Education for Practicing Medicine as a Vocation and it's Advantages in Crisis Situations

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Abstract: This article analyzes the importance of developing the vocational dimension of education for professionalism in the medical professions. Initially we will analyze whether there is an obligation for the medical staff to work when exposed to a high risk to get infected by a disease, as well as the nature of this obligation (legal, civic, professionally ethical, moral), starting from the crisis in the medical system generated by the outbreak and spread of the SARS-CoV-2 virus. In the second part of the article, we will detail the conflict between education focused on respect for employee rights and the vocational dimension of the medical professions. Our conclusions argue for the need to implement educational programs that develop the perception of health professionals on the vocational dimension of their profession.

Keywords: *SARS-CoV-2; education for professionalism; vocational education; professional duty.*

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1. Introduction

No medical system is perfect and any medical system can report vulnerabilities in certain sectors of its activity: supply, personnel, high-performance medical equipment, activity space, etc. Crisis situations are likely to highlight and increase cracks in the system. The more the vulnerabilities affect certain areas of activity, the higher the risk of blocking the system, but the essential element that keeps the medical system functional, even in conditions of equipment shortage, is the human resource (Agba & Ocheni, 2019).

The medical crisis caused by the SARS-CoV-2 virus, on the one hand produced this highlighting of pre-existing problems in medical systems (neglect of training of medical staff for extreme emergencies, insufficient amount of stocks of protective equipment, drugs and apparatus) on the other hand, and on the other hand, due to the overcrowding of the medical system, it created new problems, which in periods of normality seemed inconceivable.

One of these problems is the reluctance of the medical staff to provide medical services due to the personal risk of being contaminated with the SARS-CoV-2 virus, by coming into contact with infected patients or by continuing, in general, the activity when the disease spreads, when it has reached the stage of intra-community infection and any patient is a potential carrier and transmitter of the virus.

The huge difference between the demand and supply of protective equipment worldwide has objectively created the insufficiency or even lack of such equipment in certain medical units, and subjectively has generated the feeling that the fight against the disease will be done exclusively with one's own efforts. Unlike normal times, in this case there is no real possibility to get help from collaborators, allies, traditional partners, as they also face similar problems.

The lack of allies and immediate prospects (Gaitan (Botezatu), 2019) has amplified the feeling of insecurity generated by the real risk of illness to which medical staff are exposed in the performance of their duties and, at a time when society expects from these people an extreme professionalism, when doctors should have been the saviors of the sick, the medical staff were also put in the situation of balancing professional duty with personal needs. An infected medical staff can transmit the disease to their own family, co-workers or even patients, and through this, the rescuer becomes the danger.

In a period of crisis when, for the patient, the role of the medical staff acquired, at a psychological level, an almost messianic dimension, part of this staff, under the impact of the lack of protective equipment, self-demystified and began to show real reluctance towards the practice of one's own profession. In some cases this reluctance is manifested by extreme reactions such as protests, resignations, early retirement applications, ad-hoc strikes (refusal to enter work) etc. The reactions in society, manifested in social media, and in mass-media (whether printed, radio or TV) were divided between the following: empathy with the risky situation of the medical staff, support for the financial bonus system implemented in order to stop "desertions", media coverage of examples of personal sacrifice made by some medical staff, in order to create an atmosphere of adhesion to the missionary idea of doctors in situations of generalized crisis. Last but not least, there have been many attitudes of vehement criticism of the reluctance of the medical staff to practice their profession when confronted with the risk to their own health, and the idea of a real obligation of the medical staff to remain active, even in these conditions, was advanced.

Therefore, the question arises: what are the limits of the professional duty of the medical staff to carry out their activity in conditions of extreme risk to their own health, respectively if such an obligation actually exists and what is its nature: legal, civic, professionally ethical, moral?

2. Competency-based education and vocational education - effects on professional obligations

The European education system, dominated by the provisions of the Bologna Process (European Commission, nd), is split between science-based education and vocational education, but the field of vocational education includes only areas such as military, theological, sports, art and pedagogical (Eurydice, n.d.). While competencies (professional skills) are acquired through learning, in the case of vocational education, what prevails is the existence of a talent. The vocation is a talent that must be cultivated and developed. In the education process based on scientific skills, skills are formed: to accumulate information, to make correlations between the accumulated information, to help people who are still learning to create an individual system of continuous accumulation of information, on their own, after leaving schools (Bowden, n.d.).

Medicine is not a vocation, according to this education system, but a science. What prevails for the medical staff is not the "calling" for the job, but the scientific knowledge, and in fulfilling the medical act,

professionalism prevails, not sentimentality. Thus, empathy towards the patient must be transformed into communication skills, as the ability of the medical staff to make decisions with lucidity, unaffected by emotional aspects, is considered imperative. As an effect of an education system that excludes emotion and replaces it with skills, it is not surprising that the perception (Simbotin, 2020) of the medical staff about their profession is moving further and further away from the messianic, saving image of the profession and is getting closer and closer to the common system of rights and obligations.

The vocational side of medicine could suggest the existence of a spiritual dimension of the medical practice, through which society invests doctors with its expectations, represented by the belief that the doctor, faced with an extreme situation, will give up his own safety to play the role of a savior of lives for his fellow human beings. Although there are several variants of text, this vocational side appears constantly in the modern version of Hippocrat's oath (the version we use in this article is the one written by Prof. PhD MD Louis Lasagna, the Academic Dean of the School of Medicine at Tufts University, in 1964): "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug" (Tyson, 2001).

The artistic side of the medical act and the obligation to treat patients with human warmth and empathy, although it is only a secondary dimension of the competence-based education, is nevertheless a sufficiently important element to be included in the most famous professional oath in the world. This obligation suggests a dimension of practicing medicine that is related to the humane side of the doctor, to his individual morality, which exceeds the framework of professional ethics itself. As a moral obligation in conditions of crisis and exposure to personal risk of infection, the virtue that seems to stand out in these conditions is courage. But can we reasonably force medical staff to comply with a genuine obligation to have courage?

The Hippocratic oath also introduces the civic component of the doctor's obligations: "I will remember that I remain a member of society, with special obligations to all my fellow human beings" (Tyson, 2001). The question that arises, therefore, is whether these special obligations to society include the obligation not to leave the job, the duty in the event of a real risk of illness of one's own person, as a civic obligation. Such a type of obligation could be supported by the fact that society has advanced for each medical professional the financial resources of their professional education and training, and once the person reaches professional maturity, that person has

a real obligation to fulfill his professional mission for which society has made its investment. Therefore, this argument lies in the principle of social solidarity (Küçük, 2016), more precisely the exchange of solidarity, from society to the future doctor, in the phase of his professional training, and then from the doctor to society, in the phase of practicing the profession by the doctor trained thanks to the care of society.

However, the Hippocratic oath also says, "I will prevent disease whenever I can, for prevention is preferable to cure" (Tyson, 2001). Therefore, even if the obligation of courage and the civic obligation of doctors still remain uncertainly argued, there is certainly an obligation of doctors not to make their own patients ill, and this obligation may be violated by a doctor who does not benefit from barrier equipment to ensure that he, once infected by patients due to lack of such equipment, will not transmit the disease to other patients with whom he will come into contact after getting infected himself.

3. The conflict between education for employee rights and education for practicing medicine as a vocation during a pandemic

The dimension presented above of the Hippocratic oath overlaps with the legal obligation not to evade the fight against potentially infectious diseases, an obligation which in most states of the world, in case of violation, is a crime. And yet, in the face of the need for medical staff to treat patients in an overcrowded medical system, it is insisted on the existence of this duty of the medical staff to expose themselves to extreme risk, although this also exposes, to the same risk, the uninfected patients, who come into hospital units with medical conditions other than the infectious disease whose control is desired. The family members of those doctors and the extended medical team with which those doctors come into contact end up being equally exposed. And as for the doctors themselves, the problem arises that the insistence on imposing a moral obligation on them to remain at work violates two fundamental rights: the right to life and the right to health.

There is a hierarchy of human rights, and the right to life and the right to health are considered the most important (Farer, 1992), so they surpass any professional obligation. These are the parameters imposed by human rights education, which over time has given rise to a true culture of protecting the employee at work. Such an approach is capable of convincingly combating the argument of the existence of a civic obligation of doctors to work in conditions of risk, on grounds of social solidarity, as well as the argument of the the fact that this risk is an assumed risk,

according to which when choosing the medical profession, doctors implicitly assumed the risk of exposure to a whole plethora of diseases, some of which have a high potential for infectivity.

The principle of solidarity is also provided in Chapter IV of the Charter of Fundamental Rights of the European Union, which clearly sets its limits through the text of Article 31 para. 1: “every worker has the right to working conditions which respect his or her health, safety and dignity”(EU, 2000). Therefore, the principle of solidarity and the idea of risk assumed are fought, we appreciate, by the principle of proportionality: the high conditions of protection created by modern medical equipment (Neofet, 2019) against the risk of disease considerably reduce the probability of infection of medical staff, and the option to practice this profession, was chosen by future doctors, with this aspect in mind, is influenced by it. Therefore, the risk assumed was proportional to the risk perceived by those doctors at the time of choosing their profession. When the current risk exceeds the perceived risk, the assumed risk theory no longer finds its legitimacy.

In the vast majority of countries, non-payment of wages and failure to ensure working conditions while failing to respect the right to life and health of employees are fundamental violations of the individual employment contract by the employer (Reymann & Guzy, 2017). This violation entitles the employee to leave the workplace immediately, until the situation is remedied, without being subjected to any sanctioning treatment by the employer (for hospitals in the public health system, the state).

Also, the resignation is a unilateral decision of the employee, which does not even have to be motivated (Dobel, 1999) and which cannot have the effect of stopping the employee from subsequently getting hired by another employer. Therefore, the solutions circulated in the media to stop the phenomenon of resignations from the medical system (imposing a longer notice period or banning further practice) are opposed by the legal analysis presented above, any solution to the contrary violating the right to work or the right to safe working conditions for those doctors, even if the discourses in the media try to picture this as an abuse of rights (Ignatescu, 2019).

4. The conflict of values

It is noted that although the work system emphasizes values such as safety at work, as well as the right to choose your job or employer and, respectively, to resign unilaterally, crisis situations, such as the one generated

by the Covid-19 pandemic, which creates an obvious state of danger to medical staff, prove that in such contexts society, employers (hospital management) and even officials translate their discourse to values such as courage, the spirit of self-sacrifice, self endurance etc. These values are not, as we have shown above, novel elements for the way the value system that guides the medical professions is constructed, but what is happening now is a shift in emphasis (Frunza & Grad, 2020), from the specific values of competence-based education to a set of values that are promoted with priority by vocational education. To draw a parallel, the spirit of self-sacrifice for the benefit of the Other and the stoic acceptance of performance in a stepparent context are more related to the discourse on values promoted in confessional education. In fact, due to the fact that the activity of medical staff has the effect of saving the lives of patients, public speeches in recent times make obvious links between the two situations, doctors are assigned a role with a deep messianic load, to save the body, an attribute that bares a similar burden to the activity of the representatives of religious cults, for the salvation of the soul.

This new discourse on the values that govern the medical profession, widely covered by traditional and online media channels, creates a value confusion in the medical staff, as self-sacrifice involves a form of fatalism, like putting the Other before their own interests, which contrasts with the right to work in a risk-free environment. Education for professional ethics is the one that mediates between the instinct of conservation and the spirit of sacrifice, creating bridges between them and bringing them together. An education based on strictly scientific reasons presupposes a non-spiritual, mental-cognitive altruism, in conditions of one's own safety, but when safety disappears, the spiritualization of the perception of one's own mission is the one that can influence the decision to stay at work or to give up.

Self-sacrifice, a value with spiritual load, presupposes the deliberate ignorance of the danger in which one finds oneself, and vocational education is a deeply spiritualized education, in which professional values of a spiritual type are promoted more easily than in competence-based education.

On the other hand, competence-based education is a scientific education, where secular values take priority, promoting here also the value of empathy towards the patient and the value of assuming the risk of exposure to diseases, inherent to the medical profession, but also values like safety at work, which is placed above them.

We note that during the Covid-19 pandemic, what was required by public opinion, hospital management and decision-makers from the medical

staff was a spiritualization of their professional life, with priority over the core values promoted by the system of education in which these doctors were trained. Crisis situations seem to require, therefore, the transformation of the education system for professionalism, through the stronger integration of the spiritual, vocational component in the education of professional ethics.

5. Conclusions

As we have seen from the aspects discussed above, there are no arguments that firmly and unequivocally support a real moral obligation of doctors to have courage, an obligation stemming from professional ethics to endanger their lives and health in order to treat patients when they are not provided with adequate protective equipment against infection, and no civic obligation of absolute solidarity, provided that the right to respect for health at work is a manifestation of the wider right to life and health, which outperforms professional obligations, whether of a legal nature or of professional ethics.

Therefore, the only solution to ensure a proactive work environment in the medical field in conditions of extreme crisis is to promote the feeling of practicing medicine as a vocation. It is necessary, therefore, to promote on a larger scale a culture of the professional vocation of the doctor to do good on a large scale, to put himself in the service of humanity, to make the other a priority even to the detriment of his own person, to keep oneself courageous in the face of risk while feeling fear, but at the same time overcoming fear (Strugar, 2018) for reasons that exceed any professional obligation, but outline a human side marked by humanism and excellence. Only such an education, promoted through educational programs organized both during university studies and after leaving school, can provide the framework for the development of a medical body that counts in its ranks those professionals that society demands so urgently in situations crisis: the heroes.

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