

## Chapter 2

# AN ANALYSIS OF THE DISCOURSE OF PROFESSIONALISM

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## INTRODUCTION

The field of medicine as a clinical profession is widely perceived to be under siege these days, though the perceived assaults come from a confusing combination of directions. Managed care organizations, government regulators, competing professional groups, “alternative and complementary” practitioners, vengeful lawyers, crusading political activists, unhappy consumers (formerly known as patients, and now unhappy for all sorts of reasons), and others attack from the outside. Meanwhile from within, the explosion of new medical information, the inability to clarify the roles of generalists and specialists, the growing concern about health disparities and the social determinants of health, the persistent inattention to prevention, the catastrophe of tens of millions who remain uninsured or underinsured—all of these crises (and any of us could name yet more) have made the clinical practice of medicine an uncertain and troubled occupation. This, in turn, has made basic medical education—the preparation of new practitioners—enormously challenging.

One response to the crises in medical practice and medical education has been a call for a “renewed professionalism.” The American Board of Internal Medicine (ABIM, 1995), the Association of American Medical Colleges (AAMC, 1998), and other professional organizations and individual educators (e.g. Pellegrino, 2002) have issued calls for a return to the ideals at the moral core of the profession of medicine. The discussion, as it is most commonly framed, focuses primarily on inculcating in physicians a set of (not particularly controversial) virtues, such as altruism, duty, and integrity. These virtues have been widely criticized as too vague, and not

surprisingly, some commentators have called for more precise, concrete, and measurable definitions (Connelly, 2003; Wear & Nixon, 2002).

The issues that underlie the recent calls for a renewed professionalism within medicine deserve focused attention, such as the concern for excellence in patient care, the appropriate regulation of practitioners, and the need to adequately serve community needs. However, we believe that the proposed approach is not an effective or useful response to the multiple crises in medical education. The problem is not just a matter of the ambiguity of the invoked virtues, but rather that efforts toward definitional precision and measurement rely on a mistaken view of language and of the relationship between language, social institutions, and practice. An even more fundamental problem is the effort to locate the solution to systemic problems of medical education and practice in the virtues of individual physicians.

We will argue that the “renewed professionalism” movement reflects deeply held (though confused) beliefs about the role and status of professions—what we will call “the discourse of professionalism.” This discourse of the professionalism is powerful in part *because* of its ideological confusion; that is, its ambiguity works to unify and solidify social networks and interests, and to make that unity seem natural and inevitable. However, the organizing work of professionalism discourse has become increasingly untenable, and the tensions within this discourse—especially as it is used within medicine—are becoming more difficult to avoid. The discourse of medical professionalism is not likely to be salvageable through the “new professionalism” project. What is instead required is the more difficult (and politically charged) project of re-negotiating the social contract between physicians, communities, and other occupational groups.

This paper will begin with a discussion of two broad models of language, the conventional one of language as a symbolic or representational system, and an alternate one, in which language is seen as a social practice. We will then examine the social context within which the discourse of professionalism is enacted and the multiple purposes it serves. In particular, we will focus on the recent changes in social and cultural institutions and practices upon which medical professionalism depends and through which it occurs. Recent calls for a “new professionalism” tend to ignore those institutions and social changes (as well as the problematic aspects of the profession’s claims to authority and power). As a result, the movement is limited in its ability to help physicians and educators cope with those changes and transform those institutions, or to help contemporary communities negotiate more effectively with the medical system to meet

their own needs. Finally, we will address how the confluence of discourse theory and the rhetoric of virtue ethics offers the potential to see a more useful direction for the reform of medical education and medical professionalism.

## **AN ALTERNATIVE MODEL OF LANGUAGE**

The conventional model of language presumes that language is referential and transparent. Language is held to be comprised of words, and these words are symbols that represent or refer to “things in the world.” These things may be objects (a table), ideas (honesty), or activities (running), and for each, meaning is derived from the word’s correspondence with its object. Additionally, this model assumes that we can reliably know to which objects the words refer. By this criterion, good language is that which allows one to see through it with a minimum of ambiguity to the objects it represents (Rorty, 1979).

By contrast, an alternative account calls attention to how languages function as social practices—not as names for public objects or private experiences, but as interactional events and social transactions. (While our account here is drawn largely from post-structuralism, there is a broad consensus among several contemporary philosophies of language, including Bakhtin [1984], Rorty [1979], Shotter [1993], Wittgenstein [1958], and others; see Stewart [1996] for an excellent overview.) Languages include words, of course, but these words point not toward objects but to other words, making a chain of signifiers. The linkages of this chain rely upon social processes and interactions to establish shared understandings about what the signifiers mean and, most importantly, how they are used (Allen & Hardin, 2001). Meanings are not fixed or predetermined, but they are limited by their contextual use; some interpretations are more strongly warranted than others. Thus, far from being transparent, these signifiers are taken to be understandable only when situated in a particular context (Gee, 1999). The ambiguity of terms such as “altruism,” therefore, results not from a lack of definitional precision, but from the breakdown of the social practices and conventions that give it meaning by providing it shape, form, substance—and recognizability. The definition of altruism can be found in any dictionary, but knowing which behaviors and motives count as altruistic in a particular setting is a socio-cultural process and cannot be made fully explicit.

To emphasize the distinction between the notion of languages as “words and symbols” and the notion of languages as “social practices,” we

sometimes use the term *discourse* (Fairclough, 1992; Van Dijk, 1997). Discourses are composed of the practices and institutions of a particular social community, organized around a topic or activity, within a particular historical and cultural context—what people do, and how they do it. These social structures are largely responsible for the production of language, but are themselves contingent upon language to make them possible (Torfing, 1999). Various discourses are not just different words for the same things; instead, they help to construct *different* things, different ways of doing things, *and* different kinds of power.

This construction of difference is especially important in relation to the category of “personal experience.” Discourses provide people with vocabularies through which to explain, to themselves and to each other, their actions and motivations in a way that is understandable (Mills, 1940). Accounts of experience are *always already* an interpretation of what has happened, and these accounts are subject to reinterpretation in the process of telling them to others. “What counts as experience is neither self-evident nor straightforward; it is always contested, and always therefore political” (Scott, 1992, p. 387). The production of language is always a communal enterprise, a series of negotiated exchanges with other speakers over time. Linguistic behavior only works when it is recognized by its audience as a certain kind of gesture (Gee, 1999). Through language, communities reproduce their structures, discipline their members, and enact social practices. Language is what we do, not merely how we talk about what we do (Shotter, 1993).

In addition to the elements of language as “social action” and as “vocabularies of motives and experience,” three other elements of the post-representationalist approach to language are important for our purposes here. First, there is the multiplicity of available discourses. There is always more than one discursive option available to a speaker, more than one discourse circulating in society related to a particular topic. Second, there is the unevenness of this multiplicity. The full range of discourses potentially available at any one time and place are not equally available to all speakers, nor are they all equally powerful. The more hegemonic discourses (those produced by and reproducing powerful social institutions) tend to obscure competing discourses by making their own assumptions seem natural and unmarked, while discounting alternate constructions of the world or performances of identity (Nelson, 2001). In this way, discourses function as disciplining forces. That is, what it is possible to say or do is both enabled and constrained by the available linguistic and performative vocabulary (Torfing, 1999).

Finally, there is temporality and historicity. Discourses are not static, but dynamic and evolving. There is a constant negotiated process of reproduction, resistance, and creativity as communities work to determine meanings (Bakhtin, 1986). People can invoke discourses in ways that cut across or undermine the usual intent or pattern of a discourse. As they take up and use multiple discourses, the tensions among them may generate new or transformed discourses. In their turn, the practices and institutions they reinscribe are also transformed over time (Fairclough, 1992; Gee, 1999).

This view of language provides us with a way to look at the discourse of professionalism as a site of social action, a place where various communities are acting, and to locate those sites and communities in history. The discourse of professionalism helps to construct certain experiences and limit others, and is deeply entangled with particular institutions, power relationships, and cultural arrangements. It is a discourse that organizes relationships, provides plausible motives for people and causes for events, and is a site of struggle and change as those arrangements and institutions are adapted, resisted, and transformed.

The discourse of medical professionalism, then, includes these three aspects: *language* (the words used to describe and carry out the activities of medicine), *practices* (the behaviors that are entailed), and *institutions*. The language of professionalism includes the naming of virtues, such as altruism, duty, and excellence; it also describes who is included and who is excluded (e.g., physicians vs. “allied” professionals), the nature of the problems that profession is responsible for, and so on. The practices of professionalism are those which reinforce the assumptions of professionalism: the dyadic provider-patient relationships; the hierarchical naming of physicians, other health care providers, and patients; the expectation of unpredictable work hours (Lupton, 1994). When we refer to the institutions of professionalism, we are primarily referring to the social and cultural ones, the ideas rather than the buildings. Thus hospitals, for example, support professionalism not only in their physicality, but also in their ideological structures, which are designed around the work of physicians (Starr, 1982). Other institutions also participate in the discourse of professionalism, such as marriage and other gendered institutions, the authority of science, and academic medicine.

This understanding of the discourse of medical professionalism guides us away from efforts at definitional precision, away from asking what particular terms mean (or should mean.) Rather, we can ask, what does this language *do*? What are we using it for, and perhaps, what is it using *us* for? Why is it being taken up *now*, and by whom, and for what practical or political purposes?

For example, “excellence” is defined by the ABIM proposal as “the conscientious effort to exceed ordinary expectations” (ABIM, 1995, p. 6). Beyond the obvious questions of “by how much?” and “what is a ‘conscientious effort’?” there is the thornier question of how the baseline “ordinary” expectations are established. To what extent are those expectations determined by the physical resources available to the physician (for example, the lone physician in a rural hospital vs. an urban tertiary care center)? Who has the power to determine those “ordinary” expectations—patients? Other physicians? The insurance company?

To understand how the discourse of professionalism works to accomplish these tasks, we need to situate the professions in a broader social and historical context. We specifically want to draw attention to the relationship between the *social structures* of the professions (especially the medical profession) and the *discourse* of professionalism—and in several areas, to notice the growing gaps between them, the ways that professionalism discourse is less able to effectively *make sense* of the contemporary practice of medicine. (We mean the phrase “making sense” more literally than is usually implied—i.e., the *construction* of sense and meaning, the giving of order, form, and substance.)

## THE DISCOURSE OF PROFESSIONALISM

There are four points about our understanding of professionalism that are most relevant for this discussion. The first is the idea that professions are rooted in a *social contract*, an agreement between the State and the members of the occupational group. The second is that this social contract is widely acknowledged to function poorly in a number of key aspects. The third is that the professions—like all social organizations—rely upon and are enacted through an interlocking set of institutions, including languages, cultural mores and expectations, and interpersonal relationships. The final point is that being a profession is neither an inherent attribute nor an objective characteristic of any particular occupation. Professionalism is not, in a sense, a status at all; it is a *claim* to a certain status, a claim that is more or less successful within a particular social context (Abbott, 1988; Park, 2004). None of these points about professions is, by itself, very controversial. Taken together, however, and viewed through the prism of discourse theory, they provide insights about the challenges faced by those promoting education in medical professionalism.

The conventional description of the professions as operating under a social contract refers to the idea that society (via the State) grants professional

groups a degree of autonomy in exchange for self-regulation. Professional self-regulation is the promise that the profession will establish and enforce standards of education and practice, and that incompetent or unethical practitioners will be disciplined, sanctioned, or excluded. This policy of self-regulation (with minimal interference from the State) is justified by the premise that professional groups are in the best position to evaluate and manage the conditions of practice for their own members.

This contract has a *collective* nature; it is a contract between all medical professionals and society. A physician's professional ethics are not personal virtues, values, or rules; rather, they are derived from her or his adherence to a set of group norms. This is important because it brings our attention back to the institutions, social practices, and cultural arrangements through which professionals operate.

In addition to the ideal of "self-regulation," two other concepts are crucial to this version of professionalism: (a) that professional practice is oriented toward the public good, rather than the self-interest of either individual or collective professionals, and (b) that there is a legitimating body of knowledge—the *science* of medicine or nursing, or legal knowledge—distinct from tradition, mere whim, or self-interest (Freidson, 1970; Moore, 1970).

Sociologists and historians have become increasingly skeptical of professional claims in all these areas (Abbott, 1988; Freidson, 1970, Starr, 1982). The ability or willingness of professional groups to regulate the practices of their members, the extent to which professions can put the public good above their collective self-interest, and even the solidity of the knowledge base on which professional practice allegedly rests—all of these have come to be seen as far more dubious and partial than professionalizing proponents would have us believe. For most sociologists and historians, professionalism—or more precisely the process of professionalization—is principally about the control of work, about who is allowed to do it (and who is not), the status of those practitioners, and the conditions under which the work is to be done.

The claims to professional status are efforts to control the conditions of work, training, compensation, and evaluation; they are claims to a cultural authority as well (Foley & Faircloth, 2003; Park, 2004). Medicine's power to define problems and assign solutions is not only the result of its control over conditions of work, but from its success in persuading the public that it speaks from a position of knowledge, compassion, and objectivity—that its voice is to be trusted, relied upon, accepted. Notwithstanding its current troubles, U.S. medicine has been extraordinarily successful in that

persuasion (Starr, 1982). Professionalism in general and medical professionalism in particular are inextricably entangled with power and privilege, and have a long history of abuse of that power.

It is not necessary to take the sociological critiques of professionalism to mean that the medical community is engaged in deliberate deception. The trust developed between the professional and the client may be quite genuine, as might be the devotion to duty, the confidence in the science, the fellowship with one's colleagues. Discursive approaches to language provide a useful way to understand how this works. In this approach, the discourse is considered to be most effective when there is congruence among the ready-at-hand language, the dominant cultural traditions, the social practices of daily life, and the institutions in which physicians live and work. However, as the social context in which medicine is practiced changes, and the gaps between these elements widens, the unifying and solidifying work of this discourse is less effective, and the trust offered by the public becomes more tenuous and contested.

It is important to notice that the vocabulary of professionalism is deployed for different purposes with different audiences. For those within a particular occupational group, it is taken for granted that professionalism is a positive ideal, that it is connected with virtue (or some specific set of virtues), and that increasing professionalism means increasing the quality of practice. Professionalism in this context serves to promote confidence and authority, to identify some problems as important and others not, and to foster solidarity with other members.

When directed toward the public, by contrast, the discourse of professionalism is intended to foster trust in both the process and outcome of treatment. It is intended to reassure clients that practitioners are qualified, their judgments and advice are reliable and true, their services are necessary, and (not insignificantly) their fees justified. For both groups, professional discourse serves to obscure the power and privilege possessed by the practitioner group over the lives and interests of others, making that power and privilege seem natural, appropriate, and inevitable.

An example of the "naturalizing" power of this discourse is the way in which it institutionalizes (and makes invisible) a certain set of gendered relations. While the discourse of professionalism emphasizes the autonomy of practitioners, the practical work and lives of physicians are inextricably entangled with, and dependent upon, the work of others, primarily the work of women. In the public sphere, the work of physicians is dependent upon the work of less-prestigious occupations, such as nurses, social workers, physical and occupational therapists, and others, as well as an ensemble of



even lower paid workers, such as housekeepers, nursing assistants, secretaries, and clerks. The labor of these workers is largely made invisible by the discourse of medical professionalism, through its exclusionary focus on the individual practitioner (Davies, 1996).

As an illuminating counter-example, we would note that the discourse of professionalism is more complicated when invoked by members of other health care occupations. For nurses and social workers, as an example, the power and privileges of professionalism are far more tenuous than for physicians (Melosh, 1982; Reverby, 1987). Both of these largely female groups, doing work that historically has been devalued or ignored, have always worked under conditions in which their work is constrained by institutions, and clearly entangled with the work of others (Abbott & Meerabeau, 1998). Claiming professional status thus works paradoxically, both to assert their right to the autonomy and status of other professional groups, and to call attention to the limits of those as markers of professionalism. Regardless of the efficacy of the claims to professional status by these groups, however, the increasing use of the discourse of professionalism by them has disrupted the credibility of medicine's claim to a uniquely privileged and autonomous practice. By making their own labor more visible, nurses, social workers, and those in other health care occupations have also made more visible the dependence on and interconnectedness of medicine to their work.

Medicine's dependence on a set of gendered relationships and social structures is equally important in the domestic or private sphere. At home, the conventional role of the physician relies on women's work as well, assuming the availability of a supportive spouse, childcare provider, and homemaker to enable the obligations of the professional calling. For physicians with children, in particular, the daily tasks such as playing with and reading to children, caring for them when they are sick, transporting them to extracurricular activities, and managing play-dates and homework have traditionally been done by mothers. Meanwhile, the preparation of meals, the maintenance of the home, and the nurturance of the social network have traditionally been done by wives (Cowen, 1983). Waiting at home for a repairman and waiting at home for a child after school are alike in that someone must *be* at home, not just intermittently, but day after day, night after night. The traditional wife and mother waits for the physician as well, providing a safe harbor, a warm dinner, a listening heart. This support has allowed physicians to maintain extended and unpredictable working hours, to cope with the emotional challenges of sickness and death, and to belong to a community outside the hospital and clinic—to have a life as well as a career. The supportive labor by others in the domestic sphere also, of

course, allows the medical system to expect this kind of work schedule of individual physicians (Hochschild & Machung, 1989; Hochschild, 2003).

The profound, although incomplete, shifts in social roles for men and women over the last few decades, including the entrance of more women into the practice of medicine and more generally into the paid workforce, have interrupted these assumptions. Most obviously, women physicians are less likely to have a spouse who can manage their private lives while they focus on their professional roles. (The pool of potential wives for female surgical residents is remarkably small.) To some extent this is also true for men, who are increasingly likely to have spouses with their own careers, interests, and obligations outside the home. Male physicians are also more likely than in past generations to make participation in childcare and other familial obligations a priority.

In linguistic terms, we might say that these young physicians are caught between several powerful and competing social discourses, for example, one about parenting and the other about professionalism. The professionalism discourse emphasizes that the interests of the patient take priority over the self-interest of the physician. Meanwhile, the discourse of modern parenting instructs parents that the most valuable assets they can give their children are time and attention. (This emphasis on individual parenting is enforced by the lack of social resources, such as access to flexible childcare arrangements and part-time work schedules, and school schedules that presume a stay-at-home caregiver.) Both of these discourses highlight special obligations to people with dependency needs, but neither offers guidance as to how those obligations should be reconciled or combined. Other competing discourses include the contemporary emphasis on building emotional intimacy with one's partner, adequate "self-care," and creating "balance" between work, family, play, and personal meaning (Hafferty, 2003). All of these obligations pull away from a simple or straightforward application of altruism, fidelity, or public service.

In addition to the changes in gendered relations, there are changes in other institutions that surround and support medical professionalism. Patients approach their physicians with a broader (and sometimes contradictory) set of discourses available to them for negotiating the physician-patient relationship. Patients come to their appointments armed with information from the Internet and with directives from pharmaceutical companies to "Ask your physician!" Consumer groups urge patients to come with a list of questions, to take notes and "shop around," to be more skeptical of advice and more involved in decision-making. The growing discourses of patient rights, patient autonomy, and patient involvement all complicate the traditional role of physician as expert with privileged knowledge.

Some patients, however, never get to an appointment at all because a growing number of persons living in the U.S. are un- or under-insured. The virtue of fidelity can reasonably be understood and practiced with a single patient, but when faced with a caseload of patients, communities, populations, or society-at-large, the meaning of this principle is much less clear. The framing of the physician-patient relationship as a “dyad” makes it difficult to negotiate questions of wider social responsibilities, to take up questions of social policy, or even to make sense of the multiple demands on any given practitioner. When the medical profession has taken up the topic of nationalized health care (through the AMA and other professional organizations), it has repeatedly affirmed its commitment to this conservative notion of fidelity by opposing socialized medicine (Navarro, 1993; Rothman, 1994).

Meanwhile, the assumption of the professional’s clinical autonomy is challenged by the changing structure of health care institutions and the financing of those institutions. Physicians are increasingly providing care as members of collaborative teams, and as salaried employees in large group practices. They share patients with specialists (both physician and non-physician), and relinquish care to hospitalists when their patients are institutionalized.

Indeed, physicians today are facing multiple forms of external review of their clinical practice. Although managed care organizations have been the most explicit about this evaluative process, all health care institutions are looking carefully at how resources are utilized, both capital and human. The question of clinical efficacy for a particular patient has been supplemented by questions of efficacy and cost-effectiveness for populations. What care should be provided, and by whom, and who should decide? How much attention should providers give to financial considerations in clinical decisions? How should we evaluate quality of care? Should the emphasis in medical practice be on standardization or individualization? The traditional discourse of professionalism provides little or no help on these issues.

The movement for evidence-based practice (EBP) is another form of external review that runs counter to the presumptive autonomy of the clinical practitioner (Tanenbaum, 1994). The EBP movement is particularly skeptical of the idea of “clinical judgment”—the idea that individual physicians are in the best position to know what is best for their individual patients. EBP proponents assert instead that individual practitioners are often wrong about what works, either because of various biases built into their memory of practice, or because they simply cannot keep up with the flood of new studies (Tanenbaum, 1999). While in some ways the EBP movement relies on traditional and even conservative ideas about science (for example

in its preference for quantitative data from large, randomized, and highly standardized clinical trials), in other ways the EBP approach works to undermine the authority of the science of medicine. Any given recommendation is only “the best we know now” and could just as easily change tomorrow; in fact, the recent history of medical guidelines in several areas has demonstrated this instability to alarming proportions (e.g., hormone replacement therapy).

Though the discourse of professionalism has long been effective in covering over internal conflicts and bridging external tensions, it can no longer contain the contradictory changes occurring in society. Multiple competing discourses are increasingly challenging the hegemony of traditional medical professionalism, including consumerism, changing social roles for men and women, and systems-based approaches to quality-improvement and patient safety. In light of this analysis, recent calls for a renewed professionalism would seem to be an overly simplistic solution to a complex situation. The social pressures to which it is attempting to respond are too diverse to be contained by the old model.

Professionalism has always been a negotiation between the interests of professionals and those of the public. What has changed are both the perception of those interests and the context in which those negotiations occur. Health care is increasingly the work of teams and systems, not autonomous individuals or even single professions. Notions of the “public good” are in themselves more contested and uncertain. A host of social changes has shifted both the internal demographics of medical students and their expectations and options for the future. A renewed professionalism would need to take into account all these changes. Attempts to concretize professional virtues, and hold medical students accountable for them, have got the process exactly backwards. What we first need to do is re-negotiate the social practices on which those values rest, and re-configure the institutions that produce them.

As this discussion has shown, the discourse of medical professionalism depends on—and operates through—a set of interlocking institutional, cultural, political, and economic structures, structures which the discourse renders largely invisible. Those social systems are now in transition, however, and the tensions and contradictions in them are more apparent. Because of this, the discourse of professionalism no longer works and no longer makes sense, for it is increasingly unable to account for the lives and choices of its participants.

## **DISCOURSE AND VIRTUE ETHICS**

By using the language of virtue, medical educators are acknowledging that this effort to revive professionalism is essentially an ethical project. Setting aside our skepticism about possible motives for this latest version, the project of developing virtues in novice practitioners has a venerable history, which has been recently reinvigorated (MacIntyre, 1984; Pellegrino & Thomasma, 1993). The effort to help members of the medical community become the right kind of people, to develop in them the moral character required to act appropriately, is a task undertaken with the ethical intent of ensuring that novice physicians will honor the social contract established between the profession and the public.

While derived from very different intellectual traditions, the *practical* work of virtue ethics shares much with discourse theory. Like virtue ethics, discourse theory suggests that moral activity is guided more by implicit cultural norms than by explicit rules, that we learn by doing, and that our ethical character is shaped by the community in which we live and act (McKinnon, 1999). All communities discipline their members, strive to make them become certain kinds of persons rather than others, and construct those choices as “natural.” Virtue ethics and discourse theory understand the nature of action very differently, however. While discourse theory calls attention to the central role of language in establishing, communicating and enacting normative practices, virtue ethics presumes that behaviors arise from proper character. Character, though it can be enhanced through teaching, is an essential feature of an individual, and even the correct action cannot be considered virtuous unless it arises from this innate desire to do and be good (Aristotle, 1962).

What virtue ethics assumes, discourse theory makes explicit, and the professionalism project seems to have forgotten, is that for this discipline to be effective, there must be strong community consensus about the virtues being established. This consensus must be supported by everyday practices and by social institutions. The virtue ethics model presumes a fairly homogeneous community with clearly delineated roles and strong mentors, for the virtues are learned through the internalization of these roles, and through living out those roles in one’s own life and work (Pellegrino, 2002).

This ideal of a stable community is clearly at odds with the pluralistic and fragmented nature of contemporary American society. Novice physicians (medical students and residents) are enmeshed in a variety of powerful social discourses, not only medical professionalism, and they (like all of us) are pulled in many directions in the construction of their identities, their values,

and their practices (Good & DelVecchio Good, 1993). Within medical schools, the traditional hegemony of wealthy white males is eroding. The view of language outlined here would suggest that this discourse of professional virtues is not equally accessible to those who do not fit this demographic: women, minorities, and students from the working class, for example (More & Milligan, 1994; Beagen, 2001).

The social contract between physicians and society is a social system of rights, duties, and reciprocal relationships. Individual virtue is tied to community virtue in that physicians are (in this model) entitled to certain privileges and expectations in exchange for their service to the community. To the extent that physicians are no longer receiving the social power they desire and the society is not satisfied with the service they receive, it is a collective problem. It reflects a breakdown in reciprocity on both sides of the contract.

Virtue ethicists and discourse analysts would agree that it is not enough to give students words—the names of virtues—because words alone do not have meaning; they must be backed by practices. Even if we give students those practices, however, even if they have role models to teach them these practices, the practices have to make sense within (and make sense of) the institutional structures as they currently exist (both internal and external to health care). It is not enough to have faculty who can empathize with the struggles of a physician missing his daughter's soccer game in order to admit a patient; that is not developing virtue but rather using "altruism" to maintain a dysfunctional system. We must create ways of taking care of patients that also allow the taking care of children. Similarly, it is not enough for faculty mentors to rail against the intrusions of managed-care organizations into the patient-provider relationship without at the same time showing young physicians other ways of taking up the issues of distributive justice and the proper allocation of limited resources.

The effort to locate professionalism in individual physicians misses the collective nature of values and virtues, the ways they are fundamentally community-based practices. Virtues require community support, not only in the educational process, but also in the practical sense of institutions structured so as to make the exercise of those virtues possible. Language works by pointing toward knowledge to which we already collectively have access. We must be able to recognize and participate in embodied practices and institutions, or the words cannot have meaning. We need virtues that can inspire moral courage and right action, but more than lists of virtues, we need new *institutions* to support and embody such virtues.

## CONCLUSIONS

Efforts to revive the discourse of professionalism within contemporary medical education and practice are therefore both misguided and unworkable. They are misguided because they are based on mistaken and unhelpful ideas about the way languages work. Language cannot be imposed from “out there,” but must be negotiated in the context of daily practices and interactions. The work of making sense relies on the recognizability of the discourse for the people using it. These efforts are unworkable because they are trying to do too many different things under a single rubric. We cannot easily disentangle the “noble ideals” of professionalism from its more tawdry and self-serving components; we cannot simply extend the old arrangements that privileged a certain class to include a wider population; we cannot recreate the social conditions, public and private, that made both the privileges and the virtues meaningful and practical.

Continuing to use the language of professionalism without confronting the institutional and cultural infrastructure upon which it depends—and the changes that have occurred in those supporting structures, incomplete and uneven though they are—will only exacerbate the confusion and hostilities that characterize the current debate. What we need to do instead is both much harder and more ordinary. We must create institutions in which it is possible for medical trainees and practitioners to behave decently, to provide adequate care for their patients and to lead reasonable lives (with families, other interests, and enough sleep, for example). We must continue to renegotiate the moral, political, and economic relationships and contracts among health care providers, patients, and communities. We must avoid the siren songs of nostalgia, sentimentalism, and cynicism. We must find language to express and inspire moral courage and integrity without requiring either heroic self-sacrifice or the invisible sacrifice of others.

A more nuanced view of the relationships among language, experience, social practices, and institutions, will help us here, as will a humbler view of medical practice. The challenges of medical education and practice have some particular characteristics, but many of them are shared by other health practitioners, by other occupations, and by all working people. We can all appreciate the difficulties of blending careers and families, of making room both for the work and the people one loves, for those are the difficulties of many working people. We urge physicians and medical educators to look at those difficulties as *public* problems, needing public solutions, and not as failures of individuals who are insufficiently dedicated. The problems of medicine cannot be addressed at the level of the individual practitioner, nor

even at the level of the individual discipline. Physicians, with other health care workers, need to engage with their communities in a political process to decide how health care will be provided, including by and for whom. The social nature of discourse refocuses our attention on the needs and desires of the practitioners, of the various involved communities, and especially, on the negotiated nature of the moral agreement between them.

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