College of Physicians is based on the individual attitude of its members aiming to do things as best as possible. It does not matter that this predisposition of the will is innate or the result of imitating the exemplary behaviour of another professional of reference. It is only a starting point, an aspiration. That aspiration can only be maintained, consolidated, and fully manifested in the appropriate context : the community created by those who share the same aspiration.

That must be the conviction motivating voluntary incorporation to the College of Physicians. That conviction assumes that only peer opinion can decide professional competence. To make it possible, one must trust the predecessors who ordered medical practice according to the canons of good practice. But this capacity to regulate the profession must be recognised by society. Society will do so to the extent professional competence adapts to the needs of citizens in the field of health and health care.

For all these reasons, advanced democratic societies—if they want to maintain professional excellence, avoiding bureaucratisation of practice and legal framing of the clinical relationship—will do well to delegate the certification of professional competence in the Colleges of Physicians. The professional self-regulation this implies is the ideal way to order a complex practice, in a plural society with multiple codes of conduct and high expectations regarding public services.

The ethical value of all this is based on two criteria already mentioned. The first is that incorporation into the collective must be voluntary. The absolute guarantee of the commitment of professionals to good medical practice is that it must be an act of conscience, not imposed, i.e., the result of personal deliberation and, therefore, a free decision. The

second is that as professional corporations, the Colleges of Physicians organise medical practice, not according only to their interests but also primarily attending to the common good. They must do it in an exercise of self-regulation understood not as corporatism looking exclusively for the interests of professionals but as a service to society, prioritising appropriate care to people. It is up to the legislators to incorporate and make these proposals feasible.

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The challenge of becoming a socially accountable physician

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The challenge of becoming a socially accountable physician

Social accountability is defined by a triple capacity : to identify priority health needs and challenges in society, to adapt one's work to best meet those needs and challenges and to ensure that undertaken actions lead to the highest possible impact on people's health through efficient partnership with other stakeholders. Any health actor, including the physician, should be concerned.

Several models promote the social role of physicians, such as the WHO five-star doctor model, the Canadian CanMEDS and the Physician Charter. They all suggest the physician should hold a central position in the health care system by understanding and acting on health determinants affecting individuals as well as populations. But there is an obvious gap between good intentions and the real situation. For physicians to become truly socially accountable and adapt their behaviour accordingly, a large consensus must be reached between health professional associations, academic institutions, health service organisations and public authorities to adapt their respective missions and programmes for better quality, equity and efficiency in the health system.

Social accountability to improve impact on health

More than ever societies face pressure to ensure person-centred care, equity, relevance and efficiency in the health service delivery to their citizens. This situation is due to a unique combination of factors worldwide : an ageing population, greater public awareness and expectations, increasing cost of health care, better recognition of social and environmental determinants of health, rampant inequity and poverty and an emerging need for new types of health professionals. Every organisation or institution is called to revisit its mission and programmes to contribute to alleviating the situation. Health professionals, physicians in particular, are central to these efforts, because of their intimate relationship with patients and through them their families and society at large.

What is social accountability?

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Social accountability is defined by a triple capacity : to identify priority health needs and challenges in society, to adapt one's work to best meet those needs and challenges and to ensure that undertaken actions lead to the highest possible impact on people's health through efficient partnership with other stakeholders. In principle, social accountability is an obligation for any organisation, institution, group or profession in any sector claiming its commitment to serve society, whether society is identified as individuals, a community, a district or a nation. It embraces a very wide spectrum of activities, from the protection of the global environment and making a reasonable use of the resources of our planet to the respect for human dignity.

UNESCO declares that universities should be socially accountable as 'Relevance in higher education should be assessed in terms of the fit between what society expects of institutions and what they do'

The International Organisation for Standardisation (ISO) defines social responsibility of the enterprise as 'a voluntary integration of social and ecological concerns in its commercial activities and in its relationship with stakeholders'. In a more recent statement it further declares that 'an organisation is held responsible for the impact of its decisions and activities on society and the environment through an ethical and transparent behaviour with effect on sustainable development including in health and social well-being'. Similarly, UNESCO declares that universities should be socially accountable as 'Relevance in higher education should be assessed in terms of the fit between what society expects of institutions and what they do'. WHO, by its definition of health as a 'state of complete physical, mental and social well-being' and its constant call for social justice as exemplified by the Strategy of Health for All in the 1970s and the Universal Health Coverage in the 2010s, has always urged UN Member States to implement socially accountable policies.

Accountable to whom and for what?

One is accountable for what has been publicly and explicitly promised to be done. A public national health system is accountable to citizens for its explicit commitment to provide the best possible health services. Citizens may therefore request that everyone in the nation should have access to health care. They may also expect a better protection against health risks and better action on the different health determinants, these being environmental, cultural, economic and political.

Similarly, other key stakeholders in the health system, such as health service organisations, health insurance schemes, health professional associations, academic institutions and health professional schools as well as civil society, should also explicitly declare what they are committed to deliver. In the case of medical schools, as early as 1995 WHO defined their social accountability as : 'the obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organisations, health professionals and the public'.

There are two striking points in this definition which are relevant to other health partners : obligation and jointly. The obligation alludes to the fact that being socially accountable should be a fundamental ethical attitude while the definition of priority health concerns should emerge from a consultative process with other health partners. In 2010, the Global Consensus on the Social Accountability of Medical Schools, a socially accountable medical school, was described as holding four attributes :

- Responding to current and future health needs and challenges in society
- Reorienting its education, research and service priorities accordingly
- Strengthening governance and partnerships with other stakeholders
- Using evaluation and accreditation to assess their performance and impact

While the above core principles should inspire any health actor aiming to be socially accountable, including physicians, it has been strategically wise to first examine the role of medical schools, whose mandate is to educate doctors. Being models of social accountability, schools should therefore be prone to inculcate similar principles to their graduates. In Canada, social responsibility and accountability are core values underpinning the roles of Canadian physicians and Faculties of Medicine. This commitment means that, both individually and collectively, physicians and faculties must respond to the diverse needs of individuals and communities throughout Canada, as well as meet international responsibilities to the global community.

Nevertheless, a gap exists between the role models offered by the educational institution and the actual modalities of practice of future doctors. The medical school as the producer of the workforce is just one of the key stakeholders, while socially accountable behaviours should be universally appraised and rewarded throughout the health system, from national health policy level to health insurance rules, health service organisation and financial rewards.

The physician in society

Obviously, the prime social obligation of doctors is to provide the best possible care to their patients. Besides curative measures, doctors are also seen as key references to prevent risks of ill health and to counsel on healthy lifestyles related to nutrition, mobility, avoidance of substance abuse, security at work, social interaction. With the current high emphasis on narrow specialisation, the human touch must be regarded as essential in taking into consideration the comprehensive

context in which patients and citizens live.

Among the other values on which social accountability should be based are equity and efficiency. Equity in health indeed plays an important part in health actors' *ethos*. Physicians should feel concerned by the well-being of the population living in a given area whose members do not properly benefit from health services because of their socio-economic status, their cultural differences or their living in remote places. Another key challenge nowadays is the sustainability of the health care delivery system requiring a better use of human, financial and technical resources. Physicians should therefore support reforming efforts for greater efficiency in the health care system, eventually by task shifting among the health workforce and enhancing participatory management.

For ages, the physician has been considered as pivotal in the health care delivery system, if not in the political sphere, as alluded to by the famous 19th century German histopathologist, Rudolf Virchow : 'physicians are the natural attorney of the poor and the social problems should largely be solved by them'. In the original Hippocratic Oath, there was little or no mention of a social role for the physician. It was only in the middle of the last century that revised versions of the oath referred to ethical issues and later to the obligation to treat not only an organ but a sick human being, whose illness may affect his/her family and their economic stability. It was further revised in 1964 to state that physicians, as members of society, have a special obligation to all their fellow human beings, including those who are sound of mind and body as well as the infirm.

In 1996, the World Health Assembly passed the resolution WHA48.8 'Changing Medical Education and Medical Practice for Health for All', urging countries 'to collaborate with all bodies concerned, including professional associations, in defining the desired profile of the future medical practitioner and, where appropriate, the respective and complementary roles of generalists and specialists and their relations with other primary health care providers in order to respond better to people's needs and improve health status'. In the WHO strategy document to implement this resolution entitled 'Doctors for Health' reference is made to the 'Five-star doctor' model (Table 1), also first cited in a peer reviewed journal, Academic Medicine in 1992.

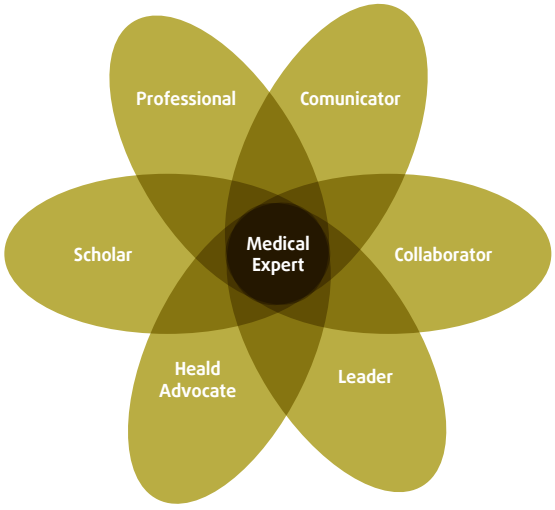
The 'Five-star doctor' model is an affirmation that the profile of the doctor should be shaped by the same forces influencing the health care system of the future. The role of the doctor is to be re-examined as part of the re-examination of the roles of all health care providers. Other models have confirmed the social role of doctors, in a way that is very consistent with the features of social accountability, namely the Canadian *CanMEDS* (Figure 1), the *Physician Charter* and the British *Tomorrow's doctor* from the General Medical Council.

The CanMEDS profile is composed of six aptitudes of which three suggest actions beyond the boundaries of a medical clinic : collaborator, leader and health advocate. As a collaborator, the physician may delegate tasks to other health professionals, i.e. a pharmacist may be asked to immunise people, a nurse to follow-up chronic patients, a social worker to educate helpers of Alzheimer patients. As a health advocate, the

Table 1. The five-star doctor.

Care provider Who considers the patient holistically as an individual and as an integral part of a family and the community, and provides high-quality, comprehensive, continuous and personalised care within a long-term relationship based on trust.
Decision-maker Who chooses which technologies to apply ethically and cost-effectively while enhancing the care he/she provides.
Communicator Who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health.
Community leader Who, having won the trust of the people among whom he/she works, can reconcile individual and community health requirements and initiate action on behalf of the community.
Manager Who can work harmoniously with individuals and organisations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data.

Figure 1. The CanMEDS model.



physician may be expected to counsel public authorities on social determinants of health. As a leader, the physician may facilitate the coordination of a group for more effective action towards priority health concerns, within a health setting or in a community.

The Physician Charter defined professionalism in medical practice around three basic principles : patient welfare, patient's autonomy and social justice. The principle of primacy of patient welfare is put forward while patient autonomy is meant to empower patients to make choices that determine their health. The social justice principle is to encourage doctors to work actively to achieve a fair distribution of health resources in a population. Professionalism can therefore be considered as a contract between society and the medical profession reflecting cultural values.

The physician and social accountability

There are many commonalities between the three different models examined, as they project the future role of physicians. Besides the capacity to deliver the best possible service to the patient, beyond the traditional one-to-one care provider to care receiver relationship, several of the suggested aptitudes tend to position the physician as a central figure in the complex health care context. These aptitudes refer to individual care as well as community interaction, which are pillars of the social accountability concept.

Applying social accountability in individual care

Physicians are expected to provide person-centred care and consider patients in their living and working environment, taking into account their cultural, social and economic conditions in providing advice or prescribing any procedure. With easy access to medical information, patients have greater expectations and become more critical of proposed services. This feature opens an opportunity to dialogue with patients and their families and empower them to adopt more healthy lifestyles, and become more self-reliant and reasonable consumers of health products. This is even more pertinent with the increasing prevalence of chronic diseases. Hence, the imperative needs for physicians to master communication skills in order to help patients and citizens to be as autonomous as possible, active in maintaining their own health and eventually health advocates for people living nearby.

Applying social accountability in community interaction

Being socially accountable implies being in partnership with other stakeholders in the health sector

Being socially accountable implies being in partnership with other stakeholders in the health sector. Physicians would make an active contribution to acting on health determinants in the neighbouring environment, i.e. being a public advocate to limit pollution hazards or contributing to poverty reduction programmes. On a wider scale, physicians may actively collaborate in national public health campaigns targeting priority health concerns, i.e. participating in health information and education in schools or workplaces. Physicians may also choose to work in multiprofessional health settings, sharing space, information and competences with various professionals in the health and social sector, in providing a more comprehensive service to patients and participating in a population-based prevention and health promotion programme.

Conclusion

There seems to be a general agreement on the principle to apply the concept of social accountability to physicians. However, little evidence is available of strategies to translate the concept into practice. A similar gap between idealism and reality is experienced with the promulgation of Human Rights and the ecological awareness to preserve our environment. If social accountability in the health sector is to become a national policy, one progressive stakeholder may feel prejudiced if all others remain conservative and lukewarm in applying changes in their habits and prerogatives. In countries ruled by democracy, behavioural changes can only occur through a national consensus patiently built by wide consultations with relevant actors, substantiated by evidence of added value offered by alternative practices on common well-being and supported by a rewards system.

Nevertheless, on several occasions, physicians have demonstrated their social accountability either on a personal basis or in a group practice. For instance, those working in rural and remote areas are often committed to catering for holistic health needs of patients and populations. Likewise, national associations of multi-professional health centres recommend similar commitment, whether settled in rural or urban areas. At the international level, WONCA – the world organisation of family doctors – is a strong promoter of the social accountability of physicians, as exemplified by the regular granting of a Five-star doctor award to general practitioners. To a minor extent, other medical specialties advocate socially accountable practices, as seen with the Physician Charter published by a group of internists. In certain countries, it is not rare to see dermatologists offering a free consultation once a year to detect melanomas and paediatricians doing the same to identify early symptoms of asthma.

Physicians are generally aware of profound sociological changes and the need to adapt in order to remain a central reference in the health care delivery system. Younger generations of physicians are keen to build a career that provides continuous professional satisfaction and is relevant in meeting pressing health challenges in their society. It is up to medical associations in alliance with academic institutions, public authorities, health care organisations and the public to elaborate policies and design appropriate strategies to change the culture for a progressive institutionalisation of socially accountable medicine and health.

Take home messages

- Be aware of the gap between good intentions conveyed by the social accountability concept and the feasibility of its implementation, due to resistance to change, and become an advocate for reforms using credible arguments.
- Collaborate in adapting medical education programmes based on the expected competences of a socially accountable medical doctor.
- Promote partnerships between medical schools, medical associations and health care services to experiment health care delivery models in a given territory, to address priority health issues in a population.

– Participate in policy initiatives in the design of good practice guidelines highlighting social accountability principles and strategies which physicians could apply and be rewarded for.

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Autonomy : the physician's freedom to make independent decisions in the best interests of patients and for the good of society

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Autonomy : the physician's freedom to make independent decisions in the best interests of patients and for the good of society

Definition and development

The *Code of Medical Ethics* of the American Medical Association of 1847, inspired by the thinking of Thomas Percival, proposed that physicians assume a series of obligations to the community, while the community, in return, grants the medical profession a series of special prerogatives, one of the most salient being the freedom to establish its own standards and norms. In other words, society grants the medical profession autonomy. As was to be expected, this almost immediately gave rise to discussions about what exactly is meant by professional autonomy and the question as to whether the standards promulgated by the medical profession are mandatory for all physicians or whether they are free to set them on an individual basis.

Autonomy can be understood as the capacity someone has to make decisions without the help of another. The Cambridge Dictionary of English defines it as 'the ability to make your own decisions without being controlled by anyone else'. Another sense given by the Longman Dictionary of Contemporary English is that of the 'freedom that a place or an organisation has to govern or control itself'. Since the late 19th century '(medical) professional autonomy' means that the medical profession establishes and enforces the standards of quality of its practice.

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The modern concept of autonomy, proposed mainly by Kant, refers to the physician's ability to abide by the standards established by the medical professional community, whether scientific or

related to professional ethics, which she herself accepts as such, without any external coercion. In this sense, an autonomous person is one who acts freely according to a chosen plan, that is, within the framework of a freely adopted norm. This derives from the fact that anyone who is unable to reflect in order to freely choose a plan is destined to be controlled by others.

In October 1987, the 39th Assembly of the World Medical Association (WMA), held in Madrid, defined the main element of professional autonomy as the guarantee that physicians have the freedom to exercise their professional judgement in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals. This principle has been reviewed by the WMA itself on several occasions (2005, 2008 and 2018), and now reaffirms the importance of professional autonomy as an essential component of high quality medical care and therefore a benefit to the patient that must be preserved. The WMA committed its national medical associations to maintain and guarantee this essential ethical principle, that is, professional autonomy, in the care of patients.

The *Code of Medical Ethics* of the Spanish Medical Colleges Organisation (*Organización Médical Colegial*), on the one hand, is a set of guidelines on conduct with which it responds to its desire and capacity for self-organisation of the Spanish medical profession. On the other hand, however, it also constitutes a tribute to the physician's autonomy and independence, from her responsibility and dedication to the interests of the patient and of society. The aforementioned code carefully takes up the main lines of the rules on the principle of patient autonomy established by current legislation, although, as is logical, with greater delicacy and approximation to the clinical relationship.

Relationship with other fundamental values and principles

The autonomy and independence of the physician's professional practice is related to the following aspects.

Patient autonomy and their right to information

In relation to health, there is probably no other principle of such importance in the Western world today as that which declares the autonomy of citizens and of doctors when it comes to making responsible decisions after respecting the decision made by their freely informed patient.

Professional autonomy is essential to help patients make informed decisions and, moreover, it allows physicians to reject requests from patients or family members that are unjustified or contrary to good practice

Effectively promoting patient autonomy and their right to quality information inevitably involves preserving and paying attention to the physician's autonomy and independence. Patients have the right to decide freely on the option they prefer

with respect to their own health. To this end, they must be appropriately informed and advised by professionals who have been well trained and have received a good education based on the available evidence, who freely offer their knowledge, recommendations and opinions to patients and to society in general, and who are also committed to what they recommend. Professional autonomy is essential to help patients make informed decisions and, moreover, it allows physicians to reject requests from patients or family members that are unjustified or contrary to good practice. Consequently, citizens are free to demand the care they need and consider necessary ; patients are autonomous and free to decide, after being properly informed, what is best for them in relation to their health ; and doctors are autonomous and free to offer patients and citizens – with regard to their health care and quality of life – what is necessary and best for them, in the best way and at the best price.

Agency relationships in the practice of medicine

An agency is a place, or a time, where two people exchange information, objects or consumer goods**.** In the agency there is a seller or supplier, who informs the buyer of the characteristics of the object or service he wants and, of course, what it is worth or the price she has to pay to acquire it. Times are changing for physician-patient relationships. When discussing, for example, the possible options for treating fractures of the femur neck of a certain patient, we must all agree (because it is required by law and professional ethics) on the need to inform the patient or, where appropriate, the family of the pros and cons of each of the possible treatments. This information that the physician explains and gives to his patient, which helps him decide which option is best for her, whether it is a diagnostic, therapeutic or surgical procedure, is what is called an 'agency relationship'.

In everyday life, when a client comes into an agency, he usually has a clear idea beforehand of what he wants to buy. He informs himself before and during the interview with the seller, and decides freely, according to his preferences or purchasing power, whether or not to purchase the object or service. This is what is known in economics as a normal, perfect or symmetrical 'agency relationship'. But what happens in medicine? The difference in the information available, in this case between the patient (client) and the doctor (supplier), is so great that the patient usually has to accept (acquire/allow/decide on) what the doctor says, advises or recommends. This is what is called an 'imperfect agency relationship', that is to say, a relationship is established between the physician and the patient with a great asymmetry of knowledge between the two of them. It is difficult to find another activity in life in which the situation is so asymmetrical, but at the same time so important in terms of its consequences. Indeed, in this relationship, the health consequences of wrongful decisions can be very serious and often the patient will not have another opportunity. In short, we find ourselves in an agency relationship where the physician (supplier) will be largely responsible for both the supply and the demand. The doctor, in his relationship with the patient, must strive to ensure that, in each case, this asymmetry is as small as possible. From this relationship emerges, on the one hand, the need to maintain and strengthen the bonds of trust

between the patient and her doctor and, on the other, to ensure that the doctor is independent and free to offer his opinion and diagnostic and therapeutic proposals.

Communication and the medicalisation of life

Everything related to individual and collective health takes on extraordinary relevance in today's society. The 'medicalisation' (everyday issues or those arising from life itself seek answers in medicine) and the 'medicamentalisation' of life (daily processes that give rise to displeasure seek and obtain a medicine to treat them) are exaggerated and seem to be endless. The media, with the support of health professionals, play a decisive role in the construction of the state of opinion on everything related to health and especially health care. The physician's freedom and autonomy, based on the legal and deontological responsibility that is demanded of her, are essential and constitute a fundamental determinant when it comes to offering the general population reliable and well grounded information on everything related to their health and quality of life.

The medicalisation and medicamentalisation of daily life induced and encouraged by the incentives of the pharmaceutical and technological industry, with the collaboration of certain professional sectors, together with the tolerance of political and economic sectors, make it very difficult to counter. Both use a vast amount of healthcare resources and energy in a useless way, they generate and induce a demand for unnecessary technology and medicines that increase the pressure on the doctor, alter the dynamics of the physician-patient relationship and give rise to serious avoidable risks for patients.

Training, evaluation and research

In the 1970s, Percival and Cabot considered that probabilistic studies and research provide the best evidence to know the effectiveness of interventions. Thus arose what was later defined as evidence-based medicine, and with it clinical practice guidelines that went against the traditional form of medical practice, hitherto based on accumulated individual experience. The commitment to promote the best quality reinforces society's confidence in the medical profession by legitimising its autonomy to regulate itself. Clinical practice based on the best available evidence benefits both patients and society. But the results obtained by the medical profession also legitimise and strengthen its capacity for self-governance and self-regulation.

The commitment to promote the best quality reinforces society's confidence in the medical profession by legitimising its autonomy to regulate itself

Ongoing assessment of professional practice should be used for the benefit of patients in order to ensure the continuing quality of care provided by competent physicians. Within this concern there is also the need to monitor advances in scientific medicine and the use of safe and effective therapeutic methods that are not subject to outside interests. Similarly, clinical trials should

at least meet the standards of protection required by the Helsinki Declaration of the WMA, which must exclude the application of questionable scientific theories to patients.

Economic limitations

Such financial constraints or unjustified increases in the cost of medicines and technology can cause health administrations to interfere with clinical autonomy by attempting to impose rules and limitations that go against the scientific evidence and ethical standards of the medical profession

The ever-present economic limitations in relation to health care should be considered from two very different and contrasting perspectives, where the physician's autonomy and independence are of the utmost importance. On the one hand, it must always be remembered that, while it is true that economic resources are finite and the resources for improving the sensation of health and well-being tend to infinity, it is ethically indispensable that the physician, after offering the patient what she technically and ethically considers necessary to preserve his health, must introduce some degree of economic sense into her decisions. Limitations in public services and health benefits, as well as the establishment of priorities in them, especially when they are free at the time when they are demanded, are fundamental to ensure the survival of public services and their capacity to continue to distribute wealth and health security under equal conditions. Such financial constraints or unjustified increases in the cost of medicines and technology can cause health administrations to interfere with clinical autonomy by attempting to impose rules and limitations that go against the scientific evidence and ethical standards of the medical profession.

On the other hand, policies of indiscriminate cuts and cost reduction are commonly applied more particularly on the population and the areas of health care where they are easier to apply, thus eroding the doctor's autonomy to exercise his profession. Low salaries, unbalanced distribution of budgets and resources between rural and urban areas, between primary care and hospitals, reductions in the amount of time dedicated to each patient, inequality in access to diagnostic methods and treatments or to a specialist due to waiting lists... all this reduces the quality of the patient's care, since it also reduces the effective independence and autonomy of the professional.

Importance for the patient, the professional and society

The physician's professional autonomy and clinical independence are substantial elements for the best physician-patient relationship, and good medical practice along with the best patient service will both depend on them. Society grants this prerogative to the medical profession as a whole, not to the professional as an individual. Hence the need for the medical profession, as a collective, to take responsibility for regulating the autonomy and freedom of the medical practice of each and every one of its members. Consequently, the autonomy and independence

that justify the medical profession's freedom of opinion and prescription are not absolute values that allow problems to be resolved simply by appealing to them and to justify the doctor's behaviour in any decision that is made. The physician's professional autonomy and independence will be limited by the scientific evidence, the values and the professional and ethical standards of the medical profession. In short, they constitute the substratum where the physician's principles and values, known as medical professionalism, grow and are maintained.

The professional autonomy and clinical independence of the physician who assumes the ultimate responsibility for the patient's care must be respected by other members of the team. Nevertheless, it should be remembered that, whenever possible, and in the best interests of patients, professional dilemmas should be discussed in a clinical session with absolute freedom and without fear of retaliation, after which the most appropriate decision should be taken in each case. Being accountable and offering explanations to other professionals in an environment of loyalty to the patient and without any restrictions on professional freedom is an act of extraordinary ethical and scientific value that represents a guarantee and security for patients.

Self-regulation and medical professionalism

The principle of medical autonomy is related to professionalism. In a broad sense, medical professionalism includes three key dimensions : expert knowledge, self-regulation of the profession, and the obligation to subordinate self-interest to the needs, interests and autonomy of the patient. Thus, it meets a social need with a high responsibility for the physician, who acts under the control of the professional group to which she belongs. Physicians must converge, specify, explain and disseminate the technical competencies, principles and values with which they undertake to carry out their professional practice and which coincide with the model of self-regulation represented by the Spanish Medical Colleges Organisation, to which all physicians must be accountable for their conduct.

Because of the characteristics of both health care and the practice of medicine, physicians need a high degree of individual autonomy and independence to control the terms and particularities of their obligations, commitments and daily practice. Professional autonomy can only be maintained if physicians subject their activities and decisions to the critical evaluation of other colleagues, and even to the opinions of their patients. Only on the basis of this peer-to-peer contract can a model based on association membership assume responsibility for the regulation of medical practice. In exchange for the privileges resulting from this self-regulation of the profession, the model of belonging to official colleges must guarantee the competence and conduct of its members.

The 39th Assembly of the WMA held in Madrid in October 1987 made a statement that was editorially revised in May 2005, when it was established that 'As a corollary to the right of professional autonomy, the medical profession has a continuing responsibility to be self-regulating. In addition to any other source of regulation that may be applied to individual

physicians, the medical profession itself must be responsible for regulating the professional conduct and activities of individual physicians'.

The Spanish Medical Colleges Organisation and, with it, the official medical associations are necessary as ethical and democratic spaces of professional and managerial freedoms, placed at the service of patients and of the best medical practice in order to meet the requirements of self-regulation. Medical associations are forums of medical thought in which to create ethical, professional and clinical intelligence that are set up as instruments of governance of the medical profession, to guarantee essential public rights for the care of the population's health, and placed at the service of citizens, of society and of the best medical practice.

The WMA, at the aforementioned Assembly in Madrid and the consecutive reviews, stated that 'cost consciousness is an essential element of self-regulation. The highest quality of care can be justified only by assurances that the cost of such care will allow access to that care for all citizens'. Again, physicians are particularly qualified to carry out the necessary assessments and make decisions regarding the control of health expenditure. The proper use of resources, the introduction of economic sense in the decisions of physicians and the ethical relationship and efficiency are provided for and form part of the code of ethics of the Spanish Medical Colleges Organisation.

At the same time, it should be pointed out that expenditure control should not be used as a pretext for denying patients the medical services they need. This obligation is recognised by the WMA when, in the Declaration of Madrid, it states that its member organisations must implement 'a system of professional self-regulation [that] will enhance and assure the individual physician's right to treat patients without interference with his or her professionally-based judgement. This is included in Chapter IV of the current Code of Ethics on the quality of medical care'. It is also the Spanish Medical Colleges Organisation's duty to promote, together with the autonomy and independence of its members, an ethically correct conduct throughout their professional activity and also their knowledge of the code of ethics, as well as their participation in the periodic updating of its contents.

Implications for daily practice

The need to protect the independence and autonomy of medical practice from the disinterest of possible social policies or from the economic neglect that give rise to inequity, or from the infinite economic interests of profit-making, especially of investment funds in the health sector, obliges us to respect and demand the mechanisms of self-regulation and control that the profession itself has to establish. The regulation implicit in the code of ethics foresees the circumstances that represent deviations or abuses of the individual independence and autonomy motivated by interests or incompetence. Thus, self-regulation is a tool for creating professional and ethical clinical intelligence that benefits both the patient and good medical practice. In short, it is not possible to understand and speak of professionalism or the values and principles of physicians without the guarantees of independence and responsible autonomy of the medical profession as a whole and of its constituent individuals.

Consequences of failing to take it into account

The pharmaceutical industry is commendable when it researches and manufactures drugs of moderate or high clinical relevance at a socially fair price. But it is not so when it performs improper functions, when it exaggerates or only offers positive research results and minimises the risks of its medicines or hides unfavourable outcomes, when it alters the loyalty of the doctor to her patient, when it encourages the medicalisation of healthy people, or hinders the independent and solid training of physicians. The attempt to exercise external control over the medical profession due to economic interests especially fostered by the large pharmaceutical and technological industry together with the insatiable extension of health care by insurance companies forces us to react in a suitable manner to prevent professional practice from being controlled and delimited by them in favour of a greater economic benefit and a medical practice that distances itself from professional responses concerned about the best interests of patients and society.

Individual and collective benefits of its correct observation

Medicine is a moral undertaking, a profession whose members enjoy autonomy and professional independence while also adhered to good clinical practice and to a code of ethics that includes a set of principles of dedication to the patient, respect for other colleagues, and professional honesty and appropriateness. These principles are the basis of medical professionalism and the foundations of the social contract between medicine and society. Dispersion of the regulation of the different aspects related to professional practice in different bodies and decision-makers would hinder the comprehensive treatment that all medical work must have. For this reason, with universal membership to associations and the democratic participation of physicians, organised along the lines of professionalism, it acts as a reinsurance of the quality of health care of the population.

Medicine is a moral undertaking, a profession whose members enjoy autonomy and professional independence while also adhered to good clinical practice and to a code of ethics that includes a set of principles of dedication to the patient, respect for other colleagues, and professional honesty and appropriateness

Internal quality control includes such relevant issues as professional certification and recertification, which were approved at the General Assembly of the Spanish Medical Colleges Organisation. In addition to certification, launched more than a decade ago and called ‘periodic membership validation’, which is carried out by the official colleges, more recently, in collaboration with the scientific societies, there is now the recertification of competence, performed by the scientific societies on their members. Both periodic membership validation and periodic membership validation with recertification are mechanisms of internal control of the quality of

care and good professional practice, which we consider to be insufficiently developed at present.

The internal control mechanism includes the suitable application of innovation in clinical practice and evidence-based preventive medicine and the cost-effectiveness of medical actions, together with debates, honest discussion and the proposal to correct the conflicts of interest from innovations to routine practice. Likewise, it is necessary to critically evaluate the assessment of the actions of doctors in the records on professional ethics. Noteworthy are the strategies that have been decided on for communicating errors and adverse processes.

Final messages

Medical autonomy is a prerogative that society confers on the profession, not on the individual physician, to which the profession as a whole must respond with effective self-regulation based on standards that are mandatory for all.

The professional autonomy and clinical independence of the physician are substantial elements for the best physician-patient relationship and for good medical practice on which the best service to the patient and society depends.

It is not possible to understand and speak about professionalism, or of the values and principles of physicians, without the guarantees of independence and autonomy of the medical profession as a whole and of the individuals it is composed of.

Today, as always, doctors must continue to establish or renew their best practices based on the available evidence, through the permanent review of self-regulation mechanisms, including good practice guidelines and the professional accreditation system (periodic membership validation and periodic membership validation with recertification).

The professional activities and conduct of doctors must always respect the code of medical professional ethics.

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Self-regulation of the medical profession : a difficult activity that requires commitment.

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Self-regulation of the medical profession : a difficult activity that requires commitment.

Definition and justification of (medical) self-regulation

The capacity of the medical profession to establish norms/codes of regulation that bind all those who practise medicine ; to be responsible for the actions and conduct of physicians in relation to the norms/codes self-imposed by the profession itself.

Although the difference between a law and a code is known, it is worth remembering that, as expressed by the moral philosopher Victoria Camps, the law regulates perfect and public duties, which are universal and demanded of all society, while a code regulates imperfect and private duties that can be demanded of oneself or of a particular collective but which cannot be imposed on or demanded of others.

In addition, the self-regulation of a collective, in this case the medical profession, must have a limit or at least fixed criteria decided by consensus. Without this, it becomes corporatism and not self-regulation

In addition, the self-regulation of a collective, in this case the medical profession, must have a limit or at least fixed criteria decided by consensus. Without this, it becomes corporatism and not self-regulation. Self-regulation does not mean that each and every collective can act as they please. In a democratic society in which a collective self-regulates, gives itself rules or establishes its own codes, it is only socially acceptable if the criteria and the policies of such codes are directed towards the common interest. In the context of the medical profession in particular, when we refer to the 'common interest' we are referring to patients and, by extension, society. Of course, this general principle should not impede that such codes facilitate working life ; the physician should understand that self-

imposed norms do not represent a straightjacket, but rather they indicate a route to follow which will facilitate their work.

Regulation of the medical profession, the state and society

At all levels, and in the medical profession in particular, fewer laws and greater self-regulation is necessary

It is necessary to insist that not all conduct can be regulated by law. In our sociocultural environment, not just in Spain, states have advanced and continue to advance in their capacity for regulation, which on many occasions appears limitless. In contrast to the Anglo-American cultures, civil society in Spain struggles to impose rules or limits independently of the State. However, is it really possible to establish rules outside the margins controlled by the State? What are these limits and how should they be defined? The answer, in a democratic society, appears simple : the citizens themselves. It is civil society that should work in favour of both self-regulation and deregulation. Citizens should be able to agree on norms of conduct and promote joint committees that regulate (in a friendly and constructive manner) the performance of two or more collectives. Our coexistence should be regulated (self-regulated) more by *retail* (by norms/codes) than by *wholesale* (by laws).

At all levels, and in the medical profession in particular, fewer laws and greater self-regulation is necessary.

It is possible that including self-regulation in this monograph as a 'value' of the physician might seem strange for someone who considers that self-regulation is not a value but simply a professional responsibility. This includes those who would classify self-regulation as a 'privilege', a concept that, in the first quarter of the 21st century, should be eradicated. These discrepancies make it necessary to state forcefully that self-regulation is never a privilege and should be considered more properly a responsibility that on occasions is thankless. Maybe self-regulation is not in itself a professional value, but without doubt it is a value of the physician to assume this responsibility. The ultimate goal of self-regulation is none other than to ensure the best possible care for the patient. As the aim of self-regulation is to pursue 'the best for the patient' and given the difficulty and risk involved in its practice, self-regulation should be positively evaluated as a value of the physician who is capable of acting according to the rules of their code even in situations that may not be comfortable for them, but are always for the benefit of the patient. Self-regulation, without doubt, can be classified as a 'value' of physicians who assume it in their clinical practice, forming the irreplaceable link, which corresponds to them as individuals in the corporate process of self-regulation.

Self-regulation in itself, therefore, is not a 'value' but rather a process ; the 'value' of the physician is to assume the responsibility of participating in collegial self-regulation.

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Self-regulation in professions

While this chapter does not cover the concept of a 'profession', it is difficult not to refer to it while self-regulation is fundamentally confined to professions, and the medical profession in particular. The role of professions in society can have different interpretations, although here it is contemplated in what is probably the most traditional manner : the 'functionalist interpretation'. It is correct that society requires the services offered by professions (health, law, education, equity or even religion), but it also demands to be protected from charlatans that are not in possession of the expertise they claim or those who abuse a possible monopoly on their knowledge and expertise. Therefore, it is necessary that professionals constitute themselves in a group, a professional organisation that assumes the responsibility of registering its members, evaluating them if necessary and taking disciplinary action towards those responsible for a negligent practice of the profession. The professional body, the medical college, should protect society from individuals who are not adequately qualified and from abuses committed by their own members (R. W. Perks, Accounting and Society, 1993).

Two necessary elements emerge from a functionalist interpretation of professions ; the existence of the group (the college in the case of the medical profession) and self-regulation as a consubstantial element for the exercise of the profession, which is none other than the protection of the citizen and the patient, if that is the case.

The area in which the value of self-regulation develops

Of the three areas of values which comprise this monograph (values of the physician as a person, values of the physician as a physician and the values of the professional), self-regulation figures in the third of these, that of the 'values of the profession', which the physician should assume. Therefore, it could be said that self-regulation is a value that can be seen as a duty that must be assumed by the physician if they want to form part of the guild, group or corporation. In our environment, this collective is no less than the medical collegiate organisations, namely the Medical Colleges and their General Council.

We accept as an axiom, and therefore we will not submit it either to discussion or to assessment, that self-regulation is an indivisible characteristic of professions in general and of the medical profession in particular. That is, self-regulation forms part of those characteristics that the majority consider consubstantial for a working activity that is considered a profession (Table 1).

Table 1. Signs for the physician's transit to moral excellence

Ethical Self Requirement :

- Search for professional excellence
- Spirit of service (placing the patient's interest before that of the doctor himself)
- Recognition of the autonomy and rights of the patient / citizen
- Compassion (feeling compassion demands a transitive verb, *doing something* ; it is not just about "*suffering with the sufferer*" but "*improving the sufferer*")

Group feeling (corporate structure)

- Own rules of conduct / Code of ethics
- Self-regulation / Quality assurance (ISO)

Specific knowledge (of high complexity)

- Autonomy in the workplace

Social recognition (perceived value of service by and for society ; its lack or loss could indicate a loss of moral excellence)

Components of self-regulation

The definition of self-regulation reveals two components. The first (capacity to establish norms of the medical profession) is basically reflected in the deontological code and it is incumbent to define it, write it and control compliance, as well as define, modify and update the norms that the group (the college) sets itself. However, the second component of the definition (to be responsible for the actions and conduct of physicians in relation to self-imposed norms/ codes) also affects the corporation, but very specifically affects each and every one of the physicians that form part of the corporation (the college) in an individual way. Ultimately, it is the governing body of the college that exercises the capacity to apply sanctions in response to specific accusations or complaints. However, it is neither the corporation in the abstract sense nor the governing body of the college that deploys police-like surveillance with regard to compliance with deontological norms. It is the responsibility of each and every professional to be attentive to how colleagues in the medical profession act, work, attend to, care for and cure. If our sons or daughters, or our husband or wife, act incorrectly, do we not correct them? Do we not indicate how something should be done? Is it not our obligation to help them? In the same way, if our colleagues, our professional brethren, have a problem, do they not also deserve our help?

It is the responsibility of every medical school graduate, once they begin their professional practice, to consider what self-regulation represents in their day-to-day work. In the first instance, to give an answer to this question, a reflection must be made on whether their activity conforms to the codes to which they have committed themselves and, if they do not, remedial action should be taken as soon as possible. However, that is not all. It is also the responsibility of every physician to observe whether their colleagues also practise the same commitment to the norms and codes of their corporation. The administration in general and the health authorities in particular understand that someone with a degree in medicine is a physician. However, the professional corporation (the collective, the guild, the college) cannot limit itself to the qualification (the credential or the 'piece of paper') to decide whether a physician

should be admitted to the group. If an individual is in possession of the appropriate medical credentials, but does not act appropriately because they do not apply the art and knowledge of the profession correctly, or they demand disproportionate reimbursement, or they do not update their knowledge, or because they do not respect or care for the patient, the corporation may rule that, although such an individual is in possession of the formal title of physician, they cannot form part of the collective (they are not 'one of us'). To continue to be 'one of us' is not free of charge ; it demands training, respect and commitment.

If an individual is in possession of the appropriate medical credentials, but does not act appropriately ... the corporation may rule that, although such an individual is in possession of the formal title of physician, they cannot form part of the collective (they are not 'one of us')

What are physicians like? Following the thread of Table, it can be said that physicians have specific highly complex knowledge, they show a spirit of service and they search for excellence (excellence is 'sought', it is pursued ; excellence is not an unattainable dream out of reach for many, and the value of a professional is the search for the route to excellence, training every day to maintain competence), they comply with the codes of their professional corporations and they put the welfare of the patient as the premise of any action. But what happens if physicians do not take responsibility for their training, they do not update their competencies or attend to patients correctly, neither caring nor curing, as they should? This refers to what happens if one is aware that a colleague is in breach of his/her professional duties. In another words, what happens if one is conscious that a colleague is not 'one of us'? Should one keep quiet and wait to see what happens? Should one look the other way and assume that someone else will do something? Or should one protect that colleague? It could be argued for and against any of these attitudes if there were not the risk of injury to a third party – the patient. Thus, when confronted with a situation in which the care of the patient is compromised, someone has to raise his/her voice to say : 'you are not acting in accordance with our code, you are not one of us'. This represents implication in the process of professional *self-regulation*.

The relevant question is that among the responsibilities of the *Deontological Code of Medicine* (CDM or *Código de deontología médica* in Spanish) and the *Good Medical Practice* (BQM or *Buen quehacer del médico* in Spanish), we can see two tasks, one relatively easy and the other more difficult to put into practice. The first is none other than the identification of professional behaviours of colleagues that do not comply with the codes established by the professional corporation itself. The second, more difficult task is to take action against such unprofessional activity when it is detected. What should be done when malpractice of a colleague is identified? It would be easy, but erroneous, to raise the subject in a negative way, by accusing the colleague. However, it should be borne in mind that patient protection is paramount, as well as the maintenance and consolidation of the reputation of the professional corporation. At the same time, in a general way, the best professional

development of each and every physician must be promoted. All of these are positive actions that require the pursuit of active policies to stimulate the good professional development of medicine.

what happens if one is conscious that a colleague is not 'one of us'? Should one keep quiet and wait to see what happens? Should one look the other way and assume that someone else will do something? Or should one protect that colleague?

One cannot be oblivious to the complexity of involvement in the process of medical self-regulation. It has already been stated that this is not about a process of accusation, but rather of finding the best way to remedy the situation. We must never lose sight of the fact that the welfare of the patient is always the driving force behind the process. The *whistle-blower* has never had a good press and it should not be claimed in this process either. The steps to be taken, which can be modulated according to circumstances and the seriousness of the situation, always follow the same general scheme. Firstly, one should speak to the colleague concerned and later, if the problem is not resolved, other actions are initiated : a consultation with the medical college, other colleagues or departmental superiors (hospital chief or head of department). Finally, when all other means have failed, it is the health authority, the management of the hospital or medical centre and/or the institution that have to address the problem. For all participants in the process, the objective is not to punish the physician but to offer the best possible remedy as quickly as possible.

In this sense, both the individual physician and the corporation (the college) must acquire greater visibility as defenders of the quality of the medical care provided

In this sense, both the individual physician and the corporation (the college) must acquire greater visibility as defenders of the quality of the medical care provided. It is not only a question for the institutions and their management/leadership, the healthcare authorities and politicians. The chain of responsibility begins with the individual physician. Today, the rules with regard to quality control have grown in all institutions. The concept of 'quality control' is widely recognised, defended and accepted. However, the process of self-regulation, which is no more than a form of 'quality control', is not viewed enthusiastically. Assuming this responsibility does not generate much euphoria. Thus, those with responsibility for the collective, the medical colleges, must work in a positive manner to ensure that the implication of the physician in self-regulation is as easy as possible and realistic without generating tensions, satisfying both the individual physician and the institution, while always benefiting the patient.

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Commitment

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Commitment

Is commitment an optional issue for doctors?

It did not occur to Dr. Rieux (Albert Camus' 'The Plague') to leave the city of Oran when the sick started dying. He understood commitment as the will to share sickness, pain and death. 'To love or to die together, and that's the only way' the doctor told himself as he listened to the radio broadcasting the show of support from other cities.

Definition

We understand commitment as an agreed-upon obligation, a given word, a contract, duty, trust. Although it can also refer to a complicated or awkward situation, we will not allude to that meaning in this document but to the aforementioned ones.

All values developed in previous pages are linked to this one ; none is more important than the others, but all make up the meaning of what being a doctor is : responsibility, honesty, loyalty, integrity, decency...

In the 2006 report, drafted by the Spanish Foundation for Medical Education (FEM) for the General Assembly of Official Colleges of Physicians, which was entitled '*Ser Médico Hoy*', commitment appears as one of the values that characterise the profession, together with altruism, discipline and efficiency.

Background

The word commitment has been very closely linked to the practice of medicine since long ago

The word commitment has been very closely linked to the practice of medicine since long ago. The quote 'medicine is art and science, but, above all, it is a personal commitment' is attributed to Maimonides, a physician born in Cordoba. On the other hand, what has been valid for many centuries is the Hippocratic Oath and physicians, knowing its antiquity, have felt proud of being recognised in it. The Oath gathers the commitment we acquire with teachers, colleagues and patients of keeping confidentiality, doing good, and avoiding surgery when unadvised.

Declaration of the World Medical Association

Closer to our times and better suited to contemporary society is the so-called Declaration of Geneva, approved by the World Medical Association (WMA) in 1948, soon after the end of World War Two. It has since been reviewed on different occasions, the last of which was in 2017, in the General Assembly of Chicago.

It starts with :

- 'At the time of being admitted as a member of the medical profession : I solemnly pledge to consecrate my life to the service of humanity ;
- I will give to my teachers the respect and gratitude that is their due ;
- I will practise my profession with conscience and dignity ;
- The health of my patient will be my first consideration ;
- I will respect the secrets that are confided in me, even after the patient has died ;
- I will maintain, by all the means in my power, the honour and the noble traditions of the medical profession ;
- My colleagues will be my sisters and brothers ;
- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient ;
- I will maintain the utmost respect for human life ;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat ;
- I make these promises solemnly, freely and upon my honour.'
- 'I pledge' and 'I make these promises', that is how this declaration begins and ends. In it lays explicit our commitment with the patient, with the medical profession and with society in general, as receivers and administrators of resources that belong to us all. Lastly, there is also a commitment with the employer in a generic sense.

This is a moral contract established between the professional and society by which the physician lends his/her service relying on a personalised relationship with the patient, based on trust and mutual respect.

The current crisis

The transformation of the doctor into a paid professional, linked to the bureaucratic control by health organisations and to the constant presence of political direction, has put at risk the keeping of this commitment.

According to Smith, in an article published in the BMJ in 1998, society has given certain privileges to the medical profession, such as 'status, above-average incomes, and the privilege of regulating [itself]' in exchange for the guarantee of being treated 'by competent doctors' and the commitment to professional values.

We, the physicians, can consider that we comply with a large portion of our commitments, but

society does so only partially. Although it shows a high level of satisfaction with our profession, it has not legislated the mechanisms that might self-regulate it, so they would be allowed, and we could ask for or demand them. In fact, our Rule of Law had not seen fit to deal with any of these issues until the Consejo General de Colegios de Médicos presented their Validation and Recertification project, which is a project that, as was to be expected, has progressed with excessive slowness.

In Manuel del Castillo's opinion published in Diario Médico in 2008, the current challenge of doctors and health organisations is to make the management systems of the modern enterprise compatible with the maintenance of professionalism, as long as we wish for the practice of medicine to stay a profession and not a job.

Determination as an associated value

Being willing to abide by this commitment is a necessary condition so it will not simply become a piece of paper. And by so doing we avoid the possibility that we might lose credit or prestige on a personal level or in the Profession.

The treatment of the patient, whichever our specialty, is a lot more effective if they feel that the doctor has the determination to share their illness with them – a determination that requires nerve and courage to share their anxiety, their pain or their fear of death.

The treatment of the patient, … , is a lot more effective if they feel that the doctor has the determination to share their illness with them

Conclusion

We must protect our commitment in order to maintain a high professional competence, to improve the quality of welfare, to facilitate access to medical attention, to manage a fair distribution of resources, to be honest with our patients, to promote scientific knowledge, to foster trust and to have a clear attitude against conflicts of interest. Lastly, we shall also commit ourselves to participate in the diverse organs of decision so as to guarantee that the objectives of health organisations will provide an answer to people's needs.

For this commitment to become easier for doctors to assume and to apply in their work, all the other participants, especially the health administration and other employers, must comply with their duty. More specifically, the following three aims must be open to doctors :

First, to give them autonomy to make clinical, organisational and management decisions in accordance with their commitment. Second, to gather the necessary resources to be able to dispense the best attention to their patients. And third, to reward them according to their level of responsibility, dedication and results.

When a patient enters your office and tells you about a health issue, they know you are telling them to trust you. That is commitment.

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