Preliminary Report of the Vertical Integration Group on Professionalism
January 2011

Outline of report

A summary of the report is presented in section C for those having interest but insufficient time to read the full report. Please read the introduction and background first.

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A. Introduction

The committee was charged with identifying how professionalism training is currently provided across the curriculum at BUSM, to ensure BUSM is compliant with LCME professionalism standards, and with making recommendations on measures to further enhance the level of professionalism shown by our students on completing the MD program. As a "vertical integration group", we aim to indicate how more cohesive training of our students across all four years can be provided, yielding a more favorable outcome.

While recommendations are made for curricular changes, even a cursory study of the literature in the area of Professionalism provides ample evidence to show that training in this area can only be partially addressed through the academic curriculum. A large proportion of professional behavior is learned though modeling, mostly by faculty and residents. The phrase "hidden curriculum" (Hafferty FW, Franks R. 1994) has come to denote the source of much of what students learn through this means. If we are to improve the standard of professionalism shown by our graduates, we must address this area also. This calls for some recommendations which are outside the aegis of our parent body, the MEC, but which we are presenting in the hope of spurring wider discussion and action in the institution as a whole. Inevitably, such actions will call for additional assessments and, in some cases, training. Given current demands on our time, nobody wants additional burdens of this kind, and yet if we omit this, the negative effects of the "hidden curriculum" are likely to persist.

B. Background

The issue of Medical Professionalism has come under increasing scrutiny over the last decade. The level of trust and respect with which the general public holds the medical profession has substantially eroded (e.g. Stevens 2001, Schlesinger 2002) and many factors have contributed to this. These include a wider recognition of medical error and iatrogenic injury, the publicity provided by mass media concerning cases of ethical and other failures by physicians and medical researchers (including abuses arising from inappropriate interactions with pharmaceutical companies), the increasing financial burdens placed on the medical system and on individual physicians, and a resulting perception of decreased time available for physician to have meaningful interactions with patients (e.g. Gruen et al 2004) .

Partly in recognition of these changes, the teaching of Professionalism in medical schools has become the subject of intense scrutiny over the last decade. In 1999 the Accreditation Council for Graduate Medicine (ACGME) implemented six general competencies, applicable to every specialty, that need to be attained during the training of residents. One of these six is professionalism. At this same time, the "Medical Professionalism Project" was begun by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation and the European Federation of Internal Medicine. In 2002, this resulted in the publication of "Medical Professionalism in the New Millennium: A Physician Charter," laying

out the expectations of a physician. As indicated by Sox (2002), the introduction to this charter is based on the premise that "changes in the health care delivery systems in countries throughout the industrialized world threaten the values of professionalism", and that "the conditions of medical practice are tempting physicians to abandon their commitment to the primacy of patient welfare". The charter (appendix A) has since been adopted by many professional bodies and medical institutions and we recommend it for consideration by BUSM as the basis for defining medical professional responsibilities (see below).

As part of a long standing "Medical School Objectives Project", the Association of American Medical Colleges (AAMC) also launched a study of the attributes encompassed by "medical professionalism" and of the role medical schools should play in ensuring that aspiring physicians ultimately achieve these attributes. Part of the outcome was the seminal 2003 study "A Flag in the Wind: Educating for Professionalism in Medicine" by Thomas Inui (2003) which has been an invaluable reference work for us.

Since the year 2000, many hundreds of papers have been published concerning all aspects of the subject of Medical Professionalism. We have attempted to survey many of these to learn about suitable measures we can implement at BUSM to enhance the professionalism of our graduates, and we cite some of these studies in this report.

Many medical and dental schools have launched their own attempts, especially over a period of about the last five years, to determine how best to instill professionalism into their graduates. We are especially appreciative of help provided in conversations and correspondence from faculty at several medical schools as well as BU School of Dental Medicine, and by documents and publications concerning specific approaches taken at the following institutions: Indiana University School of Medicine (Brater 2007), New York University School of Medicine (NYU), University School of Pennsylvania School of Medicine (Wasserstein et al 2007), Pritzker School of Medicine - University of Chicago (Humphrey at al 2007), University of Kansas School of Medicine (kumc), David Geffen School of Medicine at UCLA (UCLA), Creighton University School of Medicine, Omaha (creighton), University of Colorado Medical School (colorado), Brody School of Medicine - East Carolina University (Basnight et al 2008), Boston University School of Dentistry (Appendix B), Georgetown University School of Medicine (georgetown), University of Texas Medical Branch at Galveston (Smith et al 2007), and the Mayo Clinic (Mueller 2009).

We had already progressed with our own considerations before perusing some of these contributions from other schools, but it became apparent that remarkably similar issues are being dealt with in all schools and that faculty committees invested in making recommendations in these areas often prescribed very similar solutions to those we were developing. We therefore feel emboldened in making the recommendations described in this report, in some cases incorporating ideas developed at these other institutions.

In this year in particular at BUSM, special note is given to LCME standard MS31A, which specifically addresses many of these issues. Contributions from our own institutional LCME self-study were included in our considerations.

MS-31-A: Medical schools must ensure that the learning environment for medical students promotes the development of explicit *and appropriate professional attributes (attitudes, behaviors, and identity) in their medical students. [New standard and annotation approved by the LCME in February 2007; effective July 1, 2008.]*

The medical school, including faculty, staff, students, and residents, and its affiliated clinical teaching sites, share responsibility for creating an appropriate learning environment. The learning environment includes formal learning activities as well as attitudes, values, and informal "lessons" conveyed by individuals with whom the student comes into contact. These mutual obligations should be reflected in agreements (for example, affiliation agreements) at the institutional or departmental levels.

It is expected that each medical school should define the professional attributes it wishes students to develop in the context of the school's mission and the community in which it operates. Examples of professional attributes could come from such resources as the American Board of Internal Medicine Project Professionalism, or the AAMC Medical School Objectives Project. Such attributes should also be promulgated among the faculty and staff associated with the school, with suitable mechanisms available to identify and promptly correct recurring violations of professional standards. As part of their formal training, students should learn the importance of demonstrating the attributes (attitudes, behavior, professional identity) of a professional and understand the balance of privileges and obligations that the public and the profession expect of a medical doctor.

In addition to defining the attributes of professionalism expected of the academic community, the school and its faculty, staff, students, and residents should regularly assess the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct, and develop appropriate strategies to enhance the positive and mitigate the negative influences.

C. SUMMARY REPORT:

Summary of Findings:

Based on our findings regarding current training, assessments and other procedures related to professionalism development, the committee believes that BUSM is in compliance with LCME standards (MS-31-A). However, we also believe that further improvements can be made to enhance the outcome for our students.

The committee has found that the school is currently providing multiple opportunities for students to learn and develop high standards of medical professionalism. These are provided through curricular and extracurricular components which were all recognized by the committee as being of high quality and value. Assessments of student professional behavior are obtained, where appropriate, across the curriculum. In classroom courses, assessments are made where attendance is required and small group sizes permit ready identification of the behaviors of all students (e.g. Gross Anatomy and IP-I and II). Particular emphasis on professionalism assessment exists in all areas involving patient interactions, ICM I and II (appendix C) and in the clerkships (PTRIME assessment – appendix D). These assessments are both formative and summative. Satisfactory performance in this area is required for completion of all clerkships.

Course directors, clerkship directors, the Office of Student Affairs, the Student Evaluations and Promotions committee and the Medical Education committee take any issues of non-compliance in the area of professionalism very seriously. However, the committee feels that mechanisms for monitoring assessments of professionalism in a uniform, longitudinal manner should be improved and that simpler procedures for reporting and responding to specific instances of non-compliance should be implemented.

Summary of Recommendations

The committee has made recommendations on how to further promote the development of the highest professional standards in graduates of BUSM, across all phases of student medical education.

- **Documentation of standards and expectations:**
  - The committee recommends that the school adopt the document "Medical Professionalism in the New Millennium: A Physician Charter" (see appendix A) as the basis for defining medical professional responsibilities.
  - The committee also recommends that the school develop a document paralleling the "Code of Ethics" recently drawn up at BUSDM (see appendix B), to make clear the expectations of day-to-day "professional" behavior by of all members of the BUSM

community. This would establish an environment in which a new "hidden curriculum" could contribute to a **virtuous** cycle in student and resident training.

- **Hidden Curriculum**

To further emphasize the value placed by the BUSM on professionalism, we suggest that professionalism assessments for all faculty and staff be included in their annual reports. Assessment tools are currently being implemented to provide students with the means to assess teaching faculty and residents, including their professionalism. Tools and reporting mechanisms will need to be developed for assessment of professionalism among all faculty and staff (using input from peers, colleagues, advisors, chairs or other supervisors, and, where appropriate, trainees). These assessments should be linked to criteria established in the "Code of Ethics" proposed above. Measures of professionalism should also be included in all future hiring and promotions recommendations considered by the school.

- **Admissions:**

We recommend the inclusion of specific sample "professionalism scenario" questions as part of the interview process, to help improve our selectivity for those students likely to achieve the highest standards in this area (Kleshinski et al, 2008).

- **Centralized oversight:**

We propose the establishment of a new centralized entity, clearly identified with the issue of professionalism and having "standing" in the school. In part, this entity will work with course directors and clerkship directors to help coordinate the presentation of material specifically in the area of professionalism to students in a more cohesive manner across the curriculum. Additional possible roles for this entity are also suggested (see Full Report).

- **Extra-curricular:**

  - The student body should be encouraged, and receive support, to promote and expand their existing Professionalism Interest Group.

  - Student participation in existing extra-curricular opportunities in professional development and service learning should be strongly encouraged. At a minimum, students should be expected to participate in such activities where it does not conflict with academic demands (e.g. Summer at end of year I).

  - Additional seminars or other events in which professional behaviors are discussed and promoted should be provided in the school, and student attendance strongly encouraged.

- **Recommendations for specific additions or changes to the curriculum:**

  Preclerkship years.

  - Introductory presentation on Professionalism (by name), to follow orientation, giving an overview of professionalism training and expectations in the program, but having particular focus on issues of professionalism of immediate relevance to matriculating students.
  - Course directors should review tenets of professionalism with the students during orientation sessions.
  - Professionalism-related "scenarios" should be included within IP cases across the first two years, for discussion by students.
  - Students should be required to write short (e.g. 1 page), ungraded self-reflection pieces on professionalism-related issues on a semester by semester basis. We recommend that Academies Advisors be asked to review and discuss the reflections written by their advisees and to confirm that the requirement has been met.

  Clerkship years

  - Clerkship orientation sessions should be modified and coordinated to include cohesive, explicit teaching on professionalism, while identifying any additional expectations of each clinical discipline in this regard.
  - Longitudinal series (ICM3) This would be a seminar-type series in small groups with no more than 10 students (ideal 7-8 of the same students) with same faculty which would meet for two hours in the afternoon 3-5PM once during each rotation. All students would be required to attend (unless they were more than 30 miles from campus).
    - Cases/discussions
    - Readings (ethical cultural, psychosocial)
    - Reflective writings using the critical incident narrative format
  - Grand rounds with specific emphasis on professionalism
  - Professionalism-oriented OSCE
  - Development of 360 degree assessments in the clerkships (see below).

- **Student assessment, monitoring and reporting**

  - The assessment tool used in IP and ICM courses should be updated, including use of clearer "outcomes-based" terminology.
  - Uniformity in the use of the PTRIME assessment tool in the clerkships is to be encouraged. While recognizing the technical and administrative difficulties associated

with implementation, the committee also encourages the development and use of 360° assessment tools [*] in the clerkships.

- All assessment tools should provide for data accrual and longitudinal monitoring of professionalism development, as students progress through the program.
- We recommend the development of a simple mechanism for reporting professionalism infractions by specific individuals. Reports should be reviewed promptly by a small faculty and student committee and referred to an appropriate authority for response. Responses should be graded, depending on the severity of the infraction, and where possible aimed at remediation rather than punishment. Where appropriate, censure should be decided by the SEPC in conjunction with OSA, in accordance with relevant policies.
- As a counterpoint to remediation and censure for non-compliance, the committee also recommends that the same reporting mechanism (above) be used to contribute to identifying individuals who manifest outstanding performance in the area of professionalism in consideration for awards for high standards of professionalism.

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[*] **360-Degree assessment**
A method used to assess interpersonal and communication skills, professional behaviors, and some aspects of patient care and systems-based practice. Usually, evaluators completing rating forms in a 360-degree evaluation are superiors, peers, subordinates, and patients and their families. Most 360-degree evaluation processes use a surveyor questionnaire to gather information about an individual's performance on several topics, such as teamwork, communication, management skills, and decision-making. Most 360-degree evaluations use rating scales to assess how frequently a behavior is performed. The ratings are summarized for all evaluators by topic and also overall to provide feedback. Such feedback is more accurate when the evaluation is intended to give formative feedback rather than summative. Reproducible results are easily obtained when several evaluators rate examinees; a greater number of faculty and patients are needed for a greater degree of reliability. http://www.iime.org/glossary.htm

D FULL REPORT

Findings on current training of students

- Overview:

The committee reviewed all aspects of current training and assessment of students in the area of professionalism at BUSM, engaging in discussions with course directors and other relevant individuals in the school and obtaining summaries of professionalism training and assessment from clerkship directors. Discussions were also held with Gail March (OME), who generously helped guide us in identifying relevant material in the BUSM curriculum database and showed us how to use available database searching tools, Peter Shaw provided insights into current assessment tools and possibilities for further development in this area. We also held meetings with individuals directing or contributing to related extracurricular activities, including the Academies of Advisors (Phyllis Carr), Student-Run Professionalism Interest Group (Hilal Abuzahra) and the ATM Committee (Doug Hughes).

The committee identified many important means by which the school is currently promulgating the importance of professionalism to our students and providing training. During our review, all of the existing individual training components received high praise by the committee membership.

In their very first days at BUSM, students receive a laminated document from the Office of Student Affairs outlining professional expectations (appendix F). The subject appears repeatedly throughout the curriculum: in didactic settings in Anatomy, HBM, EPH, IP, ICM, DRx and the clerkships, and is included in formative and summative assessments of students in ICM and IP and in the clerkships. It is also a focus of the activities of the Academies of Advisors during all years. Outlines of these various current components are provided below, although full descriptions are not included in the interests of limiting the length of this report.

Conversations with students on the committee, and with others, indicate that while they recognize and value the training provided, they feel the current approach is somewhat fragmented, with the subject appearing under many different headings, resulting in some confusion and loss of focus, and sometimes ambiguity. We believe that there are opportunities to enhance cohesiveness in the way professionalism is presented in the curriculum in general and especially during clerkship orientations. Longitudinal integration of the material presented, across the program, with appropriate emphasis on the stage of development of the student in the program, should also be improved.

Contributions of the “hidden curriculum” to student training is a significant focus of the MEC, which has recently adopted a teacher-student compact, based on AAMC guidelines, encompassing some of the important concerns in this area (see appendix E). Assessments of

teaching faculty, including measures of professionalism, are also currently being implemented. However, we believe the hidden curriculum needs to be addressed in an open and systematic manner throughout the school, engaging all faculty, staff and students in a dialog to recognize and respond to the issue. Proposals are made below, under “Recommendations” in this regard.

❖ Current training in preclerkship years

- Orientation

During orientation for matriculating students, OSA provides each with a laminated definition of professionalism (Appendix F).

The White Coat Ceremony aims to mark the student's transition into medical school. The Hippocratic Oath is read, family and friends are invited and many students now consider it a rite of passage in the journey toward caring for patients.

- Curriculum

We have identified aspects of professionalism training in the following course components, although recognize that this may not be an exhaustive listing.

  - Gross Anatomy

The Department of Anatomy and Neurobiology manages the gross anatomy course during first semester of the first year of the medical curriculum. The anatomy faculty considers the course an excellent opportunity to help introduce students to medical professionalism. The course begins with, “Human Anatomy: Becoming a Doctor, the Process of Professionalism”, a session comprising: a dialogue about students' expectations; video of a donor discussing her decision to donate her body to our program; and a lecture on the professional, ethical, philosophical, religious, and spiritual dimensions of human dissection. The experience of cadaveric dissection in particular provides a setting to pursue several important developmental goals for future physicians. Work in the lab requires teamwork and communication skills that help transition students from competitors into colleagues. Dissection provides an opportunity to practice respect for others by how students treat the bodies of the donors. Time is made for moral reflection on death and human suffering. Students experience the social contract of medicine by hosting a memorial service for the families of the donors at the conclusion of their first year. Finally, an ongoing research project measuring change in professionalism attitudes among students is carried out to monitor if the course is having a positive impact on the professional development of our students. BUSM is an emerging leader in promoting professionalism within anatomical education (Pearson and Hoagland, 2009).

  - Human Behavior in Medicine

Includes material in which the following areas are presented:

Medical Student Mental Health: Physicians' suicide and alcohol and/or drug abuse, physician/medical clinicians and stalking, sexual harassment during training, risk factors for medical student and physician divorce,

Professionalism: The elements of professionalism, the forces that work to inhibit professional behavior, methods to combat unprofessional behavior, differentiating between open and closed questions and when to use them in a patient interview, the limits of confidentiality in reference to health law, differentiating healthy skepticism from insidious cynicism, how attitude is a part of professionalism and how a physician's cynical attitude can adversely affect his or her success and career development

Ethical & Legal Issues in Medicine: legal definitions of medical malpractice, including damages, dereliction, duty, tort, compensatory damages, and punitive/exemplary damages, the responsibilities for physicians reporting impaired physicians, legal competence as it relates to emancipated minors, involuntary hospitalization, criminal law, and how questions of competence are resolved, the components of informed consent, the law as it relates to the treatment of minors, including exceptions to parental consent requirements

In addition, a number of the lectures discuss how to address particular scenarios in a professional manner, e.g Care of the Homeless Patient, how to be professional and respectful with this demographic when providing treatment and how to ascertain whether a patient is homeless, Culture & Illness, how to be culturally competent and understanding when working with patients from other cultures.

- Essentials of public health

Learning objectives include:

- Recognize what constitutes a moral dilemma in medicine and public health.
- Define and distinguish ethics, law, religion, and human rights approaches to resolving dilemmas in medicine.
- Develop substantive principles and procedural approaches to resolving moral dilemmas in medicine.
- Explain the inextricable link between health and human rights.
- Recognize the importance of socioeconomic status and education for the health status of populations.
- Be familiar with the Universal Declaration of Human Rights, the Covenant on Civil and Political Rights, and the Covenant on Economic, Social, and Cultural Rights.

- ICM I and II

Aspects of Professionalism exist in all parts of the ICM-I curriculum.   Students learn interviewing and physical exam skills, and professionalism is addressed in the core curriculum as well as in the clinical work students do in terms of issues with patient care, privacy and personal comportment with regards to the student's personal interactions with peers, faculty, staff, standardized patients and patients in practice. Students are evaluated on this by their Small Group Facilitator, their Site Mentor and by a standardized patient in their End of First Year Assessment (OSCE Exam).

In the ICM-2 course students are oriented to their role as students, including: completing the preparatory assignment before class, keeping diagnostic kit charged at all times, bringing diagnostic equipment to sessions as directed, as in the third year clerkships, attending all sessions (i.e. mandatory).

The following professional behaviors are specifically enforced: timeliness, dressing appropriately for the setting, and showing respect for patients as well as staff and other students. In addition, students are expected to begin the process of self-directed learning and self-assessment and are asked to identify clinical skills in which one could improve and address them (by reading, reviewing on-line materials such as the ICM Web Page, addressing with instructor, or practicing with a friend)

Evaluations are completed at three nodal points in the course, and all students are evaluated on professionalism by this standard measure. In addition, students who fall short of the mark are identified to the course director, who meets with individually with them to review and reorient.

- IP

Learning objectives include **:** Acting in a manner respectful of their team, including arriving promptly, prepared, and treating their group members.

Facilitators assess professionalism behavior by students in the IP sessions as part of their evaluation of student performance.

- DRx

Expectations of professional behavior are referred to several times in the DRx "overall" syllabus, including specific reference to, and examples of, appropriate and inappropriate responses in course assessment

In the Foundations Module students attend a lecture by David Coleman and a panel discussion that address issues regarding conflict of interest. The current policy at BUSM/BMC on interactions with representatives of the pharmaceutical industry is specifically addressed. Faculty members throughout the DRx course include financial disclosures in their presentations, which exemplifies appropriate professional conduct.

The health law section of DRx discusses legal responsibility and professional standards of care, board of registration, licensure, violations of professional standards, beginning and end of life, and fiduciary nature of the doctor / patient relationship.

In the ID Module there are 2 2-hour small-group, case-based sessions in which students work in teams of 2-4 to complete short-answers on the cases. The LO's and goals for these sessions include specific examples of professional behavior.

In the second Year DRx 6 course, during the Oncology block, Dr. Doug Hughes and Dr. Ariel Hirsch conduct a live interview with a cancer patient and the students are encouraged to ask the patient questions regarding patient-doctor interaction.

❖ Current training in clerkship years

We conducted an analysis of the formal clerkship curriculum at BUSM by contacting the Course Directors of each of the core clerkships. The following is the summary of where professionalism is discussed in each of the clerkships. While there is some overlap, there lacks a cohesive, recapitulated professionalism content and as a result, students report significant confusion on these issues.

- Pediatrics (Colin Sox)
    - Humanism Seminar/Reflective Practice (Ben Siegel)
    - Professionalism Review during orientation
    - Required simulated patient session on confidentiality in adolescent health core conference (students role play adolescent and parent)

- Psychiatry (Doug Hughes)
    - Professionalism Review during orientation
    - Formal component of mid-rotation and final evaluations

- Ob/Gyn (Jodi Abbott)
    - Orientation includes altruism, reliability and responsibility
    - Values clarification workshop
    - Team building workshop – review appropriate team communication
    - Operating Room protocols/scrubbing workshop
    - Patient communication in the pelvic exam workshop
    - Lecture on refugee health (cultural competence)
    - Lecture on substance abuse in pregnancy (compassion with difficult patients)

- Ambulatory Care (Suzy Sarfaty)
    - Orientation: attendance, behavior

- Reinforced: patient interaction and interviews
- Communication Skills workshop (dealing with problematic encounters, ways to deal with difficult patients by staying professional, ways to interact in the medical hierarchy)

- Internal Medicine (Warren Hershman)
  - Discussed extensively at orientation
  - Reinforced at mid-clerkship feedback
  - Mandatory reflection exercise (student-driven discussion based on clinical experiences)
  - Discussed in student report sessions

- Geriatrics (Lisa Norton)
  - Reviewed at orientation
  - Reviewed at the time of home visits
  - "End of Life" series respect for patients' values
  - Elder abuse lecture
  - Health literacy discussion – effective patient communication

- Surgery (Erica Brotschi)
  - Surgical staff models professional behavior
  - Syllabus covers seven problem-based chapters on professionalism: physician-patient communication, physician-patient relationship, responsibilities to patients, loss of empathy, ethics and financial conflict of interest, medical student role, withdrawing/withholding treatment including lectures by James Petros

- Family Medicine (Miriam Hoffman)
  - Orientation, mid and final evaluations
  - Core curriculum: burnout, idealism and patient non-compliance
  - Standardized patient work on doctor-patient communication
  - Small group case discussions and role play

- Neurology (Anna Hohler)
  - Orientation, mid and final evaluations
  - Weekly case presentations
  - Professionalism handouts on the neurology "Blackboard" site

- Radiology (Johanne Dillon)

  - Orientation includes patient communication, altruism, responsibility, reliability, attendance, and punctuality.
  - Professionalism discussed and reinforced at mid-rotation feedback where it is a formal component. Also a component of final evaluation.

❖ Current Free time electives

- The Healer's Art elective is offered at BUSM Winter/Spring 2011 (Robert Saper/Eileen Pierce)

The Healer's Art course addresses the human dimension of becoming a physician. Major themes of the course include:

- Sustaining idealism and altruism
- Medicine as a calling to serve others
- Learning how to grieve and heal loss
- Preventing medical student stress and burnout
- Cultivating compassion and listening skills

- Spectrum of Physician's Advocacy (**run by 2nd year students 2011**, see http://www.bumc.bu.edu/enrichment/fte/)

This elective offers a broad overview of the many roles of the physician as an advocate and focuses on conveying an understanding of the social context of disease along with connecting students to opportunities for further development of advocacy/health services research skills. This course was developed and is largely organized by medical students. Topics to be covered include:

- the social determinants of health,
- direct advocacy in patient care,
- working with communities to implement effective health interventions,
- translating community and public health concerns into good health policy,
- methods/opportunities to address global health inequities.

❖ Current Extracurricular activities (parentheses show name of discussant or correspondent to VIG)

- Student-Run Professionalism Interest Group (Hilal Abuzahra)

This interest group, launched by students in 2008, conducts events in order to discuss professionalism. By example, a discussion was held on professionalism pitfalls in the 3rd year and four topics were discussed specifically: (a) dealing with peers, (b) dealing with superiors, (c) dealing with intimidation/questioning, and (d) dealing with death/dying.

- Appropriate Treatment in Medicine (ATM) Committee (Doug Hughes)

The ATM Committee works to assure that the environment for learning is the best it can be for medical students and to assure that medical students have the opportunity to learn in an environment that is maximally supportive, collegial, non-threatening, and conducive to academic pursuits. The ATM provides a mechanism for students to report inappropriate treatment and, where appropriate, for suitable action to be taken to resolve any such problem.

- Office of Medical Education (Gail March)

The Office of Medical Education (OME) is responsible for the evaluation of the four-year curriculum at the School of Medicine, and for working with faculty and students to improve all course offerings. The Office also directs the Integrated Problems course in first and second year (Karen Kelly – course director) and the Introduction to Clinical Medicine course in the first and second year (Nannette Harvey and Lorraine Stanfield – course directors). This Office also coordinates campus-wide education programming on all topics including Professionalism.

- Academies of Advisors (Phyllis Carr)

The Academies of Advisors is an innovative advising, mentoring, and career development program at BUSM. Created in the spring of 2003, the Academies is organized by the Office of Student Affairs and was designed to improve the advising and mentoring of our students through ongoing guidance and support from experienced faculty members, educators, and role models of professionalism. The ultimate goal of the Academies is to support students, promote professional, ethical, and humanitarian values and for the students to develop meaningful and collegial relationships with their advisors. During all years of the program large and small group meetings of the Academies of Advisors, are used at intervals to promulgate professionalism in various ways, including review of relevant publications and discussions on pertinent subject materials.

- Service activities (John Polk, Ana Bediako – OSA/Office of Enrichment)

BUSM provides multiple opportunities for students to engage in non-curricular activities promoting humanistic values, including many service opportunities coordinated through the Office of Enrichment. Examples include the The Outreach Van Project and the CCHERS Program (see others at http://www.bumc.bu.edu/busm-osa/servicelearning/).

Recommendations

" The good news is that everything need not change at once and that starting anywhere, within any niche of institutional activity, has the potential to lead on to change elsewhere in the complex and highly interconnected organizational ecology of the academic health center, so long

as the organizational leadership is attentive and facilitating this change from the top. " - **Inui, 2003**

❖ Proposed documentation of standards and expectations

- **Medical professionalism**

The committee considered many sources for a "definition" of professionalism (e.g Swick 2000, Epstein and Hundert 2002, Wagner et al 2007, Passi 2010). These considerations resulted in the recommendation that we adopt "Medical Professionalism in the new millennium, a physician's charter" as a guiding document for expectations of medical professionalism (Appendix A). This is a project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine (ABIM, 2002).

Despite limitations (e.g. Reiser and Banner, 2003), this is probably the most widely accepted working "definition" of Medical Professionalism. We believe that our students should have a full understanding of this document soon after they arrive at medical school. However, this document is targeted to the physician. During their training, and especially in the PreClerkship years, where there is relatively little patient contact, we believe the students need additional guidelines translating the charter in terms of issues appropriate for their current experience. These issues need to be addressed early to the students, and to be reinforced and added to over time, to ensure relevant concepts are addressed as they progress. Literature suggests that early inculcation with the principles of professionalism and repetition provide for improved outcomes in graduates. Recommendations below address these issues.

- **BUSM Professionalism guidelines**

"Under present circumstances, students become cynical about the profession of medicine - indeed, may see cynicism as intrinsic to medicine - because they see us 'say one thing and do another.' Additional courses on 'medical professionalism' are unlikely to fundamentally alter this regrettable circumstance. Instead, we will actually have to change our behaviors, our institutions, and ourselves." – **Inui 2003**

"In our academic medical centers, this means providing an environment that is consistently and clearly professional not only in medical school but throughout the entire system of care." –

Stern and Papadakis, 2006

To help address the issue of the "hidden curriculum" we recommend that the school develop a document paralleling the "Code of Ethics" recently drawn up by BUSDM to spell out expectations of all members of the BUSM community in terms such as respect, truth, responsibility, fairness and compassion. It is important that the subject of professionalism be demonstrated to be a high priority for BUSM by raising the "profile" of the subject across our entire community. Also to this end, assessments of all faculty and staff in the area of professionalism are proposed (see below).

Given that many of the individuals modeling professionalism to our students are not solely affiliated with the School of Medicine, we also need to engage in a dialogue on this subject with Boston Medical Center's Chief Executive Officer (Kate Walsh) the Vice President of Nursing (Lisa O'Connor), the Chief Medical Officer (Ravin Davidoff), the Director of Graduate Medical Education (Maxine Kessler) and all residency program directors, to discuss ways in which we may ensure that house officers and staff are appropriately trained, mentored and assessed in modeling the highest professional standards.

❖ Tackling the hidden curriculum

The committee recognizes that the great majority of the faculty, residents and staff at BUSM work to the highest standards of professionalism. However, we also recognize that cases exist of occasional and sometimes repeated non-compliance among members of our community. In the interest of our trainees, current and future patients, and the BUSM community as a whole, we need to ensure the highest standards are maintained. To this end, the proposed "Professionalism guidelines" (above) should be supported by adequate training to provide for the development and modeling of professional behavior by faculty, residents and staff. Mechanisms should also be implemented to ensure that this behavior is assessed. Non-compliant individuals must be identified and, where possible, remediation provided, or censure applied. While representing a technical and administrative challenge, we encourage the development of 360 degree evaluations that will permit assessment of, and by, all parties concerned in student training and not just of the students (e.g. Rees and Shepherd, 2006, Mueller, 2007, Berk, 2009). Implementation of changes of this kind would require significant dialog with all concerned at BUSM, BUMC and off-campus sites, to ensure "buy-in" and participation. The central "professionalism" entity, discussed above, could be developed to provide for training in use of these tools. Where needed, non-compliance

could be identified to this central agency through an on-line reporting mechanism and, if deemed appropriate, remediation or censure suggested to the appropriate faculty or staff supervisor.

To provide further emphasis on the value placed by the school on professionalism, we suggest that such professionalism assessments be extended to all faculty and staff, and that the results be included in annual reports. Proposals have been made to develop peer assessment tools for teaching faculty. Tools and reporting mechanisms would need to be developed for assessment of all faculty and staff by peers, colleagues, supervisors or chairs, and where appropriate trainees (e.g. Berk, 2009). Measures of professionalism should also be included in all future hiring and promotions recommendations considered by the school.

❖ Admissions

We recognize the excellent work of our admissions office in screening the many applicants to BUSM, and the difficulty of accurately identifying professionalism traits in a population of students who are primed with "best behavior" responses. However, based on information in the literature, we recommend that the admissions office include questions on standardized professionalism scenarios during the admissions interview (Kleshinski et al 2008). Responses to these questions can be used to help supplement current procedures for characterizing student attitudes in this area and to help refine acceptance criteria in the area of professionalism. [Eva et al (2004) have developed an apparently successful "admissions OSCE" involving a "multiple mini-interview" with assessment under a number of scenarios. However, we are concerned that this may be excessively cumbersome and demanding for the admissions office to administer.]

❖ Centralized oversight of professionalism training

The committee proposes the establishment of a central entity to be responsible for working with course and clerkship directors to help coordinate the presentation of material specifically in the area of professionalism to students in a more cohesive manner across the curriculum. This entity would also work to ensure a longitudinally integrated progression of development in professionalism, as the students proceed through the program, oversee the proposed changes to the curriculum, coordinate related educational activities and monitor student assessments to identify problems with training or assessment tools and to recommend improvements.

This entity could also serve to help enforce professionalism standards. Course directors report confusion over mechanisms for reporting specific instances of non-compliance in the area of professionalism. An institutional Disciplinary Code exists with procedures and mechanisms defined for dealing with academic and professional misconduct (http://www.bumc.bu.edu/busm-osa/files/2009/04/final-revised-disciplinary-code-october-7-03.pdf). However, there is a need for a simpler reporting mechanism, which can be used by faculty, and where appropriate by relevant

staff, to give notice of unprofessional behaviors by students that may not rise to the level of misconduct described in the Disciplinary Code. We suggest that such specific instances of non-compliance should be reported using a novel on-line reporting mechanism. The proposed "professionalism entity" could be charged with reviewing these reports through a small faculty and student review committee, and making recommendations for action to the OSA and SPEC. We envisage the "entity" also having the capacity to provide for remediation services in this area though self-reflection work and other methods, in response to recommendations from OSA and SPEC. Levels of severity of behavioral problems and their consequences would need to be established and clear guidelines set. Some institutions have set low thresholds for "flagging", with all events noted in the student's record but no long-term consequences for single incidents and increasing consequences with additional occurrences. Some have established more stringent thresholds including a "3 strikes and out" policy (e.g. see Basnight et al 2008).

Included in the category of "professionalism infraction" are inappropriate student responses to course evaluations. Instances of unprofessional comments by students in course evaluations occur each year. Students should be given clear guidelines on what is and is not acceptable comment. The school should develop a mechanism whereby the anonymity of respondents in evaluations can be over-ridden in rare instances, to identify anyone showing gross non-compliance. The guidelines for this process should be clear to students. Instances of apparent unprofessional responses could be dealt with by reports referred to the central professionalism review committee (faculty and students). If deemed appropriate, the identity of the respondent could be determined and appropriate action taken in accordance with relevant policies.

The same reporting system used for non-compliance could also be used to help identify exceptionally positive behavior by students, to contribute to evaluations in making awards for professionalism. The creation of novel awards by the school specifically for students manifesting high standards of professionalism should be considered, in addition to the existing Leonard Tow Humanism in Medicine Award (http://www.humanism-in-medicine.org/index.php/programs_grants/awards/leonard_tow_humanism_in_medicine) or induction into the BUSM chapter of the Gold Humanism Honor Society (http://www.bumc.bu.edu/enrichment/gold-humanism-honor-society/) or AOA. (In the context of the perceived importance of professionalism, it is of note that the awarding of AOA honors includes assessment of professionalism, commitment to service, sense of ethics etc. in addition to academic performance. On occasion students with the highest ranked GPAs have not been elected to AOA for this reason (see http://www.alphaomegaalpha.org/how.html)).

[In the future, we hope the proposed central professionalism entity might also have a role in promoting opportunities in the area of professionalism-training for all members of the BUSM community: students, faculty, residents and staff (see below)].

- ## Extracurricular professional development opportunities

While many students do participate in available extracurricular professional development, we believe that there should be stronger encouragement for students to do so. Participation in these activities will promote professional attitudes. The value of participating in existing extra-curricular opportunities in professional development and service learning, and the means of accessing them should be emphasized to students repeatedly from the time of their matriculation. Even those students who need to devote all their time to their academic studies during the school year should be encouraged to use part of their summer between first and second year to participate in these activities.

❖ Proposed curricular changes for preclerkship years

- **Orientation in first year:**

A unique opportunity exists to reinforce professional behaviors in students during their first weeks at BUSM. These efforts can then be refined and supplemented during subsequent phases of their training. Many incoming students arrive with varying degrees of "undergraduate" behavior and some have difficulty transitioning to the behavior expected in a professional school. While mechanisms are currently in place to recognize the transition (e.g. White coat ceremony, reading of Hippocratic Oath) and to begin to guide professional development (e.g. components of Gross Anatomy and HBM, and the Academies of Advisors), we believe that the students should be given explicit guidelines on behavior expected of them immediately.

The current orientation week is very crowded with necessary introductions and formalities. Details of material presented during this time tend to become lost to the students. We suggest that after orientation is complete, a single required presentation be given to cover issues of Professionalism (identified by name in the title of the presentation). The presentation should set out professional expectations at BUSM, provide the students with a guideline on how this subject will be addressed in the curriculum, emphasize the importance placed on the subject in the school, and the consequences of non-compliance. This session would form a prelude to broader issues presented in the lectures in HBM and be the forerunner to repeated emphasis in the orientation sessions for each course.

Providing clear guidelines at the outset of the program will help prevent the appearance of undesirable behaviors. **Current first and second year course directors** have repeatedly expressed concerns about specific professionalism-related issues with some students. Based on these concerns, we suggest the orientation session could include considerations on:

Attendance: Members of the committee have had some disagreement as to whether attendance should be required of students during the large lecture courses of the PreClerkship years. Since our students are adult learners, it was generally felt that attendance at lectures should remain

strongly recommended but optional. In the case of guest lecturers or any instance where a patient is present, respect for guests or patients should then demand attendance. Course directors should also establish clear guidelines for acceptable late arrivals.

Cheating: This should be obvious, but should be spelled out in the context of the Honor Code and its requirements, and consequences.

Plagiarism: While this may be a subcategory of cheating, it warrants separate consideration given the prevalence of the practice (Cole, 2007), recently estimated to be evident in 5% of all residency essays at one local institution (Segal et al, 2010).

Course assessments: Students should understand that course assessments will be required of them throughout the program. These are generally anonymous and intended to provide for improving course quality over time. Students should be provided clear guidelines on what is and is not acceptable comment. (see also above, under “Centralized oversight”).

Respect: The student body is diverse, including many who are not in the MD program. Room and space shortages can put pressure on student interactions but, as always, disagreements need to be dealt with in a professional manner.

All staff of the institution should always be treated with respect. This includes, but is not limited to, staff in the Office of Student Affairs, the Registrar’s Office, Office of Student Financial Services and the Office of Medical Education. Inappropriate interactions with staff members may be reported and will have consequences (see above, under “Centralized oversight”).).

Social networking: Students need to be clear what is and is NOT appropriate on Facebook and other social network sites. There is a fast-growing literature regarding this phenomenon, discussing benefits and costs to social network usage in the context of medical professionalism, as well as case examples (e.g. Chretien et al 2009, Macdonald et al 2010, Chin, 2010, Farnan et al., 2008).

Email: Students should recognize that email is a major source of information flow in medical school and hence they **must** check bu email regularly, not allow mailboxes to become full, and respond promptly to all email from faculty and administrative staff.

- **Written self-reflection**

The use of self-reflection as a means of enhancing awareness and standards of professionalism is in widespread use (e.g. Niemi 1997, Novack 1999, Sobral 2000, Epstein and Hundert 2002). We recommend that students be required to write a short reflection piece each semester on a professionalism issue of immediate interest or concern to them. We propose that these reports be used to enhance the interactions of students with their Academies Advisors. A student would be required to meet with their Advisor to review their self-reflection each semester. The self reflections are not intended to be graded but the Advisor would deem whether an adequate effort has been made and report its completion.

- **Integrated problems**

Discussions with Dr Karen Kelly (course director for IP) suggest that it is appropriate to include specific scenarios, or components of cases, into IP that introduce issues of professionalism for discussion by students with their facilitators. These components could include, for instance, cases of inappropriate behavior by attending physicians, residents, staff or other students, situations associated with death and dying, or other ethically challenging situations that will encourage discussion and reflection on how to deal with such circumstances. We recommend that such case components be introduced into IP repeatedly across the preclinical years.

It is recognized that the addition of this issue to the IP curriculum may require appropriate faculty development for the facilitators.

- **Assessment (preclerkship)**

  - Student assessment

In 1997 faculty at BUSM identified key behaviors associated with medical professionalism and incorporated the assessment of these behaviors into a Supplemental Student Evaluation form for use in years 1 and 2. This document forms the basis for current assessment of professionalism of students in IP in years 1 and 2, and ICM I and ICM II. These assessments should be updated including the use of clear "outcomes-based" language. The results of these professionalism assessments (and that included as part of the ICM-I OSCE) need to be incorporated into a database with other professionalism assessments throughout the curriculum to permit longitudinal measures of development.

  - Teaching faculty assessment

Assessment of the teaching faculty by students in the preclinical years is currently under development and should include assessment of professionalism. Mechanisms for reporting these assessments need to be developed by the MEC (e.g. do reports go to course directors or departmental chairs?)

- ❖ **Proposed curricular changes for clerkship years**

As described above, the clerkship directors have identified specific instances where professionalism is instructed and discussed in each of the core clinical clerkships. We propose changes and additions to the existing syllabi in an effort to provide a more cohesive educational experience for our students with specific attention paid to content-specific and real-time professionalism education.

- <u>General Clinical Orientation:</u>

- Aimed at all third years with standardized professionalism expectations for all core clinical rotations.

- Clerkship-specific existing orientation sessions:
    - Sessions should be modified to include additional teaching on professionalism and the expectations of each clinical discipline in this regard.
    - Having course directors *specifically and formally* introduce tenets of professionalism to the students. Revisiting of professionalism discussions as students see patients.

- ICM – 3:
    - We recommend a horizontally integrated continuation of the Introduction to Clinical Medicine course throughout the third year and this proposal is outlined in detail in Appendix G.
    - This would include:
        - Longitudinal series, cases/discussions, readings (not necessarily medical), reflective writing, etc, and overseen by clinical faculty.
    - Also include: Cross-Cultural Integrative Medicine in order to promote culturally-grounded patient care.
- Formal didactic instruction on professionalism
    - Case-based or through readings, clerkship directors and/or other clinical faculty would be expected to provide didactics on professionalism.
- Medical center-wide grand rounds with specific emphasis on professionalism
    - As all would be invited, this would allow interaction between the students and the ancillary staff caring for patients at the Institution including nurses, social workers, nutritionists, etc.
- Professionalism-oriented OSCEs that would allow for situation-based discussion about professionalism issues
- Responsibilities of Department Chairs
    - Department chairs are expected to educate and monitor their clinical and teaching faculty as to the expectations of a more standard professionalism educational experience for the rotating students.
- Standardization of Professionalism Assessment

    - Clerkship assessments should be standardized with regard to professionalism evaluation so that students will know the exact objective measures for which we evaluate professionalism, rather than the current more subjective measurements used.
- 360 degree evaluations
    - Inclusion of assessment by non-physician staff including nursing, inpatient teams, etc, as well as patient and patient family evaluation of the student.

E. Committee membership

AbuZahra, Hilal	Student. BUSM III	
Calixte, Nahomy	Student. BUSM IV	
Carr, Phyllis, M.D.	Associate Dean	Office of Student Affairs
Head, James, Ph.D. (Co-chair)	Professor	Physiology & Biophysics
Hirsch, Ariel, M.D. (Co-chair)	Assistant Professor	Radiology/Oncology
Hughes, Douglas, M.D.	Associate Professor	Psychiatry
Joseph, Lija, M.D.	Associate Professor	Pathology & Laboratory Medicine
Kavanah, Maureen	Associate Professor	Surgery
Levine, Sharon, M.D.	Associate Dean	Office of Academic Affairs
Lowe, Robert, M.D.	Associate Professor	Medicine
Pearson, William	Teaching associate, Doctoral Student	Anatomy and Neurobiology
Schmutz, Mason	Student, BUSM III	
Siegel, Benjamin, M.D.	Professor	Pediatrics
Stillman, Michael, M.D.	Clinical Assistant Professor	Medicine
Watsjold, Bjorn	Student, BUSM II	

F. Appendices

Appendix A

MEDICAL PROFESSIONALISM IN THE NEW MILLENNIUM: A PHYSICIAN CHARTER

Preamble

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of the healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

Fundamental Principles

Principle of primacy of patient welfare. The principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate

prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the

educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

2004 ❧ ABIM FOUNDATION ❧ ACP FOUNDATION ❧ EUROPEAN FEDERATION OF INTERNAL MEDICINE

APPENDIX B.

BUSDM "Code of Ethics"

PDF attached separately.

APPENDIX C. – Assessment for IP/ICM

Boston University School of Medicine

Integrated Problems Student Evaluation

Student: Year: Fall 2009

CORE COMPETENCY	BEHAVIOR, ABILITY, OR SKILL	Outstanding	Appropriate	Cause for Concern	No Basis To Judge	Comments and Explanations (required for all boxes below)
Basic Science Knowledge and Use	1. Competent discussion of basic science information					
	2. Reference to relevant material in concurrent courses					
Problem Solving	3. Clear analysis of case					
	4. Development of hypotheses					
	5. Appropriate formulation of research questions					
	6. Organization of research					

	results					
	7. Summarization of results to advance the understanding of the case					
Effective Communication	8. Ability to communicate research results orally					
	9. Ability to discuss issues and question others constructively					
Self-directed Lifelong Learning	10. Enthusiasm for learning/ Scientific curiosity					
	11. Preparedness for assignments					
	12. Initiative in carrying out assignments					
	13. Participation in group assignments					

PLEASE TURN OVER.

Student: Year: Fall 2009

CORE COMPETENCY	BEHAVIOR, ABILITY, OR SKILL	Outstanding	Appropriate	Cause for Concern	No Basis To Judge	Comments and Explanations
Professionalism	14. Interaction with peers (respect/ patience/ teamwork/ leadership/ helping)					
	15. Interaction with faculty					
	16. Assumption of responsibility					
	17. General demeanor (temperament/ maturity / attitude)					
	18. Other (honesty and integrity/ morality)					

Self-knowledge	19. Ability to self-assess					
	20. Response to feedback					

21. Student's two strongest competencies:	22. Student's two areas for improvement:
1.	1.
2.	2.

23. Plans for improvement:
1.
2.

Faculty Signature (required):____ date: __________________

Student Signature (required) ____ date: __________________

APPENDIX D.- PTRIME assessment from clerkship

CLERKSHIP EVALUATION FORM

Boston University School of Medicine

Student Name:_____________________________ Dates: from ____________ to ____________

Site: ____

Evaluator Name:_________________________ Evaluator Level PGY ______ or Attending _____

COMMENTS (REQUIRED):

Please provide a narrative description of the student's performance. It is most helpful if you describe one or two specific events that illustrate the student's strengths and areas that need improvement. Please avoid global comments such as "very good student", which do not provide meaningful feedback to the student.

FORMATIVE COMMENTS: (not for inclusion in the Dean's Letter; this is designed to inform the student about areas on which to work/improve/change.)

CONCERNS NOTED: (not for inclusion in the Dean's Letter. If necessary, a separate letter may be sent.)

Using the following descriptions of student behavior, please check the one box that most accurately reflects your impression of the student's performance- i.e., the level at which the student is consistently performing. Qualities should be cumulative as the rating increases (as you move from right to the left), e.g., the highest rating for Reliable/Responsible assumes that the student also "Reliably and punctually fulfills assigned patient care responsibility but no more."

Professional/Humanistic Attributes and Behavior

1. Reliable/Responsible-Reliably and responsibly contributes to patient care.

□ **Seeks additional responsibility** beyond what is assigned.	□ **Takes initiative** to identify patient care issues/needs. Ensures appropriate transfer of patient care.	□ **Reliably and punctually** fulfills **assigned** patient care responsibility but no more.	□ Functions as **observer;** Does not assume patient care responsibilities.	□ Exhibits **lack of preparation, unexcused absences.**	□ Unable to assess.

2. Honesty and Integrity-Demonstrates honesty and integrity in all interactions.

□ Demonstrates an effort to **promote ethical behavior of the team.**	□ Demonstrates an **awareness of limitations** and **asks for help** appropriately.	□ **Accepts responsibility for error**; Appropriately **identifies position;** Maintains privacy, **confidentiality.**	□ Does **not consistently** exhibit **forthrightness.**	□ **Misinforms** others with respect to position, patient information or knowledge base.	□ Unable to assess.

3. Altruism and Advocacy- Interests of the patient are more influential in guiding behavior than the self-interest.

□ **Accepts inconvenience** to meet patients' needs; Outstanding **patient advocate.**	□ Works to **meet patients' needs.**	□ **Identifies patient's/family's needs;** Promotes the common good of the team above self.	□ Does not subordinate own **self-interests.**	□ Behaves in a manner that is **insensitive or inattentive** to patients' needs or feelings.	□ Unable to assess or not applica-ble.

4. Humanism- Builds therapeutic relationship through a respectful, empathic approach that gains trust of patient.

□ **Gains confidence and trust** of patient and family; Identified as preferred patient provider.	□ Demonstrates **empathic understanding of and responds to patient's predicament.**	□ Demonstrates **active listening and sensitivity to patient's concerns;** Communicates in a manner that patient understands.	□ Demonstrates **respect** through appearance and behaviors.	□ **Avoids patient** interactions; Behaves in **insensitive** manner.	□ Unable to assess or not applica-ble.

TEAM MEMBER/SYSTEMS

5. Develops productive, collaborative working relationships with members of the health care team and effectively contributes to the provision and improvement of quality patient care.

□ **Exhibits leadership skills** as a team member; **Manages complex systems** to provide and improve quality of patient care.	□ **Contributes to team decisions** to develop and implement management plans; Demonstrates knowledge of systems of care.	□ **Participates with team** to provide quality care by implementing team recommendations and working within the systems of care.	□ **Partakes minimally with team** and requires redirection form the team to ensure effective patient care.	□ **Demonstrates an inability to work with team** by failing to listen, to participate and/or to recognize the role of team-based medical practice.	□ Unable to assess or not applica-ble.

REPORTER

6. History/Interviewing Skills- Elicits an accurate, reliable history using appropriate technique.

□ Appropriately complements interview with **outside information resources.**	□ Exhibits appropriate **mix of facilitative, directive and clarifying behaviors**; Elicits appropriate **biopsychosocial** context.	□ **Identifies major issues**; Obtains accurate, chronologic **story** in appropriate detail.	□ Interviews in **unfocused** manner.	□ **Elicits inaccurate information** or **misses major issues.**	□ Unable to assess or not applica-ble.

7. Patient Examination Skills-Performs an appropriately focused, accurate physical exam.

□ Regularly elicits **subtle findings**.	□ Examines thoroughly and in appropriately **focused** manner.	□ Uses an **organized** approach; Identifies **major findings.** Sensitive to **patient comfort.**	□ **Misses major** findings.	□ Elicits findings that are **unreliable;** Demonstrates a **disorganized** approach or is **insensitive** to patient comfort.	□ Unable to assess or not applica-ble.

8. Write-ups and Progress Notes-Provides well-organized, accurate and comprehensive write-up that demonstrates reasoning.

□ Provides a complete **assessment and plan** that considers patient psychosocial context. .	□ Provides **coherent assessment** with pertinent **supporting information/rationale.**	□ Provides an **accurate, well-organized**, appropriately detailed, chronologic **story** and a complete **problem list.**	□**C**ommunicates in **disorganized** manner.	□ Provides **inaccurate** information or **misses major** issues.	□ Unable to assess or not applica-ble.

9. Oral Presentations-Delivers convincing and pertinent oral presentation that is appropriate for the setting.

□ Provides focused presentation that is **tailored to situation; Justifies** proposed assessment and plan of major problems.	□ Presents with **good flow** and minimal use of notes; **Omits non-pertinent** information.	□ **Speaks** with good eye contact; Provides well-organized description of present illness in appropriate detail.	□ Provides irrelevant data; **Rambles.**	□ Presents in **disorganized** manner or **misses major** issues or information.	□ Unable to assess or not applica-ble.

INTERPRETER

10. Analysis/Synthesis-Prioritizes problems and develops an appropriate patient-specific differential diagnosis.

□ Demonstrates **understanding of complex issues; Supports assessment** with scientific evidence; Integrates the **biopsychosocial model and ethical** issues into assessment.	□ Constructs a **prioritized problem list; Assesses severity** of illness; States patient care goal(s) and determines whether patient is progressing toward target outcome.	□ Provides reasonable **patient-specific differential diagnosis that is supported** by the data; Identifies and labels all **major problems** at appropriate level of specificity.	□ Provides **incomplete problem list or differential diagnosis;** Frequently reports data without analysis; Fails to recognize urgent problems.	□ **Does not provide** a problem list, differential diagnosis or interpretation of basic data.	□ Unable to assess or not applica-ble.

MANAGER

11. Management-Offers reasonable diagnostic and therapeutic plans supported by data and sound reasoning.

□ **Educates patient** regarding alternative diagnostic and therapeutic options, **benefits and risks; Negotiates** treatment plan with patient; Initiates response to urgent problems.	□ **Integrates new data, patient perspective and ethical dimensions** into care plan, and adjusts plans accordingly;	□ Offers **reasonable diagnostic & therapeutic options** for the major clinical issues; **Supports these options** with clinical and scientific data	□ **Inconsistently offers** reasonable diagnostic & therapeutic options; **Inconsistently supports** these options with clinical and scientific data.	□ **Does not participate** in clinical decisions concerning patients.	□ Unable to assess or not applica-ble.

12. Procedures-Performs procedures with appropriate technical proficiency, understanding of benefits/risks, and attention to patient needs and concerns.

□ Demonstrates **unusual proficiency** and skill.	□ Identifies **indications, contraindications and complications.**	□ Demonstrates **sensitivity to patient** safety, concerns, comfort; Shows **technical proficiency**.	□ Exhibits **poor preparation or technique.**	□ **Fails to try or improve** in the performance of basic procedures.	□ Unable to assess or not applica-ble.

EDUCATOR/SELF-DIRECTED LEARNER

13. Effectively identifies and addresses learning needs and productively shares this learning with colleagues.

□ Effectively **educates colleagues and patients**; Conducts self-assessment, seeks feedback and sets goals.	□ **Critically appraises** validity and applicability of **scientific evidence** to clinical problems.	□ **Identifies learning needs**; Reads regularly; Uses appropriate information resources; **Consistently improves** with feedback.	□ Demonstrates lack of or **inconsistent improvement** in knowledge/ skills.	□ **Does not read regularly** about patient issues.	□ Unable to assess or not applica-ble.

KNOWLEDGE

14. Medical Knowledge-Demonstrates a strong understanding of the relevant scientific information and concepts needed to provide patient care.

□ Demonstrates knowledge of the **current scientific literature.**	□ Demonstrates **strong, broad-based knowledge** base that enables student to understand issues beyond patients under his/her care.	□ **Exhibits knowledge** of the scientific information and concepts needed to provide patient care;	□ **Shows Major knowledge gap**s which require substantial teaching and impede ability to provide care.	□ **Demonstrates lack of knowledge** such that the student cannot function at the expected level in the clerkship.	□ Unable to assess.

15. Medical Knowledge-Demonstrates a strong understanding of the relevant ethical and socio-cultural information and concepts needed to provide patient care.

□Demonstrates knowledge of the **current literature.**	□ Demonstrates **strong, broad-based knowledge** base that enables student to understand issues beyond patients under his/her care.	□ **Exhibits knowledge** of the ethical and socio-cultural information needed to provide patient care.	□ **Shows Major knowledge gap**s which require substantial teaching and impede ability to provide care.	□ **Demonstrates lack of knowledge** such that the student cannot function at the expected level in the clerkship.	□ Unable to assess.

APPENDIX E.- Teacher-student compact (AAMC).

Compact Between Teachers and Learners of Medicine

Preparation for a career in medicine demands the acquisition of a large fund of knowledge and a host of special skills. It also demands the strengthening of those virtues that undergird the doctor/patient relationship and that sustain the profession of medicine as a moral enterprise. This Compact serves both as a pledge and as a reminder to teachers and learners that their conduct in fulfilling their mutual obligations is the medium through which the profession inculcates its ethical values.

Guiding Principles

DUTY Medical educators have a duty, not only to convey the knowledge and skills required for delivering the profession's contemporary standard of care, but also to inculcate the values and attitudes required for preserving the medical profession's social contract across generations.

INTEGRITY The learning environments conducive to conveying professional values must be suffused with integrity. Students learn enduring lessons of professionalism by observing and emulating role models who epitomize authentic professional values and attitudes.

RESPECT Fundamental to the ethic of medicine is respect for every individual. Mutual respect between learners, as novice members of the medical profession, and their teachers, as experienced and esteemed professionals, is essential for nurturing that ethic. Given the inherently hierarchical nature of the teacher/learner relationship, teachers have a special obligation to ensure that students and residents are always treated respectfully.

Commitments of Faculty

- We pledge our utmost effort to ensure that all components of the educational program for students and residents are of high quality.
- As mentors for our student and resident colleagues, we maintain high professional standards in all of our interactions with patients, colleagues, and staff.
- We respect all students and residents as individuals, without regard to gender, race, national origin, religion, or sexual orientation; we will not tolerate anyone who manifests disrespect or who expresses biased attitudes towards any student or resident.
- We pledge that students and residents will have sufficient time to fulfill personal and family obligations, to enjoy recreational activities, and to obtain adequate rest; we monitor and, when necessary, reduce the time required to fulfill educational objectives, including time required for "call" on clinical rotations, to ensure students' and residents' well being.
- In nurturing both the intellectual and the personal development of students and residents, we celebrate expressions of professional attitudes and behaviors, as well as achievement of academic excellence.
- We do not tolerate any abuse or exploitation of students or residents.
- We encourage any student or resident who experiences mistreatment or who witnesses unprofessional behavior to report the facts immediately to appropriate faculty or staff; we treat all such reports as confidential and do not tolerate reprisals or retaliations of any kind.

Commitments of Students and Residents

- We pledge our utmost effort to acquire the knowledge, skills, attitudes, and behaviors required to fulfill all educational objectives established by the faculty.
- We cherish the professional virtues of honesty, compassion, integrity, fidelity, and dependability.
- We pledge to respect all faculty members and all students and residents as individuals, without regard to gender, race, national origin, religion, or sexual orientation.
- As physicians in training, we embrace the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions with patients, colleagues, and staff.
- In fulfilling our own obligations as professionals, we pledge to assist our fellow students and residents in meeting their professional obligations, as well.

APPENDIX F.

Document provided by OSA to students at orientation

PROFESSIONALISM

Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity, and respect for others. It implies an ethical standard above the legal code.

ALTRUISM places the interested of others above our own self-interest. We generally think of this in regard to patients, but it also includes our colleagues and peers, and more generally, the interests of society.

ACCOUNTABILITY – We are accountable to society to meet the health needs of that society, as well as to individual patients and to adhere to medicine's time-honored ethical precepts. This also included helping colleagues meet their responsibilities. If one of your peers is having difficulty understanding course material, take the time to be of help. Teaching someone else generally cements the knowledge in your own mind – which is the silver lining.

EXCELLENCE entails a conscientious effort to exceed ordinary expectations and to make a commitment to life-long learning.

DUTY is the free acceptance of commitment to service, which entails being available and responsive to the needs of others. In a broader sense, it is volunteering one's skills and expertise for the welfare of the community.

HONOR and INTEGRITY are the consistent regard for the highest standards of behavior – being fair, truthful, meeting commitments, keeping one's word and being straightforward.

RESPECT for others, including peers, nurses, and staff in all of the various offices you deal with, such as the Registrar's Office, Office of Student Financial Services, and Office of Student Affairs. It is important to see every individual beyond their job – from the department secretary to the custodian – as a human being deserving of respect.

TIMELINESS – whether it is being on time for class or completing assignments when they are due

HUMANISTIC QUALITIES – Compassion, courtesy, and sensitivity to the needs of others.

Taken from "Project Professionalism" from the American Board of Internal Medicine

APPENDIX G ICM III

HUMANISTIC MEDICINE: THE PROFESSIONAL DEVELOPMENT OF THE PHYSICIAN BUSM III (or ICM III)

“One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring for the patient” Francis Weld Peabody 1881-1927

“ Only those who regard healing as the ultimate goal of their efforts can, therefore, be designated as physicians” Rudolph VIrchow 1821-1902

“Medicine is a social science in its very bone marrow…No physiologist or practitioner ought ever to forget that medicine unites in itself all knowledge of the laws which apply to the body and to the mind”

“A physician is obligated to consider more than a diseased organ, even more than the whole man - he must view the man in his world” Harvey Cushing 1869-1939

“It is our duty to remember at all times an anew that medicine is not a only a science, but also the art of letting our own individuality interact with the individuality of the patient” Albert Schweitzer 1875-1965

I Horizontal Integration

Goals and Leaning Objectives:

Goal: Through the process of interacting, in the third year, in small group seminars with experienced clinical faculty, the student will incorporate and integrate the human qualities of becoming an effective clinician by incorporating and expanding:

1. An ethical perspective and integration of ethics into the patient physician relationship
2. A cross cultural and integrative medicine perspective and integration of CCIM into the patient physician relationship.
3. A self-reflective capacity, enhancing one’s professional competencies as a humanistic physician to improve one’s sense of professionalism as a physician and to relate more fully in the patient-physician relationship.
4. The physician’s understanding of his/her responsibility to society

Leaning objectives: The student will:

1. Define the principles of ethics in the patient- physician relationship and demonstrate the competency to engage in ethical problem solving and appropriate management of ethical concerns that arise in that relationship.
2. Discuss the professional responsibilities of the physician in interaction with the health care system, the local community, society at large and professional organizations.
3. Integrate Cross Cultural and Integrative Medicine into all patient- physician relationships

4. Discuss the social, cultural, spiritual/religious, psychological and political issues of personal and institutional racism, sexism, power, and bias as they affect the physician-patient-family relationships.
5. Incorporate the skills of reflective practice: the use critical incidents and narrative medicine to explore one's personal, cognitive and affective perspective on the practice of medicine.

Structure of the seminars:

1. Groups of third year students (8 each) with **one or two** clinical faculty, meeting 9 times throughout the year for 2-2.5 hours in small group settings Ideally, the clinical faculty will be members of the Academy of Advisors and the specific group advisors if possible.
2. The use of cases, readings, discussion and refection
3. 9 seminars; timed as to not interfere with clerkship exams: I seminar for each of the 9 clerkships/electives will include:

    a. One hour to address ethics and cultural issues in cases developed by the committee in consultation with the clerkship directors
    b. One hour devoted to sharing and reflective discussions of critical incidents. All students will be expected to write 3 "critical incident report" during the year. These reports will be reviewed by the faculty who suggest sections of the readings required to be included in the discussion
    c. Discussion of selected readings
    d. A syllabus or readings that incorporate the learning objectives of the course (e.g. Ann Fadiman: The Spirit Catches You, You Fall Down, Anatolia Broyard: Intoxicated by My Illness. Atul Gawande: Complications, Jerome Groopman: How Doctors Think. and others)
    e. Opportunities to practice specific cultural or ethical skills (for example: using standardized patients to learn how to give bad news)
    f. Adherence by all participants to the principles of professionalism and confidentially in all discussions

4. Grading will be pass/fail with comments on professionalism and attendance will be required. This will be a separate course not connected to the clerkships.
    Administration

    a. The course will be administered through the OME
    b. The MEC will appoint a course director upon recommendation by the CCS.
    c. Faculty development and rewards will be designed.
    d. A course evaluation and criteria for evaluation of students will be designed
    e. An educational research agenda should be developed

G Literature and links

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