

Review Article

Teaching professionalism in medicine: what, why and how?

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ABSTRACT

The increased attention that “medical professionalism” has received lately exposes the deficit in our educational system and indicates the need for more work to be done to ensure an effective teaching and assessment of this competency. The concerted efforts made by many reputable organizations are great steps in the right direction. Nonetheless, many medical schools are still lagging behind. Literature has been clear about the importance of formal teaching in establishing professional behaviors in the medical school graduates; failing in this regard is certain to have unfavorable outcomes. Furthermore, current literature suggests many teaching strategies and assessment tools that can help in achieving this goal. However, many inadequacies are still there.

Teaching professionalism requires, in addition to an explicit core curriculum that spans the continuum of medical education, special efforts in terms of imparting the non cognitive skills as well. Respectable role-models play a major part in this process. Helping students to reflect on the real life encounters in a safe environment is, probably, one of the most effective tools at our disposal. Many obstacles that may hinder this educational endeavor have been described in the literature. Negative role models and the “hidden curriculum” are among the most dreaded ones and they deserve an extra effort to overcome.

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INTRODUCTION

The recent plethora of writings about medical professionalism and the heated debate over what is perceived as a threat to it attests to an increased interest in this subject. This surge of interest seems to be fueled by the apparent politicization of healthcare, the conflicts of interest regarding commercialism and its influence on medical practice along with the anxieties emanating from an ever increasing rate of medical litigation, with the defensiveness and cynicism that this engenders in clinical practice [1, 2]. In this review, we will try to look into the basis of medical professionalism, its evolution over time and the way to foster its development in the future generation of medical practitioners.

From healers to professionals

Modern Medicine, at least in part, is the contemporary embodiment of the ancient art of healing, present since the earliest days of civilization [3]. Today's physicians, as such, are the natural successors of the old time healers and they are expected to function competently as both healers and professionals.

The practice of medicine and the ways of teaching it were far simpler than they are these days. It was very usual to pass the desired values and behaviors down from one generation of physicians to another by the means of the respected role-models. This mechanism of teaching is clearly no longer sufficient; it cannot be relied upon as the only tool for fostering professionalism in current trainees due to the increased complexity of healthcare delivery system and the major challenge it poses to the old model worldwide. The profound changes in today's health care system have created the need for more efficient ways to teach Medicine in general and medical professionalism in particular.

What is professionalism anyway?

The word "professionalism" is derived from the Latin *professio*, or public declaration. Professions, as defined, are occupations granted a special status by the

society so that the "Professionals" can deal with the needs that are valued by the community they serve.

The currently esteemed status of professions in our society was not always that good. It was harshly criticized and many looked upon 'the profession' as "a method of controlling work" [4], and in some cases as a menace to the public interest; in Daniels' words "the more powerful the professions, the more serious the dangers in concern for public service, and zealously in promoting the practitioners' interests" [5]. Despite these negative views, the status of "the profession" received a major boost from the reality of everyday medical encounters. Sir James Spence [6] expressed that elegantly: "the essential unit of medical practice is that moment in the intimacy of the consulting room when a patient who is ill, or believes himself to be ill, confides in a doctor who he trusts. This is a consultation, and all else in medicine derives from it." Freidson [7] concluded, "Professionalism remains necessary and desirable for a decent society." Another thorny point in this discourse is the fact that "Professionalism" has different meanings for different people in different contexts. Kuczewski [8] proposed to define it as the norms of the relationships in which physicians engage in the care of patients. On the other hand, Calman [9] proposed what he called 'key values' expected of professional doctors. These values include: high standard of ethics, continuing professional development, ability to work in a team, concern with health as well as illness, concern with clinical standards, effectiveness and audit, ability to define outcomes, interest in change and improvement, and finally research and development [9]. Actually, the various meanings given to professionalism can be usefully grouped into two broad categories of functions; those promoting professionalism as a term of excellence in medical practice, and those denoting "meeting certain standards" and hence hinting to the issue of control [10].

This vagueness in defining the term "medical professionalism" made the case for a normative definition based on common observable behaviors

instead of “key values” [3]. Such behaviors were the foundation stone for the project of Association of American Medical Colleges (AAMC) to incorporate professionalism into medical student outcomes and accreditation and re-accreditation processes [11]. The American Board of Internal Medicine used this same set of behaviors in its “Project Professionalism” [12]. In the year 2002, a combined North American and European Internal Medicine Boards project published the “Physician’s Charter—a declaration on medical professionalism requirements for the new millennium”. This charter defined three fundamental principles of professionalism:

1. **The primacy of patient welfare.** This principle focuses on altruism, trust, and patient interest that must not be compromised by “market forces, societal pressures, and administrative exigencies”.
2. **Patient autonomy.** This principle incorporates honesty with patients and the need to educate and empower them to make appropriate medical decisions.
3. **Social justice.** This principle addresses physicians’ societal contract and distributive justice, that is, considering the available resources and the needs of all patients while taking care of an individual patient [13].

Subsequently, more than 120 medical organizations have endorsed this charter and it has been translated into ten languages [14].

Why is it important to teach professionalism?

In the middle of the nineteenth century, with the advent of licensing laws, the profession of modern Medicine acquired its status and virtually seized a monopoly over its practice. This development was generally accepted as both patients and society at large need the services of reliable competent healers; Professionalism in this context could be considered as the means of organizing these services. Based on this putative agreement, the society granted professionals autonomy in practice, an important role

in regulation, a privileged status and financial rewards on the understanding that the profession in return will assure the competence and ethical conduct of its members and address issues of concern to society. If individual physicians or the profession in general fail to meet society’s legitimate expectations, this social contract will be altered, with a consequent change in Medicine’s professional status. This implicit contract remained very much unchallenged until recently as professional self-interest has seemingly predominated over altruism and the society has sought to re-define this relationship and make the contract more explicit [15,16].

Presenting professionalism in this context provides a sound base for professional obligations, along with clear reasons for meeting them. Students must learn this at an early stage of their education and understand the consequences of failure to meet these obligations. Unfortunately, the concept of professionalism remains very vague for most of medical students. The reasons for professional obligations are not fully understood and the relationship between teaching and assessment is not quite logical. Furthermore, an increasing body of evidence suggests that efforts to impart professionalism to students have some impact on their professional status and conduct. In a case-control study, correlating students’ performance in medical school with subsequent unprofessional behavior, investigators showed that students who exhibited unprofessional behavior in medical school were three times more likely than those who did not to undergo disciplinary action by regulatory organizations. Specifically, the code of “severe irresponsibility” had an odds ratio of 8.5, and the code of “diminished capacity for improvement” had an odds ratio of 3.1 [17].

Luckily, many medical schools now address this important topic in some manner although the strategies utilized to teach professionalism may not always be adequate. In a survey conducted in the academic year 1998-1999 gauging the extent of teaching professionalism in the US medical schools,

106 (89.7%) schools reported that they offer some formal instruction related to professionalism; but only 64 (55.2%) schools have explicit methods for assessing professional behaviors [18]. Despite this clear inadequacy, medical educators remain the best to be entrusted with the job of imparting the desired professional qualities and attitudes to future physicians. However, to succeed in this critical task, medical schools need to address the following three issues seriously:

- Improving the selection process of their future graduates
- Improving the formal instruction of the current students
- Purging the learning environments of unprofessional practices [19].

A road map to teach professionalism

As we alluded to earlier, teaching medical professionalism formally has a relatively short history and only recently has become a requirement. Formal instruction in both professional values and the rationale for upholding professionalism are being increasingly integrated into medical curricula. Apparently, developing curriculum pertaining to professionalism is not an easy task, nonetheless, the core values need to be delivered explicitly throughout the course of medical education, with more-complex subjects being introduced along the educational process [20].

The current wisdom suggests the following steps in teaching professionalism [21]:

- Setting the expectations
- Performing assessments
- Remediating inappropriate behaviors
- Preventing inappropriate behaviors
- Implementing a cultural change

Obviously, the first step is to clearly define the expected behaviors for the institution and its affiliates, followed by the development of policies delineating the due processes: reporting channels, remediation processes, and follow-up. Both learners and teachers should receive a list of expected behaviors for which

they will be held accountable with explanation of the consequences of acting inappropriately.

Beyond this initial orientation and the written documentation, the teaching of professionalism should be incorporated at all levels, and training should be offered in relevant topics such as conflict management, feedback, supervisory skills, and assessment. The cognitive material should include the value system of medicine, which must be internalized by all physicians during the long process of becoming professionals. This material, as mentioned earlier, should be introduced as early as possible, with an increasing complexity and should span both undergraduate and postgraduate education.

Teaching the cognitive components can be facilitated through courses in the history of medicine with emphasis on how the concept of medical professionalism evolved. Instructions can be delivered in form of lectures to provide frameworks, definitions and stimulate curiosity. Other forms of teaching are also helpful, small groups sessions may be used to explore personal interpretations and biases, whereas, problem-based learning or collaborative learning formats are believed to be very helpful in this regard [22]. These techniques might be augmented further by creating opportunities to participate in community service activities in which professional responsibilities are highlighted [23].

Focusing on the cognitive base alone is certainly not sufficient. Non-cognitive components are extremely important as well since professional identity arises “from a long term combination of experience and reflection on experience” [24]. Non-cognitive skills include among others: communication (language, empathy, integrity), collaboration (responsibility, respect, duty), and continuous improvement (recognition of limitations and motivation to improve). The student must be provided with stage-appropriate opportunities to experience the challenges faced by practicing physicians and to reflect upon these events in a safe environment so that the process of reflection becomes habitual. An extra effort must be made to ensure that all students have the opportunity to

experience real or simulated clinical situations. When this approach is not feasible, small-group discussions involving case vignettes, video clips, narratives, role-plays or other educational methods may suffice. However, what students hear in the classroom may not make the most durable impression, it is what they see and experience in the everyday practice. Their faculty members, residents and fellow students act unintentionally or otherwise as “role-models” which shape their attitudes and harden their perceptions about the real expectations of the profession [25].

Role-models, who have an extremely important part to play in this process, must understand professionalism and be able to stimulate reflection on the pertinent aspects of professionalism being modeled. Unfortunately, negative role models do exist. They are responsible, at least partly, for the well-documented cynicism that can develop in some students. Interestingly, some of these negative role models come from sources other than medical community, e.g. the media; they may represent an important challenge to the students’ professional development. Medical educators have to be aware of this and to deal with it appropriately as well [21].

Another hindrance to this process is the so called “hidden curriculum”; it usually impairs the students’ ability to reflect upon their experiences leading them to distance themselves from patients more than is needed to maintain professional responsibility [26]. Identified elements of the “hidden curriculum” include among others: routines, rituals, symbols, institutional slang, control systems and power structures [27].

On the other hand, many positive reinforcement techniques have been suggested to improve the process; for instance, if a student was complemented by a patient or nursing staff on a professional behavior, the teacher should make sure this behavior is acknowledged in a meaningful way such as directly praising the student, listing the comment on the student evaluation tool, sending an e-mail to the clerkship director, or completing a praise card for exemplary behavior [28].

Finally, we should remember that a stepwise

approach over the progression from medical student to a practicing physician and the insight gained from patients’ encounters would certainly enhance our understanding and abilities to promote professional attitudes and behaviors [29].

How about the assessment?

The question of whether professionalism can be assessed reliably is a concerning one. A growing body of evidence indicates that this objective is quite feasible [30]. Assessing professionalism is meant to determine if trainees have learned this core competency and what kind of deficiency they need to address [31]. Moreover, unless we hold students accountable for demonstrating these attributes in a high-stakes assessment, they are unlikely to place a high priority on achieving the putative standards. Stern put these two facts in a very precise way “if it can’t be measured, it can’t be improved” and “they don’t respect what you expect; they respect what you inspect” [32]. Thus, the endeavors to improve the students’ performance in the realm of professionalism should start with the development and implementation of valid measures of the desired attributes. Educators must explicitly incorporate the expected behaviors into their formative and summative evaluations. Successful feedback would help in improving learners’ performance and their final evaluation as well. However, if they fail to improve, a follow up is very much in need [19].

Professionalism is clearly multidimensional in nature; this means a combination of assessment tools is required. In a literature review by Wilkinson et al [33] nine clusters of assessment tools were identified: observed clinical encounters, collated views of coworkers, records of incidents of unprofessionalism, critical incident reports, simulations, paper-based tests, patients’ opinions, global views of supervisor, and self-administered rating scales.

Although many promising approaches are under evaluation, no single measure or set of measurements has yet proven sufficiently reliable and valid to meet the desired psychometric criteria. Some of the approaches

currently in use are direct observation by faculty, peer assessment, Professionalism Mini-Evaluation Exercise (P-MEX), the objective structured clinical examination (OSCE), critical incident reports, and learner-maintained portfolios [34]. To sum it up, a multiple-source evaluation by peers, nurses, patients, and other coworkers is preferred compared to the one carried out by direct supervisor alone. Judging a learner's knowledge and decision-making abilities is important but knowing how that person behaves in the middle of the night when duty calls is definitely very important as well.

The remediation

Lapses in professionalism do happen; they may affect a behavior (e.g. lack of respect for patients), a performance (e.g. inability to concentrate on tasks at hand), an attitude (e.g. arrogance), or a lack of accountability (e.g. frequent tardiness). Categorizing lapses this way is helpful in determining the best course for remediation plan.

A fair and reliable assessment and remediation should consider the contexts in which lapses did occur, the conflicts that lead to such lapses, and reasons behind learner choices to resolve conflicts [35]. Following identification of the unacceptable behavior an early meeting with the student should be scheduled to explain what is acceptable and how to make amends. The possible consequences for not improving should be outlined. Frequent follow-up is required to praise improvements and discuss ways the student can continue to progress. Developing a supportive institutional culture is of utmost importance. In addition, many activities outside of work life can help improve both attitudes and job performance too.

On the other hand, we must not overlook the many

factors that may impair the remediation process, some of these factors are the inappropriate tools used, the shortage of time necessary to intervene, worry over future impact to the student's career, professed lack of skills to address the issues, the potential for strained relationships, and fear of student retribution or litigation. Communicating these fears through proper channels and clear delineation of responsibilities can help alleviate some of these concerns [36].

CONCLUSIONS

Implementing a program for teaching professionalism in medical schools is a necessity not a luxury. It should permeate all aspects of the medical education and has to cross departmental lines. It is necessary at the undergraduate and postgraduate levels and will certainly be a requirement of the continuing professional development of the future. Literature affirms that professionalism is a competency requiring formal teaching. The performance assessment using multiple evaluators and multiple methods is of a paramount importance. Many strategies that can be used to advance professionalism in the educational environment are available, however, that optimum mix of methods is yet to be found.

Success of any given program requires a strong institutional commitment expressed by the allocation of both curricular time and resources. The teaching environment must support and reward professional behaviors and not tolerate unprofessional ones with special attention to the case of negative role models who must be offered remediation or even removed from contact with trainees. A faculty development program on teaching professionalism may prove to be the best investment in this regard.

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