Submissions on topics related to professionalism are welcome. Manuscripts should conform to the *CQ* Guidelines for Contributors. All submissions should include an abstract and should be sent electronically to the Professionalism section coeditors, Mark Wicclair (wicclair@pitt.edu) and David Barnard (barnardd@ohsu.edu).

Vulnerability and Trustworthiness

Polestars of Professionalism in Healthcare

DAVID BARNARD

Abstract: Although recent literature on professionalism in healthcare abounds in recommended character traits, attitudes, or behaviors, with a few exceptions, the recommendations are untethered to any serious consideration of the contours and ethical demands of the healing relationship. This article offers an approach based on the professional's commitment to trustworthiness in response to the vulnerability of those seeking professional help. Because our willingness and ability to trust health professionals or healthcare institutions are affected by our personality, culture, race, age, prior experiences with illness and healthcare, and socioeconomic and political circumstances—"the social determinants of trust"—the attitudes and behaviors that actually do gain trust are patient and context specific. Therefore, in addition to the commitment to cultivating attitudes and behaviors that embody trustworthiness, professionalism also includes the commitment to actually gaining a patient's or family's trust by learning, through individualized dialogue, which conditions would win their justified trust, given their particular history and social situation.

Keywords: professionalism; healing relationship; vulnerability; trust; trustworthiness; social determinants

> The dignity of the physician requires that he should look healthy, and as plump as nature intended him to be; for the common crowd consider those who are not of this excellent bodily condition to be unable to take care of others. Then he must be clean in person, well dressed, and anointed with sweet-smelling unguents that are not in any way suspicious. This is, in fact, pleasing to patients. The prudent man must also be careful of certain moral considerations—not only to be silent, but also of great regularity of life, since thereby his reputation will be greatly enhanced; he must be a gentleman in character, and being this he must be grave and kind to all.
>
> Hippocrates, *The Physician*[1]

At least since the time of Hippocrates physicians and other health professionals have promulgated standards of conduct for members of their profession. Genuinely patient-based justifications for these standards are relatively recent.

A version of this article was originally presented at the third annual meeting of the Academy of Professionalism in Health Care, Louisville, Kentucky, May 7–9, 2015.

Cambridge Quarterly of Healthcare Ethics (2016), **25**, 288–300.
© Cambridge University Press 2016.
doi:10.1017/S0963180115000596

https://doi.org/10.1017/S0963180115000596 Published online by Cambridge University Press

By "patient-based" standards I mean those that are based on or derived from serious consideration of the contours and ethical demands of the healing relationship—what we might call professionalism's ethical and humanistic core. Traditionally, these standards have been profession based, promoted as necessary to protect the economic and political interests of members of the in-group, to demonstrate their elevated social status, to maintain collegiality, and to justify prerogatives of autonomy and self-regulation. To the extent that profession-based standards have included behaviors or attitudes directed to patients that physicians have considered necessary to win patients' trust and acknowledgment of the physician's authority, these standards might more properly be termed patient *focused* rather than patient based.[2]

Although we are looking at relative emphases rather than hard-and-fast dichotomies between what I have called patient- and profession-based standards, I would argue that there is considerable continuity in a centuries-long, predominantly profession-based history of such standards. This history extends from the time of the Hippocratic physicians, through Thomas Percival's *Medical Ethics* in 1803, and to what Paul Starr has described as the efforts of late nineteenth- and early twentieth-century American physicians to stand out from the myriad other practitioners of the healing arts on the basis of exclusive standards, privileges, and dignity, in order to establish what the Hippocratic physicians also sought to establish—namely, cultural authority and market control.[3]

Seen through the lens of this history, the lately burgeoning literature on medical professionalism does not look much different from what has come before. Although this recent literature abounds in recommended character traits, attitudes, and behaviors and is by self-report more patient based than prior efforts, with a few exceptions the recommendations are untethered to any serious consideration of the contours and ethical demands of the healing relationship and therefore represent little change from the profession-based, or at most patient-focused, standards of the past. After reviewing some of this more recent literature, this article offers a patient-based justification for standards of professionalism in healthcare that emphasizes the professional's commitment to *trustworthiness in response to the vulnerability of those seeking professional help*.

A representative example of the more recent approaches to standards of professionalism in healthcare—what Delease Wear and Brian Castellani have aptly described as "end-of-term checklists, or virtue checkpoints throughout the curriculum"[4]—is the P-MEX, or Professionalism Mini- Evaluation Exercise, proposed by Richard Cruess and colleagues.[5] A product of a literature search and a workshop for faculty and residents at McGill University intended to identify observable behaviors indicative of a medical student's professionalism, the P-MEX includes 24 such behaviors, culled from an initial list of 142, that observers may assess on a four-point scale when watching a student either in a simulation exercise or in an actual patient encounter. The 24 items are grouped into four domains (doctor-patient relationship skills, reflective skills, time management, and interprofessional relationship skills), with one item appearing in two domains. For our purposes and in our limited space, it will suffice to reproduce a few examples from two of the domains:

Doctor-patient relationship skills

- Listened actively to the patient
- Showed interest in the patient as a person

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- Showed respect for the patient
- Recognized and met patient needs
- Advocated on behalf of a patient and/or family member
- Maintained appropriate boundaries with patients/colleagues

Interprofessional relationship skills

- Maintained appropriate boundaries with patients/colleagues
- Maintained appropriate appearance
- Addressed own gaps in knowledge and skills
- Demonstrated respect for colleagues
- Avoided derogatory language
- Maintained patient confidentiality
- Respected rules and procedures of the system[6]

A second example of the behavioral checklist approach that has gained wide currency—indeed, that may have become the current gold standard in academic medical circles—is the "behavioral and systems view of professionalism" (let us call it the BSVOP), which has been erected on the foundation of a document released jointly in 2002 by the ABIM Foundation, the ACP Foundation, and the European Federation of Internal Medicine: "Medical Professionalism in the New Millennium: A Physician Charter."[7] The charter itself consists of a brief preamble on the importance of "reaffirming the fundamental and universal principles and values of medical professionals" in the context of an "explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization"; a list of three "fundamental principles"—the primacy of patient welfare, patient autonomy, and social justice—and a set of ten "professional responsibilities."[8]

Arguing that "simply knowing right from wrong or having an internal compass does not suffice" but, rather, that "demonstrating professionalism is based on a set of practiced skills honed over time,"[9] the authors of the BSVOP have translated the concepts and values expressed in the charter into specific "professionalism behaviors."[10] In their volume *Understanding Medical Professionalism*, Levinson and her colleagues explain how they did this.[11] Skipping over the charter's preamble and the three fundamental principles, they organize the ten professional responsibilities into four groups representing what the authors identify (without further explanation) as "four core values": patient-centered care, integrity and accountability, pursuit of excellence, and fair and ethical stewardship of healthcare resources. Within each of these core values they then propose what they call "sample behaviors that can be demonstrated by individual physicians with patients and family members, and by colleagues and team members interacting together."[12] (A separate set of behaviors refers to organizations.) The result is a table that, in form and in large measure in content, looks similar to the P-MEX. Again, in the interests of space, here are a few of the items to be demonstrated with patients and family members:

Patient-centered care

- Communicate effectively, demonstrating empathy and compassion, and actively work to build rapport
- Promote the autonomy of the patient, eliciting and respecting patient preferences and including the patient in decisionmaking
- Act to benefit the patient when a conflict of interest exists

Integrity and accountability

- Maintain patient confidentiality
- Maintain appropriate relationships with patients
- Promptly disclose medical errors; accept responsibility for and take steps to remedy mistakes

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Pursuit of excellence

- Adhere to nationally recognized, evidence-based guidelines (e.g., guidelines issued by the Agency for Healthcare Research and Quality and/or the U.S. Preventive Services Task Force), individualizing as needed for particular patients but conforming with the guidelines for the majority of patients

Fair and ethical stewardship of healthcare resources

- Do no harm; do not provide unnecessary/unwarranted care
- Commit to deliver emergent care equitably, respecting the different needs and preferences of subpopulations, but without regard to insurance status or ability to pay
- Deliver care in a culturally sensitive manner[13]

No one can reasonably object to any of the items excerpted here, or to the others in the complete tables for the P-MEX and the BSVOP. They all seem to be reasonable expectations of physicians or other health professionals, and—allowing for the greater attention to patient autonomy and cost containment in modern times—resonate thoroughly with traditional profession-based or patient-focused (but not patient-based) standards, even down to the echo in the P-MEX's item "maintained appropriate appearance" of the Hippocratic admonition that "the dignity of the physician requires that he should look healthy, and as plump as nature intended him to be."

Yet, with respect to both lists, the question remains, Why these items and not others? Tellingly, Levinson and her colleagues say that the behaviors in their tables are only "samples"—that their lists "are intended to be illustrative but certainly not exhaustive"[14]—yet nowhere do they provide any principle of selection by which readers might make additions. It is not even clear why some of the items in the BSVOP have been assigned to one core value rather than another (why is "deliver care in a culturally sensitive manner" under "fair and ethical stewardship of healthcare resources" rather than "patient-centered care," for example), or how seriously we ought to take potential conflicts between items (e.g., between the mandates to "[elicit] and [respect] patient preferences" and to "adhere to nationally recognized, evidence-based guidelines").

It is hard to avoid the conclusion that these lists, like many recently proposed standards of professional conduct for physicians, are not reasoned conclusions of a process of reflection on and analysis of the healing relationship but, rather, loose compendia of whatever virtues or positive characteristics came into their authors' minds (or into the minds of their informants) when trying to describe a good doctor or colleague.[15] Judah Goldberg, in his critique of the intellectual confusion spawned by the fashion for the White Coat Ceremony at medical schools, distinguishes these parochial, socially constructed behavioral conventions typically invoked under the heading of professionalism from a more rigorous, philosophically grounded foundation for professional formation in medicine that he associates with humanism:

> In contrast to humanism, which is logically constructed out of foundational principles and can therefore develop a sophisticated hierarchy of moral responsibilities, professionalism confronts a static field of arbitrary conventions without any analytic tool for assigning moral weights. Acting unprofessionally means little more than deviating from the conventions of medicine. By itself, professionalism cannot explain why lying to a patient, for instance, is worse that wearing a T-shirt to work, other than to grade different professional traditions as more or less central to medicine.[16]

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What Goldberg discusses under the term "humanism" I have been referring to as professionalism's ethical and humanistic core. And my main point with respect to the prevailing approach to standards of physicians' professional conduct is that being more explicit about this ethical and humanistic core offers a more secure justification than is often provided for particular standards, while also providing a reference point from which to oppose forces and inducements (themselves sometimes justified with reference to "professionalism") that tend to compromise professionalism's ethical and humanistic core.[17]

My interest in navigating toward standards of professional conduct for health professionals by the twin polestars of vulnerability and trustworthiness is not entirely original. My main sources of inspiration are the work of Edmund Pellegrino, Robert Sokolowski, and Jos V. M. Welie. I want to call attention briefly to their key contributions and then explain how I intend to expand and extend them.

Pellegrino's project to "reconstruct medical morality on the basis of the fact of illness and the act of profession" rests on his description of illness as an ontological assault that leaves the person in a state of "wounded humanity": subject to the loss of most of the freedoms we think of as peculiarly human, and forced to place him- or herself under the power of another person—"an involuntary need [that] grounds the axiom of vulnerability from which follows the obligations of the physician."[18] The physician's responsive "act of profession" is the promise to that needy and vulnerable person that he or she has the skills to help and will act for the patient's interest. The physician's obligations are those that make this promise authentic (i.e., one that can be trusted): technical competence, ensuring the moral agency of the patient (primarily through the process of informed consent), and respect for the individualized nature of the transaction.

Similarly for Sokolowski, it is human beings' susceptibility to an involuntary need for others' help that grounds the fiduciary relationship that is the hallmark of a profession. What is at stake in such a relationship is not merely satisfaction of passing desires or wants but decisions and actions affecting fundamental well-being and possibly the future direction of one's life, deliberations belonging to the classical sense of the word "prudence." In a fiduciary relationship, Sokolowski writes, "I submit my own prudence to that of the professional. In a limited way I hand over the steering of my life to this person. . . . I must do so, because I have wandered into an area of life in which my own knowledge does not equip me to steer by myself."[19] I trust the professional with my prudence initially not because of any prior relationship or friendship that may exist between us—indeed, in many cases (paradigmatically, entering an emergency department in a foreign city) the professional is a complete stranger to me—but precisely because he or she has been certified *as a professional*, whom I therefore trust to abide by the profession's norms.

Welie also grounds his analysis of professionalism in what he calls the "existential vulnerability [that] arises out of the combination of a significant human need that must be relieved and complete dependency on experts for that relief."[20] Writing in the context of dentistry, and explicitly contrasting the patient-based aspects of professionalism with those centered on practitioners' economic well-being, Welie insists that the hallmark of professionalism is to be *deserving* of the trust placed in the professional by the vulnerable, dependent patient. He then proposes several "professional responsibilities"—for example,

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competence, peer review, internal discipline, noncompetition, objectively beneficial services, standardized treatments, avoidance of conflicts of interest, nondiscrimination, and fostering access—that, although not intended to be exhaustive, would seem to justify the public's trust.[21]

My contributions begin with suggestions for enriching the account of vulnerability that unites Pellegrino's, Sokolowski's, and Welie's analyses, and by noting some ambiguities in the concept and experience of trust. After proposing my own set of standards for professional conduct that I believe grow out of these reflections, I suggest three further refinements to an analysis of vulnerability and trustworthiness in the context of professionalism: (1) the importance of individualized dialogue in determining the conditions for gaining a patient's or family's justified trust, (2) the idea of the social determinants of trust, and (3) the idea of shared vulnerability between patients and the professionals who care for them.

Although a succinct and serviceable definition of vulnerability might simply read, "being at increased risk of harm, and/or having a decreased capacity to protect oneself from harm,"[22] for our purposes, vulnerability is best understood within a cluster of concepts that also includes the ideas of need and dependency, and in dialectical relationship with notions of agency and resilience. In the introduction to their rich collection of essays on vulnerability, Catriona Mackenzie, Wendy Rogers, and Susan Dodds capture the breadth of the concept:

> Human life is conditioned by vulnerability. By virtue of our embodiment, human beings have bodily and material needs; are exposed to physical illness, injury, disability, and death; and depend on the care of others for extended periods during our lives. As social and affective beings we are emotionally and psychologically vulnerable to others in myriad ways: to loss and grief; to neglect, abuse, and lack of care; to rejection, ostracism, and humiliation. As sociopolitical beings we are vulnerable to exploitation, manipulation, oppression, political violence, and rights abuses. And we are vulnerable to the natural environment and to the impact on the environment of our own, individual and collective, actions and technologies.[23]

Mackenzie, Rogers, and Dodds distinguish among three kinds of vulnerability. The first of these, inherent vulnerability, is the aspect that figures in the work of Pellegrino, Sokolowski, and Welie—namely, vulnerability that is directly related to the human condition, and that entails our susceptibility to illness and death. Mackenzie and her coauthors enlarge the notion by emphasizing *socially created* forms of vulnerability resulting from unequal or discriminatory social, political, or economic arrangements, which they call situational vulnerability, and *the aggravation or exacerbation of vulnerability* (and its associated dependency or even shame) that can arise from paternalistic or demeaning efforts to help vulnerable people, which they call pathogenic vulnerability.[24]

Sara Clark Miller defines as "fundamental needs [those] ends that agents cannot forgo if they are to continue to use their agency effectively in the world to make choices, set ends for themselves, and relate to others."[25] It is an essential feature of human vulnerability, Miller continues, that "in order to avoid experiencing harm or to restore agency when we do, others have to meet our needs, that is, others must help us. We are dependent on them for this help, as we are not capable of meeting all our needs on our own: sometimes they must help us by developing, maintaining, or restoring our agency."[26] Her list of fundamental needs, which she develops in dialogue with Martha Nussbaum's analysis of

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"central human functional capabilities,"[27] includes nutrition and water, rest, shelter, a healthy environment, bodily integrity, healing, education, attachments, social inclusion, play, and security[28]—all of considerable relevance to the health professions, especially from the standpoint of a biopsychosocial model of health and disease and the social determinants of health.

When we turn to health professionals for help in meeting our needs, especially in the setting of an illness that compromises cognitive and deliberative capacities and the emotional equilibrium necessary for the thoughtful weighing of options, we are in a state of involuntary dependence. The relationship at its inception is not one between free, equal, and rational contractors. As Annette Baier has written,

> Philosophers who remember what it was like to be a dependent child, or know what it is like to be a parent, or to have a dependent parent, an old or handicapped relative, friend or neighbor will find it implausible to treat such relations as simply cases of comembership in a kingdom of ends, in the given temporary conditions of one-sided dependence.[29]

Involuntarily needy and dependent—that is, vulnerable—we *trust* that health professionals will

- *Not exploit* our vulnerability for their own self-interested ends
- *Not increase* our vulnerability through paternalistic or degrading forms of help that perpetuate dependency or undermine self-esteem
- *Reduce* our vulnerability by
    - Alleviating sources of vulnerability related to disease
    - Aligning with others to alleviate sources of health-related vulnerability aggravated by social, political, or economic arrangements
    - Enhancing our capacity for self-determination by preventing, eliminating, or reducing limitations related to disease or its treatment.

At its ethical and humanistic core, professionalism is the commitment of health professionals to be *deserving* of this trust—in other words, to be trust*worthy*. For, although patients, or other people in "temporary conditions of one-sided dependence," may trust, this trust may be misplaced, misguided, irrational, or dangerous to one's own most important interests and ends. In Baier's words,

> Where one depends on another's good will, one is necessarily vulnerable to the limits of that good will. One leaves others an opportunity to harm one when one trusts, and also shows one's confidence that they will not take it. . . . Trust, then, on this first approximation, is accepted vulnerability to another's possible but not expected ill will (or lack of good will) toward one.[30]

Thus, whereas when ill, I am primarily vulnerable due to the illness, when I trust my physician to help me I am now also vulnerable specifically to him or her.

To these structural ambiguities in trust relationships—built in, so to speak, to their structure of one-sided dependence—Jay Katz adds the psychological distortions of unconscious, irrational factors in human relationships, notably transference and countertransference reactions of patient and professional, respectively, wherein a patient's irrational fantasies of being taken care of by an idealized carer meet the caregiver's narcissistic investment in his or her own knowledge, power, and altruism.[31] Primarily concerned with establishing the need for physicians to acknowledge uncertainty as part of the process of informed consent, Katz distinguishes trust "based on blind

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faith—on passive surrender to oneself or to another"—from trust that is "*earned* through conversation" in which both parties acknowledge to themselves and to the other what is known and not known about the decision to be made.[32]

If we now ask what attitudes, behaviors, and standards of conduct are the criteria and embodiments of health professionals' trustworthiness when vulnerable people seek their help—which in aggregate constitute the ethical and humanistic core of professionalism—Katz's emphasis on informed consent conversations that acknowledge uncertainty is part of the answer. A more complete answer would include the following:

- Technical competence
- Respect for individuality and promotion of self-determination
- Empathy
- Truthfulness
- Transparency as to the grounds for recommended courses of action
- Protection of privacy and confidentiality
- Avoidance of harm
- Avoidance of conflicts of interest
- Nonabandonment
- Fairness in allocation of time, attention, and healthcare resources
- Advocacy for social, political, and economic arrangements that contribute to people's opportunities to lead healthy lives
- Self-criticism and willingness to demand accountability from colleagues for adherence to these professional values

This is a familiar list, and one that resonates especially with the elements of professionalism according to Pellegrino, Sokolowski, and Welie, as well as with the ten professional responsibilities in the ABIM charter. My contributions so far have been to propose, as a principle by which to generate these elements, the professional's commitment to trustworthiness in response to the vulnerability of those seeking professional help and to ground them in a more robust understanding of vulnerability—including the ways in which caregiving itself can aggravate vulnerability, intrinsically, as Baier suggests, or as a function of a particular caregiver's demeaning or dehumanizing manner of providing help, as Mackenzie, Rogers, Dodds, and Miller suggest. I have also pointed to some of the ambiguities of trust.

Notwithstanding the plausibility of these general elements of patient-based professionalism (what might be termed prime facie professional commitments), the attitudes and behaviors that actually do gain trust are patient and context specific. Our willingness and ability to trust health professionals or healthcare institutions will be affected by our personality, culture, race, age, and prior experiences with illness and healthcare, and the relative supportiveness or insecurity of our socioeconomic and political circumstances, among other factors. Therefore, in addition to the commitment to cultivating attitudes and behaviors that embody trustworthiness, a patient-based understanding of professionalism would also include the commitment to actually gaining a patient's or family's trust by learning, through *individualized dialogue*, the conditions that would win their justified trust, given their particular history and social situation.

Among many reasons to credit the importance of individualized exploration of the conditions of a patient's or family's justified trust (and the corollary responsibility to suspend automatic allegiance to particular assumptions about "professional" behaviors with that patient or family) are the diversity of patients' and families' expectations or desires for "shared clinical

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decision making," cultural and ethnic diversity in approaches to care near the end of life, and the widespread societal burden of trauma from adverse childhood experiences. Alexander Kon has called attention to the "shared decision making continuum,"[33] on which patients' or surrogates' preferences for participation with physicians in clinical decisions range from patient- or agent-driven to purely physician-driven decisionmaking. Elizabeth Murray and her coauthors demonstrated this spectrum with a cross-sectional survey of the American public, reporting that, although a majority of respondents favored some degree of shared decisionmaking, 9 percent of their large national sample preferred a paternalistic approach in which information transfer was mainly one way from physician to patient, and deliberation about treatment took place by the physician alone or in consultation with other physicians.[34] These findings suggest (pace Pellegrino, Katz, and the authors of the ABIM charter) that for patients whose preferences are for more physician-centered deliberation and direction of treatment, defaulting to the currently favored professional standard of shared decisionmaking, without sensitive, individualized dialogue, could more easily provoke mistrust and feelings of abandonment than gain the patient's or family's justified trust.

There is also ample evidence of cultural and ethnic diversity in preferences for communication and clinical decisionmaking near the end of life.[35] People differ in their openness to explicit discussion of prognostic information, and in their interpretations of physician recommendations to consider changing goals of care from all-out efforts to prolong life to an emphasis on palliation, quality of life, and comfort. Clinicians may regard these behaviors as enactments of responsible clinical judgment and compassion. People with particular orientations toward communication of negative information, or with individual or communal histories of oppression, discrimination, or mistreatment in society or the healthcare system, may experience them as callousness or as being manipulated into foregoing potentially beneficial care. Similar differences and similar mistrust—often similarly influenced by a community's collective memory of past abuses—emerge among potential participants in clinical trials, especially among minority populations.[36]

Another example is the decade and a half of research confirming and extending the Adverse Childhood Experiences (ACE) Study, which found "a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults."[37] We know from these studies, and the overwhelming evidence on the social determinants of health, that much illness is a result of the social, psychological, and economic conditions in which people grow, live, work, and age.[38] People bring their damaged bodies to the clinic, but for many people their damaged bodies are the products and consequences of damaged lives. They need medical treatment, of course, but perhaps even more they need support in finding or regaining safety, empowerment, and some measure of control in their world. Such "trauma-informed care" must often begin with exquisitely sensitive explorations of the conditions or even the possibility of trust before treatment can begin.[39]

These latter examples suggest that even expanding the discussion of trustworthiness to include patient- or family-specific dialogue is incomplete, in that it appears to place the entire burden of conveying genuine trustworthiness to patients on the individual practitioner, without adequate recognition of

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the structural conditions affecting people's willingness or ability to trust health professionals—what might be termed the *social determinants of trust.* Annette Baier alludes briefly to this in her comments on "the *network* of trust," and "such society-wide phenomena as climates of trust," commenting that to treat only two-party trust relationships is unrealistic, because "any person's attitude to another in a trust relationship is constrained by all the other trust and distrust relationships in which she is involved."[40] I alluded earlier to sources of vulnerability rooted in social arrangements and the professional obligation to align with others to address these as a part of reducing our vulnerability. In the present context we might emphasize that advocacy for more just social, political, and economic arrangements contributes both to the health professional's being deserving of trust and to actually gaining trust more broadly throughout the population.[41]

One further implication of my emphasis on the necessity of dialogue with patients, families, and even communities on the conditions of their justified trust in the professionals who care for them is a strong caution against the current vogue for assessing professionalism on the basis of externally observed behavioral indicators. Shiphra Ginsburg and colleagues have previously pointed out two significant limitations to a behavioral observation approach: inconsistent interpretations and applications of evaluation criteria by faculty observers and—more directly related to the present context—the lack of access to students' *rationales* for the choices or behaviors they exhibit in the scenarios. As Ginsburg and coauthors explain, "Behaviors alone do not give us all the information we need to make accurate judgments. Knowing how a student construes a particular professional dilemma, and what values s/he perceives as conflicting, is critical information."[42]

I would go further. If the primary components of patient-based professionalism are commitments to (1) cultivating attitudes and behaviors that embody trustworthiness and (2) actually gaining a patient's or family's trust by learning the conditions that would win their justified trust through individualized dialogue, and if the conditions for gaining justified trust are context specific, then no observed conformity to items on a prefabricated behavioral checklist (no matter how thoroughly vetted and pretested by panels of experts) will, by itself, meaningfully discern patient-based professionalism on the part of a student. What is needed instead, at a minimum, is a setting in which students reflect on their encounters with patients through narratives and dialogue with peers and preceptors, analyzing them for, among other things, what they perceived and investigated about their patients' dispositions and capacities for trust in the encounter, and how their actions with the patient responded to their appreciation of these factors. Such an approach seems to be underrepresented, however, among currently fashionable methodologies for the assessment of professionalism.

Having emphasized vulnerability as one of the twin polestars of professionalism in healthcare, it is worth observing in conclusion that professionals bring their own vulnerabilities to their encounters with patients. Although this can promote empathy and solidarity in caring relationships and is therefore to be prized rather than avoided or denied,[43] the ability to translate shared vulnerability into therapeutic relationships requires continuing self-awareness and self-care. At bottom, this involves the self-understanding that we—physicians, nurses, healers from all traditions—live in the same world that our patients

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inhabit and share the same vulnerabilities to what John Keats (who trained as a physician himself) described as

> The weariness, the fever, and the fret
> Here. Where men sit and hear each other groan;
> Where palsy shakes a few, sad, last gray hairs,
> Where youth grows pale, and spectre-thin, and dies.[44]

I believe that our acknowledgment of this shared vulnerability, in this common world, is the ultimate touchstone of humanism, and genuinely patient-based professionalism, in healthcare.

Notes

1. Hippocrates, *The Physician*, I. In: Jones WHS, trans. *Hippocrates*. Vol. II. Loeb Classical Library. Cambridge, MA: Harvard University Press; 1967, at 311.
2. I am grateful to Mark Wicclair for suggesting the distinction between "patient-based" and "patient-focused" standards for professional behavior.
3. Richard Cruess and Sylvia Cruess provide an historical survey of the uses and connotations of "professionalism" as understood by physicians themselves, and in the literature of medical ethics and the social sciences, in Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. *Academic Medicine* 1997;72(11):941–52. My interpretation of the predominantly profession-based character of this history draws primarily on the following sources: Edelstein L. The professional ethics of the Greek physician. *Bulletin of the History of Medicine* 1956;30:392–418; Starr P. *The Social Transformation of American Medicine*. New York: Basic Books; 1982; Berlant JL. *Profession and Monopoly: A Study of Medicine in the United States and Great Britain*. Berkeley: University of California Press; 1975; Larson MS. *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press; 1977; Johnson TJ. *Professions and Power.* New York: Macmillan; 1972; Gallagher WT. Ideologies of professionalism and the politics of self-regulation in the California state bar. *Pepperdine Law Review* 1995;22(2):485–628; Goode WJ. Community within a community: The professions. *American Sociological Review* 1957;22: 194–200; and Pellegrino ED. Professionalism, profession and the virtues of the good physician. *Mount Sinai Journal of Medicine* 2002;69(6): 378–84. For a discussion of Percival and his near contemporary, the Edinburgh physician John Gregory, disputing the characterization of medical ethics from this period as predominantly profession based, and arguing that Starr, Berlant, and others have misread Percival as having been simply concerned with "medical etiquette" rather than with "medical ethics" in a more modern sense, see McCullough L. *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine*. New York: Springer; 1998. For a similar argument concerning Percival, see Pellegrino ED. Percival's *Medical Ethics*: The moral philosophy of an 18th-century English gentleman. *Archives of Internal Medicine* 1986;146(11): 2265–9. Scholars have also pointed to strands of thought concerning physicians' moral responsibilities to patients within the ancient and classical world that articulate something more closely approximating a patient-based approach; see, for example, the tradition exemplified by the first-century author Scribonius Largus, discussed by Edelstein and by Edmund Pellegrino in Pellegrino ED. Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. *Journal of Medicine and Philosophy* 1979;4(1): 32–56.
4. Wear D, Castellani B. The development of professionalism: Curriculum matters. *Academic Medicine* 2000;75(6):602–11, at 603.
5. Cruess R, McIlroy JH, Cruess S, Ginsburg S, Steinert Y. The professionalism mini-evaluation exercise: A preliminary investigation. *Academic Medicine* 2006;81(10 Suppl):S74–S78.
6. See note 5, Cruess et al. 2006, at S76.
7. Medical Professionalism Project of the American Board of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Annals of Internal Medicine* 2002;136(3):243–6.
8. See note 7, Medical Professionalism Project of the American Board of Internal Medicine 2002, at 244.
9. Levinson W, Ginsburg S, Hafferty FW, Lucey C. *Understanding Medical Professionalism*. New York: McGraw Hill; 2014, at 3.
10. Lesser CS, Lucey CR, Egener B, Braddock CH III, Linas SL, Levinson W. A behavioral and systems view of professionalism. *JAMA* 2010;304(24):2732–7.
11. See note 9, Levinson et al. 2014, at 3–11.
12. See note 9, Levinson et al. 2014, at 7.
13. See note 10, Lesser et al. 2010, at 2734.
14. See note 9, Levinson et al. 2014, at 7.

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15. Additional lists such as these, which seem to have been derived in a similar manner, can be found in Van de Kamp K, Vernouij-Dessen MJFJ, Grol RPTM, Bottema JAM. How to conceptualize professionalism: A qualitative study. Medical Teacher 2004;26(8): 696–702; Green M, Zick A, Makoul G. Defining professionalism from the perspective of patients, physicians, and nurses. *Academic Medicine* 2009;84(5):566–73; Accreditation Council for Graduate Medical Education. *Advancing Education in Medical Professionalism: An Educational Resource from the ACGME Outcome Project*; 2004; available at http://www.usahealthsystem.com/workfiles/com_docs/gme/2011%20Links/Professionalism%20-%20Faculty%20Dev..pdf (last accessed 29 Apr 2015); and Reynolds PP, Martindale J. Development of the Medical Professionalism Behavior Assessment Tool. Abstract presented at the Annual Conference of the Association for Medical Education in Europe, Milan, Italy, 2014 Aug 30–Sept 3.
16. Goldberg J. Humanism or professionalism? The white coat ceremony in medical education. *Academic Medicine* 2008;83:715–22, at 717.
17. Examples of self-serving compromises that can be masked by appeals to "professionalism" might include lucrative participation in pharmaceutical company speakers bureaus ("colleague education"), refusals to speak publicly about substandard practice on the part of a colleague ("maintaining public confidence"), or resistance to a broadened scope of practice for, e.g., nurse practitioners or physician assistants ("patient safety").
18. See note 3, Pellegrino 1979, at 44–5.
19. Sokolowski R. The fiduciary relationship and the nature of professions. In: Pellegrino ED, Veatch RM, Langan JP, eds. *Ethics, Trust, and the Professions*. Washington, DC: Georgetown University Press; 1991:23–43, at 27.
20. Welie JVM. Is dentistry a profession? Part 1. Professionalism defined. *Journal of the Canadian Dental Association* 2004;70(8):529–32, at 531.
21. Welie JVM. Is dentistry a profession? Part 2. The hallmarks of professionalism. *Journal of the Canadian Dental Association* 2004;70(9): 599–602. An article by Herbert M. Swick that is frequently cited in recent professionalism literature—unlike the writings of Pellegrino, Sokolowski, or Welie, oddly enough—makes similar points, but with much less analysis. See Swick HM. Toward a normative definition of medical professionalism. *Academic Medicine* 2000;75(6):612–16. See also Doukas DJ. Where is the virtue in professionalism? *Cambridge Quarterly of Healthcare Ethics* 2003;12:147–54; note 3, Pellegrino 2002; and, for a deep analysis of professionalism that ranges far beyond medicine, Sullivan WM. *Work and Integrity: The Crisis and Promise of Professionalism in America*. 2nd ed. San Francisco: Jossey-Bass; 2005.
22. Rogers W, Mackenzie C, Dodds S. Why bioethics needs a concept of vulnerability. *International Journal of Feminist Approaches to Bioethics* 2012; 5(2):11–38, at 12.
23. Mackenize C, Rogers W, Dodds S, eds. *Vulnerability: New Essays in Ethics and Feminist Philosophy.* New York: Oxford University Press; 2014, at 1.
24. See note 22, Rogers et al. 2012. See also Spiers J. New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing* 2000;31(3):715–21; Sellman D. Towards an understanding of nursing as a response to human vulnerability. *Nursing Philosophy* 2005;6:2–10; and Hoffmaster B. What does vulnerability mean? *Hastings Center Report* 2006;36(2): 38–45.
25. Miller SC. *The Ethics of Need*. New York: Routledge; 2012, at 37.
26. See note 25, Miller 2012, at 37.
27. Nussbaum M. *Women and Human Development: The Capabilities Approach*. New York: Cambridge University Press; 2000.
28. See note 25, Miller 2012, at 41–2.
29. Baier A. Trust and antitrust. *Ethics* 1986;96: 231–60, at 248.
30. See note 29, Baier 1986, at 235.
31. Katz J. *The Silent World of Doctor and Patient.* New York: The Free Press; 1984, especially at 142–50.
32. See note 31, Katz 1984, at xiv–xv; emphasis added.
33. Kon A. The shared decision-making continuum. *JAMA* 2010;304(8):903–4.
34. Murray E, Pollack L, White M, Lo B. Clinical decision-making: Patients' preferences and experiences. *Patient Education and Counseling* 2007;65:189–96.
35. Carrese JA, Rhodes LA. Bridging cultural differences in medical practice: The case of discussing negative information with Navajo patients. *Journal of General Internal Medicine* 2000;15:92–6; Crawley LM, Marshall PA, Lo B, Koenig BA. Strategies for culturally effective end-of-life care. *Archives of Internal Medicine* 2002;136(9):673–9; Wallace MP, Weiner JS, Pekmezaris R, Almendrai A, Cosiquien R, Auerbach C, et al Physician cultural sensitivity in African American advance care planning: A pilot study. *Journal of Palliative Medicine* 2007;10(3):721–7.
36. Corbie-Smith G, Thomas SB, St. George DM. Distrust, race, and research. *Archives of Internal*

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Medicine 2002;162(21):2458–63; Braunstein JB, Sherber NS, Schulman SP, Ding EL, Powe NR. Race, medical researcher distrust, perceived harm, and willingness to participate in cardiovascular prevention trials. *Medicine* 2008;87(1): 1–9.

37. Felitti V, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 1998;14(4):245–58, at 245. See also Corso P, Edwards V, Fang X, Mercy J. Health-related quality of life among adults who experienced maltreatment during childhood. *American Journal of Public Health* 2008;98(6): 1094–100.
38. World Health Organization Commission on the Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva: World Health Organization; 2008.
39. Rosenberg L. Addressing trauma in mental health and substance use treatment. *Journal of Behavioral Health Services Research* 2011;38(4): 428–31.
40. See note 29, Baier 1986, at 258.
41. The structural conditions affecting patients' or communities' trust are not the only factors largely outside the individual practitioner's immediate control. The institutional environment within which the practitioner works—its policies, procedures, and general atmosphere, which can be more or less welcoming or intimidating, agency-enhancing or agency-sapping, for patients and families—is also likely to affect trust. Additional constraints on professional behavior with patients and families with likely influence on the practitioner's ability to gain their trust come from institutional approaches to practice management, e.g., expectations regarding practitioner workload and patient volume, management surveillance, and pay-for-performance measures. Some of these issues have been discussed under the heading of "organizational professionalism"; see, e.g., Egener B, McDonald W, Rosof B, Gullen D. Organizational professionalism: Relevant competencies and behaviors. *Academic Medicine* 2012;87(5):668–74.
42. Ginsburg S, Regehr G, Lingard L. Basing the evaluation of professionalism on observable behaviors: A cautionary tale. *Academic Medicine* 2004;79(10 Suppl):S1–S4, at S4. It is interesting to note that Ginsburg, despite these substantial misgivings, appears two years after the publication of this critique as one of the coauthors of the report on the exclusively behavioral P-MEX discussed previously, as well as the volume elaborating on the BSVOP; see note 5, Cruess et al. 2006, and note 9, Levinson et al. 2014. For another thoughtful critique of the behavioral approach to the evaluation of trainees' professionalism, see Misch DA. Evaluating physicians' professionalism and humanism: The case for humanism "connoisseurs." *Academic Medicine* 2002;77(6): 489–95. I thank Joseph Carrese for calling this article to my attention.
43. See note 22, Rogers et al. 2012, at 23; note 25, Miller 2012, at 94; note 24, Spiers 2000, at 719.
44. Keats J. Ode to a nightingale. In: Stillinger J, ed. *John Keats: Complete Poems*. Cambridge, MA: Harvard University Press; 1978:279–81, at 280.

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