

# MONOGRAPH

## An Overview on Educating Future Physicians Concerning Professionalism

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### Introduction

Medical professionalism is currently a widely discussed topic within health professions training programs, teaching hospitals and physician specialty societies. In medical education circles, a host of organizations have issued statements on professionalism in the last five years<sup>1-5</sup>, with increasing calls for greater emphasis on this topic. There are several factors that appear to be “driving” this emphasis: increased scrutiny of the medical profession by society; publicized lapses in ethical judgment on the part of health care professionals; the patient safety movement; and increasing calls for a more centralized health care system that provides a minimum level of coverage for all Americans.<sup>6</sup> There is also limited evidence that poor professionalism by medical students is predictive of future problem behaviors regarding medical licensure and related issues.<sup>7-8</sup>

Additionally, the educational process for physicians has undergone a dramatic shift in the past decade. This shift is described as one that features more emphasis on an outcomes-oriented approach to both medical education and the continued certification of practicing physicians.<sup>9-10</sup> Early leadership in this regard was provided by the Accreditation Council for Graduate Medical Education (ACGME), the national accrediting organization for all residency training programs in the USA. The ACGME’s revision of accreditation standards to require curricula within a framework of “six general competencies” (patient care, medical knowledge, practice-based learning & improvement, interpersonal & communication skills, professionalism,

systems-based practice) was a major paradigm shift in residency training, and included much emphasis on professionalism.<sup>2</sup> This trend is also now reflected in accreditation standards for undergraduate medical education, along with a demand for formal education and assessment of professionalism and the learning environment for medical students.<sup>11</sup> A recent search of the Association of American Medical College (AAMC) national curriculum database (CurrMIT) revealed that 55 North American schools list “professionalism” as a component of training in their curricula for the 2006-2007 academic year. It is very likely that nearly all medical schools are addressing this topic in one way or another.

While much has been written on the topic of professionalism in medicine, it is our belief that there remains a lack of clarity about four issues arising from the continuing emphasis of this topic:

- 1) The definition of professionalism; what is the precise subject matter that should be taught to medical students and/or resident physicians in training?
- 2) The teaching of professionalism; how should this topic be taught, by what methods or processes?
- 3) The assessment of professionalism; how should we evaluate our learners to be assured that they have learned the material and, as a consequence, are behaving professionally?
- 4) The broader application of professionalism; what are the implications of this emphasis for academic health care institutions as a whole?

While a detailed examination of these four questions is beyond the scope of a single paper, we provide an overview

of these issues within this monograph so that medical educators may better understand the current emphasis on professionalism and further consider what role they should play in addressing them. Our institution recently appointed a multidisciplinary task force that worked for approximately a year on these issues, resulting in a plan of action for teaching and assessing medical professionalism across all levels of physician training within our medical center. Accordingly, this monograph will briefly address each of these four issues, explain the recommendations reached by our task force and subsequently endorsed by our school and, finally, outline our plan to implement this new program at our institution.

### *What is the Definition of Professionalism?*

“Our youth love luxury. They have bad manners, contempt for authority; they show disrespect for their elders and love chatter in place of exercise; they no longer rise when elders enter the room; they contradict their parents; chatter before company; gobble up their food and tyrannize their teachers”

*Socrates, 9<sup>th</sup> century B*

“The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine; or, to put it more bluntly, they are too ‘scientific’ and do not know how to take care of patients”.

*Sir Francis Peabody, noted English physician, 1927*

In whatever way we may choose to define the concept of medical professionalism, it seems likely that there has been controversy about what it means for quite some time! If medical schools and residency training programs are to be expected to teach and/or assess student professionalism, they must arrive at a “working definition” to guide their educational efforts.

Professionalism is a broad and multi-faceted construct in the current health professions education literature. Our review of the literature revealed far more information regarding how to define professionalism, compared with material concerning how it may be taught and assessed. The classic definition of professionalism consists of three separate but related concepts: an advanced level of training or expertise in a particular field, a commitment to service, and a high degree of autonomy in practice and self-regulation.

One of the most frequently cited definitions comes from the joint effort of three groups: the American College of Physicians, the American Board of Internal Medicine, and the European Federation of Internal Medicine. This group issued its “Charter on Medical Professionalism” in 2002, and defines professionalism using ten responsibilities (competency, honesty, patient confidentiality, appropriate

relationships with patients, improving care quality, improving access to care, just distribution of finite resources, commitment to scientific knowledge, maintaining trust by managing conflicts of interest and commitment to professional responsibilities) based on three broad principles (the primacy of patient welfare, patient autonomy and social justice). This document is mentioned in nearly all current references to professionalism, and is widely acknowledged to be influential due to its adoption by many physician groups. However, it has also been criticized as being too paternalistically-oriented.<sup>12</sup>

The ACGME,<sup>2</sup> through its Outcomes of Medical Education project, has defined professionalism as “a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population”. All resident physicians, regardless of specialty choice, are expected to be taught these principles; and, teaching faculty are expected to assess resident understanding and application of them in some manner. Each medical specialty, through its own Residency Review Committee, reviews the efforts made by residency programs to develop curricula in professionalism and offers advice about possible assessment methods.

The AAMC has also published a review document that examines the education of physician trainees on professionalism.<sup>1</sup> This document lists characteristics of professionalism as defined by the AAMC’s Medical School Objectives Project: physicians are expected to be knowledgeable (scientific method, biomedicine), skillful (clinical skills, reasoning, condition management, communications), altruistic (respect, compassion, ethical probity, honesty, avoidance of conflicts of interest) and dutiful (population health, advocacy and outreach to improve non-biologic determinants of health, prevention, information management, health systems management). The report references numerous efforts by a variety of other groups to define the core concepts of professionalism.

What about the accrediting body for medical schools, the Liaison Committee on Medical Education (LCME)? While past versions of LCME standards discussed this subject only indirectly, this approach is changing. Effective July 1 2008, a new LCME standard (MS-31A) will require that accredited schools “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”.<sup>11</sup> This new standard is discussed in its annotation section in greater detail. Schools are expected to “define the professional attributes it wishes students to develop in the context of the school’s mission and the community in which it operates”, and to ensure that these attributes are also “promulgated among the faculty and staff associated with the school”. The standard requires schools to “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”. Clearly, the LCME now expects medical schools to have a more formal approach to the

teaching and assessment of professionalism, and to actively monitor the learning environment as a whole.

At least one attempt to define professionalism involved a qualitative inquiry approach using carefully-constructed focus groups that gathered input from a variety of constituents about how professionalism should be taught and assessed.<sup>13</sup> This interesting study found common themes related to knowledge and technical skills, good relationships with patients and individual virtues; but also noted differences between constituent groups regarding how professionalism should be defined. The authors note that these differences “reflect the inherent challenges to teaching professionalism successfully”.

Indeed, even a casual examination of the various documents purporting to define professionalism reveals that these definitions have both commonality and differences. A major delineation in the literature pertains to whether the concept of medical professionalism should more narrowly focus on the physician-patient relationship or whether a broader definition should be used, including the concept of civic professionalism where, it is argued, physicians have a moral obligation for involvement in society.<sup>14</sup> This delineation turned out to be a key area of discussion for our task force.

The responsibility of medical educators to actively address the teaching and assessment of professionalism is well stated by one prominent author: “given that doctors hone their professional attitudes during their formative years as students and residents, medical educators have a critical role to play in ensuring that future doctors are prepared to fulfill their obligation to be trustworthy.”<sup>15</sup> Our task force was charged to form our own definition of professionalism for the purpose of determining how it should be taught and assessed at our school, not only because of the perceived importance of the issue within medical education but in anticipation of the new requirement from LCME. In addition to a review of the literature, we also reviewed policy-oriented documents from approximately 10-12 other medical schools to gain insight into how professionalism was defined elsewhere. For example, Menna and coworkers (2005) described efforts at one medical school to design and implement a new program whereby students are taught a set of professionalism expectations and evaluated across all four years on these criteria<sup>16</sup>.

We also reviewed several existing documents in use at our school, which were regarded to be relevant to defining professionalism. These documents included school-wide exit objectives adopted in 2000 concerning professional attributes of our students; policy and procedures taken from the faculty manual of our parent university (East Carolina University, or ECU) on academic integrity; a formal code of conduct for all employees of our parent university (ECU); a specific code of conduct for our medical school faculty; the student honor code for our medical school; and a code of ethical behavior promulgated by our primary affiliated teaching hospital, Pitt County Memorial Hospital (PCMH). Copies of these documents can be furnished upon request. All of these external and internal documents served as useful background and helped inform the eventual adoption of a

new medical school policy which explicitly defined “Teaching & Assessing Medical Professionalism”. This new policy defines eight core elements of medical professionalism as follows:

1. **Integrity & Trustworthiness:** displays honesty and forthrightness; adheres to ethical standards; truthful in all communications; maintains confidentiality; reports inappropriate behavior by colleagues.
2. **Compassion & Respect for Others:** considerate; cooperative; displays empathy; respectful of different socioeconomic backgrounds & cultural traditions; sensitive; respects authority.
3. **Teamwork & Professional Demeanor:** works well with others; maintains composure in difficult circumstances; inspires trust; avoids inappropriate remarks; adheres to local dress codes.
4. **Responsibility & Sense of Duty:** completes assigned duties; sets & achieves realistic goals; follows policies; responds promptly when called; detail-oriented; places patient needs first.
5. **Accountability & Initiative:** flexible; delegates effectively; accepts personal responsibility for mistakes; asks for help when needed; discloses medical error when appropriate.
6. **Scholarship & Commitment to Learning:** punctual; attends classes, clinics, other required events; seeks additional knowledge and skills; seeks feedback; willing to assist other learners; is self aware of areas for improvement.
7. **Concern for the Welfare of Patients:** treats patients & families with dignity; respects patient privacy & cultural values; maintains accurate information in patient records; advocates for patients.
8. **Self-Care & Self-Growth:** maintains personal health & hygiene; cares for self; seeks advice, counsel or tutoring when needed; avoids harmful behaviors.

The definition of professionalism reflected in this policy was based primarily on the fact that our school and our parent university were already “on the record” with official statements related to professionalism. While our task force did not think the more global, socially-oriented aspects of professionalism were unimportant, we decided to recommend a policy including a definition that focused more narrowly on the role of students within the learning process, and on the patient-physician relationship. We felt that such an approach was justified primarily by the fact that our charge was to relate professionalism to the teaching process within medical school and residency training. There was agreement among the task force members that emphasizing the role of the physician in larger society was not as germane to our immediate task (although we felt that such issues were adequately addressed within the formal curriculum of our medical school).

The resulting policy also requires professionalism to be “taught formally, emphasized informally and assessed by the faculty of the school”. In regard to assessment, the policy states that “all health professions trainees as well as teaching faculty should be assessed concerning medical

professionalism, within the guidelines and procedures of each specific training program and department”. Also, regarding teaching and assessment of medical students, the policy empowers the school’s Executive Curriculum Committee or an appointed sub-committee thereof to monitor all aspects of this program consistent with the school’s governance code.

In summary, our group spent much time examining the medical education literature and other sources to arrive at a definition of professionalism that we felt was workable for our institution, reflected key components identified by various groups, focused primarily on student roles and responsibilities for learning and patient care and avoided long debates about the various aspects of how to define such a broad construct. In so doing, we felt it likely that an observation from the AAMC report previously cited about the various descriptions found in the literature concerning professionalism was correct:

“All explications of professionalism then devolve into descriptions of the general qualities of a virtuous *person*, one who works in the field of medicine, and how such a virtuous person would act. While the processes of coming to these various descriptions of professionalism differ and may have had formative value in their respective organizational domains, in the end and at a deeper level, the final accounts are all the same”.<sup>1</sup>

What likely matters most is not so much whether all medical educators or practicing physicians agree on a precise definition of professionalism. Rather, we agreed that the concept itself must be addressed in a more explicit manner than we had previously accomplished in our curriculum and our institution; and that such emphasis has the potential for great benefit not only to our students, but to the entire academic medical center.

### ***How Should Professionalism Be Taught During Medical School?***

The literature on how professionalism should be taught to medical students and resident physicians is mostly descriptive and anecdotal in nature, likely due to the relative newness of this area of formal emphasis within medical education. Teaching professionalism involves both formal, planned curricular offerings and activities that fall into the category of the “hidden” or “informal” curriculum, where students learn from both positive and negative role models observed during teaching experiences. In particular, this informal teaching/role modeling is felt to be a powerful influence on student behavior and learning.

The present trend appears to be the provision of more formal, explicit teaching on professionalism by adding lectures and other activities to the first two years of the curriculum. Many medical schools, including ours, have courses involving clinical activities early in the curriculum and these courses provide obvious opportunities to address professionalism issues. However, for the most part, medical students spend the majority of their time in lectures during

years one and two. What can be done during basic science courses to address professionalism? In an excellent series of articles published in 2006 in the journal *Clinical Anatomy*, several basic scientists describe efforts made to address professionalism in a variety of ways. Activities discussed include team building, reflective exercises, preparation of a clinical anatomy chart and progress notes, peer teaching and review, commemorative services, and interaction with body donor relatives.<sup>17-18</sup> Several authors in this series argue powerfully for the lasting impact that early exposure to professional attitudes, behaviors and practices has on medical students in the “proto-professional” (or early in training) stage, with one author stating emphatically that “how students approach the cadaver, whether with respect, empathy and sensitivity, or with callous disregard, can predict their later approach to patients”.<sup>19</sup> We examined our four year medical student curriculum and discovered that we were addressing various aspects of professionalism in the following activities:

- During a required session as part of our *Personal & Professional Leadership* (PPL) experience for year one students. This experience is a series of structured meetings in small groups whereby students discuss a wide range of subjects and are prepared for the experience of medical school. Our group recommended expansion of this concept beyond the first year of medical school, with the hope of linking the experiences to both mentoring activities and preparation of some type of reflective exercise by students (e.g., portfolio).
- As part of the “white coat ceremony” experience wherein year one students take an oath of affirmation to the medical profession and receive their white coats. It was noted that some schools do not award the white coat until later in the curriculum (e.g., at the beginning of year three); or supplement the year one white coat ceremony with another ceremony when students begin core clinical training.
- During our year one and year two *Social & Ethical Issues in Medicine* courses. Students receive lectures and participate in case-based small group experiences focused on issues related to professionalism.
- During our year one *Doctoring* course. *Doctoring* is a longitudinal, two semester course that provides an introduction to the medical profession as well as biostatistics, training in standard interviewing and physical exam techniques.
- During our year two *Clinical Skills* course, an extension of the year one *Doctoring* course that delves further into special types of physical examination techniques and other clinical issues.
- During the orientation session for year three students (immediately prior to the beginning of the core clerkship year). Our group recommended a new panel presentation/discussion session on professionalism from the perspective of an attending physician, a nurse educator and our senior associate dean for academic affairs. We also recently added a session where year four students (i.e., those who just completed the core clerkship year) meet with the rising year three students

and reflect on their experiences and insights into how medical students make a valuable contribution to the clinical team.

- During our year four *Transition to Residency* course, where senior students spend two weeks revisiting key topics and learning about medico-legal issues as well as other residency-oriented and health system subjects. Activities include discussion of residency training issues (e.g., duty hours, patient safety & care quality, community service) and input from a panel of resident physicians from our teaching hospital. Also, the six general competencies (patient care, medical knowledge, practice-based learning & improvement, interpersonal & communication skills, professionalism, systems-based practice) are introduced as a framework for students' further training in their chosen disciplines. The professionalism competency, in particular, is presented in an interactive format by two senior physicians who have previously dealt with medical staff issues & concerns within our teaching hospital.

Two additional ideas were put forward by the group, both regarding didactic experiences during the third year of medical school. It was proposed that each of the six core clerkships develop one lecture each on the meaning of professionalism within the context of their particular discipline. It was also suggested that we create a system of focus groups within the third year, whereby students would have a "safe haven" to discuss and reflect upon both positive and negative aspects of their clinical training experiences, with emphasis on issues related to ethical issues and professionalism.

We feel that our overall approach to the formal teaching of professionalism is consistent with recommendations found in the literature such as those offered by a fourth year medical student who stated that "while didactics are certainly an important part of the process, they alone are not sufficient...it was largely through observation, mentoring and role modeling that the concepts were finally solidified and internalized".<sup>20</sup> This raises the issue of the informal curriculum and its impact on student learning of professionalism. The literature is ripe with examples, both positive and negative, of the impact made on young physicians in training by older, more seasoned faculty members who set examples for them in the clinical setting. The opportunity to both experience and reflect upon these examples is of great importance to the learning of clinical medicine.<sup>21</sup> Yet, as one seasoned educator well states, "physicians-in-training are not exposed routinely to the knowledge, skills and attitudes necessary for the practice of self-reflection nor does medical training provide them with the structural opportunities to do so".<sup>22</sup> We are continuing to explore ways to impact the informal curriculum, recognizing that this presents a far greater challenge.

It was also recognized that students and residents learn a great deal about professionalism by spending time outside the walls of the academic medical center itself. Opportunities to experience rotations in underserved

communities, in other countries or in one's own community with private practitioners afford the learner greater insight into what it means to be a medical professional in various contexts. Our curriculum currently provides this opportunity, and our institutional culture reinforces it by encouraging students and residents to volunteer their time to local causes such as free clinics and fund raising activities for health-related research. These learning experiences, some within and some outside the formal curriculum, are valuable and reinforce the unique obligations associated with the profession of medicine.

In summary, our group reviewed our current teaching on professionalism and made recommendations to further emphasize formal teaching during all four years of the medical student curriculum. Less obvious was how to significantly impact informal teaching/role modeling during the clinical years. And, we also felt that addressing the teaching of professionalism to residents would be challenging, due primarily to the de-centralized nature of residency training and the need to structure educational activities around discipline-specific requirements.

### ***How Should Medical Student Learning and/or Students' Professionalism Be Assessed?***

The formal assessment of professionalism is a relatively new idea. Medical student education is often very grade-oriented, and this fact can contribute to a very competitive learning environment for students. In spite of previous factors mentioned that are "driving" the current emphasis on professionalism, most medical schools have hesitated to embark on a formal system of assessing student professionalism, either because of lack of resources or for fear of litigation in the event of dismissals on the basis of non-professional behaviors. A key concern only now beginning to be reflected in the literature regards how data gathered about student learning of professionalism should be summarized, for example in the Medical Student Performance Evaluation or "Dean's letter". Related to this issue, one must also determine what types of data concerning the professional behaviors of students will be collected; who should have access to those data; and how the data should or should not be used.

Our task force review found that there was little formal assessment of student professionalism in our medical school curriculum. A single core clerkship in year three included a professionalism item on the form used by faculty to rate overall student clerkship performance; few if any comments are received from faculty in this regard. It would appear that, when a given student is having issues with professionalism, it must rise to an extremely high level of concern before any formal review takes place; emphasis is upon handling issues of this nature more informally wherever possible, or ignoring them altogether. It is therefore possible that many incidents of unprofessional behavior go unreported in our school. This approach could have resulted in the graduation of some students (likely a

very small number) despite faculty concerns about these students' professionalism. At the time of our review, there was no real mechanism in place to allow for systematic formal assessment of students in this regard.

With the advent of the six competencies of graduate medical education (i.e., patient care, medical knowledge, practice-based learning & improvement, interpersonal & communication skills, professionalism, systems-based practice), it is likely that more assessment effort regarding professionalism has begun within the GME realm than in the medical school curriculum. Residency directors are now required to assess the professionalism of their trainees in some manner. Our institution is participating in a national pilot project conducted by the National Board of Medical Examiners wherein a new instrument for assessing resident professionalism in selected disciplines is being field tested. However, GME educators in our group stated that no uniform efforts were present within our institution's residency training programs to assess professionalism; efforts being made were very program-specific. Our task force was challenged to consider whether to recommend an institution-wide system of assessing the professionalism of our learners.

A variety of assessment methods are represented in the medical education literature, depending on which particular aspects of professionalism one might wish to assess. The task force examined several descriptive articles on this issue, including two literature review articles<sup>23-24</sup> and several recent descriptive and research-oriented articles.<sup>7-8, 25-28</sup> A proposed ratings instrument for pilot testing was created based on our definition of professionalism (previously described) and on our review of the literature. The instrument consists of eight items and uses a three point rating scale (3=no issues whatsoever; 2=some concern about this issue; 1=definitely a problem area). A suggestion to add a 4<sup>th</sup> rating scale point reflecting high achievement in a particular realm was not supported by the group as a whole. Further, the task force recommended that an online assessment system be developed to implement the data collection process.

The task force extensively discussed when to collect data. Some schools collect data on student professionalism only in very narrow, well-described "incident only" circumstances, i.e., when there is a noticeable lapse in professional behavior. Other schools work more proactively to assess student professionalism "across the board". Our task force favored the latter approach; but recognized that doing so would create significant challenges in terms of data collection and analysis. It was ultimately recommended that all students be assessed during all required courses/clerkships in all four curricular years via a secure, online data collection system. In particular, the need to base ratings of professionalism during the clinical years and within residency training on direct observation of clinical performance was felt to be of critical importance to the data collection procedures established.<sup>29</sup>

By using a carefully designed computerized system, it was felt that the burden on course directors and other faculty would be minimized to some extent. And, after establishing baseline use of the instrument, it may be possible to scale back data collection efforts to a less frequent schedule based on the results of data analyses.

Two other issues were discussed related to assessment. One, it was strongly recommended that the same ratings instrument be used across all courses within the medical school curriculum; and across GME training programs in our medical center, an idea that has been previously endorsed by at least one national medical education group.<sup>30</sup> It was hoped that this common assessment platform would facilitate the development of a reliable measurement, and enable efficient "tracking" of individual students over time. Two, it was recommended that a parallel system of peer ratings be implemented at some future point, whereby medical students and residents would be asked to provide peer review of the professionalism of their colleagues in training. The medical education literature indicates that peer review is effective in determining where professionalism issues exist among trainees, and educationally desirable in that students as well as residents will be subject to peer ratings throughout the course of their careers and should be prepared for these experiences.<sup>31-32</sup> Peer-review of professional behavior within some type of small group setting is one method which we will likely pursue in the future.

Another important issue centers on how to use the data collected as a result of this new assessment program. The task force spent a considerable amount of time on this issue. Key conclusions of this discussion were:

- Medical students who are strong academically but who exhibit profound difficulties with professional behavior should not be allowed to graduate from our school.
- Students who are identified early as having difficulties with professionalism should receive the opportunity to learn from their mistakes via mentoring, counseling or other forms of assistance, so that they may proceed through the curriculum.
- Decisions made about individual student professionalism and whether difficulties would prevent graduation should be based on a pattern of behavior observed over time (rather than on a single incident, unless egregious). Some schools have undertaken a "three strikes and out" policy. Our group supported this approach as consistent with the need to teach professionalism, remediate students who experience difficulty and prevent graduation only in a small number of cases where such issues cannot be resolved in spite of the best faith efforts of all involved.
- Systematic monitoring of the assessment program and review of resulting data should take place through the auspices of a "Professionalism Committee" appointed by the Dean. This Committee would be charged with a variety of educational tasks related to professionalism, including its primary duty of reviewing assessment data

concerning student professionalism and making recommendations to the appropriate administrative Review & Promotion Committees. There are several existing models of this approach that our group reviewed during its deliberations, and the experiences of other schools should prove valuable as part of our development of this program. Graduate students, medical students and residents should be represented on the Professionalism Committee and student input is considered vital to its success.

### ***The Broad Application of Professionalism to Academic Health Centers***

A final issue concerned the implications of a renewed emphasis on professionalism for our academic medical center as a whole. Our group felt that the overall teaching environment at our institution could benefit from the positive cultural change that could take place as a result of our recommendations to implement further teaching and assessment of professionalism in medicine. In order for a high degree of professionalism to be maintained, it was felt that we needed an institution-level emphasis whereby all affected constituents would be included in learning about this topic and participating in assessment procedures appropriate to their specific work contexts. This approach would result in learning and employment environments where high levels of professionalism are taught, role modeled, assessed and generally valued at all levels (i.e., not just by trainees but also by faculty, staff and administration). Related to this more broad application of professionalism to the institution, we felt strongly that there was a need for targeted staff and faculty development on this issue for such culture change to occur. Instituting a formal assessment program whereby medical students and residents are systematically reviewed concerning their levels of professionalism was felt to be a necessary, but not sufficient, component of culture change. Discussion was held concerning:

- Whether the existing course and/or faculty evaluation systems (i.e., student ratings of instruction) should be modified to allow students opportunities to provide feedback on professionalism-related items. We determined that such activity was happening during some courses/clerkships but not consistently across the medical student curriculum or residency programs. It was recommended that a more standardized approach be implemented in this regard.
- Whether faculty should be formally reviewed on “citizenship” or similar concerns related to professionalism at the time of the annual performance review by the Department Chair. We ultimately recommended that this activity be instituted, ensuring that such efforts would coincide with ongoing efforts by other groups within our medical center (e.g., Dean’s Executive Council, Vice Chairs of Diversity, PCMH Committee on Physician Health).
- Whether resident physicians and/or fellows should also be rated by medical students on their overall teaching

activities and, specifically, on professionalism-related items. Since approximately 50% of all teaching of medical students is performed by residents (according to our AAMC annual graduation survey), we felt that gathering this feedback would likely prove useful.

The task force recommended that these actions take place, while recognizing that policy changes would be required to accomplish these goals.

What are the implications of emphasis on professionalism for academic medical centers and medicine as a whole? While beyond the scope of our group’s charge, we wish to make a few informed observations. First, there is evidence that both physicians and the general public value the ongoing professional involvement by physicians in social advocacy roles (e.g., community health, patient advocacy, health literacy, health system reform, political involvement, public safety).<sup>6, 33</sup> Second, it seems apparent that the connection between professionalism and such topics as patient safety, quality of care and the so-called “problem doctors” phenomenon is a matter of wide scrutiny and therefore critically important at this time in the history of medicine. If physicians are to be afforded the continued opportunity for self-regulation, the medical profession must assume leadership roles and act quickly to address health care quality, patient safety and physician performance issues.<sup>34-35</sup> Third, our rhetoric on this issue must be equaled by our willingness to act constructively to bring about organizational change where needed. As an example, we should consider efforts made as part of an appreciative inquiry-based program at the University of Indiana School of Medicine, whereby a deliberate and sustained campaign of positive culture change based on concepts of professionalism have been ongoing for several years.<sup>36</sup> Our school recently participated in a development conference offered by faculty and staff at IUSOM, and returned enriched for the experience of learning more about this campaign. Fourth, it is apparent that professionalism has achieved increased importance in continuing medical education and in the process applied to the credentialing and re-credentialing of physicians to the medical staff of hospitals. For example, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has revised its policies and procedures to reflect a new emphasis on the evaluation of physician practice behaviors (including professionalism) as a required part of credentialing procedures.<sup>37</sup> In our view, this trend will continue to receive the detailed attention of a wide variety of accrediting and physician licensing organizations within our state,<sup>38</sup> and within the health care system as a whole.

Subsequent to our own task force work on the issue of professionalism, our institution has undergone significant leadership changes and other organizational issues that have further demonstrated (at least to us) the need for vigilance concerning the powerful effect of what the LCME labels as “the learning environment” on all who work and train here. A recent report from a different ad hoc committee which analyzed our organizational culture resulted in strikingly

similar findings to that of our professionalism task force, and we are presently exploring ways to implement many of the recommendations of both groups.

## CONCLUSIONS

“The third year of medical school has been the most degrading experience of my life. I can certainly see why some physicians are unhappy and bitter individuals, with the beginning of this frustration starting in medical school”.

*Third year medical student, Class of 2002, anonymous medical school, USA*

The current emphasis on professionalism in medicine and medical training is likely to continue. Our school is fortunate to have had an opportunity to explore this topic in some depth through the work of an appointed task force. By considering the definition of professionalism, how it may best be taught and assessed and the broader implications of professionalism for academic medical centers, perhaps the time may come when we no longer hear of observations like the one made by a graduating medical student above. Our duty as medical professionals demands that we work toward such a time.

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